

Support for SB549 – HER Continuity of Care Act.pdf

Uploaded by: Alikeh Jackson

Position: FAV

Subject: Support for SB549 – HER Continuity of Care Act

Dear Members of the Senate Committee,

As a parent, I strongly support SB549, the HER (Healing, Equity, Representation) Continuity of Care Act. When a young person enters mental health treatment, families are often left out of the care process, even though we are the ones who support them before and after treatment. This lack of communication makes it harder for families to help their loved ones recover and transition safely back home.

SB549 ensures that individuals can include trusted advocates in their care planning, strengthening support systems and improving continuity of care. Families should be partners in healing, not shut out of the process.

Thank you for supporting this important legislation.

Sincerely,

Alikeh Jackson

Atlanta, GA

testimony SB 549.pdf

Uploaded by: April Worsley

Position: FAV

Written Testimony: SB 550

BILL: SB 550 – Health Care Decisions Act – Surrogate Decision Making – Mental Disorders

IDENTIFY AS: The H.E.R. Parity Act (Health – Equity – Representation)

COMMITTEE: Senate Finance Committee

HEARING DATE: February 24, 2026

POSITION: SUPPORT (FAV)

NAME: April Worsley

TO: Chair Beidle and members of the Senate Finance Committee

Testimony:

I am writing today as a witness to a systemic failure. As a close friend to a mother who has spent years navigating the intersection of the healthcare and criminal justice systems for her child, I have seen firsthand how the current law serves as a barrier rather than a bridge to safety. I am here to urge a FAVORABLE report on SB 550 (The H.E.R. Parity Act).

I have watched a devoted parent exhaust every legal and personal resource to protect a child who lives with multiple disabilities and a mental health disorder. Despite having an Advanced Health Directive and Power of Attorney in place, this family has been repeatedly blocked from authorizing essential mental health treatment.

As a friend standing on the sidelines, the absurdity of the current system is clear:

- **The Revolving Door:** I have seen a cycle where a child is discharged into unsafe conditions because the law barred the mother from acting as a surrogate. These are parents who are legally forbidden from helping until the situation escalates into a police matter.
- **The Toll of Procedural Negligence:** I have witnessed administrative chaos and facilities not considering all information relevant for treatment planning. There are consistent communication breakdowns regarding insurance and care coordination that a surrogate could have resolved in minutes if the law allowed them to be heard.
- **The Criminalization of Health:** When we block a surrogate from authorizing stabilization for a mental disorder, we aren't protecting autonomy. We are ensuring the crisis continues until it lands in the criminal justice system. This transition from a medical

crisis to a legal one is a tragedy for the family and a massive, preventable financial burden on our state.

A Waste of Taxpayer Dollars

As a resident and taxpayer, it is frustrating to watch public funds poured into repeated emergency room visits, improper discharges, and the subsequent costs of the legal system—all because we refuse to recognize a surrogate's voice for mental health in the same way we do for physical health.

Guardianship is an overly restrictive solution for a temporary crisis of capacity. SB 550 provides a more precise tool: it honors the patient's documented wishes through an empowered surrogate.

Families are fighting to be the safety net their loved ones deserve. The current law is the only thing cutting that net. I respectfully urge you to support SB 550 to ensure that representation and equity finally extend to those in our mental health community.

Sincerely,

April Worlsey

5705 Deer Pond Lane

Camp Springs, MD 20746

SB549_FAV_CorineDonley.pdf

Uploaded by: Corine Donley

Position: FAV

TO: Chair Beidle and members of the Senate Finance Committee

FROM: Corine Donley

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

POSITION: SUPPORT (FAV)

Dear Chair Beidle and Members of the Finance Committee,

I am writing to you today as a grandmother who has experienced the heartbreak of my family navigating a terrifying mental health crisis alone. I am urging a favorable report for SB 549, the H.E.R. Continuity of Care Act to ensure there is healing, equity, and representation in a mental health crisis.

As a family, we did not wait for a tragedy to act. We were proactive. We ensured that the proper legal documents were fully executed and in place—the very documents this bill seeks to protect. We believed these papers were the voice for when my loved one could not find their own. We believed they guaranteed our right to support them, to advocate for their safety, and to ensure they received the continuity of care needed.

Instead, we were met with a wall of silence.

Despite presenting our legal authority, our family was blocked. During this crisis, the system failed my loved one in two distinct, devastating ways that SB 549 would have prevented:

Failure of Informed Advocacy: The healthcare team did not adequately explain my loved one's rights or ensure that they truly understood their options for family involvement. In the fog of a psychiatric emergency, a patient cannot be expected to navigate complex legalities alone. Advocacy is only "informed" if the facility is held to a standard of clear, verbal communication.

The Dismissal of Preparedness: By blocking a family that had already established legal standing, the facility rendered our years of preparation useless. The system chose to isolate a vulnerable individual rather than recognize the legal directives intended to protect them.

SB 549 is essential because it mandates the "Plain Language" requirement. It ensures that facilities are held accountable for actually informing individuals that they have the right to have their family present. It ensures that when a family takes the responsible step of putting legal directives in place, those documents are honored, not ignored.

Watching my loved one suffer while their Advocate has the very papers that should have been allowed to help them was a soul-crushing experience. No family should have to stand by helplessly because a facility failed to honor the law or properly inform a patient in crisis.

I respectfully ask for a favorable report on SB 549 to ensure that families are respected as partners in care when the stabilization is at stake.

Sincerely,

Corine Donley

DBrittMillhouseSB549--written.pdf

Uploaded by: Delores Millhouse

Position: FAV

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Delores Britt-Millhouse

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Healing our children and empowering our families!

Written Testimony in Support of SB 549

Strengthening Family Participation in Mental Health Treatment Planning

March 6, 2026

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

My name is Delores Britt-Millhouse. I am a resident of Legislative District 25, represented by Nick Charles, and I serve as the 2026 Maryland Mother of the Year® with American Mothers, Inc. I submit this written testimony in support of Senate Bill 549.

I would like to acknowledge Senator Charles for introducing legislation that strengthens families and promotes collaboration in mental health care. I also recognize District 25 constituent Theresa Smith, whose experience helped bring attention to the challenges families face when trying to support a loved one during mental health treatment.

Mental health challenges affect families across every community. National data shows that **1 in 5 adults in the United States experiences a mental health condition each year**, and nearly **1 in 20 adults' lives with a serious mental illness**. In Maryland, federal behavioral health surveys estimate that **more than one million adults experience a mental health condition annually**. These numbers represent families throughout our state who may one day face a mental health crisis.

As a certified Adult and Youth Mental Health First Aid trainer, I teach community members how to recognize the signs of a mental health crisis, listen without judgment, and help connect individuals to appropriate professional care. In many cases, families are the first to notice when something is wrong and are the ones encouraging individuals to seek treatment.

