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The Honorable Delegate Bagnall, Chair & The Honorable Delegate Cullison, Vice Chair
House Health Committee

The Honorable Delegate Bartlett, Chair & The Honorable Delegate Jeff Davis, Vice Chair
House Judiciary Committee

Re: Letter of Support for House Bill 1306 – Assisted Outpatient Treatment – Surrender or Seizure of Firearms

Dear Chairs Bartlett & Bagnall, Vice Chairs Davis & Cullison, and Committee Members,

I am a psychiatrist who specializes in suicide prevention. I serve as Medical Director of the Johns Hopkins Center for Suicide Prevention, Chair of the Maryland Suicide Fatality Review Committee, and as a member of a national advisory board assisting other states in establishing suicide fatality review committees modeled after Maryland's work. I write today not on behalf of Johns Hopkins University or the State Suicide Fatality Review Committee, but as a representative of the Maryland Psychiatric Society in strong support of House Bill 1306.

Maryland's Assisted Outpatient Treatment (AOT) program was designed for individuals at the most severe end of psychiatric illness. These are not patients receiving routine outpatient care. AOT applies to individuals with serious mental illness who have demonstrated repeated hospitalizations, documented treatment nonadherence, and in many cases a history of violence or dangerousness. They represent a small but extremely vulnerable population. Importantly, they are at very high risk of harming themselves, and are also in some rare cases at risk of harming others while in an acute crisis.

Predicting who will attempt suicide is difficult. Psychiatry does not have a crystal ball. However, we do know something very important: most suicide attempts are survived. Approximately 92 percent of attempts do not result in death. The most common method of attempt, medication overdose, has a fatality rate of roughly 2 percent. Those survivors come to our hospitals and clinics. They receive treatment. Many stabilize and recover. Only a relatively small proportion, about 6 percent, will go on to later die by suicide in a subsequent attempt.

Firearms are different. When a person attempts suicide with a gun, the chance of survival is extremely low. Although only about 5 to 6 percent of suicide attempts involve a firearm, those attempts account for the majority of all suicide deaths. The lethality of the method transforms what might otherwise have been a survivable crisis into a fatal outcome. Many suicidal crises are brief and impulsive. When lethal means are immediately available during those moments, death is far more likely.

House Bill 1306 takes a careful, targeted approach. It does not automatically prohibit every individual enrolled in AOT from possessing firearms. Instead, it requires a court that has already determined by clear and convincing evidence that a person meets the criteria for involuntary outpatient treatment to make a further, individualized determination: whether that person is likely to endanger themselves or others if they have access to a firearm. Only if the court makes that specific finding does the temporary prohibition apply, and it lasts only for the duration of the AOT order.

This approach strengthens patient safety while preserving due process. It streamlines the judicial process so that a separate proceeding, such as filing for an Extreme Risk Protective Order, is not required in order to address an immediate and foreseeable risk. By allowing the firearm access determination to occur within the AOT adjudication itself, the court can ensure that this critical component of safety planning is not overlooked. The bill provides clear procedures for surrender, storage, and timely return of firearms once the order expires, reinforcing that the restriction is temporary and tied directly to the period of heightened clinical risk.

This is not about criminalizing mental illness. It is about recognizing that a psychiatric crisis is precisely the period when access to a firearm is most likely to be fatal. Providing judges the authority to temporarily restrict firearm access for individuals found likely to endanger themselves or others during AOT enrollment is a narrowly tailored, evidence-informed suicide prevention measure.

On behalf of the Maryland Psychiatric Society, I respectfully urge a favorable report on House Bill 1306.

Respectfully submitted,

Paul S. Nestadt, MD
On behalf of the Maryland Psychiatric Society

Chair, Maryland State Suicide Fatality Review Committee

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