Knable testimony SB707 and HB 1014 pdf.pdf
Uploaded by: Ashlee Reyes
Position: FAV

ClearView
COMMUNITIES

February 18, 2026

RE: Testimony regarding Maryland SB 707 and HB 1014

Position: Support

To Whom it May Concern:

I have been a psychiatrist for 36 years, and my career has been focused on care for people with severe mental illnesses such as schizophrenia and bipolar disorder. I am currently the medical director of a long-term residential rehabilitation program for young adults with severe mental illnesses.

SB707 and HB 1014 make needed clarifications to Maryland's standard for emergency evaluation and involuntary psychiatric hospitalization – clarifications that will allow individuals with severe mental illnesses to receive treatment before they reach a point of crisis or tragedy.

Right now, the requirement that a person be "a danger to the life or safety of the individual or others" is often interpreted so narrowly that families and clinicians cannot act until harm is imminent. For people who lack awareness of their illness, this delay can lead to homelessness, victimization, incarceration, or irreversible deterioration.

These bills clarify that:

- Danger does not need to be imminent
- Personal and medical history should be considered
- "Danger to self" includes inability to meet basic needs or substantial deterioration in judgment when the person cannot make an informed decision about treatment

These changes do not expand who can be hospitalized - they simply ensure that the existing standard is applied consistently and humanely. They allow intervention at the point when treatment can still prevent suffering, protect safety and preserve lives.

Sincerely,

611 W. Patrick Street, Frederick, MD 21701
Main Phone (240) 439-4900 Fax (301) 378-0113

Michael B. Knable, DO
Medical Director

611 W. Patrick Street, Frederick, MD 21701
Main Phone (240) 439-4900 Fax (301) 378-0113

L. Shears Testimony.pdf
Uploaded by: Ashlee Reyes
Position: FAV

Dear Honorable Members of the Maryland General Assembly,

I am writing in strong support of SB707 and HB1014, legislation that aims to enable treatment before tragedy for individuals living with Severe Mental Illness (SMI) who lack awareness of their condition and their need for care.

My name is Laura Shears-Coates. I am a Certified Rehabilitation Practitioner (CRFP) through the Psychiatric Rehabilitation Association (PRA), hold a Master's degree in Social Work, and have worked in the behavioral health field for over 20 years. I am also the owner of Takes a Village For Change, LLC, a Maryland-based outpatient mental health clinic that works daily with individuals suffering from SMI. Throughout my career, I have served some of our state's most vulnerable residents (individuals whose illnesses impair their insight, judgment, and ability to make life-sustaining decisions).

In my professional experience, one of the most heartbreaking realities we face is the limitation of our current system: we often must wait until someone presents an imminent danger to themselves or others before meaningful intervention can occur. By that point, significant damage (medical, psychological, social) and sometimes irreversible has already been done. Repeated hospital admissions become reactive measures rather than preventative care. This is not a system designed for early intervention; it is a system that too often responds only after crisis has escalated beyond control.

I also write to you from a deeply personal place.

In July 2023, my younger brother, Joshua D. Carey, passed away at the age of 31 due to the effects of a severe mental health illness that prevented him from recognizing his need for treatment and medication compliance. His illness robbed him of insight. Although our family could see his symptoms worsening, he did not meet the threshold of imminent danger required for intervention. We were forced to stand by and watch as his mental and medical conditions declined. Hospitalizations occurred only after life-threatening emergencies arose. Each time, he was stabilized and released, without the sustained support he so desperately needed.Ultimately, his body gave out. He passed away because he was unable, due to his illness, to consistently take medications that would have sustained his life.

Today, I speak to you not only as a clinician and business owner, but as a grieving sister and now an only child who lives each day with the pain of knowing that earlier intervention could have made the difference between life and death.

SB707 and HB1014 represent an opportunity to modernize our approach to severe mental illness by allowing intervention before tragedy strikes. These bills would:

• Enable earlier, structured treatment for individuals whose illness impairs insight and decision-making
• Reduce repeated crisis-driven hospitalizations
• Support families who are currently powerless to intervene
• Protect first responders who are too often placed in dangerous, last-minute crisis situations
• Most importantly, save lives

This decision carries a profound weight. It has the power to preserve life, or, if we fail to act, to allow preventable deaths to continue.

I humbly ask you to consider my brother, Joshua D. Carey, and the many Marylanders like him who cannot recognize their own need for care because of the very illness that threatens their survival. Please give families and providers the tools to intervene before imminent danger becomes the standard for action.

No family should have to endure the pain we continue to carry.

Thank you for your time, leadership, and commitment to the health and safety of our communities.

Respectfully,

Laura Shears-Coates, MSW, CRFP

Owner, Takes a Village For Change, LLC

Grieving sister of Joshua D. Carey

M. Go Testimony.pdf
Uploaded by: Ashlee Reyes
Position: FAV

SB 707 & HB 1014

Margaret Go

Position: Support

My eldest son died by suicide at college after attempting suicide by accessing the roof of a building at his college and threatening to jump off head first. When he went to see a counselor the next day he said he had changed his mind and did not want to go to the hospital. He continued to struggle and the mother of the friend in whom he confided that he was still struggling with thoughts of suicide called the counseling office to tell them to do more for him. He was so clearly a danger to himself and to others, as he could have injured someone if he had jumped off the roof of their building. Because privacy laws are very strict in California, we were not called. He killed himself a few days later by accessing yet another of the college building's rooftops. Older trained psychiatrist medical doctors have told me that before strict privacy laws and higher standards for involuntary commitment, patients were given more time to become stabilized, diagnosed, and given preliminary treatment to observe the efficacy of medication or talking therapies while they were hospitalized. This takes time and can be done in a humane way, without excessive restraint or any at all.

SB 707 and HB 1014 make needed clarifications to Maryland's standard for emergency evaluation and involuntary psychiatric hospitalization— clarifications that will allow individuals with severe mental illness to receive treatment before they reach a point of crisis or tragedy.

Right now, the requirement that a person be "a danger to the life or safety of the individual or others" is often interpreted so narrowly that families and clinicians cannot act until harm is imminent. For people who lack awareness of their illness, this delay can lead to homelessness, victimization, incarceration, irreversible deterioration, or death.

These bills clarify that:

Danger does not need to be imminent.

Personal and medical history should be considered.

“Danger to self” includes inability to meet basic needs or substantial deterioration in judgment when the person cannot make an informed decision about treatment.

These changes do not expand who can be hospitalized—the y simply ensure that the existing standard is applied consistently and humanely. They allow intervention at the point when treatment can still prevent suffering, protect safety, and preserve lives.

I beg you to usher in a new era of more enlightened and effective standards to help the many people who suffer from mental illness, who are not receiving the humane care they need, and whose families suffer terribly trying to help their loved one receive the care they need when the patient suffers from anosognosia and refuses treatment.

Thank you,

Margaret Go

8912 Brierly Road

Chevy Chase, Maryland 20815

R. Dima Testimony.pdf
Uploaded by: Ashlee Reyes
Position: FAV

SB 707 & HB 1014

Position: Support

Rania Dima

9433 Carriage Hill Street

Frederick, Maryland 21704

Dear Madam Chair and Members of the Committee,

Disability justice for the severely mentally ill will only come when we start addressing chronic brain diseases as the biological disability they are, and when we recognize that denying access to timely medical intervention is not only discrimination, but systemic oppression. I am deaf-blind. I cannot read a sheet of paper to save my life. I can't; my eyes are broken. My son has a psychotic brain disease. He cannot see that he has a severe mental illness to save his life. He can't; his brain is broken. Without my hearing aids, I cannot understand the voices around me. Without medication, my son cannot understand that the voices in his head are a symptom of his disease, and the longer he stays in psychosis without treatment, the more damage occurs to his brain and the less likely he is to recover.

For the past four years, I have tried to get medical intervention for my son, only to watch him get caught up in the criminal justice system and slip away to his disease. When he fell into crisis, instead of help, a SWAT team busted down his door, pepper bombed his condo and dragged him to the hospital. Instead of keeping him, the hospital released him after the mandatory hold despite telling us that they had plenty of evidence to admit him. Because my son was still in psychosis, the Sheriff's office took him to jail where he sat for the next 470 days to await his trial, even though he had no prior criminal record. He sat there without treatment, with his brain still on fire. As a result, he refused the state's offer of Not Criminally Responsible, believing it to be a trap set by the conspiracy, accrued additional charges, spent a month in solitary confinement, and came out of jail still very sick and blaming me for putting him there. The judge's solution was to order him to have no contact with me or my husband, the two people in the world who are supposed to be there for him the most. He can't even contact his younger sisters, who are growing up without him. Now,

we are stuck waiting for the next crisis to unfold with our hands tied. And all the while, my son has never received the treatment he so desperately needs.

As a broken-hearted mother, as a disabled person, I ask that we address severe mental illness as the biological disability it is and fix the system where we can. Every disability deserves accommodations and timely medical intervention. SB 707 and HB 1014 make needed clarifications to Maryland's standard for emergency evaluation and involuntary psychiatric hospitalization—clarifications that will allow individuals with severe mental illness to receive treatment before they reach a point of crisis or tragedy.

Right now, the requirement that a person be "a danger to the life or safety of the individual or others" is often interpreted so narrowly that families and clinicians cannot act until harm is imminent. For people who lack awareness of their illness, this delay can lead to homelessness, victimization, incarceration, or irreversible deterioration.

These bills clarify that:

- Danger does not need to be imminent.
- Personal and medical history should be considered.
- "Danger to self" includes inability to meet basic needs or substantial deterioration in judgment when the person cannot make an informed decision about treatment.

These changes do not expand who can be hospitalized—they simply ensure that the existing standard is applied consistently and humanely. They allow intervention at the point when treatment can still prevent suffering, protect safety, and preserve lives.

Thank you,

Rania Dima

Speaks Written Testimony in Support of SB 707 and
Uploaded by: Ashlee Reyes
Position: FAV

Written Testimony in Support of SB 707 and HB 1014

Date: February 19, 2026

Submitted by: Andrea Warren Speaks & Douglas Speaks, Sr.
Position: Support

Chair and Members of the Committee:

We are writing in strong support of SB 707 and HB 1014. We are Maryland residents and parents of an adult son living with severe mental illness. Our family has experienced firsthand the devastating gap in our current law — a gap that delays treatment until a situation becomes dangerous or tragic.

Our son, who is a college graduate with a degree in computer science began experiencing symptoms of severe mental illness in 2020 during the COVID-19 Pandemic when he had to finish his senior year remotely. As his condition progressed, he lost awareness of his illness and continues to refuse treatment. His judgment and reasoning has deteriorated significantly. He became unable to make rational, informed decisions about his care, even as his condition has worsened. He has not worked since 2020 and is unable to care for himself.

As his parents, we have done everything we know that is possible to support our son, but still the law is not on our family's side. We have participated in support groups with the National Alliance for Mental Health (NAMI) of Montgomery County, called the Montgomery County Crisis Center to respond to crises at our home, called the Montgomery County Policy over 27 times to our home for acts of violence and aggression, contacted the Montgomery County Council for resources, consulted with Maryland Legal Aid, and have petitioned the court several times for an emergency evaluation.

Our son has been hospitalized several times at Pratt Hospital, Holy Cross Hospital, and Sibly Hospital, only to be repeatedly discharged because of his refusal for treatment. His most serious hospitalization was due to a suicide attempt where he spent several days in ICU at Holy Cross Hosptal.

Written Testimony in Support of SB 707 and HB 1014

Currently, we have a guardianship case that is stalled in court due to hospital physicians' unwillingness to complete the physician certificate required for a guardianship case. Recently, we learned of the passing of HB 0576 - Maryland

Assisted Outpatient Treatment and have filed a petition for this treatment for our son. However, we have been told by the court that we have to wait until July 1, 2026. In addition, people in authority seemed to know very little about this new law which leaves citizens like myself lacking knowledge how to proceed.

Under current Maryland law, intervention has been nearly impossible unless there was imminent danger. Yet anyone who has lived through this knows that deterioration does not always look like an immediate act of violence. Instead, it can look like:

- Gradual loss of self-care
- Inability to maintain employment
- Severe decline in reasoning and judgment
- Paranoia and distorted thinking
- Refusal of necessary medical treatment

By the time the legal threshold for intervention is met, families are often facing crisis, homelessness, incarceration, or irreversible harm.

SB 707 and HB 1014 offer a compassionate and practical solution. These bills recognize that:

- "Danger to self or others" may be a substantial risk — not only imminent harm.
- A person's medical and personal history should be considered.
- Inability to provide for basic needs is a form of danger.
- Significant deterioration in judgment and reasoning can prevent someone from making informed decisions about life-saving treatment.

These clarifications do not criminalize mental illness. They prevent tragedy.

Families like mine are forced to watch our loved ones decline, knowing they need treatment but lacking the legal ability to help. We are told to "wait until

Written Testimony in Support of SB 707 and HB 1014

something happens." That is not a compassionate policy. That is reactive policy.

Treatment before tragedy is not punishment — it is protection.

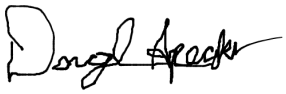
Our son is not a statistic. He is a human being with dignity, intelligence, and potential. But severe mental illness can rob individuals of insight into their own condition. When that happens, families and clinicians need tools to intervene before harm occurs.

These bills strike a careful balance between civil liberties and public safety. They acknowledge that untreated severe mental illness can impair judgment so profoundly that an individual cannot act in their own best interest.

We urge this committee to support SB 707 and HB 1014 so that families like mine do not have to wait for irreversible harm before help becomes available.

Thank you for your time and consideration.

Respectfully,



Andrea Warren Speaks
9 Eastmoor Drive
Silver Spring, MD
240-750-4333

Douglas A. Speaks, Sr
9 Eastmoor Drive
Silver Spring, MD
240-687-0969

BYeiser Testimony SB707-word FINAL.pdf
Uploaded by: Bethany Yeiser
Position: FAV

SB707 Testimony, Finance Committee

From: ***Bethany Yeiser, B.S.,*** President, The CURESZ Foundation , Phone: 513.515.5950
Email: bethany.yeiser@curesz.org, Website: www.curesz.org

Feb 24, 2026

Position: FAVORABLE

Before I became homeless, I had been an honors student studying biochemistry and molecular biology at the University of Southern California on scholarship. I was competitive, scoring great grades, doing research and dreaming of obtaining an MD or PhD to cure cancer. But in 2002, just months before I was scheduled to finish my bachelor's degree, schizophrenia showed up like thief, interrupting and taking away my promising young life and future plans.

Rather than graduating from college and pursuing further education**, I found myself homeless in the Los Angeles area, eating food that was discarded in garbage cans and eventually sleeping outside every night in a churchyard near USC.**

During my senior year of college, my best efforts had produced failing grades in subjects that used to be easy for me. But I told myself I was not trying. I told myself I could work if I wanted to. The reality was that my shattered mind left me totally disabled, and I was not capable of working any job.

After three years of looking for garbage to eat on USC's campus**, I was briefly incarcerated for trespassing** on my beloved campus where I had once been the honor student.

On March 3, 2007, several months after my incarceration, I woke up in the churchyard screaming back at the voices in my mind, which were the most tortuous thing I have ever encountered in my life. When I least expected it, a police officer approached me and handcuffed me. He told me I was being taken to a psychiatric ward for observation.

The resulting involuntary hospitalization, which I never would have consented to, radically changed my life. I hated being hospitalized. I thought nothing was wrong with me, unaware that my experience hearing voices was psychosis. I wanted to return to my dirty, homeless life outside on the streets of LA. I thought that was my right.

But instead, I was mandated to begin antipsychotic medication. In treatment, I no longer wanted to be homeless. **With treatment, I was able to return to school, and finally finished my molecular biology degree with high honor.**

Today I live in my own apartment and work as President of the CURESZ Foundation (Comprehensive Understanding via Research and Education into SchiZophrenia). All of these wonderful developments in my life have been possible because I was hospitalized against my will.

Today I ask the question "Why"? **Why was I left to rot away on the streets of Los Angeles, eating garbage and getting soaked at night when it rained, over 13 months?** My parents would have done anything to help but I was too paranoid of them to accept their help.

Why didn't my parents and the police have the right to petition for an involuntary evaluation for hospitalization when I clearly had a mental illness and was unable to care for myself, and why didn't this happen before I broke the law?

Many people throughout the United States are in the same position I was. They are desperately ill, however, they are not an imminent danger to themself or others. They are in desperate need of medication, but too sick to understand they need treatment**. Involuntary hospitalization is often the only hope, as it was for me.**

Again, I ask, why was I not committed to a hospital sooner?

We must do better for our homeless people who are too ill to ask for help.

And we must do better for those living in their parents' home who badly need treatment, but are not yet an imminent danger to self or others. Many moms and dads must wait as their loved one becomes sicker and sicker until they qualify for involuntary intervention. This would never happen in other brain disorders such as Alzheimer's Disease or Parkinson's disease.

SB707 C.Snyder-Testimony (1).pdf
Uploaded by: CHERIE SNYDER
Position: FAV

Testimony for SB707
February 24, 2026; House Health Committee
From: Cherie L. Snyder, 87 S. Broadway, Frostburg, MD 21532 (Allegany County)
Position: Support

For over 20 years I have unsuccessfully sought help for my 42-year-old son Bryan who is severely mentally ill with schizophrenia and anosognosia (neurological condition which precludes him from understanding that he is ill and needs treatment).

Because of the current "danger to self or others" definition, only twice when there was a crisis have I been able to get Bryan admitted to our community hospital inpatient psychiatric unit. And then only, 1) with the help of skilled, mental health-trained police officers and, 2) at my insistence that he be admitted when emergency room staff wanted to discharge Bryan to the community.

Despite caring post-hospitalization community supports that have tried to help him after his 5-6 day stays in the psychiatric unit, Bryan has needed much more intensive, long-term care. This has been denied to him due to his behaviors not presenting as "a danger to the life or safety of the individual or others." As a result, he has continued to live in his own private hell – delusional, paranoid, angry and isolated. His home is filthy, mice invested, and filled with trash. He only eats food from cans delivered by Amazon plus a few weekly deliveries of hot food from a local pizza shop. He let no one in this trash filled house for over 3 years. This deteriorated state was not considered sufficient for him to be in "danger".

That is until August 2025 when a police officer saw him removing a sign from a fence at 2 AM and stopped to check on what he was doing. Although Bryan has never been violent in his 20 years of isolation with no consistent treatment for psychotic and paranoid delusions, **he became afraid and said he would go in his house and get a knife – which he did.** Fortunately, Bryan did not attempt to stab him. And fortunately for Bryan, the officer did not shoot him in self-defense.

Murder or death or other physical harm could have easily been the outcome. Instead, the result was that Bryan was charged with multiple felonies and taken to the Allegany County Detention Center. There he was eventually evaluated and found incompetent to stand trial. Three and a half months later he finally was assigned to treatment at Finan State Hospital – getting treatment he has needed for so many years as he struggled with severe psychosis, paranoia, and anosognosia.

Our family was relieved! Nothing else has gotten Bryan the care he needs. It took committing a crime that could have resulted in death or injury to either the officer or Bryan to finally get him help.

If HB1014 is passed, people like Bryan will not need to threaten others and have criminal charges in order to get treatment. They can receive help BEFORE they are so severely debilitated and BEFORE there is a serious crisis with criminal charges, personal harm, or death. And taxpayers will not have to cover the costs of public defenders, judges, Detention Centers – not to mention jail terms and trials, wounded or dead police officers and traumatized community members.

Illness must be treated, not punished. Access to emergency evaluation and involuntary

psychiatric hospitalization for those who are so ill that they cannot seek the help they need is humane and just.

PS: Bryan is making significant progress at Finan State Hospital – and he is aware of that progress!

Right to Treatment SB707 FAV Written Testimony She

Uploaded by: Damian Lang

Position: FAV

Sheppard Pratt

Written Testimony

Senate Bill 707 – Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)

Senate Finance Committee

February 24, 2026

Thank you for the opportunity to submit testimony in support of Senate Bill 707, which updates and clarifies the statutory definition of "danger to the life or safety of the individual or of others" for purposes of emergency evaluations and involuntary admissions under Maryland mental health law.

As the nation's largest private, nonprofit behavioral health provider, and a statewide safety-net system serving more than 80,000 people annually, Sheppard Pratt supports SB 707 because it strengthens patient safety, improves clinical decision-making, and ensures individuals experiencing serious psychiatric crises can access timely, appropriate treatment.

SB 707 Modernizes Maryland's Outdated Standard

Current Maryland law relies heavily on an "imminent danger" threshold that is clinically outdated and often unworkable in real-world emergencies.

SB 707 replaces that narrow standard with a more clinically accurate framework that evaluates:

- Substantial risk, whether or not imminent;
- The individual's current condition; and
- Available medical, psychiatric, and personal history.

This updates Maryland law to reflect contemporary evidence-based psychiatric practice and aligns with the approach used by many other states.

Provides Clear, Objective Criteria for Clinicians & Law Enforcement

SB 707 enumerates specific indicators of danger, including when a person:

- Is at substantial risk of harming themselves or others;
- Is engaging in behavior likely to result in criminal justice involvement directly related to their mental disorder;
- Cannot meet basic needs such as food, clothing, shelter, self-protection, or safety, creating a substantial risk of serious harm or death; or
- Is experiencing a significant deterioration in judgment or behavioral control that is likely to result in one of the above outcomes.

These criteria help clinicians make consistent, defensible, trauma-informed, and safety-oriented decisions, reducing unnecessary subjectivity and improving statewide uniformity.

Reduces Emergency Department Boarding & Preventable Crises

Maryland's overly narrow "imminence" standard often results in:

- Delayed treatment;
- Emergency room overcrowding and prolonged psychiatric boarding;
- Increased risk of self-harm, exploitation, or victimization; and
- Increased likelihood of police involvement or incarceration.

Clarifying the standard helps ensure individuals receive treatment, not criminalization, when their symptoms escalate.

Promotes Early, Stabilizing Intervention

Psychiatric crises often escalate rapidly. Early identification of substantial risk:

- Prevents tragedy;
- Reduces involuntary inpatient admissions by intervening earlier;
- Supports the health-care system's ability to manage caseloads; and
- Improves outcomes for individuals, families, and communities.

SB 707 is particularly vital given Maryland's ongoing pediatric and adult behavioral health boarding crises and the growing intensity of psychiatric emergencies statewide.

For these reasons, Sheppard Pratt respectfully urges a favorable report on Senate Bill 707.

Thank you for your consideration.

SB707DrCharlesRichardson_FAV
Uploaded by: Dr. Charles Richardson
Position: FAV

Testimony for the February 24, 2026 meeting of the Senate Finance Committee
Topic: SB 707 Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)
By: Charles Richardson, MD (Address: 7662 Sweet Hours Way; Columbia, MD 21046, District 13)

My support for Senate Bill 707 comes from my prior work as a psychiatrist at Spring Grove Hospital for over thirty years. When I started in 1989, criminally-involved patients were in the minority. Now, although the patients are no more violent, virtually 100% of newly admitted patients carry criminal charges, too often for non-violent crimes. Sadly, patients' charges significantly increase their hospital stay, longer than clinically justified, and often longer than they would have served in jail if found guilty. These lengthy admissions have also made the mental health system less efficient. Compared to years past, the hospital now serves fewer patients per bed per year. Most importantly, with respect to this legislation, criminal charges of the mentally impaired, could often be prevented if a patient whose psychotic illness was clearly out of control, had been civilly certified for treatment before their increasingly erratic behavior became criminal in nature. In my view, Maryland's overly restrictive definition of "dangerousness," has made it easier for authorities to deal with a psychotic patient's disruptive behavior by jailing them for a crime rather than hospitalizing them for treatment.