However, once treatment begins, families can sometimes find themselves excluded from important conversations about care. Senate Bill 549 helps address this gap by ensuring individuals admitted to mental health facilities are informed, in plain language, of their right to

include trusted family members or other authorized individuals in the development and review of their treatment plans when they choose to do so.

Research consistently shows that family engagement strengthens recovery outcomes. Studies have found that when families are involved in treatment planning, individuals often experience **improved treatment adherence, fewer relapses, and reduced hospital readmissions**. Family participation also helps reinforce stability and support when individuals transition back into their communities.

This legislation does not diminish patient rights or autonomy. Instead, it reinforces patient choice while recognizing an important reality: recovery from mental health challenges is often stronger when individuals are supported by the people who know them best.

As Maryland Mother of the Year®, I have the privilege of hearing from families across our state, and their stories consistently remind me that mental health recovery is strongest when families are informed, supported, and included in the process.

For these reasons, I respectfully request a favorable report on Senate Bill 549.

Thank you for your time and consideration.

Yours in Service,

Delores Britt-Millhouse

2026 Maryland Mother of the Year®
American Mothers, Inc.®

DBrittMillhouseSB549--written.pdf

Uploaded by: Delores Millhouse

Position: FAV

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For these reasons, I respectfully request a favorable report on Senate Bill 549.

Thank you for your time and consideration.

Yours in Service,

Delores Britt-Millhouse

2026 Maryland Mother of the Year®
American Mothers, Inc.®

Written Testimony in Support of Maryland Senate Bi

Uploaded by: Eboni Burch

Position: FAV

Written Testimony in Support of Maryland Senate Bill 549

Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals

Dear Chair, Vice Chair, and Members of the Committee,

I am writing to express strong support for Maryland Senate Bill 549, which strengthens patient-centered care by ensuring that individuals receiving mental-health treatment have the opportunity to involve trusted support persons in treatment planning when appropriate.

Mental health treatment rarely occurs in isolation. Many individuals rely on family members or trusted advocates to assist with medication adherence, transportation to appointments, recognition of early warning signs of relapse, and implementation of treatment recommendations. When supportive individuals are appropriately informed and included in treatment planning, continuity of care is strengthened and the likelihood of successful recovery increases.

This collaborative approach becomes especially important when an individual's mental illness significantly impairs judgment, insight, or decision-making capacity. Individuals experiencing severe psychiatric symptoms may at times be unable to fully understand treatment recommendations or effectively advocate for their own needs. In these circumstances, family members or trusted support persons often serve as a stabilizing presence—helping ensure that treatment plans are followed, medications are taken as prescribed, and appointments are maintained. Excluding these individuals from the treatment planning process can create barriers to recovery and disrupt continuity of care.

SB 549 appropriately balances the need for patient autonomy with the realities of serious mental illness. The bill ensures that patients are informed of their right to authorize participation by a trusted support person in treatment planning discussions, while preserving the patient's ability to withdraw consent at any time when they have the capacity to do so. The legislation also acknowledges existing legal mechanisms such as mental health advance directives, durable powers of attorney for healthcare, and supported decision-making agreements that may designate individuals who are authorized to assist in care when a patient's capacity is compromised.

Importantly, SB 549 includes several safeguards designed to protect vulnerable individuals and prevent potential exploitation. The bill requires medical providers to exercise professional judgment in determining whether the participation of a designated individual is supportive of the patient's wellbeing. If a provider determines that involvement could cause emotional or physical harm, undermine treatment, or otherwise be inconsistent with the patient's best interests, the provider retains the authority to limit or deny participation.

These protections are particularly important for individuals who may be mentally incompetent or whose illness significantly limits their ability to assess the intentions of others. By requiring provider confirmation that the designated individual is supportive and appropriate, the legislation helps ensure that family members or others are not attempting to take advantage of vulnerable

individuals. This safeguard maintains a critical layer of professional oversight while still allowing patients to benefit from the involvement of trusted support persons.

Concerns have also been raised regarding privacy and confidentiality. These concerns are understandable given the sensitive nature of mental health treatment. However, SB 549 maintains strong confidentiality protections by requiring patient authorization before any participation occurs and by allowing providers to restrict information sharing when clinically warranted. Rather than weakening privacy protections, the bill reinforces the patient's right to decide who may be involved in their care while preserving the clinician's ability to intervene if concerns arise.

Questions regarding administrative burden are also addressed by the fact that the procedures contemplated by this legislation—informing patients of their rights and documenting consent—are consistent with existing healthcare practices. Healthcare providers routinely obtain written consent for treatment decisions and release of information, making these requirements a modest and manageable extension of current protocols.

Mental health recovery is strengthened when treatment providers, patients, and trusted support systems work collaboratively. For individuals whose illness may impair their ability to advocate for themselves, the involvement of supportive family members or trusted individuals can be essential in maintaining stability and ensuring continuity of care. By requiring both patient authorization and clinical confirmation that participation is appropriate and supportive, SB 549 creates a balanced framework that protects vulnerable individuals while promoting coordinated and effective mental-health care.

For these reasons, I respectfully urge the committee to provide a favorable report on Senate Bill 549.

Thank you for your time and consideration.

Respectfully submitted,
Dr. Eboni Burch
Clinical Psychologist

SB549_ Matthew.pdf

Uploaded by: Matthew Thompson

Position: FAV

Public Comment: Continuity of Care and the Power of Informed Advocacy - Support for SB 549

TO: Chair Beidle and members of the Senate Finance Committee

FROM: Matthew Thompson (Healthcare Professional and Long-term Advocate)

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)
POSITION: SUPPORT (FAV)

I am writing today as a healthcare professional and a support person who has been a witness to a person's mental health journey for several years (to protect their privacy, I will not identify who they are). In my professional life, I am quite aware of the importance of patient privacy and autonomy; these are the cornerstones of ethical care. However, I am also acutely aware of how a patient's loved one can make the critical difference in the continuity of care through tireless advocacy.

I am here to urge a FAVORABLE report on SB 549.

The Vital Role of the Consistent Caregiver

Over the years, I have seen firsthand that a mother is often the only consistent person standing between a child with multiple disabilities and a total systemic collapse. While medical staff and case managers may change, the mother remains the historian and the primary protector. I have watched her tirelessly advocate to ensure the patient's rights were protected and that they received the care they desperately needed, even when the system itself created barriers to that very care. I have witnessed the "revolving door" that occurs when this expertise is ignored:

- **The Witness to Crisis:** I have been the person to call the mother late at night to get this person help, because she knew exactly what to do and how to do it. Her knowledge is the most effective tool available in a crisis. Don't shut out the mothers who can actually help turn a medical crisis around.
- **The Breakdown of Continuity:** I have seen the devastating results of decompensation when a patient is discharged prematurely because the facility shut out the mother—the one person who truly understands the patient's baseline—by failing to adequately inform the patient of their right to have family participate in the treatment plan.
- **The Toll of Procedural Negligence:** As a healthcare worker, it is painful to watch administrative chaos and insurance hurdles preventing proper health care, effectively forcing a health crisis when this is preventable if the family member or chosen advocate is involved.

