ON OUR OWN OF MARYLAND

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WRITTEN TESTIMONY IN OPPOSITION TO SB 707 (House Health Hearing): Mental Health Law - Danger to the Life or Safety of the Individual or of Others - Definition (Right to Treatment)

Thank you Chair Bagnall, Vice-Chair Cullison 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 affiliate, independent Wellness & Recovery Organizations served 10,000 community members living with mental health and substance use challenges, many of whom are uninsured and unhoused.

We deeply appreciate the intentional and collaborative efforts made by the Senate sponsor to obtain feedback from stakeholders to improve and amend SB 707. We strongly support the amendments which will clarify “recent and relevant” conduct and require data collection and reporting from BHA surrounding the use of EPs. Data collection has been a longstanding recommendation across stakeholders in the advocacy community, and we are excited to see that finally be implemented.

However, **OOOMD maintains our opposition to the “inability to meet basic needs” component of SB 707**, which would significantly broaden the “dangerousness standard” for which an individual experiencing a mental illness could be Emergency Petitioned (EP) for evaluation and Involuntary Admission (IVA) into a hospital setting.

The proposed language would make basic needs such as shelter, clothing, food, medical self-care, etc., a litmus test for involuntary intervention. 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.

The basic needs provision is so broad that many individuals who do not require forced emergency intervention could become entangled in the process leading to trauma, financial consequences, mistrust and stigma of engaging in services, and harmful encounters with law enforcement.

As example, we caution how following scenarios could be interpreted as requiring an Emergency Petition under an expanded definition:

- An 18 year old college student who is currently in treatment for an eating disorder has not been eating for days due to stress about an upcoming exam. After hearing him mutter "if I fail this class I'm going to kill myself," his roommate calls 988 to report their concern.

- A 67 year old gentleman recently lost his wife to cancer. He is struggling with depression, has not been attending his medical appointments, and the trash has been piling up outside of his home. One night, he trips and falls in the backyard and begins weeping intensely. It is obvious he has not showered in a while. His neighbors call 911 on him because they are unsure what to do and feel he is unable to care for himself.

- A 35 year old woman who has autism is without family support and has been having difficulty managing public transportation to get to her doctor's appointments due to the sensory overload. Her doctor tells her that she must come in person for lab work to monitor a medical condition. On her way, she has a meltdown on the bus and the bus driver calls law enforcement on her.

While the above scenarios may not be the intended subjects for the bill, we have heard many stories from individuals who were EP'd because the responding professional (therapist, call center counselor) felt they must resort to the EP process to avoid their liability risk of noncompliance with the legal standard. However, the consequences of unnecessary use of involuntary interventions for individuals create long-term health, economic, and legal consequences:

- High-stress experiences worsen mental health symptoms, increase fear and mistrust of the system, and can lead to increased rates of suicide or overdose.[1]
- 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]
- Research has shown that people of color are significantly more likely to be subjected to involuntary commitment.[3,4]

[1] 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
[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] 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
[4] 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

Focus on Community Services & Recovery Resources

Involuntary interventions too often produce traumatic experiences which become a turning point of disengagement away from behavioral health services. Overreliance on Emergency Departments and hospitals drain resources away from the agile, effective, community-based recovery support and treatment services that actually help people sustain long-term recovery and wellness, like:

- 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

Particularly for people struggling to meet basic needs, the needed solution is not a change in statute, but investing in community resources and supportive housing. As one example, Denver's Supportive Housing Social Impact Bond Initiative (2016-2020) provided permanent housing subsidies and intensive services leading to 77% of participants remaining in stable housing, decreased arrests by 30-40%, and offset costs associated with accessing emergency services.[5] Without funding adequate long-term supports and solutions, expanding the standard will lead to continued cycling in and out of emergency systems without addressing the root causes.

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 inclusion of "basic needs" will have harmful impacts for individuals experiencing behavioral health crises and the systems that seek to serve them. **We urge an unfavorable report on SB 707. Thank you.**

[5] Peiffer, E. (2021, July 15). Housing First breaks the homelessness-jail cycle. Urban Institute. https://www.urban.org/features/housing-first-breaks-homelessness-jail-cycle