Broadening the dangerousness criteria could diminish an individual's presumed right to not be hospitalized against their will. But there are safeguards to the civil commitment process, including a hearing before an Administrative Law Judge, the right to appeal, and time limits on the judgment. Once clinically stable, the civilly committed patient can be discharged without judicial review. Ironically, a patient who is protected from civil commitment because he is not judged to be "imminently," or "right now" dangerous," which is how the standard is currently interpreted, risks far greater loss of liberty if arrested on even minor charges. And tragically, it is often the ill patient's family members who are put at risk of violence if the danger becomes "imminent," in this restrictive sense. For the patient, delayed treatment worsens long term prognosis in terms of functioning, and treatment responsiveness. Persistent illness can also destroy a person's life, in terms of lost jobs, relationships, and previously accrued savings. A surgeon does not wait for an inflamed appendix to burst before operating. Delaying treatment until danger is imminent is waiting too long, both for the patient, and for the community.

Recognizing signs of mental impairment is not hard. Judging whether a person's behavior poses a risk of harm is far more complicated. That would depend on the nature of the person's thoughts. Do they believe they are being followed by enemies. Do they feel that strangers intend to attack them. Are their hallucinated voices warning them of danger from their previously trusted family. Are they able to control their behavior while experiencing extreme emotional fluctuations. Are they able to plan for their welfare. These questions require the careful, tactful, and knowledgeable interviewing of a trained clinician. The police, who have the necessary but unenviable task of intervening with mentally impaired individuals, do not have the expertise to decide whether or not someone could be a danger. Deciding that a person is not certifiable based only on the absence of immediately observed dangerous behavior and the person's denial of suicidal thoughts is just not valid. Psychiatrists don't presume to be able to precisely predict who will become violent, but we are trained to elicit the information needed to predict potential for harm. And ultimately, it is the Administrative Law Judge who decides whether the patient meets the criteria for involuntary admission.

Senate Bill 707, by specifying that “imminent danger” is not required for involuntary treatment, could reduce the number of patients who are burdened by criminal charges, while also reducing the risks inherent in delayed treatment. It would also acknowledge the complexity and importance of a careful consideration of an individual’s potential for harm beyond what is immediately observable.

I respectfully request that the committee approve SB 707.

Thank you.
Charles Richardson, MD

SB707_Ireland_Support.docx.pdf
Uploaded by: Emilienne Ireland
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Emilienne Ireland, 5100 Wyoming Road, Bethesda, MD 20816; 301-801-5432 Ireland.emi@gmail.com
Position: Support

Our son Matthew was a high-functioning young man, with a job he loved, friends, a sweet girlfriend, an apartment, and a car. Yet, gradually, he lost each of these. Two years, ago, he needlessly died a horrible, painful death because of a suicide attempt caused by untreated schizophrenia. His parents repeatedly tried to get him the treatment he urgently needed. Unfortunately, in his delusional state, he did not realize he was ill, and so would not consent. . Maryland's Danger standard denied him that treatment because it was interpreted as requiring imminent danger for involuntary hospital treatment Our hands were tied.

As his untreated disease got worse, Matt's delusions became threatening. On one occasion, in an attempt to quiet the voices that tormented him, he smashed things in our house. He began to suspect that we, his parents, were actually extraterrestrial lizard creatures from another world. Matt told us our crimes would soon be exposed and we certainly would be executed. We petitioned the court to have him receive the treatment he obviously needed. Matt was taken to the hospital for evaluation, but refused all medication and was not considered an imminent danger so he was released. We were fortunate to find Dr. David Pickar, who had led schizophrenia research at NIMH for many years. He said that although Matt was suffering from schizophrenia, he would likely benefit greatly from treatment. On the spectrum of schizophrenia functioning, Matt was exceptional. Very articulate and able to interact pleasantly with others, able to conduct research, able to reason well and carry out plans. Much of his brain worked very well. But he needed treatment with antipsychotic medication in order to recover.

Matt moved to an apartment, but was evicted for starting a huge bonfire just outside the building. At the next apartment, Matthew was cited by a fire safety inspector for disabling the fire alarm and having an explosive substance illegally stored in his refrigerator. At the court hearing, Dr. Pickar testified that Matt needed treatment, and would get worse without it. However, Matt somehow pulled himself together and presented a calm, likeable young man to the presiding judge. Matt had researched the statutes, and he argued that the amount of explosive material in his apartment was just below the chargeable amount. The judge said he was quite impressed at Matt's argument. Then, with stupefying ignorance, and brushing aside the expert testimony of Dr. Pickar, the judge pronounced that "Matt has the right to remain psychotic if he so chooses." With those words, the door to recovery for Matt was slammed shut. The judge had decided that Matt did not pose an imminent danger to himself or others, despite clear evidence to the contrary from family and a highly qualified medical specialist. Tragically, the judge was proved wrong on both counts.

A few months later, during a visit to our home, Matt told us he was leaving for Colorado. We were surprised. He often ran out of food and we took him out to get groceries every week. "Sweetie, why are you going so far away? How will we visit you?" I asked. He turned away from my gaze and said softly, "It's for your own safety, mom." At that moment, our son, despite his psychotic state, saw and bravely acknowleged what the judge and Maryland laws had refused to see. I will always be grateful that he wanted to protect us. How I wish Maryland laws had protected him.

Within the year, I received a phone call that my son had died by suicide, having set fire to his camper van. It was the dry season in Colorado, and the extensive fire could easily have spread to neighboring homes and caused many deaths. In the explosion, Matt received severe burns over 96% of his body, but did not die immediately. When the police arrived, Matt told them, "I tried to kill myself and failed. Please shoot me." Instead, he was airlifted to the emergency burn unit in Aurora, Colorado. The doctors realized that he would not survive his horrific burns, and began to treat him for severe pain while they tried to contact next of kin. They intubated him to keep his airway open, or else the pain medication would not work. They also had to make at least a dozen long and deep incisions all over his body to prevent the massive swelling of the burned tissue from compressing his lungs and vascular system. After a few hours of fruitless efforts to find his family, they stopped trying to keep him alive, and allowed his suffering to end, at last.

Is this the "freedom" that Maryland law has in mind when deciding whether a floridly psychotic person may refuse treatment that both family and doctor are urgently requesting? It is cruel and barbaric to withhold treatment from a person who urgently needs it but cannot understand that they are ill. Schizophrenia strikes our young people in their prime of life. Have mercy on them, I beg of you.

SB707_Moran_FAV.docx.pdf
Uploaded by: Emilienne Ireland
Position: FAV

SB 707, Mental Health Law - Danger to the Life or Safety of the Individual or of Others -= Definition (Right to Treatment)
Senate Finance Committee
Date: February 24, 2026
From: Mary Ellen Moran, Bowie, MD 20716
Position: SUPPORT

As an individual with bipolar disorder and a son with schizophrenia, I am pleased to support SB 707. The current references to danger to the life or safety of the individual or of others are open to interpretation. The definition in SB 707 eliminates this uncertainty by including all aspects of danger to self or others. This Bill would ensure persons with serious mental illnesses would receive needed treatment when unable to make an informed decision to seek treatment.

When I become manic and then psychotic, my behavior is not threatening; it is dysfunctional and bizarre. I can't safely drive a car, prepare meals or take proper care of myself and my son, 63 years old, who lives with me as a result of his serious mental illness. Also, I cannot make a rational and informed decision on any matter including whether to seek treatment.

Once when visiting my sister in Virginia, I became irrational and acted weird. She called 911 and a crisis response team was sent. I don't recall much about the event but do remember that a police officer who was a member of te team talked me into gong to the hospital. According to my sister, it took hours.. She also told me that some members of the team were of color and that I used the "N" word. This is the only time in my life that I said the "N" word.

Upon arrival at the hospital I was vaguely aware of where I was and concerned they might not admit me. When the police officer removed the handcuffs I became violent and had to be restrained. I was in the hospital for five days, during which I received medication and other treatment, became stable and was discharged. I then was able to safely resume activities of daily living.

Based on the foregoing, I respectfully request that you give SB 707 a favorable report.

SB707 G.Beck-Testimony.pdf
Uploaded by: Gina Beck
Position: FAV

Testimony for SB 707
February 16, 2026; Senate Finance Committee
From: Gina Beck, Montgomery County

POSITION: SUPPORT

I am a 68-year-old resident of Montgomery County. **My son is 34 years old. He was diagnosed with Schizophrenia in 2016. As a 6'1'' 225 lb. black man with dreadlocks. He is immediately scary looking to some, and even more so if he is acting out due to his mental illness. Just "being" is a danger to his life.**

My son's story clearly illustrates the inadequacy of the current definition of danger, and the resulting extreme risk to the mentally ill person and others. He was unmedicated for 16 months, experiencing extreme psychiatric deterioration, delusions and paranoia.

His Group Home Director, with over 25 years of experience, contacted the Montgomery County Crisis center several times in hopes of getting him involuntarily admitted to a hospital psychiatric unit.

One call was when my son became very agitated because he was being denied cigarettes. At this point he had been hearing voices and experiencing delusions for several weeks. He cornered and pushed a staff member. The Montgomery County Crisis Center determined he did not meet the danger standard, so he remained in the home unmedicated.

On the next occasion he resisted staff efforts to get him to cooperate with house rules, like bathing and doing chores. He was agitated, ranting, making wild accusations, with absolutely no grasp on reality. He had not bathed in months and was eating only sporadically. He barricaded himself in his room with his mattress. Again, the Crisis Center was called. The Crisis team leader, after speaking briefly to him through his barricaded bedroom door, decided he did not meet the danger standard.

During the 16 months my son did not take medication the Crisis Center was called 4 times. Each time his behavior did meet the danger standard. A few weeks later my son attacked the Group Home Director knocking him down a flight of stairs. Police were called and finally my son was hospitalized in a psychiatric unit for a little over 30 days.

Even then if was a struggle. The hospital tried to release him a total of 4 times, the first was even before the hearing with a judge on the 8th day, who ordered that he be involuntarily admitted and medicated. The medication ordered by the judge did not begin until the 12th day of hospitalization, and on 13th day, the hospital tried to release him again. I had to argue with and threaten both the hospital and my insurance company with legal action every day to keep him hospitalized until we could secure a safe place for him to be released to. This took immense time and considerable money.

Psychosis is real and dangerous. Untreated it leads to psychiatric deterioration, personal neglect, and possible brain damage. People should not have to be attacked, and the ill person should not have to attempt suicide before they can be involuntarily admitted. We live in Maryland in the United States of America, not some third world country.

I understand that the laws currently in place are meant to protect human rights, but they are not protecting human beings!

An explicit danger standard definition would have prevented what happened to my son and to the wonderful Group Home Director who was doing everything he could to provide proper care.

I ask your support to implement a danger standard explicitly providing:

- The danger need *not* be imminent,
- Any available personal, medical and psychiatric history must be considered,
- Being unable to provide for basic needs (food, clothing, shelter, medical care, self-protection), or
- Suffering substantial deterioration of the individual's judgement, reasoning or ability to control behavior.

Respectfully and emphatically, Gina Beck
garnerflowers@gmail.com
301-518-2841

SB707 D.Herrmann-Testimony.pdf
Uploaded by: Janet Edelman
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Darrell E. Herrmann
Position: SUPPORT

I was diagnosed with schizophrenia in 1984 while serving as a Captain in the United States Army. After being medically retired, I went back to college and earned a BS in Computer Science. I worked very successfully as a computer programmer for 18 years until the stress of working while coping with my illness became too great and I went on disability. I have lived very successfully with schizophrenia for more than 40 years.

When psychotic you have hallucinations and delusions. Hallucinations are sensory experiences such as hearing voices which aren't really there. Hallucinations can affect any of the five senses and be any experience you can imagine having with those five senses. Delusions are fixed false beliefs which often seem illogical or nonsensical to those around you. They could be that you are president of the USA, or the Pope, or that an alien has replaced a family member and is out to harm you. There is no practical limit to what form a delusion can take, it just has to be something the person can conceive. These hallucinations and delusions feed on and reinforce each other. **To the person in psychosis, they are reality and no amount of persuasion or evidence can shake the person's belief that they are true**.

Once on antipsychotic medication, the person usually stops having new hallucinations and delusions. The person still remembers the hallucinations and delusions they had while psychotic. Because the person experienced them with their own senses they are usually viewed as factual. The result is the patient does not question their reality. **Until and unless the patient realizes some of their past experiences may not have been real, they don't have insight**. There are things that happened to me 40 years ago during my first psychosis that to this day I don't know for sure what was real and what was hallucination and delusion.

This inability to distinguish what was and was not real is very common and at the core of Anosognosia or lack of insight and is why it is so difficult to treat people with psychotic illnesses. Our mental health system has no good answer to this problem, and each person must realize on their own that memories may not have been real in order to take the first steps towards recovery. Some people never or only with great difficulty come to realize that they cannot trust that their experiences were real.

For these reasons, providing for treatment when someone is in the throes of psychosis and anosognosia is essential. It is important to codify the need-for-treatment standards of **substantial impairment in the individual's ability to make a rational and informed decision about treatment and/or the inability to care for oneself**. **I urge you to support SB707 for the benefit Maryland citizens**.

Darrell E. Herrmann
<deherrmann@aol.com>
Policy Director/Ohio
National Shattering Silence Coalition

SB707 Z.A.-Testimony.pdf
Uploaded by: Janet Edelman
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Z.A., Montgomery County
Position: Support

As a grieving mother who recently lost her precious son to suicide, I want to tell how the current danger standard contributed to his death in the hope that no one else goes through what I am going through. It was his (third) suicide attempt and he was again in the ICU for days. After he was medically stable, he was evaluated for involuntary certification for transfer to the psychiatric unit. However, he said he was no longer feeling suicidal and did not agree to be admitted to the psychiatric unit. Therefore, he was released without taking into consideration his documented recent history of multiple suicide attempts and bipolar depression. That did not meet their interpretation of Maryland's danger standard for involuntary hospital admission because he did not say he was still suicidal. They sent him back to his home without giving him any psychiatric treatment after a serious suicide attempt. He died by suicide days later.

My son suffered from schizophrenia and anosognosia. Because of the illness he was unable to recognize that he was ill and needed treatment. He was hospitalized many times over the years. Often, after a few days, he was released prematurely because even though he refused medication he did not meet the danger standard for involuntary hospitalization, although it was clear he could not meet his basic needs. After each episode there was less recovery.

A year and a half ago, things had gotten much worse. He stopped showering, eating, and talking, saying things like he didn't want to live. Clearly, he had all the signs and symptoms of someone being dangerous to himself. I repeatedly conveyed my concern to his care team each time that he was in the hospital, but each time, he was not taken to a hearing for involuntary treatment because being unable to care for oneself was not considered a danger to self.

My son continued having major depression and was unable to keep a job. Sadly, there was nothing I could do except watch my son deteriorate in front of my eyes until he once again met the stringent danger standard.

There is not a day that I don't think about him. I wonder if he would still be here if Maryland's danger standard had not repeatedly blocked his access to critical hospital psychiatric care.

I ask the committee in their evaluation to look at how laws can protect individuals with serious mental illness who are in crisis and to **define the danger standard to include the inability to care for themselves and deterioration likely to result in the inability to care for self**.

If this legislation had been in place, to facilitate treatment, my son could have had a chance to be alive today. Therefore, I urge the committee to vote in favor of this legislation.

SB707 J.Connors-Testimony.pdf
Uploaded by: Joanne Connors
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Joanne Connors, Montgomery County
Position: Support

I was diagnosed with schizophrenia 30 years ago. When I am on medicine you would never know it. I work full time, exercise, go to book clubs, and fix-up my house just like you. However, when I am off my medicine or on an inadequate dose, I have psychotic delusions and lose any insight that I have a serious illness. Then I refuse treatment of any kind in any setting. When involuntarily hospitalized and provided medication-over-objection, I improve dramatically within 24 hours and again I realize I do need the medication. I tell this story because **I am a firm believer that prompt involuntarily hospitalization for psychosis is the compassionate thing to do for someone with schizophrenia, rather than allowing them to remain psychotic until there is "imminent" risk of "physical" danger.**

When I first fell ill, I took medication willingly and did just fine. Then I thought since I was doing well, I could stop it. I became delusional and lost insight. Because of the current danger standard, it took 2 years for me to be involuntarily hospitalized and receive medication-over-objection. I lost my savings of over $100,000, lost my job, lost my health insurance, lost custody of my son, and lost my dignity. I suffered delusional mental anguish and emotional pain. I made suicide attempts, something I never do until the illness has progressed to its worst stages. My son witnessed his mom doing "crazy things" and suffered tremendous emotional pain from my eventual abandonment. Nothing scares a kid more than thinking no one will help their parent when they need it.

Four years later, during a medication change, I ended up on a non-therapeutic dose and relapsed. It took a year of me destroying my life once again to be involuntarily hospitalized, because I was not considered sufficiently "dangerous." I once again lost my savings, my job, my son, and my dignity.

I never want to go through that experience again. The last thing my family and I need when I am ill, is some police officer, doctor, lawyer or judge, denying me involuntary hospitalization, when what I need is to be safely in the hospital and get treatment. Denying me treatment when the illness has robbed me of the ability to made rational decisions about my own care is doing a disservice to me and the community.

I don't take the disservice to the community lightly. The second time I became psychotic, it took me breaking the law and getting arrested before I received involuntary treatment. The illness only gets worse over time if left untreated**.** Without treatment I live in my own reality with my own rules and laws according to my imagined beliefs. The rules and laws of society mean very little to me. Over time, I get angrier and angrier. Then I start to fight the world. I trespassed at my son's school and wrote a letter to the principal threatening the school if they didn't give me my son back. I didn't become violent, but I believe there is always a possibility I could have if left untreated long enough. So no, **a danger standard that does not include substantial impairment in the individual's ability to make a rational and informed decision about treatment, is not compassionate or medically prudent.** It puts the safety of the person and the community at risk as the illness is progresses.

I approach this no different than any illness or trauma that brings an unconscious person to the Emergency Room. I might as well be unconscious – for when psychotic, I am living in a reality all made up by my mind. **I want my doctor to treat me as such.** I want him or her to facilitate hospitalization where I can receive life-saving medication-over-objection if needed. I don't know of any other illness where someone in the Emergency Room is not provided the lifesaving treatment they need. In short, this is a disease with a biological basis. If a person's cancer was at Stage 0 but the doctor waited until the cancer was at Stage IV with brain metastasis before treating it, that person would be sued for malpractice. But this is what will continue if anyone with an obviously advanced psychotic illness is denied treatment until they are physical danger to themselves or someone else. **Please support SB707.**

SB707 L.Pogliano-Testimony.pdf
Uploaded by: Laura Pogliano
Position: FAV

Testimony for SB 707
February 24, 2026; Senate Finance Committee
From: Laura Pogliano, 4010 Linkwood Rd, Baltimore, MD 21210
Position: Support

My son became severely debilitated, catatonic, unable to walk or speak, and nearly died of starvation and dehydration because Maryland's Danger Standard for psychiatric emergency evaluation was a barrier to critical hospital treatment.

In early April of 2012, my son announced he was crippled and went to bed in the middle of the day. He believed his ankle was pulverized, he had a brain tumor, and his back was broken in three places. He promised to get up when he healed. I asked him, "When will that be?" He said that he wasn't sure, but probably not soon.

In the next two weeks, he quit eating and drinking. He couldn't trust anyone to bring him food. He saw poison being pumped into the water supply. He could only use the bathroom with assistance. He smelled, his clothes were turning black, his lips were crusted and cracked, and his hair matted. I sat by his bed for days on end, putting ice chips in his mouth, and wiping his face, begging him to make a good decision for himself and see a doctor.

Two weeks later, police crept up the stairs to his room and helped him, shaking, weak, and filthy, into a squad car to go to the hospital.

If you think that's an odd series of events, it's because I left something important out. My son was severely mentally ill. He had schizophrenia, a thought disorder that includes hallucinations, delusions, and paranoia. Before the April events, he had quit taking a medicine called Clozapine, used for hard-to-treat cases. Between February and March, he quit bathing and changing his clothes. He became disorganized and missed work, then got fired. He began sitting in the living room all day, not speaking, and staring at a television that wasn't turned on. He made no phone calls, saw no friends, made no attempts to engage in any activity. He couldn't answer even direct questions.

He was sicker than he'd ever been. He really, really needed to get to a hospital.

In early April, I phoned the Crisis Intervention team two times. I told them he was not eating or drinking, could no longer get up or walk. They said that he did not meet the danger standard for emergency evaluation and refused to come to evaluate him. I told them that he had required hospitalization 8 times in the past 4 years but they could not take that into account. Finally, I went to the local courthouse and begged a judge for an emergency petition which requires a peace officer to take the individual with a mental illness who presents a danger to self or others, to a hospital emergency room for a psychiatric

evaluation. The police served it the next morning. He was sent to Johns Hopkins Hospital where he refused medication. **In two weeks, he'd gone from functioning to being catatonic and in a wheel chair. He was 20 years old, a former athlete, pianist and drummer.**

On April 16th, he was committed to the hospital by an Administrative Law Judge. He was still in a wheelchair, still in his same clothes, unmedicated and now with his eyes rolling back. A week later, a medical panel decided that medication over objection was warranted. He was still in a wheelchair, in the same filthy clothes, but was now mute and catatonic. After a 48-hour appeal process, he finally received an injection of an antipsychotic. He was unmedicated overall approximately three months, two of those weeks spent hospitalized while he was legally barred from treatment. He'd lost forty pounds and required almost two months of hospital treatment to stabilize. That was a result of waiting to be able to seek care until he was considered a danger to himself according to the common interpretation of Maryland's poorly define danger standard. The standard was interpreted as requiring *imminent* danger and did not consider refusing food and water or psychiatric deterioration when incapable of rational thought as a danger to self. **After successful, competent medical care, he was able to walk his sister down the aisle at her wedding on July 28th.**

I want to ask you: What should I have done as a mother, when my son went to bed and tried to starve himself to death? One of the absurdities of our situation is that if my son had any other brain disorder, I would be legally negligent and abusive in not seeking medical help, but with the same injured brain. In a different disability, I am "supporting a choice" he makes to starve himself while delusional. I'm sure he was not sorry that I violated his rights, or fought to give him his life back. These are the realities of making families wait for treatment until your adult child meets the current danger standard.

In all, he was hospitalized 86 days, at a cost of over $300,000.

My son passed away in 2015. For the last 8 years I have run a weekly support group for families in Maryland and across the US whose loved ones are severely mentally ill. I have yet to meet a family who didn't live in mortal fear of both *not meeting a danger standard* to qualify for treatment, and also *meeting a danger standard*, which literally almost always involves violence, police, arrests, and incarceration. My situation, I've learned, was not unique. It's a systemic failure that we can no longer allow to continue, for both the health of the patient and families, and for the larger implications for society.