This bill is the missing piece required for true continuity of care. It recognizes that when a patient is in a crisis of capacity, the person who has been their most consistent advocate should not be legally silenced or excluded due to a lack of clear communication from the healthcare team. We must stop forcing medical emergencies into a revolving door.

- **Balancing Autonomy with Care:** This bill respects autonomy by ensuring the patient is clearly informed of their right to have family involved, honoring their documented wishes when they need support navigating their care.
- **Immediate Stabilization:** When a medical crisis occurs, time is of the essence. This bill allows for immediate stabilization by keeping the support system involved, preventing a health crisis from escalating further.
- **Representation and Equity:** By mandating the facility's duty to inform patients and honor family participation in mental health treatment plans in the same way we do for physical health, we provide families the tools they need to be the safety net their loved ones deserve.

Current law is the only thing cutting the safety net that these dedicated caregivers work so hard to maintain. Based on my professional background and the years I have spent witnessing this struggle, I am certain that SB 549 is the solution needed to provide the healing, representation, and equity the mental health community lacks. I respectfully urge you to support SB 549.

Sincerely,
Matthew Thompson

SB549-Family Involvement- FAV NAMI.pdf

Uploaded by: Morgan Mills

Position: FAV

March 10, 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.

SB549 represents a critical step forward in empowering patients and ensuring that their support systems are meaningfully integrated into the recovery process. This bill requires that facilities inform individuals of their rights to have family members or other authorized individuals participate in treatment team meetings and planning. By including a form for consent, this bill protects patient autonomy while encouraging the inclusion of trusted support systems.

By fostering collaboration between patients, their families and support systems, and treatment teams, SB549 promotes a holistic and effective approach to mental health care.

For these reasons, we urge a favorable report.

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

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

SB549_Public_Comment_Natalie_Harris.pdf

Uploaded by: Natalie Harris

Position: FAV

Public Comment: Continuity of Care and the Power of Informed Advocacy – Support for SB 549

TO: Chair Beidle and members of the Senate Finance Committee

FROM: Natalie Harris

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

POSITION: SUPPORT (FAV)

Dear Chair Beidle and Members of the Finance Committee,

I am writing to express strong support for Maryland Senate Bill 549, the H.E.R. Continuity of Care Act. As a person with a social work background, I have seen firsthand how complex and overwhelming mental health systems can be for individuals receiving care and their families. SB 549 takes an important step toward strengthening patient-centered care by ensuring individuals in mental health facilities have the opportunity to involve a trusted family member or support person in treatment planning.

Mental health treatment is most effective when patients are informed, supported, and empowered. Allowing individuals to designate a trusted participant in treatment discussions promotes transparency, strengthens communication between providers and families, and helps patients better understand their diagnoses and treatment plans. These supportive relationships are often critical to maintaining continuity of care after discharge and preventing avoidable crises.

The principles reflected in SB 549 are also consistent with core social work values, including respect for the dignity and worth of the person, the importance of human relationships, and the promotion of client self-determination. Ensuring patients are informed of their right to include a trusted support person strengthens autonomy while still respecting patient privacy and clinical judgment.

Other states have already recognized the importance of these protections. Illinois, for example, provides similar frameworks that allow individuals to designate supporters in healthcare decision-making. Under 755 ILCS 43 – Supported Decision-Making Agreements Act, individuals may formally appoint trusted supporters to assist them in understanding and communicating about their care. Additionally, 755 ILCS 40 – Mental Health Treatment Preference Declaration Act allows individuals to document their mental health treatment preferences and designate individuals to help ensure those preferences are honored. These laws demonstrate how collaborative decision-making can strengthen patient rights and improve continuity of care.

SB 549 reflects a compassionate and practical approach to behavioral health care by recognizing the value of informed advocacy and supportive relationships. No individual navigating mental health treatment should have to do so alone.

For these reasons, I respectfully urge the Committee to issue a favorable report for SB 549.

Respectfully,

Natalie Harris

Public Comment-Lessons from Illinois-Support for S

Uploaded by: Parchenney Donley

Position: FAV

Public Comment: Lessons from Illinois – Support for SB 549

TO: Chair Beidle and members of the Senate Finance Committee

FROM: [Your Name], Concerned Aunt and Federal Taxpayer

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

POSITION: SUPPORT (FAV)

The Illinois Benchmark: Unbroken Continuity of Care

In my home state of Illinois, true continuity of care is achieved because the legal and medical framework provides a clear pathway for families to remain engaged when a loved one is in a psychiatric crisis.

Maintaining the Bridge to Home: Illinois recognizes that a facility is only a temporary stop, and the family is the long-term care provider. Through statutes like the Mental Health Treatment Preference Declaration Act (755 ILCS 43/), Illinois legally mandates that an authorized surrogate has the exact same right as the patient to receive information regarding proposed treatments and to review medical records. Patients are actively informed of their right to have family involved in their treatment plans, preventing the clinical isolation that Maryland currently permits.

Honoring Directives: When a family proactively establishes legal directives—such as Mental Health Advance Directives—those documents are respected. Under the Health Care Surrogate Act (755 ILCS 40/), once a physician documents a lack of capacity, facilities are legally mandated to turn to the designated advocate or family hierarchy to authorize stabilization. This allows for private decision-making without judicial involvement, ensuring the continuity of care is never broken by administrative negligence. A family standing in a facility with legally binding documents is treated as an asset, not a liability.

Fiscal Responsibility and Accountability: Illinois treats a psychiatric readmission not as an inevitability, but as a preventable failure of the facility. Through programs that track Potentially Preventable Readmissions (PPR), Illinois actively penalizes hospitals that allow excessive behavioral health readmissions within a 30-to-60-day window. Their proactive approach to family integration ensures that state and federal Medicaid dollars are spent on effective, continuous treatment rather than the waste of repeated, preventable readmissions.

The Federal Stake: Protecting Medicaid Resources

When a state's operational loopholes force a medical crisis, it strains the federal budget. As a federal taxpayer, I have a direct interest in how Maryland manages its healthcare laws. When Maryland facilities block family advocacy, it severs the continuity of care and places an undue burden on our shared national resources:

- * Medicaid Waste: Maryland is currently wasting \$127 million annually in Medicaid funds due to preventable psychiatric readmissions. We are paying for a "revolving door" because Maryland facilities are cutting the safety net that families are trying to provide.