Please support **SB 707** to help fix this inhumane system.

SB707 EKelley - Testimony.pdf
Uploaded by: Laura Shears-Coates
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Edward Kelley III, Howard County
Position: Support

TESTIMONY OF EDWARD F. KELLEY III SUPPORTING SB707

My name is Ed Kelley and my son has paranoid schizophrenia. I have 21+ years real life experience dealing with the inadequacies of our involuntary commitment laws as they exist today. Whether naked in the snow in sub-freezing temperatures – living under a bridge – wandering for weeks talking to himself – or being victimized - I have watched first-hand the unbearable – seeing my son unable to access treatment because he does not believe he has an illness. Last year Governor O'Malley and the administration acknowledged the need to intervene earlier when they announced the funding of a new center intended to get young people at risk into immediate treatment – called **The Center for Excellence on Early Intervention for Serious Mental Illness** . **The program specifically states that 'psychosis' is the specific symptom that makes violence more likely'. The staff at the center was quoted saying that "we need to make an effort to intervene as early as possible to perhaps salvage lives that might otherwise be lost"; and, goes on to say that "the probability that people with mental illness will become violent increases significantly if they reach psychosis".** Maryland's leadership has acknowledged the problem exists – so let's address it.
On one hand we have groups saying the current laws are just fine. Does anyone on this Committee really believe that is true when we have these testimonies year after year? While we open our hearts and souls to you – others attack our testimony as anecdotal and emotional rhetoric. Is that what you believe when you hear us speak? **If the law is clear – why are we having these discussions year after year?** There are thousands of people in Maryland with the authority to evaluate a person for involuntary admission. Even if we were to assume everyone is well intended in that role – the current law creates confusion and a fear of liability – so they err to the side of taking chances with lives.
During the Continuity of Care sessions in 2013, in which I participated throughout, I asked the opposing groups if there was anything we could get changed - in regard to this issue – and other issues pertaining to the other Bills to be heard today - to better help families across Maryland. **Not one inch of movement. Not one word offered.** While I respect the opposing groups efforts – the fact is that change is required so everyone is on the same page and clarity exists that allows our providers and courts the opportunity to help those who cannot help themselves. This change will not create a huge dragnet. It will not increase stigma or deter persons from seeking help. This Bill is directed at that small population that does not believe they are ill and live with voices, delusions and paranoia.
Where does that leave us? Our son, like many others, does not believe he is ill. **It has been 21 years now – does anyone here really believe that someone with our son's illness will 'eventually seek treatment' – as is suggested by opposing groups? Would you be willing to take that risk if it were your child, spouse or parent?** Are you willing to take that risk as a legislator, after seeing tragedy after tragedy unfold? Why do we acknowledge that those with Alzheimer's at times cannot make good decisions – yet at the same time deny that same approach to someone who thought they were being hit with microwaves just prior to walking into the DC Naval Yard and killing 12 people while listening to voices?
In a February 18 2014 Montgomery Gazette, Montgomery County's County's Chief of Behavioral Health and Crisis Services is quoted saying: **We have to be able to recognize [symptoms] and treat them earlier. ... If someone comes in**

TESTIMONY OF EDWARD F. KELLEY III SUPPORTING SB707
for a second time, we have to be able to catch that and intervene before things become violent,". Dr. Newman, a prominent psychiatrist with Georgetown University is then quoted in the article: **"If they are refusing treatment and not considered an 'imminent danger,' they are allowed to sort of rot away with their rights on," Newman said.**
There are also those who feel this can be corrected thru training/education and regulations. While I have the utmost respect for the Administration's great leadership and talent, people come and go in administrations, and interpretations will be continually fought over based on respective people's perspective and/or education on the matter. That is why leaving this issue up to training and education is not enough. People only believe that change has been made when something is materially changed. Those who suffer the most deserve to be treated more humanely – and they deserve the right to avoid the stigma – the labeling - that results when they deteriorate due to lack of timely treatment. . What role you as Legislators play here this session to change all that is what remains. Please do the right thing.

SB707 Granados - Testimony.pdf
Uploaded by: Laura Shears-Coates
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Kristina Granados, Hagerstown, Washington County
Position: Support

My brother has been sick with schizophrenia for 22 years. Maryland's vague undefined danger standard has 3 times been a barrier to his critically needed treatment. The result has been 4 traumatic violent attacks: on my father, my grandfather, my aunt and my uncle, the permanent disability and loss of employment for my uncle, the loss of a son's relationship with his father, the suffering of my brother with paranoid fears for over 5 years and living homeless on the street for almost a year, the cost to the state of millions of dollars for over 5 years in the criminal justice system and at Clifton T. Perkins Forensic Hospital, and now my brother is homeless for the second time and families with children, including mine, continue to live in fear of harm every day.

In his early twenties my brother began hearing voices and became extremely paranoid. My parents could not get him help because he was over 18, and completely unaware that he was sick and refused treatment. **He attacked and choked my father severely**. He agreed to voluntary hospital admission but checked himself out after 2 days because **the inpatient doctors refused to certify him for involuntary admission.**

My husband and I lived with my parents at the time, and on one occasion, because of his delusions **he threatened to kill us in our sleep**. The next day he told us he slept with a butcher knife under his bed in case he decided he needed to kill us in our sleep. The hospital recommended we call the police, who
took him to the hospital. However, the **Emergency Room doctors refused to certify him for involuntary hospital admission.**

For our family to be safe, we could not allow him to come home. He was **homeless and on the streets almost a year.** Then my aunt and her family took him in against our advice. My grandfather lived with my aunt, and **my brother attacked him** on one occasion. One evening, **he beat my aunt and her husband in the head with a baseball bat.** Then he calmly called the police and stated he intended to kill them, but couldn't go through with it. **Susan and John were both hospitalized and John will remain on full disability as a result of this attack.**

My brother lost 5 years of his life as a patient/ inmate at Clifton T Perkins Forensic Hospital suffering with paranoid delusions. My brother finally received medication over objection which successfully treated his psychosis.

After discharge to an inpatient center, he moved to a halfway house program called Vesta. He **got a job at a gas station which he held for over a year, bought a car, AND mended relationships with his son and the rest of the family.** When all was well in his life again, **He stopped taking his meds**. He moved out of the halfway house program, and got an apartment on his own, so he didn't have to answer to anyone about his mental illness.

Now he has started having hallucinations and paranoid delusions again. he was accusing his roommate/landlord of cutting his hair while he was sleeping. He **posted psychotic incoherent words as well as violent and sexually explicit messages on social media including "Feeling cute, think I might kill".** He concocted a plan to be homeless and live in the woods near my family. This sent me into a terrified panic mode, knowing he could show up at my door at any minute while he is psychotic. It made me feel that my children and family would not be safe in our own home.

I called the Anne Arundel County Mental Health Crisis team to see if they could petition my brother for emergency evaluation to get him needed hospital treatment **before** he became homeless or attacked his roommate, my family or a stranger. I sent them screen shots of his violent postings and thoughts of murder. I gave them his psychiatric, violent and criminal history. **The mobile crisis team went to his home but did not find at that moment that he was dangerous enough YET to meet the current danger standard** and were unable to help in any way. **The current danger standard did not allow them to take into account his past violent history while psychotic or his significant psychiatric deterioration.**

Research shows that the strongest predictor of violence by a person with mental illness is prior violence. How can a person like me protect my family when there is no one who can help until it's too late? Why do we continue to wait until the worst possible outcome happens before we help these medical patients with their illness?

Now my brother has been evicted because of his behavior and is homeless and living in his car. He recently also quit his job and said he is going to move. His son has been trying to reach him for 2 months. Nobody knows where he is or what condition he is in or if he is safe and able to care for himself. **My family is still in grave danger and lives in fear.**

It is absolutely SHAMEFUL that since 2002, families like mine have been pleading for help from Maryland legislators and administrators to change this danger standard to remove the barrier to care and nothing has been done for 19 years.

I am pleading with each one of you to pass SB707 which defines the danger standard to include a grave disability with psychiatric deterioration and history taken into account. This will allow family, law enforcement, and medical professionals to help patients with serious mental illness get help when treatment is needed, not after someone has actually caused harm to oneself or others.

SB707 Hill testimony.pdf
Uploaded by: Laura Shears-Coates
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: June Hill
Position: Support

My family has experienced great trauma & pain when denied access to timely hospital treatment for the treatment of psychosis in schizophrenia. These have included the **police refusing to petition my son for emergency evaluation rather than arresting him after he attacked his father, and my son severely cutting his own throat after being denied hospital admission.**

Our son was diagnosed with schizophrenia 15 years ago. He heard voices, was paranoid, anxious and fearful. Our son loves both his parents. Unfortunately, in a delusional state his brain triggers him to think we are plotting and trying to hurt him. **He knew there was something wrong with his brain but believed the problem is there is lead in his brain.** We could never leave the house because he would get up in the ceiling searching for the people he believed were trying to hurt him. **It is hard to believe how paranoia and fear can consume an individual.**

Nine years ago, he attacked his father, knocking him out and in the process his father suffered a broken tooth and damage to one ear. The police refused to take our son to a hospital. They took him to jail over our objections. He received no treatment, but three hours later he was out by a highway, still just as dangerous.

Seven years ago my son's condition worsened with horrifying results. I heard him walking around the house at night. He had two large butcher knives, one in each hand. He said, "I'm not trying to hurt you. I'm just trying to get the people trying to get me." I convinced him to give me the knives.

A few days later he told me if I didn't get him to the hospital right away he knew he was going to die of a heart attack. He said he was anxious and wasn't getting any oxygen. He said he had something wrong with his brain, then his neck, then his back and chest. He said if I didn't hurry he would break the flat screen TV. I knew he was on the verge of another severe psychotic episode.

I took him to Calvert Memorial Hospital, but they refused to admit him. **Three days later he went into the bathroom and cut his throat, stabbed his chest, slit one wrist, and cut the other forearm severing the tendons.** This was a denial of a voluntary hospital admission, but it illustrates the **unpredictable nature of psychosis and the possible tragic consequences of delaying treatment of psychosis.**

He required more than one surgery to repair all the damage. He had a long recovery in the hospital complicated by his fear and paranoia. On discharge he was transferred to Sheppard Pratt hospital for psychiatric treatment. He received new medication at Sheppard Pratt and they kept him a month longer than the insurance authorized, absorbing the costs themselves. Eventually he moved to a supervised group home. He receives his meds and is picked up several times a week to see his therapist, caseworker, doctor and to attend group sessions. We are so pleased to see him doing so much better and no longer suffering the way he has in the past.

He has said he can't believe what he did and *he never wants to be in the bad place again*. **Timely treatment of psychosis as provided by SB707 could prevent other suicide attempts.**

SB707 JConnors - Testimony.pdf
Uploaded by: Laura Shears-Coates
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Joanne L Connors, Silver Spring, Montgomery County, MD
Position: Support

I am asking you to recommend that the dangerous standard for emergency petition and involuntary hospitalization be clarified to include those who are unable to care for themselves. This would have benefited me greatly and prevented emotional pain for my child if it were implemented when I was ill 15 and 19 years ago: I suffer from schizophrenia. When well, I am employed full time in a professional job. When ill, I retreat into my own world with irrational rules. If I could have been committed when I was unable to care for myself, instead of a year later when I was a physical danger to myself or others, I could have:

• Taken FMLA so I could keep my job while hospitalized. Instead, I lost my job and was unemployed for 18 months.
• Utilized my short and/or long term disability and therefore had some replacement income for while I was disabled. Instead, I stayed on the job until I got fired. By the time I got treatment, the option for short or long term disability income replacement is gone.
• Saved $100,000 spent from my savings since it would have been replaced by the disability insurance. Instead I live off this money and spend it all.
• Maintained my health insurance through my job. Instead, I'm too ill to even think of COBRA and my insurance is gone since I lost my job. The state then picks up part of the tab for my eventual hospital stay; I end up deeply in debt for the rest of the stay.
• Saved myself from criminal prosecution. Instead, because I'm irrational, I eventually break the law. I actually spent a few hours in jail.
• Saved myself from suicide attempts, delusional mental anguish, and dangerous situations. Instead I end up at 2 a.m. lying at a bus stop crying with emotional pain and contemplating suicide, things I never do until the illness has progressed to its worst stages.
• Protected my son from the terrible impact of this illness on the children. Instead, he witnessed his mom doing "crazy" things, and suffered tremendous emotional pain from my eventual abandonment. Nothing scares a kid more than thinking no one will help their mom or dad when they need it.

In short, this is a disease with a biological basis. If a person's cancer was at Stage 0 but the doctor waited until the cancer was at Stage IV before treating it, he would be sued for malpractice. But this is what we do in the mental health field by waiting until someone is a physical danger to themselves or others. Please be a part of the early diagnosis and treatment of this disease by supporting **SB707**. Please, allow me to be committed. It could save my life and the quality of my life and my son's life in the future.

SB707_LSCoates_Support.docx.pdf
Uploaded by: Laura Shears-Coates
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Laura Shears-Coates, MSW, CRFP, Owner, Takes a Village For Change, LLC
Position: Support

I am writing in strong support of SB707 and HB1014, legislation that aims to enable treatment before tragedy for individuals living with Severe Mental Illness (SMI) who lack awareness of their condition and their need for care.

My name is Laura Shears-Coates. I am a Certified Rehabilitation Practitioner (CRFP) through the Psychiatric Rehabilitation Association (PRA), hold a Master's degree in Social Work, and have worked in the behavioral health field for over 20 years. I am also the owner of Takes a Village For Change, LLC, a Maryland-based outpatient mental health clinic that works daily with individuals suffering from SMI. Throughout my career, I have served some of our state's most vulnerable residents (individuals whose illnesses impair their insight, judgment, and ability to make life-sustaining decisions).

In my professional experience, one of the most heartbreaking realities we face is the limitation of our current system: we often must wait until someone presents an imminent danger to themselves or others before meaningful intervention can occur. By that point, significant damage (medical, psychological, social) and sometimes irreversible has already been done. Repeated hospital admissions become reactive measures rather than preventative care. This is not a system designed for early intervention; it is a system that too often responds only after crisis has escalated beyond control.

I also write to you from a deeply personal place.

In July 2023, my younger brother, Joshua D. Carey, passed away at the age of 31 due to the effects of a severe mental health illness that prevented him from recognizing his need for treatment and medication compliance. His illness robbed him of insight. Although our family could see his symptoms worsening, he did not meet the threshold of imminent danger required for intervention. We were forced to stand by and watch as his mental and medical conditions declined. Hospitalizations occurred only after life-threatening emergencies arose. Each time, he was stabilized and released, without the sustained support he so desperately needed.Ultimately, his body gave out. He passed away because he was unable, due to his illness, to consistently take medications that would have sustained his life.

Today, I speak to you not only as a clinician and business owner, but as a grieving sister and now an only child who lives each day with the pain of knowing that earlier intervention could have made the difference between life and death.

This legislation represents an opportunity to modernize our approach to severe mental illness by allowing intervention before tragedy strikes. This bill would:

- Enable earlier, structured treatment for individuals whose illness impairs insight and decision-making
- Reduce repeated crisis-driven hospitalizations
- Support families who are currently powerless to intervene
- Protect first responders who are too often placed in dangerous, last-minute crisis situations
- Most importantly, save lives

This decision carries a profound weight. It has the power to preserve life, or, if we fail to act, to allow preventable deaths to continue.

I humbly ask you to consider my brother, Joshua D. Carey, and the many Marylanders like him who cannot recognize their own need for care because of the very illness that threatens their survival. Please give families and providers the tools to intervene before imminent danger becomes the standard for action.

No family should have to endure the pain we continue to carry.

Thank you for your time, leadership, and commitment to the health and safety of our communities.

Respectfully,

Laura Shears-Coates, MSW, CRFP

Owner, Takes a Village For Change, LLC

Grieving sister of Joshua D. Carey

Testimony on Senate Bill 707-Favorable.pdf
Uploaded by: Laurie Liskin
Position: FAV

Testimony on Senate Bill 707-Favorable

SB707- Mental Health-Danger to Life and Safety of the Individual or Others-Definition (Right to Treatment)

Finance Committee

February 24, 2026

Dear Honorable Chair Beidle, Vice Chair Hayes, and Members of the Committee,

As a family member of a person living with mental illness and a member of NAMI Howard County, I am offering favorable testimony in support of **SB707- Mental Health-Danger to Life and Safety of the Individual or Others-Definition (Right to Treatment).**

Maryland is failing its citizens with severe mental illness and their families. People with untreated severe mental illness fill our jails, live on our streets, cycle in and out of hospitals, and often are victims of violent crime. Passing SB707 can improve this dismal scenario.

SB707 would require a change in Maryland's involuntary evaluation and hospitalization law for serious mental illnesses such as schizophrenia and bipolar disorder, making it easier for the severely ill to receive prompt treatment . The current law is simple and vague; hospitalization is allowed only if "The individual presents a danger to the life or safety of the individual or of others." Maryland is the only state (along with Washington DC) that has not defined its danger standard. Too often the law is interpreted narrowly and inconsistently, depriving many of much needed treatment.

I teach NAMI's Family to Family class. Many participants tell the same story: their child/spouse/sibling cannot get care because they aren't deemed "sick enough" even though they refuse to eat, shower, or change their clothes, cannot work or communicate with people, hear threatening voices, and in bouts of mania, go days without sleeping, run up huge credit card debts, and smash holes in living room walls.

Early treatment for mental illness leads to better outcomes. Passing SB707 and expanding the definition of danger will be a lifeline for those affected by severe mental illness. I urge you to support SB707.

Laurie Liskin
4642 Smokey Wreath Way, Ellicott City, Maryland 21042

SB707 L.Montaner-Testimony .pdf
Uploaded by: Liz Montaner
Position: FAV

Testimony for SB 707
February 24, 2026; Senate Finance Committee
From: Liz Montaner, Annapolis, Anne Arundel County

Position: Support

I am the mother of a 41-year-old son diagnosed with undifferentiated schizophrenia. After graduating from Colgate University in 2009, my son began showing signs of a mental illness. He was interning on Capitol Hill when he started expressing grandiose ideas such as his ability to influence legislation with his eye movements. Unfortunately, my son was the only person who 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.

We had heard that even if we were able to convince him to go to a hospital in Maryland it was unlikely he would be admitted because he was not of obvious danger to himself or others. After several months of trying to convince our son that he needed medication we asked him to leave our house. We explained that we could not provide food and shelter without his treatment compliance. It was extremely difficult to ask our son to leave home knowing he was very ill. I believe many families are not able to take this step and yet currently in Maryland it may be the only way to have a shot at treatment.

My son ended up in New York City in the middle of a snowstorm without any coat to protect him from the weather. He called to say he had stomach cancer and was trying to get home to die with his family. We found him in Penn Station and convinced him to go to an emergency room to check out his "cancer". Once inside, the hospital was able to involuntarily commit him within 24 hours based on his inability to take care of his basic survival needs. He was kept for almost a month and was finally stabilized on medications.

If Maryland had less restrictive laws governing involuntary commitment, we might have obtained treatment sooner for our son. Research shows that early intervention results in better the long-term outcomes. That was certainly true for my own psychiatric emergency almost 40 years ago. Within days of my first psychotic break I was placed in a psychiatric hospital, was kept for almost three months, and have never had another mental health incident. My son, unfortunately, has not been as fortunate and will likely spend the rest of his life battling this horrendous illness.

Please support SB 707 so my son will not be denied treatment in the future!

MCAA SB 0707 - Mental Health Law - Danger to the L
Uploaded by: Mary Ann Thompson
Position: FAV

SB 0707 – Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)

MCAA Position: **SUPPORT**

TO: Finance Committee

DATE: February 20, 2026

FROM: Christopher Klein, President
Lamonte Cooke, Legislative Committee
Mary Ann Thompson, Legislative Committee

The Maryland Correctional Administrators' Association supports SB707/HB1014 to define the danger standard required to involuntarily certify persons with serious mental illness to timely access to care and reduce critical decompensation that can lead to incarceration and reinforce the criminalization of mental illness.

Maryland has more people with mental illness in jails and prisons than in all the State's Psychiatric hospitals combined. The number of incarcerated individuals with serious mental illness is backed by reputable data, as the literature confirms. This problem has been discussed ad nauseam. Undoubtedly, many factors contribute to the criminalization of mental illness, but at its root are State laws that have created barriers to hospitalization for the most vulnerable population with severe mental illness. A major barrier to treatment and pertinent to this bill is the unclear definition of danger, which limits the autonomy of community providers or caretakers to seek inpatient treatment for individuals with a known history of mental illness and who are undergoing severe psychiatric decompensation. Since the current danger standard prevents these very sick persons from timely accessing needed hospital care, these individuals are guaranteed an exacerbation of symptoms while in the community. Subsequently, they soon find themselves in a jail cell versus a hospital bed for not meeting the State's danger criteria for hospitalization.

Whereas proper healthcare emphasizes "early" detection and access to treatment to prevent complications of disease, Maryland disregards these same guarantees for our most vulnerable, and ADA-protected citizens who cannot advocate for themselves. Instead, the State expects these individuals to fully decompensate and hurt themselves or others before they are afforded needed inpatient emergency treatment.

If the State disregards a Maryland-licensed treating provider's autonomy to recommend needed emergency hospitalization for his patients, imagine the challenges jail staff face when these patients refuse all medications and staff interventions. They may refuse to shower, sleep, or eat, and can be found naked, drinking toilet water, or smearing feces on themselves. They also face longer incarceration for the same offense committed by their counterparts while awaiting Court competency orders. It can take from 30 to 200 days before they are admitted to the State hospital, so they continue to deteriorate physically and psychiatrically.

We often hear how incarcerated individuals' families say they exhausted every attempt to get their loved ones hospitalized. Tragically, some end up with homicide charges. Maryland has seen tragic outcomes associated with untreated mental illness. Ex. Montgomery and Charles Co. had cases where a woman killed her children, and a man killed his mother in 2011 and 2025, respectively. The current danger standard must be modified so patients with severe mental illness are guaranteed access to involuntary hospitalization to prevent additional psychiatric and physical deterioration, as well as damage to brain function and structure resulting from untreated psychosis.

The MCAA strongly urges the committee to issue a **favorable report on SB707**.

SB707 - FAV - NAMI.pdf
Uploaded by: Michael Gray
Position: FAV

Feb. 24, 2026

Chair Beidle, Vice Chair Hayes, and distinguished members of the Finance Committee,

NAMI Maryland and our 11 local affiliates across the state represent a network of more than 60,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a 501(c)(3) non-profit dedicated to providing education, support, and advocacy for people living with mental illnesses, their families, and the wider community. We respectfully request a favorable report on SB707.