- * The Cost of Exclusion: A single "serial cycle" of readmission costs over \$35,000. Clinical data proves that half of that cost—\$17,500—is 100% preventable simply by allowing family advocacy to occur. Maryland is currently paying \$35,000 per serial cycle to fund a revolving door that benchmark states like Illinois are actively refusing to pay for. Preventing stabilization drives up the national cost of healthcare and increases the burden on federal systems.

Bridging the Gap: How SB 549 Resolves the Concern

SB 549 is the bridge Maryland desperately needs. It mirrors the effectiveness we see in states like Illinois by ensuring the patient's support system is not legally severed at the hospital doors.

By mandating that facilities inform individuals of their rights in plain language and actively honor legally executed documents, SB 549 ensures that a patient's transition from inpatient crisis to outpatient stability is supported by the people who know them best. True continuity of care is impossible when the most consistent caregivers are locked out of the treatment planning process.

We have a responsibility to ensure our laws are not straining the system through unnecessary barriers. We are not asking the state to take over; we are asking the state to stop cutting the safety net that families have legally and proactively put in place. Saving lives is budget-neutral.

I urge a FAVORABLE report on SB 549 to bring Maryland in line with successful models, ensuring that healing, equity, representation, and continuity of care applies to the mental health community.

Sincerely,

Parchenney N. Donley

Parchenney N Donley

SB549 - Support.pdf

Uploaded by: Robert Malone

Position: FAV



Date: March 6, 2026
From: Rob Malone, CEO, The Arc Prince George's County
To: Senator Pamela Beidle, Chair, and Senate Finance Committee Members
Re: Support: SB549, Mental Health - Treatment Plans for Individuals in Facilities - Participation of Family Members or Other Individuals

Chair and members of the committee, thank you for the opportunity to share my support for SB549.

I serve as the CEO of The Arc Prince George's County. For years, the mental health needs of people with intellectual and developmental disabilities have gone untreated or poorly addressed. There are a number of barriers to access to services. This bill will address one of those barriers.

This bill will ensure that families and primary support systems are properly engaged in the therapeutic process. These loved ones and trusted parties should not be locked out as they have legal rights and some serve as power of attorney. People with special needs many times require someone that loves them to look out for them and advocate for what they need. Let us not allow a barrier to that advocacy and the care people sorely need continue to stand in the way. This issue is incredibly critical for young adults navigating new mental health diagnoses along with their cognitive challenges.

SB549 ensures that continuity of care is a standard right by giving an individual's chosen advocates a collaborative seat at the table.

Thank you for your time, your leadership, and your commitment to protecting some of the most vulnerable members of our community. I urge you to move this bill forward with a favorable report.

SB549_FAV_TheresaSmith.pdf

Uploaded by: Theresa Smith

Position: FAV

TO: Chair Beidle and members of the Senate Finance Committee

FROM: Theresa Smith

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

POSITION: SUPPORT (FAV)



I am submitting this testimony to urge a FAVORABLE report on SB 549, The H.E.R. Continuity of Care Act. As someone directly impacted by this legislation and knowing other families with similar concerns, I lead from a place of professional expertise and personal urgency. I hold a degree in patient safety and industrial engineering concepts from a highly reputable institution, alongside a professional background in policy development. I know exactly what it looks like when a system has broken down, especially for public health.

During my own child's mental health crisis, I watched firsthand as the system failed to follow basic compliance, patient safety protocols, and continuity of care standards. Therefore, the concerns are related to what happens for our mental health patients. We cannot afford to continue with systemic barriers.

The Procedural Breakdown: Even with legally executed documents in hand, I was denied access to the treatment process. My child was only offered a Release of Information (ROI) form, which serves a completely different, revocable purpose and does not equate to supported decision-making. In one instance, I stood holding my legally binding documents before an individual claiming to be a supervisor. He explicitly stated he had been instructed not to obtain documents from individuals.

The Case Manager Gap & Improper Discharge: A significant part of this operational failure is the timing of engagement. Even when a case manager is requested, that individual may not engage until the facility is already preparing for discharge. This delay drastically impacts the time needed to properly secure the resources required for a safe transition. Consequently, the continuity of care is severed before the patient even leaves the building. More than once, my child was improperly discharged because of this lack of early coordination.

The Failure of Capacity Assessments: During one crisis, a physician arbitrarily told me that my child had capacity and competency. Because of my background in patient safety, I inquired about how this clinical determination was made and requested that it be formally documented in the medical record. I later learned a formal assessment had not been conducted. Only upon challenging this failure was I introduced to the treatment team to be involved in the process. I was then able to help them help my child. Families without a background in regulatory science should not be required to know operational pathways just to get appropriate care.

Jurisdictional Burdens in Maryland: When statutory language creates operational failures or loopholes, the burden falls on the family. Seeking clarity, I engaged the Department of Health for Prince George's County and St. Mary's County. I learned that there are differences in how crises are handled, and it creates an insurmountable burden for families dealing with one crisis across multiple Maryland counties. The outcome may only be a filed complaint.

NOW The Solution: While the word "shall" may exist in current snapshots of the law, the lack of explicitly defined operational areas has created dangerous loopholes. What this legislation needs to fix is operational chaos in a defined mandate: ***facilities shall mandate meaningful consent discussions and shall honor legally executed documents.***

The clinical data supports a clear "engagement dividend" in mental health recovery. When family members or surrogates are active participants in the treatment and discharge process, the cycle of readmission is broken by higher medication adherence and more robust follow-up care.

Comparative Data Analysis

Metric	Engagement-Led Treatment	Traditional (Isolated) Care
30-Day Readmission	7.8%-16%	Up to 30.6%
Relapse (6 Months)	~30%-40%	50% to 70%
Outpatient Adherence	3x more likely to attend	High rates of "no-shows"
Medication Compliance	60% to 80% improvement	Poor adherence is the #1 predictor of relapse

Analysis of the "Readmission Cycle"

The lack of a "bridge" between the facility and the home is where most care lapses occur.

- **The Advocacy Gap:** Inpatient staff who actively contact family members see a nearly **300% increase** (Odds Ratio of 3.07) in the patient successfully attending outpatient appointments within 30 days of discharge.
- **The Exclusion Effect:** When surrogates are not engaged, the healthcare team often fails to verify if the patient truly understands their rights or post-care options. In our case, the team was not fully ensuring my child knew their rights or understood their options, resulting in a "revolving door" effect.
- **The 30-Day Window:** Data indicates that comprehensive discharge planning—which includes surrogate communication—reduces the risk of immediate readmission by roughly 27%.

Quantifying the Impact: Exclusion is incredibly expensive. Annual statewide Medicaid waste due to preventable psychiatric readmissions is currently **\$127 million**. A single "serial cycle" of readmission costs over **\$35,000 per individual**—and **\$17,500 of that is 100% preventable through family advocacy**.