NAMI Maryland appreciates that the topic of inpatient civil commitment is complex and controversial. The idea of court-ordered treatment can be troubling to patients, providers, and advocates because it involves balancing the fundamental right to individual liberty with the potential medical necessity of treatment, even when treatment will prevent harm to oneself or others. Although it is always a difficult question, there are times when a person's mental illness symptoms become so severe that mental health providers and courts must consider whether to follow the legal procedure for inpatient commitment. In those situations, a person should only be committed if an inpatient facility is the least restrictive environment for safe and effective treatment. Ideally, treatment would always happen in community-based settings. However, as Justice Ruth Bader Ginsberg wrote in the landmark *Olmstead* case, some people "are not prepared at particular times . . . for the risks and exposure of the less protective environment of community settings," and "institutional settings are needed and must remain available." [1]

Maryland's current criteria that should determine danger to self lacks a level of detail needed to ensure that only people in need of immediate psychiatric care will be civilly committed to an inpatient facility. NAMI Maryland encourages the Finance Committee to consider the lack of clarity in current law, the 2021 BHA workgroup recommendations, and increased protections that SB707 would put in place for people who may be subject to civil commitment proceedings.

Current Standard of Danger to Self is Vague. SB707 Provides Clarity

Maryland's legal criterion to determine dangerousness for inpatient civil commitment, "[t]he individual presents a danger to the life or safety of the individual or of others," [2] is so vague that it leads to inconsistent interpretations across the state.[3] That indistinct language is unfair to people who are being evaluated for civil commitment and frustrating to courts and mental health professionals tasked with applying it. SB707 addresses that inadequacy in the law by creating specific criteria for danger to self.

SB707 includes criteria that clarify the legal standard of dangerousness, which will allow for more accurate evaluations of whether a person actually poses a risk of harm

Stephanie Slowly-Little
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

to self. Under SB707, the court would be able to hear evidence that a person would, without treatment, "suffer substantial deterioration of the individual's judgment, reasoning, or ability to control behavior." This criterion, sometimes known as "psychiatric deterioration," allows mental health professionals and the court to consider the impending consequence of nontreatment based on current condition and an individual's psychiatric history. At least 26 states have psychiatric deterioration language in their inpatient civil commitment criteria.[4]

This legislation also would allow consideration of a person's ability to provide for their own basic needs, "including food, clothing, shelter, medical care, self-protection, or safety, to such a degree as to create a substantial risk of serious bodily harm, serious illness, or death." This criterion is rooted not only in common sense, but also in compassion. People living with serious mental illness are sometimes unable, because of their symptoms, to look after their own basic human needs. That is not their fault; mental illnesses are involuntary conditions that can, in their most severe forms, impair a person's ability to make decisions. The mental illness itself robs an individual of aspects of life that most people take for granted. For the vast majority of people with serious mental illness, medication and other treatments can reestablish and maintain their ability to provide for their own basic needs. In extreme cases, civil commitment may be temporarily medically necessary to prevent the type of harm to self described in SB707. Maryland's mental health providers and courts need these specific criteria to help determine whether a person's mental illness symptoms, through lack of immediate treatment, are causing harm to that person.

Civil Commitment Workgroup Recommendations

In 2021, the Behavioral Health Association convened a stakeholder workgroup to review civil commitment in Maryland, and a significant piece of its recommendations are reflected in SB707. Regarding the circumstances when mental illness symptoms deprive a person of their ability to provide for their own basic needs, the workgroup recommended the following language:

> 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.[5]

That is substantively similar to language contained in SB707:

> [A person will] be unable, except for reasons of indigence, to provide for the individual's basic needs, including food, clothing, shelter, medical care, self-protection, or safety, to such a degree as to create a substantial risk of serious bodily harm, serious illness, or death.[6]

Stephanie Slowly-Little
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

Eleven advocacy organizations, two community-based crisis providers, the Maryland Hospital Association, four local behavioral health authorities, four persons with lived experience, and five state government agencies (BHA, Dept. of Disabilities, MDH, OAD, OPD) took part in the 2021 workgroup, examined the issue of Maryland's inpatient civil commitment standard, and recommended the above language be part of the determination of whether a person poses a danger to self or others. NAMI Maryland urges the committee to review the workgroup recommendations. The Lt. Governor presided over that process, and although we respect the intent of that group to promulgate its recommendations as regulations, improvements to Maryland's civil commitment criteria would be more meaningful if codified as statute via SB707.

SB707 Increases Constitutional Protections

Any element of state law related to inpatient civil commitment must conform to federal legal protections that safeguard the rights and liberties of people who may be a danger to themselves or others.[7] SB707 adds due process protections to Maryland law that are currently lacking. There are two types of due process guaranteed by the Fourteenth Amendment to the U.S. Constitution. Procedural due process relates to the processes that the state must follow before infringing on a person's rights or liberty, while substantive due process relates to the reasons the state can use before doing so. Maryland already conforms to procedural due process requirements with civil commitments by requiring notice, a hearing, right to counsel, and other procedural elements necessary to safeguard against undue infringements upon personal liberty.[8] But current Maryland law is lacking in substantive due process guarantees and this bill provides safeguards needed to temporarily commit a person who is a threat to themselves or others.

Maryland currently has no clear definition of danger to self, but states must prove by clear and convincing evidence that a person "requires hospitalization for his own welfare and protection of others." [9] Asking mental health providers and courts to meet the burden of proof without a clear definition of dangerousness to self is both an unrealistic expectation on those decisionmakers and, more importantly, unfair to any person under evaluation for civil commitment. SB707's provisions, especially the criteria related to likely substantial deterioration and inability to provide for one's own basic needs, mean that a person would not be subject to inpatient civil commitment without meeting those specific requirements. Compared to current Maryland law, that is a higher bar for the state to meet and temporarily confine a person to inpatient psychiatric treatment. The state should always have such obstacles before any infringement on liberty, even if that infringement is temporary and medically necessary. SB707 would solidify substantive due process in Maryland's civil commitment law.

Stephanie Slowly-Little
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

NAMI Maryland welcomes the opportunity to work with bill sponsors, committee members, and organizations in opposition on compromises and amendments, and we urge a favorable report on SB707.

---

[1] Olmstead v. L. C. by Zimring, 527 U.S. 581, 605 (1999) (quoting Brief for American Psychiatric Association et al. as Amicus Curiae 22–23).
[2] Md. Code Ann., Health-General § 10-632(e)(2).
[3] *Involuntary Commitment Stakeholders' Workgroup Report*, Maryland Dept. of Health, 2021, https://health.maryland.gov/bha/Documents/Involuntary%20Commitment%20Stakeholders.Final%20report%208.11.21.docx.pdf.
[4] Lisa Dailey et al., *Grading the States: An Analysis of U.S. Psychiatric Treatment Laws* at pg. 39, Treatment Advocacy Center, 2020, https://www.tac.org/wp-content/uploads/2023/11/Grading-the-States-2020.pdf. Louisiana became twenty-sixth state to pass a psychiatric deterioration law in 2022, Louisiana House Bill 335 (2022).
[5] Stakeholders' Workgroup Report, pg. 2.
[6] SB707, Section 1(C)(3).
[7] O'Connor v. Donaldson, 422 U.S. 563 (1975).
[8] Md. Code Ann., Health-General § 10-622—10-624.
[9] Foucha v. Louisiana, 504 U.S. 71, 75 (1992) (quoting Addington v. Texas, 441 U.S. 418 (1979)).

Stephanie Slowly-Little
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

SB 707- Danger to the Life or Safety of the Indivi

Uploaded by: Natasha Mehu

Position: FAV

Maryland
Hospital Association

Senate Bill 707- Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment)

Position: *Support*
February 24, 2026
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 707. Clear, consistent standards are essential when clinicians are making time-sensitive decisions that affect patient care and public safety. SB 707 supports this goal by establishing a definition for "danger to the life or safety of the individual or of others" and clarifying the circumstances under which an individual may meet the dangerousness criterion for involuntary admission or emergency evaluation.

Involuntary admissions and emergency evaluations are essential tools to ensure that an individual who has a mental illness, poses a threat to their own or others' life or safety, and is unwilling or unable to receive psychiatric care, can receive a psychiatric evaluation and, when clinically necessary, be admitted to an inpatient psychiatric care unit. Despite "danger to the life or safety of the individual or others" being a mandatory criterion for these legal processes, the term is not defined in statute. The absence of a statutory definition has contributed to inconsistent interpretation and application by clinicians, law enforcement, and courts across the state. SB 707 would prevent such variability and ensure that everyone who meets the proposed threshold has access to the care and treatment they need.

By clarifying that risk may or may not be imminent and explicitly recognizing an inability to meet basic needs as a form of danger, the definition also moves closer to a preventive standard of care and ensures it can apply to individuals and situations where risk is foreseeable but not immediate.

Patients suffering from a mental health crisis often pose high risk even when that risk is not immediately visible. In some cases, the danger presents as self-neglect, including an inability to meet basic needs or perform activities of daily living. The proposed definition will ensure that these individuals can access care before their condition escalates to a more acute crisis or results in irreversible harm.

To further strengthen clarity and implementation, we also recommend aligning the definition to existing statutes and regulations. In particular, §10–708(g) of the Health-General Article governs the process for administering medication to an individual who refuses it and permits treatment when an individual is at substantial risk of relapsing into a condition that is harmful to their

health or safety. This established standard is familiar to clinicians and will help avoid confusion or ambiguity in clinical and legal application.

Maryland hospitals and health systems support SB 707's efforts to eliminate barriers to care and promote clearer, consistent standards that support timely intervention.

For these reasons, we request a favorable report on SB 707.

For more information, please contact:
Natasha Mehu, Vice President, Government Affairs & Policy
Nmehu@mhaonline.org

SB707_Nash_Support.docx.pdf
Uploaded by: Philip Nash
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Philip Nash, 5100 Wyoming Road, Bethesda, MD 20816, 301-801-5431 Phil.Tajitsu.Nash@gmail.com
Position: Support

Our son Matthew was a high-functioning young man, with a job he loved, friends, a sweet girlfriend, an apartment, and a car. Yet, gradually, he lost each of these. Two years, ago, he needlessly died a horrible, painful death because of a suicide attempt caused by untreated schizophrenia. His parents repeatedly tried to get him the treatment he urgently needed. Unfortunately, in his delusional state, he did not realize he was ill, and so would not consent. . Maryland's Danger standard denied him that treatment because it was interpreted as requiring imminent danger for involuntary hospital treatment Our hands were tied.

As his untreated disease got worse, Matt's delusions became threatening. On one occasion, in an attempt to quiet the voices that tormented him, he smashed things in our house. He began to suspect that we, his parents, were actually extraterrestrial lizard creatures from another world. Matt told us our crimes would soon be exposed and we certainly would be executed. We petitioned the court to have him receive the treatment he obviously needed. Matt was taken to the hospital for evaluation, but refused all medication and was not considered an imminent danger so he was released. We were fortunate to find Dr. David Pickar, who had led schizophrenia research at NIMH for many years. He said that although Matt was suffering from schizophrenia, he would likely benefit greatly from treatment. On the spectrum of schizophrenia functioning, Matt was exceptional. Very articulate and able to interact pleasantly with others, able to conduct research, able to reason well and carry out plans. Much of his brain worked very well. But he needed treatment with antipsychotic medication in order to recover.

Matt moved to an apartment, but was evicted for starting a huge bonfire just outside the building. At the next apartment, Matthew was cited by a fire safety inspector for disabling the fire alarm and having an explosive substance illegally stored in his refrigerator. At the court hearing, Dr. Pickar testified that Matt needed treatment, and would get worse without it. However, Matt somehow pulled himself together and presented a calm, likeable young man to the presiding judge. Matt had researched the statutes, and he argued that the amount of explosive material in his apartment was just below the chargeable amount. The judge said he was quite impressed at Matt's argument. Then, with stupefying ignorance, and brushing aside the expert testimony of Dr. Pickar, the judge pronounced that "Matt has the right to remain psychotic if he so chooses." With those words, the door to recovery for Matt was slammed shut. The judge had decided that Matt did not pose an imminent danger to himself or others, despite clear evidence to the contrary from family and a highly qualified medical specialist. Tragically, the judge was proved wrong on both counts.

A few months later, during a visit to our home, Matt told us he was leaving for Colorado. We were surprised. He often ran out of food and we took him out to get groceries every week. "Sweetie, why are you going so far away? How will we visit you?" I asked. He turned away from my gaze and said softly, "It's for your own safety, mom." At that moment, our son, despite his psychotic state, saw and bravely acknowleged what the judge and Maryland laws had refused to see. I will always be grateful that he wanted to protect us. How I wish Maryland laws had protected him.

Within the year, I received a phone call that my son had died by suicide, having set fire to his camper van. It was the dry season in Colorado, and the extensive fire could easily have spread to neighboring homes and caused many deaths. In the explosion, Matt received severe burns over 96% of his body, but did not die immediately. When the police arrived, Matt told them, "I tried to kill myself and failed. Please shoot me." Instead, he was airlifted to the emergency burn unit in Aurora, Colorado. The doctors realized that he would not survive his horrific burns, and began to treat him for severe pain while they tried to contact next of kin. They intubated him to keep his airway open, or else the pain medication would not work. They also had to make at least a dozen long and deep incisions all over his body to prevent the massive swelling of the burned tissue from compressing his lungs and vascular system. After a few hours of fruitless efforts to find his family, they stopped trying to keep him alive, and allowed his suffering to end, at last.

Is this the "freedom" that Maryland law has in mind when deciding whether a floridly psychotic person may refuse treatment that both family and doctor are urgently requesting? It is cruel and barbaric to withhold treatment from a person who urgently needs it but cannot understand that they are ill. Schizophrenia strikes our young people in their prime of life. Have mercy on them, I beg of you.

SB 707 & HB 1014 Support Rania Dima.pdf
Uploaded by: Rania Dima
Position: FAV

SB 707 & HB 1014
Position: Support
Rania Dima
9433 Carriage Hill Street
Frederick, Maryland 21704

Dear Madam Chair and Members of the Committee,

Disability justice for the severely mentally ill will only come when we start addressing chronic brain diseases as the biological disability they are, and when we recognize that denying access to timely medical intervention is not only discrimination, but systemic oppression. I am deaf-blind. I cannot read a sheet of paper to save my life. I can't; my eyes are broken. My son has a psychotic brain disease. He cannot see that he has a severe mental illness to save his life. He can't; his brain is broken. Without my hearing aids, I cannot understand the voices around me. Without medication, my son cannot understand that the voices in his head are a symptom of his disease, and the longer he stays in psychosis without treatment, the more damage occurs to his brain and the less likely he is to recover.

For the past four years, I have tried to get medical intervention for my son, only to watch him get caught up in the criminal justice system and slip away to his disease. When he fell into crisis, instead of help, a SWAT team busted down his door, pepper bombed his condo and dragged him to the hospital. Instead of keeping him, the hospital released him after the mandatory hold despite telling us that they had plenty of evidence to admit him. Because my son was still in psychosis, the Sheriff's office took him to jail where he sat for the next 470 days to await his trial, even though he had no prior criminal record. He sat there without treatment, with his brain still on fire. As a result, he refused the state's offer of Not Criminally Responsible, believing it to be a trap set by the conspiracy, accrued additional charges, spent a month in solitary confinement, and came out of jail still very sick and blaming me for putting him there. The judge's solution was to order him to have no contact with me or my husband, the two people in the world who are supposed to be there for him the most. He can't even contact his younger sisters, who are growing up without him. Now, we are stuck waiting for the next crisis to unfold with our hands tied. And all the while, my son has never received the treatment he so desperately needs.

As a broken-hearted mother, as a disabled person, I ask that we address severe mental illness as the biological disability it is and fix the system where we can. Every disability deserves accommodations and timely medical intervention. SB 707 and HB 1014 make needed clarifications to Maryland's standard for emergency evaluation and involuntary psychiatric hospitalization—clarifications that will allow individuals with severe mental illness to receive treatment before they reach a point of crisis or tragedy.
Right now, the requirement that a person be "a danger to the life or safety of the individual or others" is often interpreted so narrowly that families and clinicians cannot act until harm is imminent. For people who lack awareness of their illness, this delay

can lead to homelessness, victimization, incarceration, or irreversible deterioration.

These bills clarify that:

- Danger does not need to be imminent.
- Personal and medical history should be considered.
- "Danger to self" includes inability to meet basic needs or substantial deterioration in judgment when the person cannot make an informed decision about treatment.

These changes do not expand who can be hospitalized—they simply ensure that the existing standard is applied consistently and humanely. They allow intervention at the point when treatment can still prevent suffering, protect safety, and preserve lives.

Thank you,

Rania Dima

SB707 A.Henderson-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB 707
February 24, 2026; Senate Finance Committee
From: Amy Henderson, St. Mary's County

Position: Support

I am the mother of an adult son who has bipolar disorder. He was diagnosed 23 years ago, at the age of 20. When he was compliant with medication, he was able to work as a machinist and a welder for several years, maintain a home and take care of his family.

In 2011, my son stopped taking his medication and his condition deteriorated. He was easily agitated, had difficulty sleeping, had trouble at work, and was eventually fired from his job. In January of 2012, he went to Washington, D.C., leaving his wife and two children behind. He slept on the couches of strangers who took pity on him, climbed on statues and napped in trees. He got numerous parking tickets and moving violations. He forgot where he left his car and it was impounded twice. Several times he returned to St. Mary's County and was verbally abusive to friends and relatives. One night, he became enraged and threw objects through the front window of his home. Another time he took items from a gym, thinking the manager would "put it on his tab." He received at least two no-trespassing orders. He refused any treatment.

My husband and I were extremely upset by these events and the feelings of helplessness that overcame us. Family members and friends asked us why we weren't "doing something" about his bizarre behavior. We knew from talking to many other families that the doctors, police, and judges would not petition or order an emergency evaluation until our son threatened to harm himself or someone else. They interpret the current dangerousness standard as meaning only imminent physical harm. We were powerless to get him involuntary hospital treatment.

We believed that we would eventually get a phone call for one of three reasons: our son would be in jail, in an emergency room, or dead. We waited and dreaded what might happen. Then the call came: **our son had climbed up onto the roof of a church and lost his footing. He broke bones in both feet, and in one wrist, and required surgery.** He spent the summer recuperating and coming down from the manic high that had endangered him. His treatment cost close to $100,000. He was approved for SSDI.

We support changing the language of the laws to include psychiatric deterioration that leads to the inability to care for oneself and the consideration of medical history. We would have been able to access treatment for our son much sooner, helping him avoid life-altering injurie and prolonged mental instability.

Please support **SB 707.**

SB707 C.Weinberg-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB 707
February 24, 2026; Senate Finance Committee
From: Claire Weinberg, Montgomery County, Maryland

Position: Support

My son had Schizophrenia, and he took his own life in 1994.

One of my long-lasting memories is that of my late husband, literally on his knees, crying and begging my son to accept treatment. This was after a year in college, when he was first diagnosed with Schizophrenia. **I don't believe he ever had any awareness of the causes of his suffering (such unawareness is called anosognosia)**. Because he was paranoid, delusional and hearing voices, he **refused treatment and never realized that he had an illness.**

Since early childhood Michael was very bright, but fearful. By high school graduation he was tense and sometimes behaved bizarrely. Michael managed to get a degree in horticulture from the University of Maryland, but was too fearful to seek a job. He did some manual work for a friend and odd jobs.

When I moved to a retirement community, discussion of selling our home so frightened Michael that I kept the home for him. By1994, Michael had deteriorated and was living alone in the house, fearful and withdrawn. He stopped taking care of himself and was unkempt, depressed, paranoid, hallucinating and an utterly hopeless individual. HE TOLD ME HE HAD ACQUIRED A GUN. I contacted the Crisis Center to come and get the gun out of the house. They could not or would not.

Michael continued to refuse voluntary hospitalization. With difficulty I petitioned the court for an emergency evaluation. The police took him to the emergency room and the doctors decided **he did not meet the dangerousness standard for involuntary admission.** Michael may not have looked to be a "danger" but he was quite obviously **seriously ill, unable to care for himself, and utterly without hope.** If Maryland law had included the provisions in this bill, he would have been hospitalized and received treatment.

Instead, **two weeks after the evaluation, he shot and killed himself.**

I am 92 now, but I blame myself daily all these many years, for not finding a way to rescue my precious son. But a system that permitted timely involuntary hospital treatment could have saved him. Changing the hospital commitment law to help people like Michael could help prevent future suicides.

Please support this legislation!

SB707 D.Bennett-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Debra A. Bennett, mental health advocate and former caregiver
Position: Support

My son Ben J. Bennett, Jr. was dually diagnosed and had a severe bi-lateral hearing disability. In December 2024, at age 35, Ben tragically passed away. On December 4th he was found unconscious on a Baltimore street without identification and admitted as a John Doe to the same hospital where he had recently and voluntarily received psychiatric treatment for a month. He had sustained an anoxic brain injury and died 4 days later.

Ben had been discharged from that hospital on November 27. He left the hospital with the hope of "being successful – this time." This is what he told with me during one of our last conversations and thanked me for helping him. I believe he was unable to follow through because of his lack of awareness about his conditions and the deterioration of his brain over time. By this time, Ben had over 25+ prior emergency department (ED) admissions, hospitalizations, and crisis stabilizations.

For the majority of Ben's past ED evaluations, inpatient hospitalizations, and crisis stabilization services, I had to travel to different Maryland counties to personally file an emergency petition with the court because local police and mobile crisis teams refused to petition – either because they interpreted the danger standard as requiring imminent danger, were not willing to consider personal, medical or psychiatric history, or they did not consider psychiatric deterioration to be a danger to self.

In 2021, when Ben lived in Frederick County, he experienced a psychiatric crisis. On a Sunday evening, the police went to his apartment to evaluate him after receiving a complaint from a neighborhood store about demanding and bizarre behavior exhibited when he wanted to purchase cigarettes. His late father and sister drove there from Charles County and Alexandria, VA. They tried to convince the police to petition him for evaluation and asked them to consider his personal and psychiatric history, but to no avail. The police decided that the psychiatric deterioration he was experiencing, did not meet the requirements of the danger standard statute. The mobile crisis unit was not available at that hour on Sunday and the Court was closed. My son continued to deteriorate instead of getting treatment.

Several days later, the resident manager called me frantically reporting that my son was lying in the parking lot. After the police were called by both of us, he still was not petitioned for an evaluation. Three residents complained about his unstable behavior, one filed a Peace Order, and the resident manager was compelled to issue him a Notice to Vacate because he was disturbing the peace. I had to strongly encourage the Assertive Community Treatment (ACT) Team to file an emergency petition.

The narrow interpretation of the danger standard had not only denied my son crucial treatment, it created fear in the community and forced my son into homelessness while he was hospitalized. He was also denied continued mental health support and shelter services in Frederick County. The Frederick ACT assisted in transporting him to Anne Arundel County to try to get residential crisis service. He soon left and was hospitalized in Baltimore City. Finally, after 4 months, I was able to see Ben Jr. He was a frail, psychotic shell of himself and his mental state had significantly deteriorated. Perhaps if the danger standard made explicitly clear that imminent danger is not required, that psychiatric deterioration is a form of danger to self, and required that personal, medical and psychiatric history must be considered if available – my son would have received more timely help before the tragedy of losing his mental stability, housing, and being distant from his family.

SB 707 makes needed clarifications to Maryland's standard for emergency evaluation and involuntary psychiatric hospitalization – clarifications that will allow individuals with severe mental illness to receive treatment before they reach a point of tragedy.

Right now, the requirement that a person be "a danger to the life or safety of the individual or others" is often interpreted so narrowly that families and clinicians cannot act until harm is imminent. For people who lack awareness of their illness, this delay can lead to homelessness, victimization, incarceration, or irreversible deterioration.

SB 707 clarifies that:

- Danger does not need to be imminent.
- Personal and medical history should be considered
- "Danger to self" includes inability to meet basic needs or substantial deterioration in judgment when the person cannot make an informed decision about treatment.

These changes do not expand who can be hospitalized—they simply ensure that the existing standard is applied consistently and humanely. They allow intervention at the point when treatment can still prevent suffering, protect safety, and preserve lives.

While it is too late for Ben, I ask that you support HB 1014 to save the lives others.

Thank you.

SB707 Diaz Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Carmen Diaz, Montgomery County
Position: Support

I am a close relative of a young woman suffering from a long history of schizoaffective and bipolar disorder. She has been a victim of the danger standard for involuntary psychiatric evaluation, which acted as a barrier to receiving the treatment she desperately needed.

My relative was **homeless** for more than 3 years. She was thrown out of several shelters due to misconduct. Although she was suffering from psychosis and unable to care for herself, the mental health professionals at two of the shelters in Montgomery County claimed **she did not meet the danger standard for emergency evaluation because she was not suicidal or homicidal.** In one shelter she was assaulted by another resident.

Although my relative used to participate in voluntary treatment, in her current psychotic state, she was unable to recognize she had an illness and refused all treatment programs. My relative's family has been consumed with anxiety and fear for their loved one for 3 years.

Recently after eviction from a shelter, my relative was out on the streets for a week. Her psychotic delusions escalated and, believing she was "saving" a young child, she tried to abduct the child from a young baby-sitter while they were out walking. Next step, my relative was arrested and **put in jail in Frederick County with a felony charge.**

This unnecessary, traumatic, painful, and costly situation could have been avoided if only the Maryland Danger Standard that requires someone to be "a danger to self or others" were not so vague that professionals can interpret it as requiring imminent suicidal or homicidal behavior.

I strongly believe that the Maryland Danger Standard should be clearly defined by:

1. Including an inability to take care of daily needs
2. Making clear that danger need not be imminent
3. Including the ability to look at the person's history.

Please support SB707 which is a more humane, clear, and reasonable Danger Standard that facilitates treatment before tragedy.

SB707 J.Kaufman-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Jessica Berman | Caregiver | P: (443) 858-8936 | E: jessicabermankaufman@gmail.com
Position: Support

My name is Jessica Berman Kaufman, and I reside in Howard County, Maryland. I am the mother of a 26-year-old son living with schizophrenia and severe cannabis use disorder. Unfortunately, my son lacks insight that he lives with these severe mental illnesses, a symptom called Anosognosia.

In the midst of a serious psychotic break, completely disassociated from reality, unmedicated, and making veiled threats toward a family member, my husband and I begged the police and later physicians to hospitalize him involuntarily so he could be stabilized. Instead, our son remained actively psychotic for almost a year, unmedicated, and not believing he needed treatment. Unable to care for any of his basic personal needs and lacking capacity to make rational decisions about medical care, our son may have "died with his rights on."

In June 2024, our son voluntarily walked into a hospital emergency room and was admitted to the psychiatric unit. For the first time in months my husband and I breathed a sigh of relief. But, fewer than 18 hours later, we received a call that our son wanted to leave. The doctors agreed our son required intensive psychiatric treatment for his psychosis and mania, but because our son did not appear imminently "suicidal" or "homicidal," the psychiatrist determined he did not meet Maryland's standard for involuntary evaluation and hospital admission, which only vaguely requires an individual "to present a danger to the life or safety of the individual or others." The doctor told us that because our son understood if he left the hospital he may be homeless, he had sufficient "capacity" to make that choice.

The temperatures outside exceeded 104 degrees that day - my son had no transportation, no money, no phone, no food, and only the clothes on his back. Frightened for his safety, my husband and I brought our son home. Life in our household became increasingly chaotic and unpredictable. My husband and I felt helpless and hopeless watching our son continue to decompensate - he lost everything. A college graduate with a degree in sociology, our son was fired from his job, spent his life's savings, and maxed out his credit cards resulting in massive debt. We begged our son to get help but instead he disappeared - for almost six weeks we did not know where he was. On the verge of homelessness, his fear of living on the street finally led him to agree to seek admission to a residential treatment facility, but only so he would have housing.

Ultimately, after a year in residential treatment taking anti-psychotic medication, our son found work as an SAT tutor, and currently lives independently. However, our son still does not comprehend the gravity of his illness.

Under Maryland's current "danger" standard, families like mine are helpless to secure desperately needed timely treatment for our loved ones who lack insight, are unable to provide for basic needs (nourishment, medical care, shelter, self-protection, safety) creating a substantial risk of serious bodily harm, serious illness, or death; or lack capacity to make treatment decisions. Research shows that prompt treatment: shortens hospital stays, prevents brain damage caused by untreated psychosis, and improves long-term outcomes and recoveries.

I urge you to vote in favor of SB 0707.

SB707 JKMcIver -Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Judith Kerner-McIver, Howard County
Position: Support

I am the mother of a son with schizophrenia, who had to move her son away to another state because Maryland's laws for involuntary evaluation and treatment were barriers to his recovery. As a volunteer teacher for NAMI *Family to Family* a 12 week class and a facilitator for a NAMI *Family Support Group*, I hear of many families that have encountered the same barriers.

My son had his 1st psychotic break in 2007, just after simultaneously earning two Bachelor of Science degrees in Engineering with honors. Since then, **he has been mostly non-compliant** toward medication for his schizophrenia and psychosis **due to anosognosia (lack of insight that he has a serious brain disorder)**. He believes that the voices he hears (auditory hallucinations) are God speaking directly to him; thus he refuses to take medicines that would reduce or eliminate those communications from God.

The controlling voices wreak havoc in his life & the lives of his extended family who work so hard to help him. Worse yet was my frustration and **inability to get him help in the state of Maryland due to inadequate laws** regarding such emergency evaluation and involuntary hospitalization. Here are two examples of many attempts we made to get him help:

- We called the Mobile Crisis Team/Howard County Police Department to get him an emergency psychiatric evaluation in 2012 after he punched holes in our home's walls and was barely eating on a daily basis. **We were told that he was not "dangerous enough"** to himself or others to be admitted into Howard County General Hospital;
- He was driving himself around a tri-state area (PA-MD-VA) at high speeds, in a psychotic state, without eating or drinking anything. This was also **not considered enough "danger to himself or others" to get him a psychiatric evaluation** and involuntary treatment.

In subsequent trips to PA in 2012, his erratic behavior and then-homeless state resulted in an involuntary hospitalization because they immediately recognized his obvious poor condition and psychosis. The law in Pennsylvania for involuntary emergency evaluation, much like the standard proposed in **SB707** allows for consideration of "his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs". The Pennsylvania standard for involuntary hospital admission, similar to **SB707** includes the "inability, without assistance, to satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety".

After returning to Maryland he suffered serious debilitation in 2013. We physically moved him to a PA apartment so he could benefit from PA involuntary commitment laws. We should not have had to move our son away from his support system in MD to another state to get the treatment he desperately needed. Forty-six other states have, in statute, consideration of a person's ability to care for themselves.

It is past time that Maryland updated our law.

SB707 K.Smith-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB 707
February 24, 2026; Senate Finance Committee
From: Kathleen Smith - Waldorf, Charles County

Position: Support

My name is Kathleen Smith, and I am a resident of Charles County. I am the mother of an adult son who has severe mental illness and also developmental disabilities, including a form of autism. **Because the current standard for dangerousness is not defined to clarify that danger need not be imminent, my son did not receive the treatment he desperately needed and received a 20-year prison sentence.**

Paul had no insight that he had a severe mental illness. I paid for his apartment since he could not provide food or shelter for himself. His growing inability to control his actions, suicidal tendencies and destructive behaviors toward himself, his family and society was what led us to look for assistance through the Maryland Emergency Evaluation Petition System and Involuntary Hospital Admission process.

The current laws did not work in 2007, when my 21-year-old son left me a message on my cell phone in the middle of the night. He stated that he was standing in the middle of Crain Highway with his eyes closed, hoping a passing car would hit him. When I woke the next morning and listened to the message, I immediately called 911. Charles County Sheriffs listened to my message and told me they would do a welfare check on him. They located him at his apartment and told me that he stated he was fine. The sheriffs decided that since he was no longer in the roadway that they could not initiate an emergency petition. Clearly with Paul's history and the distraught suicidal phone message, the law should allow an emergency petition to be completed. He was also unable to care for himself, attempted to harm to himself and was rapidly deteriorating mentally. However, with how the current law is written and is interpreted as requiring imminent danger, I and the police officers were unable to obtain an emergency evaluation.

About one week after the emergency evaluation was denied, Paul voluntarily left the apartment, became homeless, and began entering other residences at night while they were occupied.

He is currently serving a 20-year prison sentence with 60 years suspended. If the provisions of this Bill had been in effect, I believe this could have been prevented.

Treatment delayed is treatment denied. The consequences of no treatment are homelessness and criminalization. Please support SB 707 so others with serious mental illness can receive timely evaluations and hospital treatment before they deteriorate and suffer the terrible outcomes of denied treatment.

Last year while not on medication the police were called to our house several times and did nothing because he didn't actively show imminent danger while they were present A few weeks after - he decided to walk on the main road and darted across the road. He was struck by a car, sustaining life threatening injuries and was on life support for over ten days.

SB707 L.Bass-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: L. Cooper, St. Mary's County
Position: Support

My adult son has bipolar disorder. He was diagnosed in 2001 at the age of 20. At that time, he and our whole family had much to learn about managing severe mental illness, as well as how our health care system would undermine access to timely treatment. For a time, my son was compliant with taking prescribed medications for his illness. He worked full-time for several years as a machinist and a welder. He maintained a home and took care of his family.

In 2011, my son's condition deteriorated severely after he stopped taking his medications. He was easily agitated, had difficulty sleeping, and eventually was fired from his job. In January of 2012, he went to Washington, DC, leaving his wife and two young children behind. He "couch surfed" in the homes of strangers who took pity on him, climbed on statues and skate-boarded all over the city. He got numerous parking tickets and moving violations. Forgetting where he had left his car, it was impounded twice. Several times, he returned to St. Mary's County and was verbally abusive to family members and friends. One night, he became enraged and threw objects through the front window of his home. Another time, he shoplifted and said he thought the store owner would "put it on his tab." He issued at least two no-trespassing orders.

His father and I were extremely upset by those events and the feelings of helplessness that overcame us. People asked why we weren't "doing something" about our son's bizarre behavior. We knew from talking to other parents that the local doctors, police, and judges would not petition for an emergency evaluation until our son threatened to harm himself or someone else. In addition, local ER doctors would not certify patients for involuntary hospital admission unless there had been a threat of physical harm to self or others, since they interpreted the current "dangerousness" standard to mean only imminent physical harm. Therefore, we were powerless to get him involuntary hospital treatment.
We resigned ourselves to anticipating one of three phone calls: that our son was in jail, in an emergency room, or dead. And so we waited and dreaded what might happen.

In April we received a call from an ER doctor telling us that our son had climbed onto the roof of a building and lost his footing. The fall resulted in fractures in both of his feet and in one wrist, requiring multiple surgeries and extensive follow-up. He spent the summer recuperating and coming down from the manic high that had endangered him. His treatment cost nearly $100,000 and he was approved for SSDI. In the fall of 2012, my son's condition had turned to deep depression and irritability. **After an altercation with his wife, he assaulted her and ended up in jail**. Several months later, he was released and began the long, slow journey to recovery.

I strongly believe that if the standard for involuntary evaluation and hospital treatment were changed to include language contained in SB707, families like mine wouldn't face the trauma that we went through when our son was so ill. Families need the language of the law changed to clarify that there need only be a reasonable expectation of danger, not imminent danger, and that "danger" includes psychiatric deterioration that leads to the inability to care for oneself, or the possibility of criminal justice involvement, and that medical history should be considered.

Thank you for attending to this important issue.

SB707 L.Cooper-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Lisa Bass Cooper, Fenwick Island, Delaware
Position: Support

Hello, my name is Lisa Bass Cooper, and I am testifying in support of SB707 on behalf of my daughter, a 39-year-old Silver Spring resident, whom I have legal guardianship of because of her serious mental illness (SMI).

My daughter suffers from schizoaffective disorder bipolar manic type. For the past seven years, she has been hospitalized more than 28 times because of her lack of insight and periodic resistance to medication because of known debilitating side effects.

Most recently, she has learned to go to the hospital for physical complaints when she feels she is slipping into another manic episode. In the past, when she has been resistant to going to the hospital. It has been difficult to get immediate treatment for her psychiatric disorder because of the danger threshold that currently exists at most emergency rooms in Montgomery County. The irony is that if she were treated sooner, she could stabilize sooner, saving the state money and her the trauma of prolonged forceful in-patient treatment to keep her and staff safe. **Instead, this "danger threshold" policy of involuntary psychiatric care puts her at greater risk of escalation of her manic behaviors before she is held against her will for her own good.**

I thought that guardianship would help bypass this situation because the court has recognized she can't make the best judgements when she cycles to the manic behaviors that make her a totally different person. But that has not been my experience.

What policymakers should consider is that mental health is not a one-size fits all. I am sure that people with mild mental health conditions may be well-served by the "danger threshold" but not SMIs like my daughter. She has a documented struggle with medication efficacy and is well known to the system. For others with her diagnosis and their supportive families, the current mental health laws and processes need to be re-examined and changed. SB707 is a step on the right direction. Currently, the danger threshold is allowing the mental health care system to get paid while those they care for continue to suffer. Everyone in the system knows it, but they are not advocating for this because they are getting paid and don't want to "rock the boat." I have spoken to numerous staff in crisis centers and hospitals who concur with me privately.

I fully support passage of SB707. I believe it will save the mental health system in Maryland critical dollars. It will also help the seriously mentally ill get treatment earlier so they can stabilize sooner and enjoy their lives.

Lisa Bass Cooper
emediapro@gmail.com
30629 Steelman Court
Fenwick Island, DE 19975

SB707 M.Eichenberger-Testimony (1).pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB 707
February 24, 2026; Senate Finance Committee
From: Marianne Eichenberger, Howard County

Position: Support

I am an advanced practice mental health nurse of 43 years living in Howard County. This legislation would improve a mental health practitioner's ability to provide more timely treatment by providing a clearer definition of "danger". The current Involuntary Treatment law does not define "a danger to the life or safety of the individual or of others." Clinicians, police, judges, and other evaluators are forced to define danger, which has created a narrow interpretation of danger as "imminent" danger. Those struggling with severe mental illness who are unable to satisfy basic survival needs such as safety, clothing, and food are not included in this limited interpretation.

The proposed bill would clarify that danger need not be "imminent" but would include those with mental illness that are unable to provide for basic needs.

The evidence shows that severely mentally ill clients who do not receive treatment in earlier stages of their illness or that have had to have multiple re-stabilizations, have a poorer response to future treatment and poorer long-term outcomes. Another negative consequence is these individuals often come to mental health care through the prison system. It is critical to help individuals into treatment so they can make informed decisions regarding their future treatment.

I worked with a client that was homeless, hearing voices that told them that others around them were the devil and need to be stopped. The client entered the system after robbing a store for food and threatening to harm the store's cashier. The client was able to enter the forensic system because of these charges and receive treatment even though they did not believe they had an illness at that time. This individual after treatment stated, "This saved my life." They described the horror of living on the streets, searching for food in garbage cans, and not understanding that the voices were not real. If the definition of danger had been clarified, this individual would have been able to receive treatment sooner.

Involuntary hospitalization requires that at least 2 more often 3 (psychiatrist, physician and mental health provider) make the determination that involuntary care is required. **Please realize that as care providers we do not make this decision for involuntary treatment lightly and that criteria are and must be followed. Our first responsibility is to our clients.**

Maryland is among the 5 states in the nation with the most restrictive standards. I have worked in a state that used a clearer definition of "danger." The clinicians appreciated the guidance in the provision of care to those seriously mentally ill unable to make rational decision because they did not understand they were ill. This bill will not cost money, because earlier treatment results in shorter hospitalizations and less use of the forensic system – police, courts and corrections.

I ask all members of the Committee to support this bill.

I appreciate the time you have taken to consider this vital issue

SB707 M.Martin-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Marilyn Martin, 11509 Emmanuel Way, Solomons, MD 20688

Position: Support

My 37-year-old son has severe schizophrenia. He now lives with his father in Montgomery County, MD. His first psychosis occurred in 2008 when he was 24 years old. Over the past decade, I have been unable to obtain timely treatment for him by involuntary emergency evaluation because too many community psychiatrists, police and judges have interpreted the standard to mean imminent danger of bodily harm with no consideration given to how delusional or disabled he was at the time. When left to further deteriorate, people with these neurological disorders can indeed become physically dangerous, most often toward their own family members, who are full-time caregivers. Just to cite three of our many examples::

- **By 2009 he refused to take medication, and he did not believe he was ill**. When his delusions included a threat to kill someone, I petitioned the court for an emergency evaluation. The judge denied it for lack of "immediacy," although the law no longer stated that imminent danger was required.

- **In April 2013, my son became so belligerent that I was afraid.** His psychiatrist failed to petition for emergency evaluation. Two months later, a neighbor reported threats to the police, who also failed to petition, although finally the doctor did so.

- **In January 2016, he was visiting me and my husband in Chesapeake Beach.** During my drive to return him to his dad's, I grew increasingly anxious about his behavior. Once I returned home, I emailed and faxed my concerns to his clinic director and to his provider that I felt endangered by his current behavior. I asked them to get him off the medication that was failing him and to please return to the previous one that worked. I heard nothing from them. When my son called me in February to request another visit, I hoped that he had received proper treatment. He had not, and he was even more dangerous. I was unable to convince him the next day that it was time to leave to return to his dad's. **Without warning, he came inside from the porch and picked up my 70-year-old husband by his neck. He kept pounding his fist into my husband's head. When I tried to intervene, my son pushed me into a wall. This episode ended when I called 911. We were lucky that an officer trained in de-escalation arrived**. The officer took my son to our local hospital, and from there, several days later, to a bed in Montgomery County for treatment.

A broadly interpreted standard leaves too many people in potential danger: the caregivers (family), the disabled people in psychosis, the police, and even the public.

Please support the changes SB707 would bring about.

SB707 Proctor Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Kelly Proctor, Howard County
Position: Support

I have lived in Maryland my entire life and currently reside in Howard County, where I serve on our Local Behavioral Health Advisory Board. Today, I am testifying on behalf of Senate Bill 707.

Five years ago, my youngest son was diagnosed with Bipolar disorder, acute psychosis, and schizoaffective disorder. Our family went from being afraid for my son, to being afraid of him during his year and a half psychosis. Calling for assistance turned out to be very stressful because we were always asked if my son had assaulted us, by the person on the other line. It became clear that **Maryland laws are reactive and not proactive in helping families in a mental health crisis. We were often in danger, sleeping in shifts and carrying pepper spray. We 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. We know that we are responsible for identifying and managing it ourselves since **the current laws do not help us. Although a mental illness diagnosis in a family is life-changing, it should not be a sentence for a lifetime of fear.**

I am confident that Maryland updating the current law defining "harm to self or others" according to SB707 will create a proactive step in aiding those in a mental health crisis. The providers of care will be able to file for help without the fear that a family feels.

I greatly appreciate you taking the time to read my story.

Please support SB707.

SB707 R.Russell-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB0707
February 24, 2026; Senate Finance Committee
From: Roger S. Russell Jr, Montgomery County, Maryland

Position: Support

I believe the revision of the dangerousness standard in this legislation would best serve those suffering from severe mental illness, their families, and the general public. **It might have helped prevent my wife's severe psychotic deterioration which resulted in her death.**

People with schizophrenia or schizoaffective disorder, such as my late wife, typically lack awareness or insight into their disease and do not know how seriously their illness is. They must be treated for psychosis to prevent the permanent worsening of their illness. Current law is often interpreted by doctors as meaning that a person must be imminently suicidal or violent at this very moment in time before they can be involuntarily hospitalized to receive needed treatment. This legislation would allow the family members to get medical care for desperately ill loved ones.

My wife of 33 years died in France after a long struggle with schizophrenia in Maryland. She had gone to France to escape paranoid fears that people or unknown forces were trying to harm her in Maryland. **She waded fully clothed, carrying her passport and family photos, into the Mediterranean Sea and swam out until she was overcome by hypothermia and drowned.** She left no note, but on the preceding day she told me of being "persecuted" and wanting to seek "asylum." Her speech was excited, at times incoherent, and reflected the feelings of extreme paranoia she often experienced.

The paranoia was simply the last episode in her long history of mental illness. She first began to experience auditory hallucinations, i.e., voices that criticized and threatened her. At that time, she willingly sought treatment for her condition and had multiple voluntary hospitalizations.

Later, she began to refuse to see her doctor and to take medications. Left untreated, her symptoms of paranoia and delusions greatly increased. She became convinced that people were trying to harm her, that intruders were entering our house at night and that menacing messages were being sent to her from pipes in the bathroom. **She would barricade the house doors, dial 911 or call human rights organizations to seek protection, or wander the neighborhood seeking someone to protect her.**

This behavior greatly disturbed me and my son. We decided to lock our bedroom doors at night. At the same time, I repeatedly sought treatment for her. Once I drove her to a hospital, but they would not admit her unless she willingly consented, which she would not do. Thus, while she was clearly significantly debilitated by her illness, lacked the capacity of rational thought, and could not make a responsible decision regarding her own well-being, she was allowed – under current state law – to remain untreated.

This revision would permit persons, like my wife, to receive essential treatment when they are at their most vulnerable and unable to make rational decisions for themselves. It would protect family members – especially children, and the public from individuals who are not aware of the consequences of their behavior. **It could help prevent the severe psychiatric deterioration that can lead to suicide.**

SB707 S.Kneller-Testimony.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Susan Kneller, Rockville, Montgomery County

Position: Support

I volunteered for 22 years, answering the NAMI Montgomery County helpline for families with a loved one with mental illnesses, including schizophrenia and bipolar disorder. I am submitting this testimony as an individual, not on behalf of any organization.

The danger standard for psychiatric evaluation and involuntary hospitalization has been a barrier to critically needed treatment. It has prevented many families from getting treatment for their loved ones, who are unable to recognize that they are ill – treatment needed to prevent tragic outcomes that result from denial of treatment, including violence, homelessness, and incarceration.

The function of the Helpline is to try to put callers in touch with resources that will help them. Our NIGHTMARE CALLER, of which I have answered many, is the person who is watching a family member with Serious Mental Illness deteriorating in front of their eyes. He or she is unable to recognize they are ill and therefore refuses treatment. Very often, the ill person is frightening and abusive to family members. **Our ability to help them is limited. Maryland's standard for an emergency petition is generally interpreted in our County by the police, judges, and crisis team as requiring imminent overt dangerous behavior, such as a threat or violence**. Often by then it is too late. A crime has been committed or someone is harmed.