When factoring in safety response, **the 60-day cumulative fiscal waste exceeds \$190 million**. We are not asking the state to take over; we are asking the state to stop cutting the safety net that families have legally and proactively put in place.

Saving lives is not only budget-neutral, but it allows the affected individual to be on a path of stabilization and recovery to full capacity.

Please support SB 549 to ensure that healing, equity, and representation finally extend to our mental health community.

Thank you,
Theresa Smith
Mother & Advocate

SB549_FAV_TheresaWalker.pdf

Uploaded by: Theresa Walker

Position: FAV

TO: Chair Beidle and members of the Senate Finance Committee

FROM: Theresa Walker, Registered Nurse

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

POSITION: SUPPORT (FAV)

Dear Chair Beidle and Members of the Finance Committee,

I am writing to you today as a registered nurse who works on the front lines of patient care, to urge a favorable report for SB 549, the H.E.R. Continuity of Care Act.

In my professional practice, I navigate the delicate balance between patient privacy, autonomy, and the necessity of comprehensive care every single day. I see the healthcare system from the inside, and I can unequivocally state that a patient's support network is one of the most critical components of their stabilization and recovery. When a patient is experiencing a severe mental health crisis, they are often in a fog that makes self-advocacy nearly impossible. The pure name of the bill is at the heart of what these patient's need: healing, equity, and representation.

Currently, there is a systemic breakdown in how facilities handle familial involvement during these psychiatric emergencies. I routinely witness two major issues that SB 549 directly addresses:

- **The Disruption of Clinical Continuity:** As a nurse, I rely heavily on the consistent caregivers—the mothers, grandmothers, and advocates—who know the patient's baseline, their history, and the nuances of their condition. When facilities block families who have legally executed documents in place, they are not just isolating a vulnerable individual; they are actively stripping the healthcare team of vital clinical context. This systemic wall of silence directly contributes to premature discharges and the "revolving door" of psychiatric readmissions.
- **The Illusion of Informed Consent:** In the midst of a mental health emergency, simply handing a patient a complex legal form is not enough. Patients are often not adequately or verbally informed of their right to have family or a designated advocate participate in their treatment plan. SB 549's "Plain Language" requirement is vital. It ensures that facilities are held to a standard of clear communication, guaranteeing that a patient truly understands their options for support.

SB 549 ensures that when a family takes the responsible step of putting legal directives in place, those documents are honored, not ignored by the facility. It mandates that patients are actively informed of their rights so that their chosen advocates are allowed to be partners in their care.

We cannot achieve true stabilization when the people who know the patient best are locked out of the room. I respectfully ask for a favorable report on SB 549 to ensure that medical emergencies are met with comprehensive, informed, and family-supported care.

Thank you,
Theresa Walker, RN

Whitney Donley Public Hearing.pdf

Uploaded by: Whitney Donley

Position: FAV

TO: Senator Pamela G. Beidle, Chair, and Members of the Finance Committee

FROM: Whitney Donley

DATE: March 6, 2026

RE: SUPPORT for SB 549 – Mental Health - Treatment Plans for Individuals in Facilities - Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

The Perspective of the Extended Family:

I am submitting this testimony as an extended family member who has had the painful privilege of a front-row seat to a systemic breakdown. I previously provided testimony to urge a favorable report on SB 550, and I return today because SB 549 is the essential next step in correcting a fractured system.

For years, I have watched a loved one—a devoted advocate and mother—tirelessly battle a healthcare system that seems designed to shut her out. But this battle does not happen in isolation. As her extended support system, we are not just observers; we are stakeholders. When the medical infrastructure fails, the extended family is forced to become the crisis response team.

We step in to fill the gaps, sharing the emotional, physical, and financial toll of navigating administrative chaos and legal barriers just to help save the life of a young adult with multiple disabilities and a mental health disorder. The breakdown of this system does not just exhaust the immediate family; it fractures the entire support network trying to hold the safety net together.

The Breakdown of Continuity of Care:

The most frustrating part of this journey is seeing how the current system isolates patients in facilities by silencing the very people who know them best. This lack of collaboration destroys any chance at true continuity of care, leading to a cycle of failed interventions.

* **The Revolving Door of Disengagement:** I have seen the "revolving door" in action, where a young adult is discharged from a facility in a state of crisis. This happens not only because of legal barriers but because loved ones are legally shut out of the treatment planning process, preventing them from holding the clinical team accountable. When families are not engaged as active participants, clinical expectations go unmet.

The child is sent home to a situation that is fundamentally unsafe, ensuring a return to the emergency room within days and throwing the family's support system back into crisis mode.

* **Systemic Negligence and Legal Fallout:** I have watched medical crises unnecessarily transform into legal ones. When mental health needs go unaddressed—often because the patient lacks the capacity to fully communicate their internal reality to facility staff without the help of a trusted individual—the result is frequently a transition from a healthcare crisis to a criminal one. We are essentially criminalizing symptoms that could have been stabilized if the facility had simply allowed for family participation and clinical oversight.

Healing, Equity, and Representation

SB 549—The H.E.R. Continuity of Care Act—is exactly what its name promises: Healing, Equity, and Representation. It removes the procedural negligence that currently leaves families standing on the sidelines.

* **Representation in Treatment Plans:** By officially integrating family members or other designated individuals into treatment plans within facilities, SB 549 ensures that a young adult is not just "processed," but accurately understood and treated.

* **Equity in Health over Criminalization:** We must stop the cycle that leads from the facility to the justice system. By recognizing the limitations of a patient's self-communication during a crisis, SB 549 allows for a more comprehensive clinical picture, prioritizing medical stabilization over incarceration.

* Healing through Continuity of Care: True healing requires a seamless transition from facility care to community and home support. By empowering the family voice in the treatment plan, SB 549 provides the structure needed to bridge that critical gap, preventing wasteful, repeated ER visits and improper discharges.

Conclusion:

We are not asking the state to take over; we are asking the state to stop cutting the safety net that families are trying to provide. Please support SB 549 to ensure that healing, equity, representation, and vital continuity of care finally extend to our mental health community.

Sincerely,

Whitney Donley

SB549_FAV_Hawkins.pdf

Uploaded by: Xzavaier Hawkins

Position: FAV

TO: Chair Beidle and members of the Senate Finance Committee

FROM: X. Hawkins

HEARING DATE: March 10, 2026

BILL: SB 549 – Mental Health – Treatment Plans for Individuals in Facilities – Participation of Family Members or Other Individuals (The H.E.R. Continuity of Care Act)

POSITION: SUPPORT (FAV)

To Chairman and Members of the Senate Finance Committee:

I am writing to urge a favorable report on SB549, the HER Continuity of Care Act.