What is wrong with this picture? SB707 would change the picture so that a very ill person could receive treatment BEFORE someone is harmed or they become homeless or incarcerated.

Some who oppose this legislation want to protect everyone's civil liberties, unless they present an imminent danger. But when the cost of that idea is violence and unbearable family disruption, we need to rethink our strategies and re-write some laws. Clarifying that the "dangerousness" standard for emergency petition and involuntary commitment includes those who cannot care for themselves or are suffering psychiatric deterioration that will likely result in the person becoming a danger to self or others would be a good beginning.

Providing treatment to those with severe illness who cannot understand they are ill, can restore their rational thought and ability to exercise their civil right. It is the only humane path to follow. **This bill would make it possible for families to get help before harm is done. I strongly urge that SB707 be the new law in Maryland!**

SB707_Fofanah_Support.docx.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707

February 24, 2026; Senate Finance Committee

From: Hawa Fofanah, PMHNP-BC, FNP-BC

Position: Support

Dear Sir/Madam,

We are waiting too long to help people with severe mental illness—until they are suicidal, violent, homeless, or incarcerated—because our current danger standard for involuntary treatment is too narrow.

I grew up in Sierra Leone (West Africa) where mental health services are extremely limited. I lost my cousin to severe mental illness, a loss that profoundly shaped my professional path. After more than 8 years practicing as a Family Nurse Practitioner in the United States, I added mental health to my license in 2021 to better serve this vulnerable population.

Despite practicing in a country with advanced health care systems, I continue to encounter the same painful barrier: the inability to obtain timely hospitalization for patients who clearly lack insight into their illness. Working closely with psychiatrist Dr. David Pickar, I have cared for individuals with schizophrenia, bipolar disorder, and other serious mental illnesses who are unable to recognize their need for treatment. Their judgment and reasoning deteriorate. They may be unable to care for themselves, maintain safety, or make rational medical decisions. Yet, if they are not explicitly suicidal or homicidal, or if the danger is not considered imminent, involuntary evaluations are frequently denied.

The consequences are devastating. Patients decline further, lose housing and employment, and cycle through emergency rooms and jails. Families are left helpless, watching their loved ones deteriorate while being told they do not meet the legal threshold for intervention. By the time the standard is met, the illness is more entrenched and recovery more difficult.

HB1014 would allow earlier intervention based on clinical reality rather than waiting for imminent catastrophe. It would help prevent homelessness, incarceration, victimization, and long-term deterioration caused by untreated severe mental illness.

I respectfully ask the Committee to support HB1014 and take an important step toward compassionate, timely mental health care.

Thank you for your time and consideration.

Respectfully,
Hawa Fofanah, PMHNP-BC, FNP-BC

SB707_LSCarey_FAV.docx (1).pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; Senate Finance Committee
From: Laura Shears-Carey | 8204 Waterford Road, Pasadena MD, 21122 | 443-410-8975 | lshearscarey@gmail.com
Position: FAVORABLE

I write to you not only as a constituent, but as a grieving mother whose son's life was lost due in part to the limitations of Maryland's current mental health laws.

My son, Joshua D. Carey, suffered from severe and persistent mental illness that included psychosis. Under Maryland law, **he was repeatedly denied life-saving medical intervention because he did not meet the "imminent danger" standard.** Although his illness made him gravely ill and unable to care for himself, he often could not articulate a specific plan to harm himself or others. Because of this, he did not meet the strict legal threshold required for intervention.

As his family, we could clearly see the warning signs. We recognized patterns of deterioration, escalating psychosis, and behaviors that signaled substantial risk long before incidents occurred. Yet, without a stated plan or immediate threat, our pleas for help were met with barriers. The law required proof of imminence, even when substantial risk due to mental disorder and prior history was evident.

My son could not provide for his basic needs. He lacked the cognitive awareness to understand when he required treatment. He was non-compliant with medication — a direct symptom of his illness — which further worsened his condition. Despite my repeated pleas for assistance, we encountered dead end after dead end within our state system.

On July 20, 2023, my son Joshua became an angel.

I firmly believe that his death could have been prevented if Maryland law recognized substantial risk of harm due to mental disorder or prior history, rather than requiring proof of an imminent, articulated plan. SB707 and HB1014 have the power to close this gap — to allow families and professionals to intervene before tragedy occurs, not after.

Since my son's death, I have struggled to function and am unable to testify in person. I carry immense guilt, wondering if I should have left Maryland for a state whose laws would have recognized Joshua's need for care before it was too late. No parent should feel that the only way to save their child is to leave their home state in desperation.

Please, when you consider SB707 and HB1014, remember my son. Remember that behind every statistic is a family who begged for help. These bills have the power to spare other mothers and fathers from experiencing the unimaginable loss of a child due to a system that failed to act in time.

Thank you for your time and for your thoughtful consideration.

A grieving parent of a son who suffered from severe mental illness

SB707_RMichael_Support.pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for SB707
February 24, 2026; House Health Committee
From: Rayetta Michael, Co-Owner of Help in the Home, LLC
Position: Support

Testimony in Support of Clarifying the "Danger to Self" Standard

My name is Rayetta Michael, and I am the Co-Owner of Help in the Home, LLC. Our agency provides support and treatment to individuals living with severe and persistent mental illness.

Maryland's current involuntary treatment law allows individuals who could otherwise live lives of meaning, purpose, and dignity to refuse treatment and instead endure marginal, often deplorable conditions—marked by isolation, fear, homelessness, and the inability to meet basic physical needs. Too often, families are left powerless, waiting until their loved one becomes "dangerous enough" to qualify for hospitalization, while praying that irreversible health consequences, violence, or death can be avoided.

This bill would clarify that an individual who cannot meet their basic survival needs meets the standard of being "dangerous to self." That clarification would allow people who are so ill that they lack insight into their condition to receive the treatment they urgently need.

In my 25-year career, I have personally known three individuals who were murdered by someone experiencing psychosis. One was Dr. Wayne Fenton, whose death received national attention. Shortly before his murder, he wrote in The Washington Post that we would never allow our aging parents with Alzheimer's disease to live on the streets, yet our laws permit our adult children with brain diseases to do exactly that. The other two victims were parents who were doing everything they could to care for their adult children—children whose only alternative, under current law, was the street.

I have also witnessed two men in the grip of psychosis refuse to eat because of delusional beliefs. Despite clear and escalating medical risk, they were denied intervention because they were not deemed an "active danger to self or others." **Only when they became emaciated and developed edema from organ failure—conditions reflected in critical lab values—did they finally meet the statutory threshold**. Their families had already watched them deteriorate for weeks.

Finally, I can share the story of a young woman who after several years of treatment and healing was living in her own apartment and working. At this time, she had support workers meeting with her twice a month and regular phone contact with her parents. It was obvious to those who cared about her when she stopped taking her medication. She deteriorated to the point of no longer being able to care for herself then left to live on the street. When arrested for trespassing, she was found incompetent to stand trial. After taking enough medication to go before the judge. She was discharged to a crisis bed in Maryland and walked away. The last contact her parents had was in November 2018, when a truck driver who found her hitchhiking to Chicago called them out of concern. It was cold, she had very little with her, and he purchased a coat and offered to help arrange transportation home. She declined further assistance and has not been heard from since.

These stories are not rare exceptions—they reflect systemic gaps in our current legal framework.

I respectfully urge you to pass this bill to clarify the "danger to self" standard. Severe mental illness is a brain disease. When individuals lack the capacity to recognize their need for treatment and cannot meet their most basic survival needs, the law should allow timely intervention. Appropriate treatment can prevent irreversible medical harm, violence, and death—and can restore individuals to lives of safety, dignity, and hope.

SB707-Lanham-Testimony (1).pdf
Uploaded by: Rayetta michael
Position: FAV

Testimony for Bill number SB707: Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)

From: Staci Lanham, 1010 Overbrook Rd, Baltimore, MD 21239
Date: Feb. 24, 2026
Position: SUPPORT

In February of 2024, my son's hands were so raw and inflamed they were cracked and bleeding. He had been washing his hands non stop and then pouring rubbing alcohol on them because he thought they were infected. He told us, as his parents, that we were not ourselves and had been replaced by others. He thought his computer and phone were hacked and people were spying on him. He thought the neighbors had cameras set up in his room. He threw away perfectly good food because he thought it was contaminated. He would barge into his younger brother's room and accuse him of stealing or wiping feces on his items around the house causing him to constantly keep his door locked. He repeatedly told us of his desire to have a gun in the house for safety. He would burn items in his room causing the room to fill with smoke. He was convinced his closet had a mold infestation so the contents were piled in the middle of the room. He thought if multi-vitamin gummies were good for you, that eating a whole bottle was even better. He was verbally aggressive, antagonistic, rude, and extremely stubborn.

Just three months earlier, he chose to go off of his medications for schizophrenia and quickly deteriorated to a condition of psychosis with paranoia and unsafe behavior. We pleaded with him to go back on his medication; but the longer he was off of them, the more he didn't trust us, his team, or the meds. Though he had not overtly threatened our lives or his own, we did not feel safe around him, knew he was not making safe choices, and we worried what he might be capable of if the situation worsened.

The Baltimore County Crisis Unit would not come to the house unless he gave his permission—which he wouldn't give. His care team at Johns Hopkins told us their hands were tied and could not help us unless he was willing to help himself. Finally, I was forced to go to the District Court of Maryland for Baltimore County for an emergency to get him there involuntarily. This was a traumatic experience for me as his mother, and for our family who knew what was happening. For my son who was escorted from our home by Baltimore County police, the experience was both traumatic and undoubtedly reinforced his belief that he could not trust his family. The emergency petition led to 2 inpatient stays—the first was involuntary for 3 weeks which allowed enough healing to happen, which led to a voluntary second one for 6 weeks a short time later.

Though we managed to get him stable again, he certainly was not thriving in an outpatient

setting so in November of 2024, my son entered a long-term residential psychiatric rehab facility. One of the questions they asked me was “How will we know if he is starting to become unwell? What are the signs that you would recognize?”

For me to explain to them how I would know he was unwell, I needed to explain how he is when he is well. My son is a kind, polite, and empathic soul. He cares deeply for his family, other people, and animals, especially our pets. He rarely angers or raises his voice even when frustrated. And if he ever does, he is super quick to apologize and make amends. It genuinely bothers him if he felt he hurt someone’s feelings in any way. He is a people pleaser at heart. We have always had a good, loving relationship based on trust. Trust that we will always love and support him, and he trusts us, as his parents and caregivers, to help guide him through this terrible mental illness journey.

So when they asked me ‘how will we know?’ I simply said, “If he ever starts being the slightest bit rude to you, that’s when you need to pay close attention.” Because my son is not that paranoid, untrusting, and antagonistic person I described above. That is his illness. We knew he was not well and the longer he stayed that way, the greater the risk for harm to himself or others.

Families know when their loved ones aren’t well. It is hard enough to navigate this arguably broken mental health system, but the current standard makes it nearly impossible to get help to our loved ones who need it the most and, due to their illness, can not advocate for themselves.

I kindly ask this committee to support this bill and in turn the families and their loved ones.

SB707_SponsorTestimony
Uploaded by: Senator Ready
Position: FAV

JUSTIN READY
Legislative District 5
Carroll County

MINORITY WHIP

Finance Committee

James Senate Office Building
11 Bladen Street, Room 315
Annapolis, Maryland 21401
410-841-3683 · 301-858-3683
800-492-7122 *Ext.* 3683
Justin.Ready@senate.state.md.us

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

February 24, 2026

Senator Justin Ready
SB 707 – Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)

Chair Beidle, Vice Chair Hayes, and members of the Senate Finance Committee,

Senate Bill 707 would facilitate access to treatment for those with serious mental illness, such as bipolar disorder or schizophrenia, who are unable because of their illness, to recognize they are seriously ill and need treatment. The goal is to provide timely treatment to prevent the current consequences of treatment denial that are being experienced: incarceration, suicide, harm to others, homelessness, and brain deterioration from psychosis.

Maryland is one of the only 2 states, along with the District of Columbia, that have no definition for the danger standard for involuntary evaluation and inpatient treatment.

The result is that there is no consistent interpretation of dangerousness across the state and very often it is interpreted as requiring "imminent" danger, even though the legislature removed that requirement in 2002. In addition, unlike 48 other states, Maryland has no explicit language specifying that the inability to meet one's basic needs constitutes a danger to self and 30 states have psychiatric deterioration standards. In Maryland, danger is frequently considered only explicit suicidal or homicidal behavior, with no consideration of the ability to meet basic needs.

Consequently, our loved ones with serious mental illness, who lack the capacity to recognize their need for treatment, are denied timely treatment. Untreated psychosis results in brain damage and frequently the inability to recognize unlawful behavior. Our county jails report being overwhelmed with up to 50% of inmates with mental illness. Our state psychiatric hospitals are overwhelmed with court orders to restore competency and no longer accept civil patients for treatment to prevent behavior that can lead to criminalization. Maryland families are left to helplessly wait for senseless tragedy to establish "danger".

This bill clarifies that danger need not be imminent, that personal medical and psychiatric history be considered when available, defines danger to include, that as a result of a mental disorder

there is serious risk of bodily harm to self or others, or the inability to meet basic needs, or lacking the capacity to make treatment decisions and without treatment will likely meet the previous criteria.

Multiple state expert panels and stakeholder groups over several administrations have recommended that the danger standard be defined. Yet our adult sons, daughters, wives and husbands, still die by suicide after being refused involuntary hospital admission to treat psychosis because of the narrow interpretation of Maryland's undefined danger standard. A danger standard that promotes timely treatment would greatly improve outcomes, help prevent criminalization, save lives, and promote recovery.

I look forward to an ongoing discussion with the stakeholders about this bill, which is crucial for preventing tragedies, reducing criminalization, and homelessness, saving the lives of our loved ones, and protecting our communities.

I respectfully request a favorable report on SB 707.

SB707 - Danger to Life and Safety - SWA.pdf
Uploaded by: Annie Coble
Position: FWA

JOHNS HOPKINS
UNIVERSITY & MEDICINE

TO: The Honorable Pamela Beidle, Chair
Senate Finance Committee

FROM: Annie Coble
Assistant Director, Maryland Government Affairs

SB707
Favorable with Amendments

DATE: February 24, 2026

RE: SB707 MENTAL HEALTH LAW - DANGER TO THE LIFE OR SAFETY OF THE INDIVIDUAL OR OF OTHERS - DEFINITION (RIGHT TO TREATMENT)

Johns Hopkins supports **SB707 Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment)** with amendments. This bill creates a definition for the "danger to the life or safety of the individual or of those" in Maryland Statute.

By refining this definition, the bill strengthens the state's ability to ensure timely, appropriate treatment for individuals experiencing severe mental health crises—before those crises escalate into irreversible harm. Johns Hopkins supports the State's efforts to create clarity regarding the dangerousness standards, and suggests aligning the definition to Health General §10–708(3)(iii) essential needs or health and safety to have better alignment and standardization for clinicians.

In Maryland, families, providers, and first responders often face heartbreaking situations in which an individual is clearly decompensating—unable to care for themselves, disconnected from reality, or engaging in increasingly risky behavior—yet does not meet the current threshold for intervention. The existing legal standard can be so narrowly interpreted that meaningful action is delayed until danger becomes imminent or catastrophic. At that point, outcomes are often worse for the individual, their loved ones, and the broader community.

Importantly, this legislation affirms that individuals living with serious mental illness deserve the same proactive medical care that we would expect for any other life-threatening condition. We do not wait for cardiac arrest before treating heart disease. Likewise, we should not wait for a suicide attempt or violent act before providing psychiatric care when clear warning signs are present.

This bill balances compassion, clinical expertise, and public safety. It moves our system toward earlier stabilization, better outcomes, and reduced long-term harm.

Accordingly, Johns Hopkins respectfully requests a **FAVORABLE with Amendments** committee report on SB707.

SB 707.pdf
Uploaded by: Ashley Clark
Position: FWA

MARYLAND PSYCHIATRIC SOCIETY

February 20, 2026

The Honorable Pamela Beidle
Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Support With Amendment: SB 707: Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment)

Dear Chairwoman Beidle & Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS/WPS represent over 1200 psychiatrists and physicians currently in psychiatric training.

MPS/WPS Supports With Amendment: SB 707: Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment) MPS and WPS very much support that SB 707 corrects serious inadequacies in current law. While some have contended that the current law allows for some latitude in interpretation, in practice, its meaning has been taking literally and had to decisions having harmful consequences. The law has had the effect of 1) limiting what the judge can consider to the patient's condition at the immediate time of the hearing and 2) the lack of a provision for "grave disability, i.e. inability to provide for health, nutrition, or safety. Our proposed amendments are attached.

The proposed bill directs the decision maker to think beyond the immediate situation and consider personal and medical history—including symptoms/behavior leading to confinement and pattern of behavior in similar episodes. So, if a patient was dangerous prior to confinement, and symptoms have not been stabilized, one might reasonably conclude that danger persists and authorize involuntary hospitalization, i.e. even if, within the structure of the inpatient until, the dangerous behavior did not emerge. The bill also states that a patient can be determined to be dangerous when the danger is not imminent. We support the idea that a patient that a patient can be considered dangerous without having engaged in overt dangerous behavior at the time of the hearing. Persistent symptoms in who was previously dangerous can itself constitute substantial foreseeable risk. However, we think the language, "whether or not the risk is imminent" implies an indefinite time frame. Instead, our amendment suggests requiring that the anticipated dangerous behavior occur in the "foreseeable future," i.e that one is considering behavior related to the current episode of illness.

In adding to the definition of dangerousness the inability to provide for one's basic needs, the proposed bill would have Maryland join 47 other jurisdictions in incorporating a "grave disability" standard into our law . This standard allows the state to intervene when a person's mental illness has so impaired functioning that they cannot meet basic survival needs, even absent imminent violence, thereby preventing foreseeable harm, medical decline, and criminalization. Too many family have watched helplessly as their loved ones, pursuant to current law, are discharged prematurely, continue to deteriorate to the point of serious psychosocial or physical damage, that cannot easily be undone.

With respect to our other amendments, we think that (C) (2) should be deleted. It seems that there are many scenarios in which a patient's behavior could lead to criminal justice involvement without being its being dangerous, e.g. trespassing, shoplifting. Also, while we realize half of the states' involuntary commitment laws do incorporate "likely to deteriorate" language, we're not comfortable with (C) (3) for two reasons: (1) to require finding that patient is unable to make an informed decision is superfluous and excessively burdensome and 2) since the entire subsection as amended would embodies the concept of foreseeable danger, the (C) (3) language seems overly broad and risks leading to inappropriate confinement.

To conclude, MPS and WPS support the intent of SB707, but believe our suggested amendments strike the right balance between the need to provide treatment to our most ill patients and the need to preserve their basic rights. With our proposed amendments, MPS and WPS ask the committee for a favorable report on SB707.

If you have any questions regarding this testimony, please contact MPS lobbyist, Lisa Harris Jones at lisa.jones@mdlobbyist.com.

Respectfully Submitted,
The Maryland Psychiatric Society & Washington Psychiatric Society
Legislative Action Committee

(C) "DANGER TO THE LIFE OR SAFETY OF THE INDIVIDUAL OR OF OTHERS" MEANS A SUBSTANTIAL RISK, ~~WHETHER OR NOT THE RISK IS IMMINENT AND~~ IN CONSIDERATION OF THE INDIVIDUAL'S CURRENT CONDITION AND, IF AVAILABLE, PERSONAL, MEDICAL, AND PSYCHIATRIC HISTORY, THAT AS A RESULT OF THE MENTAL DISORDER THE INDIVIDUAL WILL IN THE FORSEEABLE FUTURE:

(1) CAUSE BODILY HARM TO THE INDIVIDUAL OR ANOTHER INDIVIDUAL; OR

~~**(2) ENGAGE IN CONDUCT THAT WILL RESULT IN CRIMINAL JUSTICE INVOLVEMENT;**~~

(~~3~~) (2) BE UNABLE~~, EXCEPT FOR REASONS OF INDIGENCE,~~ TO PROVIDE FOR THE INDIVIDUAL'S BASIC NEEDS, INCLUDING FOOD, CLOTHING, SHELTER, MEDICAL CARE, SELF–PROTECTION, OR SAFETY, TO SUCH A DEGREE AS TO CREATE A SUBSTANTIAL RISK OF SERIOUS BODILY HARM, SERIOUS ILLNESS, OR DEATH; ~~OR~~

~~**(4) SUFFER SUBSTANTIAL DETERIORATION OF THE INDIVIDUAL'S JUDGMENT, REASONING, OR ABILITY TO CONTROL BEHAVIOR, PROVIDED THAT THE INDIVIDUAL IS CURRENTLY SUBSTANTIALLY IMPAIRED IN THE INDIVIDUAL'S ABILITY TO MAKE A RATIONAL AND INFORMED DECISION AS TO WHETHER TO SUBMIT TO TREATMENT, THAT WILL LIKELY RESULT IN THE INDIVIDUAL MEETING ONE OF THE CRITERIA ENUMERATED UNDER THIS SUBSECTION.**~~

[(c)**]** **(D)** "Electronic record" means a document communicated, received, or stored by electronic means.

[(d)**]** **(E)** "Licensed clinical marriage and family therapist" means an individual who is licensed under Title 17, Subtitle 3A of the Health Occupations Article to practice clinical marriage and family therapy.

[(e)**]** **(F)** "Licensed clinical professional counselor" means an individual who is licensed under Title 17, Subtitle 3A of the Health Occupations Article to practice clinical professional counseling.

[(f)**]** **(G)** "Physician" means an individual who is licensed under Title 14 of the Health Occupations Article to practice medicine in this State.

[(g)**]** **(H)** "Psychiatric nurse practitioner" means an individual who is:

(1) Licensed as a registered nurse and certified as a nurse practitioner under Title 8 of the Health Occupations Article; and

(2) Practicing in the State as a certified registered nurse practitioner–psychiatric mental health.

SB707 FWA 2026.pdf
Uploaded by: Debi Jasen
Position: FWA

Finance Committee
Senate Bill 707
Favorable with Amendment

Honorable Chair, Vice Chair, and Members of the Finance Committee;

Please give Senate Bill 707 a favorable report.

My brother was diagnosed with schizophrenia 30 years ago. His symptoms are severe, and he still hallucinates even when he takes the medications that are the most effective for him. David has been in and out of homelessness and jail in two states due to his mental illness (he's now permanently kicked out of Utah.) In Maryland, he was found not criminally responsible for committing a felony during a psychotic break that was triggered by people assaulting him for being mentally ill. He was locked up in a secure psychiatric facility for a long time, then put in a group home. Eventually, he was released to attempt to live independently and get a job. That didn't last.

For decades, David's schizophrenia has included auditory, visual, and tactile hallucinations. He threatened to kill me because the voices in his head told him to. He repeatedly threatened to shoot up his church because of his paranoid delusions. He has said that he couldn't take his medications because angels were pushing him down into a chair. He has seen dragons and claimed that vampires attacked him. He has been evicted time and time again after doing things like yelling all night while throwing things out of the window; living in such conditions that he attracted rats; and, most recently, spreading feces through his apartment when he couldn't think clearly enough to have the toilet fixed, or to at least stop using it. David isn't just verbally abusive and intimidating, but also often physically assaults family members when we check on him in person. And he has attempted suicide numerous times.