As an individual living with multiple disabilities, I understand firsthand that healthcare is rarely a solo journey. For many of us, "quality care" is defined by more than just a clinical diagnosis; it is defined by a support system that understands our history, our communication needs, and our daily realities.

SB549 is a vital piece of legislation because it prioritizes the following:

Inclusion of Support Systems: This bill recognizes that the involvement of a chosen support system in treatment planning is not just a preference—it is often a necessity for successful outcomes and long-term stability.

Continuity and Stability: For those of us navigating disabilities and mental health challenges, gaps in care can be devastating. This act ensures that transitions in care are seamless and that the "human" element of our recovery is preserved.

Empowerment and Agency: By formalizing the role of support networks, the state empowers patients to remain at the center of their own care, ensuring our voices are heard even in moments of crisis.

My support system is the bridge between my clinical treatment and my daily life. Ensuring they have a seat at the table during treatment planning provides a layer of safety and understanding that a provider alone cannot always offer.

I respectfully ask for a favorable recommendation for SB549 to ensure that all Marylanders have access to the comprehensive, inclusive mental health care they deserve.

Thank you,

X. Hawkins

SB549_Amendment_463322

Uploaded by: Senator Charles

Position: FWA



SB0549/463322/1

AMENDMENTS
PREPARED
BY THE
DEPT. OF LEGISLATIVE
SERVICES

23 FEB 26
12:32:39

BY: Senator Charles
(To be offered in the Finance Committee)

AMENDMENT TO SENATE BILL 549
(First Reading File Bill)

On page 1, after line 3, insert:

“(H.E.R. Continuity of Care Act)”.

SB549_FinalReprint_463322

Uploaded by: Senator Charles

Position: FWA

SENATE BILL 549

J3, J1

6lr2607

By: **Senator Charles**

Introduced and read first time: February 4, 2026

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Mental Health – Treatment Plans for Individuals in Facilities – Participation of**
3 **Family Members or Other Individuals**
4 **(H.E.R. Continuity of Care Act)**

4 FOR the purpose of requiring certain facilities to inform individuals of certain rights
5 relating to the participation of a family member or other authorized individual in the
6 individual’s plan of treatment; requiring facilities to provide individuals and certain
7 third parties with a certain form and other certain information; requiring facilities
8 to recognize certain documents as an individual’s formal request to allow a certain
9 individual to participate in a certain plan; limiting the reasons for which a treating
10 provider is authorized to withhold information on an individual’s plan of treatment
11 from certain third parties; and generally relating to treatment plans for individuals
12 with mental disorders and third-party participation.

13 BY repealing and reenacting, with amendments,

14 Article – Health – General

15 Section 10–706

16 Annotated Code of Maryland

17 (2023 Replacement Volume and 2025 Supplement)

18 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,

19 That the Laws of Maryland read as follows:

20 **Article – Health – General**

21 10–706.

22 (a) (1) Except as provided by paragraph (2) of this subsection, promptly after
23 admission of an individual, a facility shall make and periodically update a written plan of
24 treatment for the individual in the facility, in accordance with the provisions of this
25 subtitle.

2 REPRINT OF SENATE BILL 549 as amended by SB0549/463322/1 02/23/26 at 12:32 PM

1 (2) Promptly after admission of an individual to a psychosocial center, the
2 center shall make and periodically update a written plan of rehabilitation for the individual
3 in the facility, in accordance with the provisions of this subtitle.

4 (b) The Director shall adopt rules and regulations under this section that include:

5 (1) Subject to subsection (d) of this section, a description of the nature and
6 content of plans of treatment; and

7 (2) Subject to subsection (e) of this section, appropriate time periods for the
8 development, implementation, and review of each plan.

9 (c) An individual shall:

10 (1) Participate, in a manner appropriate to the individual's condition, in
11 the development and periodic updating of the plan of treatment; and

12 (2) Be told, in appropriate terms and language, of:

13 (i) The content and objectives of the plan of treatment;

14 (ii) The nature and significant possible adverse effects of
15 recommended treatments;

16 (iii) The name, title, and role of personnel directly responsible for
17 carrying out the treatment for the individual; and

18 (iv) When appropriate, other available alternative treatments,
19 services, or providers of mental health services.

20 (d) A plan of treatment shall include:

21 (1) A long-range discharge goal; and

22 (2) An estimate of the probable length of inpatient stay the individual
23 requires before transfer to a less restrictive or intensive treatment setting.

24 (e) Facility staff who work directly with and provide treatment to an individual
25 shall review and reassess the plan of treatment for the individual to determine the
26 individual's progress and any need for adjustments to the plan not less than:

27 (1) Once every 15 days for the first 2 months after admission of the
28 individual to the facility; and

29 (2) Once every 60 days for the remainder of the inpatient stay of the
30 individual in the facility.

3 REPRINT OF SENATE BILL 549 as amended by SB0549/463322/1 02/23/26 at 12:32 PM

1 (f) (1) On the admission of an individual to a facility, the facility shall:

2 (i) **[Ask] INFORM THE INDIVIDUAL VERBALLY AND USING**
3 **PLAIN LANGUAGE OF THE INDIVIDUAL'S RIGHTS AS A PATIENT TO HAVE A FAMILY**
4 **MEMBER OR OTHER AUTHORIZED INDIVIDUAL BE INFORMED OF AND GIVEN THE**
5 **OPPORTUNITY TO PARTICIPATE IN MEETINGS WITH THE TREATMENT TEAM**
6 **REGARDING THE DEVELOPMENT, REVIEW, AND REASSESSMENT OF THE PLAN OF**
7 **TREATMENT OF THE INDIVIDUAL;**

8 **(II) USING A SEPARATE, PLAIN-LANGUAGE FORM, ASK** the
9 individual whether the individual consents to family members or any other individuals
10 being informed of and given the opportunity to participate in meetings with the treatment
11 team regarding the development, review, and reassessment of the plan of treatment of the
12 individual; **[and]**

13 **(III) IF CONSENT IS GIVEN UNDER ITEM (II) OF THIS PARAGRAPH,**
14 **PROVIDE THE INDIVIDUAL AND ANY FAMILY MEMBER OR OTHER INDIVIDUAL THE**
15 **INDIVIDUAL HAS AGREED TO ALLOW TO PARTICIPATE WITH A MODEL MENTAL**
16 **HEALTH ADVANCE DIRECTIVE FORM DEVELOPED BY THE DEPARTMENT AND**
17 **INFORMATION ON SUPPORTED DECISION-MAKING AGREEMENTS; AND**

18 **[(ii) (IV) If consent is given under item [(i) (II) of this paragraph, at**
19 **least every 7 days after consent is given, reconfirm the consent and provide the individual**
20 **at a clinical visit with an opportunity to consent to additional individuals being informed**
21 **of and given the opportunity to participate in meetings with the treatment team.**

22 (2) If an individual agrees to have family members or other individuals
23 participate in the development, review, and reassessment of the individual's plan of
24 treatment, the facility shall:

25 (i) Provide a schedule of routine treatment team meetings where
26 the plan of treatment is discussed;

27 (ii) Establish a process for the authorized individuals to participate
28 in treatment team meetings;

29 (iii) If the treatment team meeting is being held outside the regular
30 schedule, inform the authorized individuals as soon as the meeting is scheduled; and

31 (iv) If the treatment team meeting is being held due to an emergency,
32 inform the authorized individuals of the outcome of the meeting as soon as practicable.