Getting David the help that he so desperately needs is always extremely difficult. Even when he went to the hospital after slamming the sharp side of a hatchet into his head, requiring many staples, the psychiatrist refused to admit him to the psychiatric ward. Even after he nearly died due a suicide attempt, the hospital psychiatrist refused to put him on an involuntary hold. Our parents have lugged boxes of medical records with them from West Virginia each time they talk to a judge to have David committed. Most of the time, we just let it go because it's such an uphill battle.

My brother is pretty consistently a danger to himself and others. He will soon be homeless again. Our parents are too old and tired to help David anymore and need to focus on their own mental and physical health. I gave up a long time ago, and only reach

out to him to see if he's still alive. It would be great if the mental health professionals who he will inevitably interact with during his next hospitalization for self-harm would be forced to treat him as a danger to himself and others. It would be fantastic if the crisis team that accompanies the police the next time my brother threatens someone or creates a dangerous situation would be able to push for hospitalization.

As for the amendment: Involuntary commitments are extremely short-term, and generally ineffective when it comes to long-term stability. My brother is discharged within two weeks (usually one), which isn't enough time for him to become stable enough to remember to take his medications or show up for appointments. He has even been discharged when his auditory hallucinations were so loud that he couldn't have a conversation with a real person. And, like just about every other mental health professional in those hospital wings, the doctor chose to release him back into homelessness rather than try to get him into a group home type of situation, or even a shelter. (One time, a psychiatrist released him within a few days simply because she was afraid of him due to his history of assault.) This creates a revolving door situation, which ultimately costs all of us – the state, hospitals, family, and the person with severe mental illness. I request an amendment that would somehow push for longer commitments in the institutions that will work with the person to become stable and have a path to general survival, rather than to just keep them off of the street for a week. I wish there were extremely long-term psychiatric facilities for the people who won't recover from severe mental illness and have proven to be a danger to themselves and others. I'm sure my brother will commit another crime, and he might get a not criminally responsible finding again, but it shouldn't take that to get him into a hospital where he can be medicated and supervised for years. He's not going to improve any more than someone with severe dementia will improve. We need to treat him and others in his situation the same way we would a senior citizen who can't be trusted to be unsupervised.

I strongly urge a favorable report for Senate Bill 707 and hope that you consider my amendment. Even without the amendment, every week that my brother won't be able to hurt himself or others is a relief. Thank you.

Sincerely,
Debi Jasen
Pasadena, MD

SB707_SPAA_FAV.pdf
Uploaded by: Evelyn Burton
Position: FWA

Schizophrenia & Psychosis Action Alliance

Promoting support, research, treatment, and public policies that improve and save lives

Testimony for SB707—Mental Health Law-Danger to the Life or Safety of the Individual or of Others-Definition (Right to Treatment)
Date: Feb.24, 2021
From: Evelyn Burton, Maryland Advocacy Chair of Schizophrenia & Psychosis Action Alliance
Position: Support

As a non-profit organization providing support, education and advocacy for individuals with illnesses that can exhibit psychosis, like schizophrenia and bipolar disorder, we constantly see the tragedies resulting from denial of critical psychiatric hospital treatment due to Maryland's outdated emergency evaluation and involuntary treatment laws. **Denial of timely treatment for psychotic illnesses results in a broad pipeline to incarceration and homelessness.** It substantially increases the risk of violence, results in **brain damage and lower recovery level. Many families are reporting the ultimate tragedy of suicide when the danger standard has blocked access to needed hospital treatment. County jails report up to 50% of inmates have mental illness and over 30% in the state prisons.** So many with mental illness have been forced into the criminal justice system that the state hospitals now are populated with those with criminal justice involvement. They no longer accept civil patients who need medium to long term treatment to stabilize or from backed up emergency rooms. This affects the care of all Marylanders.

Since 2002, families have been bring their tragic experiences before the legislature and asking for change. Every year of delay bring more suicides, incarcerations, homelessness and violence. It is past time to stop turning away and take action.

Current Gap: Only Maryland and D.C. are without a danger standard definition in mental health law.

Goal: Treatment Before Tragedy. Timely treatment under Maryland's involuntary evaluation and hospitalization law for serious mental illnesses such as schizophrenia and bipolar disorder, could prevent the behaviors caused by untreated illness that can lead to: incarceration, suicide, fatal police interactions, homelessness, victimization, and violence in the family and community. Research shows that prompt treatment: shortens hospital stays, prevents brain damage caused by untreated psychosis, and improves long-term outcomes and recoveries.

Why is involuntary treatment sometimes necessary? Certain biologically based illnesses, such as schizophrenia and bipolar disorder, can cause a neurological deficit that prevents individuals from recognizing their illness and need for treatment. Simply put, many in psychiatric crisis do not know they are ill. While voluntary engagement is always preferable, involuntary evaluation and hospital admission is sometimes the only way to provide effective treatment and establish eligibility for voluntary outpatient services or AOT.

Current Law: **A Barrier to Timely Treatment**.

Current law for involuntary evaluation and hospital admission requires that "The individual presents a danger to the life or safety of the individual or of others." Problems: No definition of danger. Often interpreted narrowly by peace officers, mental health professionals, and judges to require imminent danger of suicide or violence, even though the word "imminent" was removed by the legislature in 2002 and a clarifying Maryland Court opinion was issued in 2018. Without a change in the statute, families are helpless to secure treatment for individuals without insight, who are unable to meet basic survival needs or before their incapacity to think rationally leads to incarceration or homelessness.

Proposed Legislative Reform: Define "Danger to Life or Safety"

1. Clarify that the danger need not be imminent;
2. Require consideration of personal, medical and psychiatric history when available and
3. Define "danger" to include as a result of a mental disorder:
   A. Serious risk of bodily harm to self or others, or criminal justice involvement;
   B. Unable to provide for basic needs (nourishment, medical care, shelter, self-protection, safety), creating a substantial risk of serious bodily harm, serious illness, or death; or
   C. Lacks capacity to make treatment decisions. Without treatment, will likely meet criteria A or B above.

Reform in Other States: 49 states define their danger standard. 48 states include the inability to meet basic survival needs. (B above.) 30 states include deterioration standards (C above).

Preservation of Civil Rights: All current guarantees of civil liberties remain, including certification by 2 mental health professionals, legal representation, & judicial hearings. Timely treatment can restore rational thought and the ability to exercise one's civil rights.

Budget Impact: Reduced costs from long, repeat hospitalizations caused by delayed treatment. Police, court, and corrections savings from reduced criminalization due to timely treatment. Fewer emergency room visits.

Expected Outcomes: Fewer suicides, homelessness, police interactions, arrests, and repeat hospitalizations. Safer communities and better treatment outcomes. Reduced forensic demand for state hospital beds.

LBH FWA SB 707 Mental Health Law Danger to the L

Uploaded by: Rishi Gautam

Position: FWA

Senate Finance Committee
Date: February 24, 2026
SB 707 – Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)
Position: Favorable with Amendment
Dear Chair, Beidle, and Members of the Finance Committee,

On behalf of LifeBridge Health, one of Maryland's largest local nonprofit health system I write in support of Senate Bill 707, which would provide a clear statutory definition of what it means for an individual with a mental disorder to pose a *danger to the life or safety of the individual or of others* for purposes of involuntary admission and emergency evaluation under Maryland's mental health law. A precise statutory definition is essential to ensure consistent application by clinicians, law enforcement, and courts, and to reduce unnecessary variation that can lead to delayed care or inappropriate diversion of individuals who need treatment.

Maryland hospitals and behavioral health providers routinely assess individuals presenting with acute psychiatric needs. A clear statutory standard for "danger" helps clinicians and multidisciplinary teams make critical decisions in high-stress situations with consistency and medico-legal confidence. SB 707 continues the fundamental balance in Maryland law — that involuntary admission and treatment may be initiated when a person, because of a mental disorder, poses a significant risk to themselves or others and *less restrictive alternatives* have been considered. A legally grounded definition reduces subjective interpretation that can lead to either over- or under-utilization of inpatient care.

Under existing statute, "danger to life or safety" is a critical criterion for involuntary hospitalization and emergency evaluations. However, without a statutory definition, clinicians may apply inconsistent thresholds when evaluating similar presentations across facilities. **LifeBridge Health supports the State's efforts to create clarity regarding the dangerousness standards and suggests aligning the definition to Health General §10–708(3)(iii) essential needs or health and safety to have better alignment and standardization for clinicians.**

Individuals subject to involuntary processes retain important rights and procedural protections under Maryland law. Providing a definition of "danger" reinforces those protections by limiting the subjective discretion and enhancing transparency for patients, families, providers, and the judiciary.

SB 707 represents a crucial step in modernizing Maryland's mental health law. By defining a key statutory concept relevant to hospital and emergency evaluations, this bill improves clarity, supports consistent clinical decision-making, and strengthens protections for individuals with mental health needs. **For these reasons, LifeBridge Health urges favorable report for SB 707 with the recommended amendment reference above.**

Respectfully,
Dr. Rishi Gautam, Chair of Psychiatry, LifeBridge Health
rgautam@lifebridgehealth.org
Jennifer Witten, Vice President Government Affairs Jwitten2@lifebridgehealth.org 505-688-3495
Address: 2401 W Belvedere Ave, Baltimore, MD 21215

SB707_MedChi_FWA
Uploaded by: Steve Wise
Position: FWA

MedChi

The Maryland State Medical Society
1211 Cathedral Street
Baltimore, MD 21201-5516
410.539.0872
Fax: 410.547.0915
1.800.492.1056
www.medchi.org

Senate Finance Committee
February 24, 2026
Senate Bill 707 – *Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)*
POSITION: SUPPORT WITH AMENDMENT

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports with amendment** Senate Bill 707.

This legislation would define the phrase "danger to the life or safety of the individual or others," which is used in determining whether a patient should be involuntarily admitted and in emergency evaluations. The phrase has been defined through case law over the years, and this bill seeks to codify its meaning and provide more clarity to practitioners. We agree with the proposal but support some of the amendments recommended by the Maryland Psychiatric Society. These include:

1. Clarifying the time period the evaluator should consider to include the present and "the foreseeable future" to ensure that the time period is not wide open; and
2. Removing the reference to criminal justice involvement, which is also too broad.

With these amendments, MedChi respectfully requests that the Committee support Senate Bill 707.

For more information call:
J. Steven Wise
Danna L. Kauffman
Andrew G. Vetter
Christine K. Krone
410-244-7000

SB 707 - FWA - UMMS.pdf
Uploaded by: Will Tilburg
Position: FWA

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Senate Bill 707 – Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)

POSITION: Favorable with Amendments
February 24, 2026
Senate Finance Committee

The University of Maryland Medical System ("UMMS") supports Senate Bill 707 – Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment) with amendments. Senate Bill 707 ("SB 707") would establish a definition for "danger to the life and safety of the individual or of others" under Maryland law.

UMMS facilities include more than a dozen acute care hospitals and freestanding medical facilities that regularly perform emergency evaluations. We believe this legislation will provide needed clarity and flexibility to qualified mental health professionals that perform emergency psychiatric evaluations.

Under current law, specified health professionals (e.g., physicians, psychologists, psychiatric nurse practitioners, licensed certified social worker-clinical, and licensed clinical professional counselors) are authorized to petition for an emergency evaluation of a patient, which may result in the involuntary admission of the patient to a mental health treatment facility under limited circumstances. The process requires a qualified health professional to determine that a patient (1) has a mental disorder and (2) presents a *danger to the life or safety of the individual or of others*. If these criteria are met, and the patient is unable or unwilling to agree to admission, then the health care professional must take the steps needed for involuntary admission at an appropriate facility. A patient who is proposed for involuntary admission is afforded a hearing within 10 days to determine whether they should be involuntarily admitted or released. A hearing officer must consider all the evidence and testimony of record and order the release of the patient from the facility unless the record demonstrates by *clear and convincing evidence* that, at the time of the hearing, each of the following elements exists: (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 voluntarily admitted to the facility; and (5) there is no available less restrictive form of intervention that is consistent with the welfare and safety of the individual.

The requirement for a patient to be a "danger to the life or safety of the individual or others" is a mandatory criterion for involuntary admission – in the evaluation performed by a qualified health professional and in the review conducted by a hearings officer – yet the term is not defined in statute. The absence of a statutory definition has contributed to inconsistent interpretation and application by clinicians, law enforcement, courts, and hospitals across the State. Clinicians may hesitate to initiate emergency evaluations when danger is present but not imminent, delaying needed care, and courts and emergency departments may apply varying thresholds for involuntary admission, leading to unequal access to treatment.

UMMS supports this bill because it clarifies that "danger to the life or safety" means a substantial risk, whether or not the risk is imminent, and that the determination should include an assessment of the patient's current condition *and* "personal, medical, and psychiatric history." This reflects the realities of clinical practice, where patients suffering from a severe mental health crisis may pose a high risk without immediate manifestations.

Proposed amendment

UMMS appreciates the work of the bill sponsors to provide greater clarity on the State's dangerousness standard. In order to further strengthen this effort, UMMS recommends that the legislation incorporate or otherwise align with the established standard in §10–708(g) of the Health-General Article, which governs the process for administering medication to an individual who refuses it. In particular, SB 707 should incorporate or align with §10–708(g)(3)(iii) that allows for the administration of medication when a patient at a substantial risk of "relapsing into a condition in which the individual is unable to provide for the individual's essential human needs or health or safety." This existing language is well understood by clinicians and could provide greater certainty and standardization in the evaluation process.

For these reasons, the University of Maryland Medical System supports SB 707 with amendments, and respectfully requests a ***favorable*** report on the bill.

For more information, please contact:

Will Tilburg
Vice President, Government and Regulatory Affairs
University of Maryland Medical System
William.Tilburg@umm.edu

SB0707_MHAMD_UNFAV.pdf
Uploaded by: Dan Martin
Position: UNF

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

Heaver Plaza
1301 York Road, #505
Lutherville, MD 21093
phone 443.901.1550
fax 443.901.0038
www.mhamd.org

Senate Bill 707 Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment)
Finance Committee
February 24, 2026
Position: UNFAVORABLE

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in opposition to Senate Bill 707.

SB 707 defines "danger to the life or safety of the individual or others" for purposes of an emergency psychiatric evaluation and involuntary commitment to a psychiatric facility as including a non-imminent risk of potential future psychiatric/substantial deterioration.

Psychiatric Deterioration and Predicting Future Dangerousness
The U.S. Supreme Court holds that states may not confine to a hospital 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."[1] SB 707 would define as "dangerous" those individuals at risk of substantial psychiatric deterioration. However, 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"[2] and only "slightly more reliable than chance."[3] 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.

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 exponentially worse. While police officers may be able to assess, based on direct observation, whether a person is currently acting in a

[1] *O'Connor v. Donaldson*, 422 U.S. 563 (1975).
[2] Monahan, J., Structured Risk Assessment of Violence, *Textbook of Violence Assessment and Management* 17, 20-21 (Simon and Tardiff eds., 2008).
[3] *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)

dangerous manner, they have no expertise to form a reasonable basis that someone is experiencing 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 "substantial 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.

BHA Involuntary Commitment Workgroup
In 2021, the Behavioral Health Administration (BHA) reviewed existing civil commitment laws and examined the definition of dangerousness. Over the course of several months, BHA and a diverse group of stakeholders discussed how 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.

This was an inclusive process that included representatives from consumer and family advocacy organizations, behavioral health providers and professionals, legal rights organizations, individuals with lived experiences, hospitals, local system managers and others. The process resulted in a final report with several recommendations for improving the involuntary commitment process in Maryland, including a proposed definition of dangerousness to self or others. Notably, the group decided explicitly ***against*** recommending the inclusion of a psychiatric deterioration standard in the proposed definition.[4]

For these reasons, MHAMD opposes SB 707 and urges an unfavorable report.

[4] Findings and recommendations regarding the definition of dangerousness begin on pg. 8. The discussion about the decision not to include psychiatric deterioration in the recommended definition begins near the middle of pg. 10.

SB 707_Dangerousness Standard_UNFAVORABLE.pdf
Uploaded by: Dan Rabbitt
Position: UNF

Behavioral Health System Baltimore

February 24, 2026

Senate Finance Committee
TESTIMONY IN OPPOSITION
SB 707 - Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment)

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 100,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.

Behavioral Health System Baltimore opposes SB 707 - Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment). This bill would set a new and more expansive definition of dangerousness to be used when evaluating whether an individual satisfies the requirements for an emergency petition (EP) for psychiatric hospitalization. Expanding the circumstances where an EP could be used is unnecessary and will not result in improved care for those suffering with serious mental illness.

SB 707 has several concerning provisions that would result in more people being involuntary committed under more circumstances. The bill establishes new definitions of danger to self, such as failing to meet basic needs like food, clothing and shelter and suffering a deterioration of judgement that might lead to being a danger to self or others at some point in the future. These suggestions have been rejected by the General Assembly before, most recently in 2022. The bill also includes provisions that were not included in the 2022 bill, such as stating that the risk does not need to be imminent and that any risk of engaging in conduct resulting in criminal justice involvement is considered dangerous. These components of the bill's definition significantly expand who might be involuntarily committed.

Involuntary commitment should be to protect the safety of the individual in crisis, as well as the safety of others. As a clinical tool, it should be used judiciously and only as a last resort. EPs should also be based on clear criteria rather than an assessment of what might happen due to deterioration or a risk that is not considered imminent. Predictions of future dangerousness are notoriously unreliable, with studies consistently finding clinical assessments of future dangerousness to be "accurate in no more than one out of three predictions" and only "slightly more reliable than chance."[1,2]

The introduction of this bill follows efforts from a 2021 workgroup on involuntary commitment. That workgroup recommended improving training on when an EP is appropriate and expanding publicly available data on EPs. Neither of these recommendations have been implemented, but following through on them could help in determining whether a new, more expansive definition is warranted. Similarly, the General Assembly recently established the Assisted Outpatient Treatment (AOT) program that can support individuals through involuntary outpatient treatment. This program should be allowed to be launched prior to changing other aspects of the involuntary commitment protocol.

Voluntary, community-based treatment is much more effective than involuntary treatment. Involuntary commitment should be a last resort. **BHSB urges the Senate Finance Committee to oppose SB 707.**

For more information, please contact BHSB Policy Director Dan Rabbitt at 443-401-6142

References:

[1] *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)

[2] Monahan, J., Structured Risk Assessment of Violence, *Textbook of Violence Assessment and Management* 17, 20-21 (Simon and Tardiff eds., 2008).

SB707_OPD_UNF
Uploaded by: Krystal Williams, Esq.
Position: UNF

MARYLAND OFFICE OF THE PUBLIC DEFENDER

Natasha Dartigue
Public Defender
Keith Lotridge
Deputy Public Defender
Hannibal Kemerer
Chief of Staff
Elizabeth Hilliard
Director of Government Relations

POSITION ON PROPOSED LEGISLATION

BILL: SB 707

FROM: Maryland Office of the Public Defender

POSITION: Unfavorable

DATE: February 20, 2026

The Maryland Office of the Public Defender respectfully requests that this committee issue an unfavorable report on SB 707. We strongly oppose this bill for the following reasons:

1) Maryland's existing involuntary civil commitment system effectively identifies and manages the vast majority of dangerously ill, at-risk individuals within the state.
2) A broadened statutory definition of dangerousness will result in an unconstitutional deprivation of liberty.
3) The proposed legislative changes are based on anecdotal evidence rather than data.
4) The proposed standard is too vague and speculative, which will only perpetuate the inconsistent application it is intended to correct.
5) The ambiguity and broad scope of the suggested wording would increase the risk that individuals will exploit the process with malicious intent.
6) The current involuntary civil commitment process disproportionately affects people of color, and the proposed criteria are likely to exacerbate this issue, resulting in more people of color being targeted for commitment.
7) The proposed revisions to the involuntary civil commitment statute introduce highly subjective criteria. In Maryland, these criteria will be applied not only by mental health clinicians but also by law enforcement officers and lay persons. Relying on the judgment of law enforcement and lay persons in this context is inappropriate, given their lack of specific training and expertise. Consequently, this change is likely to significantly increase the number of individuals who are emergency petitioned and then certified for involuntary civil commitment. This will ultimately put a substantial strain on Maryland's already burdened mental health delivery system.
8) Changing the criteria for involuntary commitment and redefining dangerousness will not improve patient care, protect Maryland citizens, or enhance the lives of individuals struggling with mental illness. The General Assembly should look beyond these changes to address the myriad of issues facing this population.
9) The proposed criteria require police officers, lay persons, and mental health clinicians to predict future criminal conduct. Years of research demonstrate that individuals with mental illness are only implicated in approximately 4% of violent acts, and psychiatrists' predictions of future dangerousness are notoriously unreliable.

10) Patients face serious collateral consequences derived from an involuntary civil commitment, and these weigh heavily against using the number of mentally ill individuals eligible for commitment.
11) SB 707 calls for gross speculation because it eliminates the temporal requirement of imminent danger and allows for involuntary hospitalization based on the risk of future decompensation. At a hearing under Health-Gen. § 10-632, the fact that the speculation is cloaked as the expert opinion of a psychiatrist does not make it reliable. Such testimony is not probative. It is prejudicial. Psychiatric evaluations and assessments are not based on the kinds of precise measurements that allow for reliable predictions of dangerousness or decompensation in the future. Psychiatry involves too much heterogeneity and too many variables, and there are *no* diagnostic tests. Consequently, psychiatrists must rely on subjective and indirect means of evaluating the condition of their patients. In short, psychiatric prognostication is imprecise and prone to error because there are so many unknowns. Additionally, diagnostic error is a serious and woefully understudied problem in psychiatry. *See* Andrea Bradford et al., Diagnostic Error in Mental Health: A Review, 33 BMJ Quality & Safety 663 (2024).
12) Although well-intended, SB 707 is not a harm reduction strategy. It is a harm multiplier. The harms are not confined to the loss of liberty. As the number of people subject to involuntary hospitalization increases, so too does the number of judgment calls, i.e., cases when some would hospitalize the individual and others would not. According to a recent study published by the Federal Reserve Bank of New York, hospitalization in such cases "nearly doubles the probability of dying by suicide or overdose and also nearly doubles the probability of being charged with a violent crime in the three months after evaluation." Broadening the net of individuals subject to involuntary hospitalization would perpetuate such grievous harms. Natalia Emanuel et al., A Danger to Self and Others: Health and Criminal Consequences of Involuntary Hospitalization 39-40 (2025).

Sufficiency of Current Law

The current involuntary civil commitment system in Maryland successfully identifies the vast majority of individuals who are dangerously ill and at risk. While proponents of the proposed revision have cited multiple painful anecdotes from individuals and families who feel inadequately served, these stories should not overstate the impact of the current definition of dangerousness, as they represent rare occurrences.

The OPD's statistics demonstrate the breadth of the current system:

- In 2025, the OPD represented approximately 9,000 individuals in involuntary civil commitment proceedings.
- The OPD has represented between 8,000 and 10,000 clients annually in these proceedings over the past five years.