33 (3) The individual may withdraw the consent given under paragraph (1) of
34 this subsection at any time orally or in writing.

4 REPRINT OF SENATE BILL 549 as amended by SB0549/463322/1 02/23/26 at 12:32 PM

1 (4) A treating provider may withhold information on an individual plan of
2 treatment from a family member or other authorized individual if:

3 (i) In the treating provider's clinical judgment, the consent given
4 under paragraph (1) of this subsection was provided through coercive means;

5 (ii) The treating provider [believes it is in the best clinical interest
6 of] **MAKES A SPECIFIC, WRITTEN FINDING IN THE INDIVIDUAL'S PATIENT RECORD**
7 **THAT THE FAMILY MEMBER'S OR OTHER AUTHORIZED INDIVIDUAL'S PRESENCE IS**
8 **CAUSING DEMONSTRABLE EMOTIONAL OR PHYSICAL HARM TO** the individual; or

9 (iii) The individual requests that a specific piece of the plan of
10 treatment be withheld.

11 **(5) (I) SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, IF**
12 **AN INDIVIDUAL HAS EXECUTED A MENTAL HEALTH ADVANCE DIRECTIVE, DURABLE**
13 **POWER OF ATTORNEY FOR HEALTH CARE, OR A SUPPORTED DECISION-MAKING**
14 **AGREEMENT, A FACILITY SHALL RECOGNIZE THE MENTAL HEALTH ADVANCE**
15 **DIRECTIVE, DURABLE POWER OF ATTORNEY FOR HEALTH CARE, OR SUPPORTED**
16 **DECISION-MAKING AGREEMENT AS AN INDIVIDUAL'S FORMAL REQUEST FOR A**
17 **FAMILY MEMBER OR OTHER AUTHORIZED INDIVIDUAL TO PARTICIPATE IN THE**
18 **DEVELOPMENT, REVIEW, AND REASSESSMENT OF THE INDIVIDUAL'S PLAN OF**
19 **TREATMENT.**

20 **(II) A TREATING PROVIDER MAY WITHHOLD INFORMATION ON**
21 **AN INDIVIDUAL PLAN OF TREATMENT FROM A FAMILY MEMBER OR OTHER**
22 **AUTHORIZED INDIVIDUAL LISTED IN A MENTAL HEALTH ADVANCE DIRECTIVE,**
23 **DURABLE POWER OF ATTORNEY FOR HEALTH CARE, OR SUPPORTED**
24 **DECISION-MAKING AGREEMENT ONLY IF:**

25 **1. THE TREATING PROVIDER CONDUCTS A FORMAL**
26 **CAPACITY ASSESSMENT OF THE INDIVIDUAL;**

27 **2. THE TREATING PROVIDER FINDS THAT THE**
28 **INDIVIDUAL HAS CAPACITY;**

29 **3. THE INDIVIDUAL EXPLICITLY AND FORMALLY**
30 **OBJECTS TO THE PARTICIPATION OF THE FAMILY MEMBER OR OTHER AUTHORIZED**
31 **INDIVIDUAL LISTED IN THE MENTAL HEALTH ADVANCE DIRECTIVE, DURABLE**
32 **POWER OF ATTORNEY FOR HEALTH CARE, OR SUPPORTED DECISION-MAKING**
33 **AGREEMENT; AND**

5 REPRINT OF SENATE BILL 549 as amended by SB0549/463322/1 02/23/26 at 12:32 PM

1 4. THE FINDING OF CAPACITY AND THE INDIVIDUAL'S
2 OBJECTION TO THE PARTICIPATION OF THE FAMILY MEMBER OR OTHER
3 AUTHORIZED INDIVIDUAL IS NOTED IN THE INDIVIDUAL'S PATIENT RECORD.

4 (g) (1) If an individual admitted to a facility or any family member or other
5 individual authorized by the individual to participate in the review and reassessment of
6 the plan of treatment for the individual under subsection (f) of this section believes that the
7 plan of treatment is not meeting the needs of the individual, the individual, family member,
8 or other authorized individual has the right to request that the facility review and reassess
9 the plan of treatment.

10 (2) On receipt of a request under paragraph (1) of this subsection, the
11 facility staff who work directly with and provide treatment to the individual shall:

12 (i) Conduct a review and reassessment of the plan of treatment;

13 (ii) Communicate the results of the review and reassessment of the
14 plan of treatment to the patient and individual who requested the review and
15 reassessment, including an explanation of how all issues raised in the request were
16 considered; and

17 (iii) Include the request for the review and reassessment of the plan
18 of treatment and the outcome of the review and assessment, including the explanation of
19 the outcome, in the medical records of the individual.

20 (3) If a State facility does not make any changes to the plan of treatment
21 for the individual, the State facility shall provide referral information for the Resident
22 Grievance System established under COMAR 10.21.14.

23 (h) An individual admitted to a State facility or another individual authorized by
24 the admitted individual may request a reconsideration of the review and reassessment
25 completed under subsection (g) of this section by filing a grievance with the Resident
26 Grievance System under COMAR 10.21.14.

27 (i) (1) An individual admitted to a State facility or another individual
28 authorized by the admitted individual may appeal the reconsideration of the review and
29 reassessment completed under subsection (h) of this section by filing a request with the
30 Department's Healthcare System's Chief Medical Officer.

31 (2) The Department shall adopt regulations to establish a process for the
32 appeal of the reconsideration of the review and reassessment under paragraph (1) of this
33 subsection.

34 (j) If an individual is admitted to a State facility and the State facility is unable
35 to provide the treatment necessary to address the rehabilitation needs of an individual
36 under a plan of treatment for the individual, the State facility shall:

6 REPRINT OF SENATE BILL 549 as amended by SB0549/463322/1 02/23/26 at 12:32 PM

1 (1) Make arrangements for the individual to receive necessary treatment
2 from another facility or other health care provider outside the State facility; and

3 (2) Ensure that treatment for the individual is coordinated between the
4 State facility and the other facility or health care provider.

5 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect
6 October 1, 2026.

OPD Opposition Testimony SB 549.docx.pdf

Uploaded by: Elizabeth Hilliard

Position: UNF



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: SENATE BILL 549 Mental Health - Treatment Plans for Individuals in Facilities Participation of Family Members or Other Individuals

FROM: Maryland Office of the Public Defender

POSITION: Unfavorable

DATE: March 6, 2026

The Maryland Office of the Public Defender opposes Senate Bill 549 for the following reasons:

Senate Bill 549 will require written selection of authorized agents for individuals experiencing mental health crises. This will place an added burden on individuals who wish to have an authorized agent involved in their treatment planning process. Individuals currently possess the right to select an authorized agent, and this choice is valid even if it is not documented in writing. Currently, an individual does not need to have an advance directive in order to designate an authorized agent. This bill would require the selection of an authorized agent to be either in writing or in an advance directive – an unnecessary and cumbersome burden on someone whose liberty is already being restricted and who is in a compromised mental state.

Currently, an advance directive alone does not automatically grant an authorized agent the right to be involved in all aspects of the treatment planning process. In fact, advance directives can restrict the agent's participation or the sharing of information to only certain areas of treatment planning. But, Senate Bill 549 seems to grant unlimited access to any authorized agent in the treatment planning process.

Section 4 of Senate Bill 549 permits a treating healthcare provider to bar an authorized agent from treatment planning sessions. The bill allows for this exclusion if the agent's involvement “demonstrably causes the individual emotional or physical harm.” That standard is unworkably vague, and will be problematic in application. For instance, a physician could use this "harmful" criterion to exclude an authorized agent simply because the agent's disagreement with a proposed treatment is perceived by the physician as emotionally harmful to the patient. Further compounding this issue, the provider is required only to document this finding in the patient's record and not provide any additional document or opportunities for review.

Especially concerning, Senate Bill 549 will permit physicians to bar all social workers and investigators from the Office of the Public Defender (OPD) from attending treatment team meetings under this vague

standard. Again, this exclusion could be based on the premise that the presence of OPD staff, even those designated as authorized agents, inherently causes emotional harm to patients.

Moreover, the exclusion is permanent; no provision exists for reinstatement, even if the circumstances that initially caused the exclusion are resolved. The bill lacks an appeal process for the patient or authorized agent regarding the exclusion. Furthermore, the hospital grievance procedure is not a meaningful remedy because the final decision rests with the Maryland Department of Health. Unlike complaints filed with the Incarcerated Individual Grievance Office, there is no right to an administrative hearing in hospital cases.

Senate Bill 549 appears to allow an individual who lacks capacity to complete an advance directive. This is in direct conflict with Maryland's Advance Directive law. The bill grants excessive authority to the patient's physician and lacks necessary safeguards and removes the opportunity for appeal.

For these reasons, the Maryland Office of the Public Defender urges an unfavorable report on Senate Bill 549.

SB549 LOI.pdf

Uploaded by: Luciene Parsley

Position: INFO



Empowering People to Lead Systemic Change
The Protection and Advocacy System for the State of Maryland

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

**SB 549: MENTAL HEALTH – TREATMENT PLANS FOR INDIVIDUALS IN FACILITIES –
PARTICIPATION OF FAMILY MEMBERS OR OTHER INDIVIDUALS
BEFORE THE SENATE FINANCE COMMITTEE
March 10, 2026 at 1:00 P.M.
POSITION: Letter of Information**

Dear Members of the Senate Finance Committee:

Disability Rights Maryland (DRM), the State’s designated Protection and Advocacy organization for Marylanders with disabilities, hereby submits this letter of information to provide some clarifying information and raise some concerns about the proposed language in SB 549. DRM advocates for the rights of patients in Maryland’s five state hospitals, and fully supports patients’ right to have a family member or advocate of their choosing participate in their treatment planning while they are in the hospital receiving mental health treatment. We have some concerns that SB 549 may actually pose barriers to that right, in some circumstances. We assume that was not the intention of the bill.

Health-General § 10-701(c)(8), Rights of Individuals in Facilities, already guarantees patients in hospitals the right to have an advocate of their choosing participate in their treatment planning meetings. A verbal consent by the individual for family members or other advocate to participate should be sufficient, as currently provided by Health-General § 10-706(f). Requesting the individual to sign a form could pose an unnecessary barrier, particularly for patients who are experiencing significant symptoms of their mental health disability or who otherwise disagree with some provision on the form. For example, an individual may welcome the participation of the family member or advocate at their treatment planning meetings but object to disclosure of their medical records to the family member or advocate.

The proposed bill language on p. 3, lines 13-17 of the bill appears to be legally unsound. While DRM always supports the right of individuals with mental health disabilities to execute an advance directive, it is not legally possible for a patient who currently lacks capacity to execute an advance directive. An advance directive must be executed while the individual is capable of making informed decisions about their treatment and care, and springs into effect once the individual no longer has capacity. In this case, if the individual currently lacks capacity, any advance directive would not be legally enforceable. Conversely, if the individual **currently has** capacity to make decisions, an advance directive is not needed – the person can make the decisions themselves, without need to resort to an advance directive. We have no concerns about providing individuals with information on supported-decision making agreements, but whether or not the individual chooses to create such an agreement should have **no bearing** on whether a family member or advocate of their choosing is permitted to participate in their

treatment planning meetings – the hospital should not condition approval of the family member or advocate’s participation on the individual’s execution of a Supported Decision-Making Agreement.

The proposed bill language on p. 4, lines 11-19, (f)(5) appears to equate the individual’s execution of an advance directive, durable Power of Attorney, or a Supported Decision-Making Agreement with **conclusive proof** of the individual’s formal request for a family member or other authorized individual to participate in the development, review, and reassessment of the individual’s plan of treatment. This is not legally supportable. The facility must actually **read** the advance directive (assuming it was legally executed while the person had capacity to do so), POA, or Supported Decision Making-Agreement to ensure that it actually says that the individual wants the family member or other authorized individual to participate in all parts of the individual’s plan of treatment. In our experience, there are times that a patient may choose not to share every part of their history or treatment with their chosen family member or advocate – and that request should be honored. Similarly, the proposed bill language on page 4-5, lines 20-33 and 1-3 on page 5 does not take into consideration what the patient has **actually included** in their advance directive or POA. If that agreement or document provides that some information should be withheld from their family member or advocate, the provisions of those documents must be adhered to. An individual does not need to have capacity to execute a Supported Decision-Making Agreement, and it can be withdrawn at any time.

DRM would be happy to propose amendments to address the concerns we have raised, or otherwise participate in a workgroup to address the issues raised in this letter. Thank you for the opportunity to present these concerns to the Committee.

Should you have further questions or need additional information, please contact Luciene Parsley at 443-692-2494 or lucienep@disabilityrightsmd.org.