Furthermore, these totals do not include individuals who were taken to hospital emergency departments for evaluation and ultimately released. Maryland hospital staff have informed the OPD that approximately 50% of emergency evaluees are discharged because they do not meet the criteria

for involuntary hospitalization. This data indicates that the primary challenge is not a systemic barrier to getting individuals emergency-petitioned to Maryland hospitals. Rather, this is indicative of inappropriate and or misapplied uses of involuntary civil commitments.

Maryland's current involuntary commitment statute, which requires a standard of "danger to self or others," is already considered to be one of the most flexible and broadly applicable in the country. Its clear wording allows it to be applied to a wide variety of circumstances.

In a 2022 letter to the Involuntary Commitment Stakeholders Workgroup, the Maryland Psychiatric Society expressed support for the existing dangerousness standard. Instead of changing the definition of dangerousness, the Maryland Psychiatric Society recommends increased training and information regarding the current standard, and its intended application. The current definition, as is, effectively covers a range of complex situations involving serious risk to the individual or others. While highly trained forensic psychiatrists navigate the current statute successfully, other practitioners with less experience would benefit from comprehensive education on applying the law to various scenarios. This targeted education directly addresses the misapplication of the statute, which is rooted in a misunderstanding of the law.

The available data does not support the proponents' claim that police officers and administrative law judges narrowly interpret the current standard. In fact, OPD data indicates that Maryland judges at all levels take a broad view of danger. For example, during the 2025 calendar year, the OPD represented about 9,000 individuals in involuntary civil commitment cases, but administrative law judges released only approximately 125 of those clients at the subsequent commitment hearings. The proponents of the revised standard have not provided any data from Police departments, hospitals, or courts that suggest that this number represents only a fraction of the severely mentally ill population that would otherwise be captured under the broadened definition. They rely heavily on anecdotal evidence. OPD has multiple anecdotes about individuals that OPD represented in involuntary civil commitment cases including:

1. A young woman who was certified to speak “gibberish”. The woman was Ethopian and was speaking Amharic.
2. A trans gender teenager who was certified because his parents believed he was exhibiting symptoms of psychosis. His “symptom” was his gender-identity.
3. A middle-aged man who was certified after being declared “hyper-religious” and delusional by a peace officer. He was a minister for an African-based religious group.
4. An unhoused man who was certified after being observed eating a raw onion while reading a Bible at a mall.
5. An older woman who was certified after her family asserted that she was “cooking too much food” for them. Her psychiatrist had recently prescribed her Adderall, leading to an increase in her activity.

These anecdotes are not an adequate substitute for actual data, but they serve to demonstrate that the current standard for dangerousness already allows for an overly broad interpretation of an individual’s behavior. Essentially, for every anecdote that appears to indicate that the involuntary civil

commitment standard is inadequate, there is an anecdote that suggests the process allows for significant overreach.

The Maryland Supreme Court (formerly Court of Appeals) in *In Re: J.C.N.,* 460 Md. 371 (2018) gave a broad interpretation of the current dangerous standard. The Court found that JCN's refusal to take psychiatric and somatic medications, delusions that she could return to pursue her Ph.D. at Yale, and her refusal to believe she had a mental illness were sufficient for an administrative law judge to find her dangerous and civilly commit her to an inpatient psychiatric facility. The Court essentially interpreted Maryland's current standard to include the gravely disabled standard. In fact, every day, in thousands of instances across the State, police officers, district and circuit court judges, and mental health clinicians interpret Maryland's current standard to include the gravely disabled standard when they issue emergency petitions, certificates for involuntary psychiatric admissions, and orders for involuntary civil commitment.

In Re: J.C.N., 460 Md. 371 (2018), the Maryland Supreme Court (formerly Court of Appeals) effectively incorporated the "gravely disabled" standard into Maryland's existing criteria for civil commitment. The Court affirmed the administrative law judge's finding that J.C.N. was dangerous and warranted civil commitment to an inpatient psychiatric facility, citing her refusal to take necessary psychiatric and somatic medications, her delusions about resuming her Ph.D. at Yale, and her denial of having a mental illness. This interpretation is consistent with how the standard is applied daily across the State. In thousands of instances, police officers, district and circuit court judges, and mental health clinicians rely on this implicit "gravely disabled" component when issuing emergency petitions, certificates for involuntary psychiatric admissions, and orders for involuntary civil commitment.

While the intention behind this proposed legislation is to address the issue of inconsistent application of the current legal standard by those on the front lines, including judicial officers, emergency first responders, and mental health treatment professionals, its current drafting is fundamentally flawed and will likely fail to achieve its objective. Paradoxically, the new statutory language is poised to inherit the very same defect it aims to cure. The core problem lies in the continued reliance on highly subjective and nebulous terms. The bill introduces phrases such as **"indigence," "substantial deterioration," "substantially impaired,"** and **"substantial risk."** Each of these terms is an open invitation to widely divergent, individual, and subjective interpretation.

The basic challenge within the current civil commitment framework does not stem from an ill-defined legal standard of "dangerousness," but rather from a systemic failure to consistently and accurately apply this standard across the various institutions and individuals involved. A more effective and necessary intervention, therefore, is not legislative redefinition, but the immediate and widespread implementation of comprehensive, mandatory training for all stakeholders in the involuntary civil commitment process.

This critical need for education was identified by many participants in the 2021 Involuntary Civil Commitment Workgroup and was one of the recommendations that received consensus. Regrettably, this recommendation, to provide comprehensive training around the dangerousness standard, was

never implemented. The Workgroup also had consensus on the recommendation to gather additional data elements about civil commitment, to more readily identify uses and misuses of the current system. This recommendation has also not yet been implemented. This lack of implementation was a missed opportunity to improve the integrity and consistency of a process that impacts individuals' civil liberties and access to necessary mental health care. Ironically, the one recommendation that stakeholders could not reach a consensus on, was redefining the definition of the dangerousness standard in regulations. We urge this body to revisit the two recommendations that received full and thorough evaluation, and consensus to elevate, as the next appropriate step in addressing how civil commitments are used in Maryland.

Racial Disparity Exists In The Involuntary Civil Commitment Process

Racial bias in the involuntary civil commitment process is a real concern. Data collected by the OPD over the past year shows the disparities amongst racial groups. We see these disparities play out daily and recognize the inequitable patterns in our data. A study reported in a 2021 article in the Journal of Psychiatric Services demonstrated that Black persons of Caribbean or African descent with their first episode of psychosis were significantly more likely to be forced into treatment than non-Black individuals. Revising 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. More research is needed to explore the role of race in Maryland's involuntary commitment process and the role of racial prejudice in the assessment of dangerousness.

Revising The Dangerousness Standard Will Not Address The Myriad Issues That Impact The Lives Of Individuals With Serious Mental Illness

By redefining dangerousness to expand the number of individuals eligible for involuntary inpatient commitment, the General Assembly will not address the many concerns raised by individuals and organizations supporting this change. The language would result in inappropriate, one-size-fits-all solutions (i.e., institutionalized forced medical care regardless of complicating factors) for all situations. For example, a person might be schizophrenic and also experiencing housing or food insecurity. Involuntary hospitalization will not 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 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.

A Broad Statutory Definition Of "Dangerousness" Will Result In an Unconstitutional Deprivation of Liberty and an Infringement on Due Process Rights

It is well established by the Supreme Court that civil commitment laws should ensure a balance Between the interests of public safety and individual civil liberties. *See O'Connor v. Donaldson,*

422 U.S. 563 (1975). The Supreme Court has noted that the loss of liberty that results from civil commitment can be severe and have significant damaging long-term impacts on an individual, and as such, **the Court has emphasized the use of a "least restrictive setting" standard of care, while noting that civil commitment is the most restrictive setting**. *See Olmstead v. L.C.ex rel.Zimring,* 527 U.S. 581 (1999).

The proposed revision allows for such an expansive definition of dangerousness that individual autonomy and civil liberties are unduly at risk, particularly in regard to the following proposed text:

(3) Be unable, except for reasons of indigence, to provide for the individual's basic needs, including food, clothing, shelter, medical care, self-protection, safety, to such a degree as to create a substantial risk of serious bodily harm, serious injury, or death; or (4) Suffer substantial deterioration of the individual's judgment, reasoning, or ability to control behavior…

One can think of numerous situations in which an individual with mental illness may exercise their right to make autonomous decisions regarding lifestyle choices that may be socially eccentric or idiosyncratic, without rising to a level of dangerousness that requires civil commitment. For example, while the public might prefer that individuals with mental illness do not reside in shelters, live in encampments, or experience homelessness, such individuals have the right to determine their own living situation, even if it comes with an Increased risk to their safety, as many who face homelessness often experience. Likewise, it is well-established that individuals, including those with mental illness, have rights regarding the kind of medical care they receive, even if it involves the rejection of potentially life- saving Interventions. In both of these cases, an administrative law judge could reasonably determine that an individual be involuntarily committed on the basis of the proposed revision.

Broadening the definition leads to even more resources being spent in unproductive ways. 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.* More community-based care and social supports would be the best use of the State's dollars and time. Forced treatment has not been shown to increase outpatient compliance nor reduce readmission, and over-reliance on hospitalization is very expensive.

The proposed statute introduces a significant shift in the criteria for civil commitment by removing the traditional time limit for demonstrable dangerous behavior. This change, in conjunction with a broadened definition of "danger," fundamentally alters the legal standard for involuntary detention. Specifically, expanding "danger" to include non-imminent risks, such as the mere prediction of an individual's future mental or behavioral deterioration, allows the state to significantly restrict an individual's fundamental liberty *without* the immediate, compelling necessity that has historically been required to justify such a severe intervention.

Under established legal and constitutional principles, the power of the state to involuntarily commit an individual is typically limited to cases where there is a clear, present, and current threat of harm to self or others. The proposed statute dismantles this standard, permitting preventative detention based on

speculative or long-term risk assessments. This move raises serious due-process concerns, as it lowers the evidentiary bar for commitment and places excessive weight on predictive psychiatry rather than on objective, recent, and actionable behavior. In essence, the State can now justify the deprivation of liberty not on what the individual *has done* or *is about to do*, but on what a police officer, judge, or mental health professional predicts they *might do* at some undetermined point in the future. This is particularly troubling in light of all of the research which indicates that psychiatrists' predictions of future dangerousness and future decompensation are unreliable. See Diagnostic Error in Mental Health: A Review, 33 BMJ Quality & Safety 663 (2024).

The proposed definition includes criteria that are ineffectual, will be difficult for first responders and mental health treatment professionals to accurately assess, and will permit the unconstitutional involuntary hospitalization of individuals who may or may not become dangerous in the future. Such an expansion of the dangerousness also increases the risk that a panoply of idiosyncratic behaviors may fall under the "dangerous" umbrella.

The Proposed Changes increase The Likelihood of Abuse of The Process For Malicious Purposes

The proposed statute is problematic due to its inherent vagueness, speculative nature, and overbreadth, features that collectively raise concerns regarding its potential to increase abuse of the involuntary commitment process. The Office of the Public Defender (OPD) has witnessed malicious misuse under the existing, less permissive statutes. We are aware of numerous instances in which this process has been weaponized by individuals engaged in adversarial civil litigation, most notably in contentious divorce and child custody disputes, where one party seeks a strategic advantage or inflicts retaliatory harm by questioning the other's mental fitness.

Furthermore, this abuse is used as a tool for coercive control, particularly by perpetrators of domestic violence seeking to silence, discredit, or incapacitate their victims. The statute's lack of precise standards will disproportionately benefit those seeking to exploit a vulnerable individual's wealth, property, or estate for malicious financial gain. By lowering the threshold for involuntary commitment and broadening the criteria, the result of enacting this statute will be to significantly ease the path for those willing to manipulate and weaponize the mental health system for purely personal, malicious, and self-serving purposes.

There Are Serious Collateral Consequences Derivative Of Involuntary Commitment That Weigh Heavily Against Increasing The Number of Mentally Ill Individuals Eligible For Commitment

Involuntary civil commitment carries profound and lasting consequences for both adults and minors, adding significant burdens to vulnerable individuals with mental illnesses. These severe impacts, which can last for the remainder of an individual's life, stem automatically and potentially from the commitment and include a broad range of legal, economic, and social ramifications.

Key collateral consequences include:

- **Legal Restrictions:** Required registration with the Department of Public Safety and the FBI; restrictions on owning and purchasing firearms under both Maryland and federal law; loss of the right to vote; and loss of a driver's license.
- **Professional and Social Impacts:** Disqualification from certain employment; loss of professional licenses; inability to serve as a guardian or custodian of a child in need of assistance; loss of a security clearance; and immigration consequences.
- **Family Law:** The commitment can negatively impact child custody cases.
- **Social Stigma:** Perhaps the most significant consequence is the social stigmatization that results from being declared in need of mental treatment and committed to a psychiatric facility.

(See: DL v. Sheppard Pratt, 465 MD. 339 (2019))

Broadening The Definition Of Dangerousness Will Put A Strain On The Already Overburdened Mental Health Delivery System

Under Maryland law, the dangerous standard will be applied not only by mental health clinicians but also by law enforcement officers and lay persons. Relying on the judgment of law enforcement and lay persons in this context is inappropriate, given their lack of specific training and expertise. Consequently, this change is likely to significantly increase the number of individuals who are emergency petitioned and then certified for involuntary civil commitment. This will ultimately put a substantial strain on Maryland's already burdened mental health delivery system.

Broadening the definition will not demonstrably improve outcomes for more individuals. The high number of involuntary admissions already occurring shows that getting people in crisis into a facility is not the primary barrier to care. **The current challenge is the severe overburdening of the inpatient hospital system. Facilities are full, and emergency departments are holding patients for extended periods while searching for beds.** The OPD has represented clients who have remained in emergency departments for 60 to 90 days awaiting an inpatient psychiatric bed. **An increase in involuntary admissions, therefore, will only exacerbate the strain on a system that is already struggling to accommodate the current number of people certified for admission.**

In the current context – specifically, regarding the consideration of revising the "dangerousness" standard – the necessary foundational evidence is critically absent. The precise scope, nature, or extent of any systemic issue that might be addressed by such a revision remains completely unknown. Without a rigorous, data-driven understanding of the problem this legislative change is intended to solve, there is insufficient empirical support to justify the claim that revising the dangerousness standard would, in fact, result in a measurable enhancement of safety – either for the group of individuals subject to civil commitment proceedings or for the surrounding community. Implementing changes of this magnitude, based on unknown variables, represents a potentially detrimental policy action that privileges speculative benefit over the protection of established rights and proven equity concerns.

We therefore request an unfavorable report on SB 707.

Maryland Office of the Public Defender, Government Relations Division, 45 Calvert St, Suite 108, Annapolis MD 21401
For further information please contact Elizabeth Hilliard, Elizabeth.hilliard@maryland.gov 443-507-8414.

SB 707- FIN- MDH - LOO.docx (1) (1).pdf
Uploaded by: Meghan Lynch
Position: UNF

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

February 24, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

RE: Senate Bill 707 —Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment)—Letter of Opposition

Dear Chair Beidle and Committee,

The Maryland Department of Health (MDH) respectfully submits this letter in opposition to Senate Bill (SB) 707– Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment).

SB 707 would amend the definition of "danger to the life or safety of the individual or others" for purposes of involuntary admission and emergency evaluation under Maryland law. Specifically, the bill defines dangerousness as a "substantial risk, whether or not the risk is imminent," thereby removing the current requirement that the danger be immediate. Eliminating the imminence requirement lowers the standard for involuntary admission and may permit detention based on speculative future harm or potential future criminal activity, rather than clear and immediate danger to self or others.

Involuntary commitment has been described by the United States Supreme Court as a "massive curtailment of liberty." *Humphrey v. Cady*, 405 U.S. 504 (1972). As such, it requires substantial procedural protections to safeguard due process rights. Subsequent precedent–including *O'Connor v. Donaldson*, 422 U.S. 563 (1975), and *Addington v. Texas*, 441 U.S. 418 (1979)--reinforces that individuals may not be involuntarily committed when they are not immediately dangerous and can be safely treated in the community. In addition, *Olmstead v. L.C.*, 527 U.S. 581 (1999), requires states to provide services in the least restrictive setting appropriate to meet an individual's clinical needs.

By expanding the definition of dangerousness beyond immediate harm, SB 707 may conflict with these constitutional principles. The bill's inclusion of the phrase "will result in criminal justice involvement" is particularly concerning. The phrase is broad and undefined, potentially encompassing misdemeanor or non-violent offenses for which incarceration is not typically warranted. This framing risks conflating behaviors associated with serious behavioral health conditions with criminality. Such conflation may increase stigma, discourage individuals from

seeking voluntary treatment, and result in greater reliance on crisis or acute care services for individuals who could otherwise have been served in community based settings.[1]

Additionally, amending the standard to include "substantial deterioration" in judgment or reasoning that may "likely result" in meeting other criteria introduces a highly discretionary and subjective threshold. This lack of clarity may result in inconsistent application across providers and settings, increasing the risk of inequitable outcomes for Maryland's racially, ethnically, and socioeconomically diverse populations.

Maryland's current statute strikes a careful balance between protecting public safety and preserving individual liberty by requiring clear evidence of immediate danger. Expanding the definition of dangerousness as proposed in SB 707 risks upsetting that balance and raising due process concerns. For these reasons, the Maryland Department of Health respectfully opposes SB 707.

If you have any questions, please do not hesitate to contact Meghan Lynch, Director of Governmental Affairs at meghan.lynch@maryland.gov.

Sincerely,

Meena Seshamani, MD, PhD
Secretary of Health

[1] Ghiasi N, Azhar Y, Singh J. Psychiatric Illness and Criminality. [Updated 2025 Jun 19]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK537064/

OOOMD-2026-DangerStd-SB 707-UNFAV (Written).pdf
Uploaded by: Michelle Livshin
Position: UNF

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.**

DRMtestimony.SB707.pdf
Uploaded by: Tam Lynne Kelley
Position: UNF

DRM Disability Rights Maryland

Empowering People to Lead Systemic Change

1500 Union Ave., Suite 2000, Baltimore, MD 21211
Phone: 410-727-6352 | Fax: 410-727-6389
DisabilityRightsMD.org

SENATE FINANCE COMMITTEE

Senate Bill 707: Mental Health Law—Danger to the Life or Safety of the Individual or of Others—Definition (Right to Treatment)

February 24, 2026

Position: Oppose

Disability Rights Maryland (DRM) is the protection and advocacy organization for the state of Maryland; the federal mandate of the organization, part of a national network of similar agencies, is to advocate for the legal rights of people with disabilities throughout the state, including those with mental illness. DRM strongly opposes Senate Bill 707, which would, if enacted, impermissibly broaden the definition of danger to self or others in violation of the United States Constitution.

Senate Bill 707, intended to change the definition of "danger to the life or safety of the individual or others" for the purpose of involuntary commitment, purports to define danger as "a substantial risk, whether or not the risk is imminent..." This squarely conflicts with well-established law governing the treatment of people with mental illness. More than fifty years ago, the United States Supreme Court held in the landmark case of *O'Connor v. Donaldson*, 422 U.S. 563 (1975) that "[a] State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." 422 U. S. 573-576. To involuntarily commit an individual when risk is not imminent would be a direct disregard of the Supreme Court's holding that such confinement violates the Fourteenth Amendment of the Constitution.

Involuntary commitment of an individual with mental illness who does not pose an imminent risk also undercuts the protections guaranteed by the Americans with Disabilities Act (ADA); the ADA requires reasonable accommodation and prohibits discrimination on the basis of disability, including making decisions based on assumptions about a person based on their disability. Rather than making accommodations designed to enable individuals with mental illness to live in the community with supports, Senate Bill 707 would permit them to be involuntarily committed to psychiatric facilities, even if they pose no imminent risk to themselves or others. This is simply insupportable.

For these reasons, DRM strongly opposes Senate Bill 707 and requests an unfavorable report.

Contact: Leslie Seid Margolis at lesliem@disabilityrightsmd.org or 443-692-2505.

SB 707 Letter - Oppose.pdf
Uploaded by: Taylor Dickerson
Position: UNF

MARYLAND PSYCHOLOGICAL ASSOCIATION

9175 Guilford Road, Ste 300 #1112, Columbia, MD 21046 | 410-992-4258 | www.marylandpsychology.org

February 20, 2026
Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

RE: SB 707 – Mental Health Law – Danger to the Life or Safety of the Individual or of Others – Definition (Right to Treatment)

Position: OPPOSE

Dear Chair Beidle, Vice Chair Hayes, and Members of the Committee:

On behalf of the Maryland Psychological Association (MPA), we request an **unfavorable report on SB 707.** Senate Bill 707 expands the definition of "danger to the life or safety of the individual or of others" to include a substantial risk of harm **whether or not the risk is imminent and to encompass predictions that an individual may engage in conduct resulting in criminal justice involvement**. While the bill seeks to broaden access to treatment, and we support the intent of SB 707, its proposed definition departs significantly from longstanding clinical and legal standards governing involuntary admission. Current Maryland law appropriately requires evidence of a present and clinically supported risk tied to an individual's current condition. This focus on current dangerousness reflects well-established principles that involuntary confinement must be based on demonstrable, immediate need rather than speculative future risk.

The bill asks mental health practitioners to make determinations that exceed the limits of clinical science and professional reliability. Mental health practitioners cannot confidently assess an individual who may present a risk of harm to others when that risk is not imminent. ***Likewise, predicting that an individual is at substantial risk of engaging in conduct that will result in criminal justice involvement is inherently uncertain and not a clinically valid standard for involuntary psychiatric intervention***. The prediction of future behavior—particularly distant or non-imminent behavior—remains highly unreliable, even under structured assessment methods, and becomes increasingly speculative as the timeframe expands. Expanding the definition of dangerousness beyond imminent risk therefore creates a standard that cannot be applied consistently or reliably by clinicians. Existing law already provides mechanisms to address individuals who present a current danger to themselves or others or who are unable to protect their own safety. These standards appropriately balance the need for treatment with the protection of individual liberty.

At the same time, the **Maryland Psychological Association supports the principle reflected in §10–601(C)(3), lines 10–13,** which addresses circumstances in which an individual is unable to provide for basic needs—including food, clothing, shelter, medical care, self-protection, or safety—to such a degree as to create a substantial risk of serious bodily harm, serious illness, or death. This standard reflects a clinically recognizable condition associated with severe mental illness and functional incapacity and is consistent with established legal and clinical frameworks governing involuntary intervention. The focus on an individual's current functioning and ability to meet essential needs provides a more objective and clinically grounded basis for intervention while appropriately protecting both public safety and individual welfare.

For these reasons, the **Maryland Psychological Association respectfully urges an unfavorable report on SB707.** If we can provide any additional information or be of any assistance, please do not hesitate to contact the Chair of MPA's Legislative Committee, Dr. Stephanie Olarte, at mpalegislativecommittee@gmail.com.

Respectfully submitted,

Stephanie Wolf, JD, Ph.D.
Stephanie Wolf, JD, Ph.D.
President

Stephanie Olarte, Ph.D.
Stephanie Olarte, Ph.D.
Chair, MPA Legislative Committee

cc: Barbara Brocato & Dan Shattuck, MPA Government Affairs