



October 6, 2025

The Honorable Mindy Domb
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 33
Boston, MA 02133

The Honorable John Velis
Chair, Joint Committee on Mental Health, Substance Use and Recovery
24 Beacon Street, Room 513
Boston, MA 02133

Submitted to jointcmte-mentalhealth@malegislature.gov

Dear Chair Domb, Chair Velis, and Honorable Members of the Joint Committee:

Re: Testimony in support of H. 2198, *An Act reducing emergency department boarding* and H. 2199, *An Act ending unnecessary hospitalizations*

On behalf of the Mental Health Legal Advisors Committee (MHLAC) and the Massachusetts Association for Mental Health (MAMH), we are writing to respectfully submit this testimony in support of H. 2198, *An Act reducing emergency department boarding* and H. 2199, *An Act ending unnecessary hospitalizations*.

MHLAC provides legal and policy advocacy throughout the Commonwealth for people with mental health issues. A state agency, MHLAC's priority is to address concerns that affect clients' ability to live full and independent lives. When clients are at risk of placement in institutional settings, MHLAC seeks to protect them from unnecessary loss of liberty and to ensure access to appropriate treatment in the least restrictive setting possible.

Formed over a century ago, MAMH is dedicated to promoting mental health and well being, while preventing behavioral health conditions and associated disability where possible. MAMH is committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. MAMH seeks to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers due to their race, ethnicity, gender identity, or disability status. MAMH has a demonstrated record of furthering its mission by convening stakeholders; disseminating emerging knowledge; and providing subject matter expertise to inform public policy.

H. 2198 and H. 2199, both of which would amend G.L. c. 123, s. 12, bring essential and overdue reforms.

H. 2198 amends section 12 to protect rights and follow a state supreme court instruction

Currently, when a person is confined pursuant to G.L. c. 123, s. 12(a), an involuntary detention of a person in mental health crisis, there is no time limit on detention, no right to challenge the confinement, and no guaranteed access to legal counsel. Massachusetts residents may wait days or even weeks without receiving treatment, essentially “boarding” in emergency departments (EDs). These deprivations not only undermine due process but also cause significant psychological harm and overwhelm emergency resources.

In *Massachusetts General Hospital v. C.R.*, 484 Mass. 472, 475 (2020), the Supreme Judicial Court held that these current practices were constitutionally deficient. The Court urged expeditious legislative action to address the indefinite duration of section 12(a) psychiatric detentions “to clarify the statute and avoid future constitutional difficulties.”

H. 2198 responds directly to the Court’s concerns by establishing basic legal safeguards for people involuntarily detained under section 12(a). H. 2198 provides that individuals cannot be held for more than 72 hours at a hospital ED pursuant to section 12(a). Additionally, the bill requires that persons held for more than 48 in an ED under section 12(a) be referred to the Committee for Public Counsel Services for appointment of legal counsel.

H. 2199 amends section 12 to improve access to community-based mental health care and avoid unnecessary involuntary hospitalization

H. 2199 amends G.L. c. 123, s. 12 to require mental health professionals to consider less restrictive, community-based alternatives before authorizing an involuntary detention in a hospital. “Community Alternatives” are defined in the bill to include voluntary services that are currently available across the Commonwealth, including crisis intervention services, urgent care, community behavioral health centers, help lines and peer run services.¹ H. 2199 also requires the Department of Mental Health to gather data on involuntary detention applications, including demographic data on age, gender identity, race, ethnicity, insurance status, and diagnosis.

H. 2199 will improve the system of care for people facing a mental health crisis. For many people, community-based programs, which now include a range of services for people in crisis, are the most appropriate services to help a person through a challenging time. Moreover, use of community services preserves limited ED resources for those with life threatening health conditions. People who are treated in communities maintain relationships with current service providers and can be connected to new community providers. Research confirms that voluntary treatment in the community is more effective than that delivered in restrictive and crowded EDs.² Reaching out to community supports also helps people maintain community tenure.³ Perhaps in

¹ These would include Mobile Crisis Intervention (MCI), Behavioral Health Urgent Care, and Community Crisis Stabilization (CCS), as well as other voluntary services accessed through Community Behavioral Health Centers; MassHealth Behavioral Health Urgent Care programs, the Behavioral Health Help Line, the 988 Suicide and Crisis Lifeline, and peer-run programs.

² See, e.g., SAMHSA, National Guidelines for Behavioral Health Crisis Care: Best Practices Toolkit (2020), <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf> at 29 (“These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.”)

³ See R. Bruffaerts et al., Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service, *General Hospital Psychiatry* (2005), <https://sci->

recognition of the benefits of keeping people connected to their natural support systems, there is strong public support for voluntary community services.⁴

Additionally, the diversion of people who do not need hospital-level care from EDs benefits all people who use crisis services. People with behavioral health needs are more expeditiously served in specialized, community-based centers designed to address mental health and substance use crises with voluntary services, as opposed to waiting for care in overcrowded EDs. ED boarding is a persistent problem documented by the Massachusetts Health & Hospital Association's behavioral health boarding reports.⁵ More fully utilizing community-based services preserves hospital emergency medical care as noted above for people who actually need it, frees police to fight crime, and, since community-based mental health treatment is cheaper, saves money that can be used to provide care to more people who need it.⁶

Further, serving people with mental health issues in community crisis centers rather than in hospitals, when possible, is a legal mandate. The ADA's anti-discrimination requirement, as interpreted in the Supreme Court's *Olmstead* decision, requires that states make ongoing efforts to serve people with disabilities in the least restrictive settings possible.

Finally, H. 2199's DMH data-collection and reporting requirement will provide policymakers with demographic data regarding the use of section 12 and identify any disproportionality in employing the coercion the statute permits (e.g., race, ethnicity, gender, age, and residence).

For all the above reasons, MHLAC and MAMH respectfully request that you report H. 2198 and H. 2199 favorably out of Committee. Thank you for your consideration.

Sincerely,

Jennifer Honig, Director of Law and Policy
Mental Health Legal Advisors Committee

Jessica Larochelle, Director of Public Policy and Government Relations
Massachusetts Association for Mental Health

c: Rep. Marjorie Decker

hub.se/10.1016/j.genhosppsy.2005.04.003 at 272 ("optimal care for patients with repeat utilization of [psychiatric emergency room] facilities should include both aftercare plans and motivation-enhancing strategies. These implications may especially be important in patients with short community stays because we have demonstrated that the absence of an aftercare plan or noncompliance with aftercare was a strong predictor of short community living.")

⁴ See Deb Parker, Americans Favor Voluntary Mental Health Care Amid Federal Push for Forced Treatment, Wash U (Sept. 17, 2025), <https://source.washu.edu/2025/09/americans-favor-voluntary-mental-health-care-amid-federal-push-for-forced-treatment/>.

⁵ Mass. Health & Hospital Association, Capturing a Crisis: MHA's Weekly Behavioral Health Boarding Reports, https://www.mhalink.org/?hkey=40f7493a-e25b-4a28-9cdad7de41e622d2&utm_source=Informz&utm_medium=Email&utm_campaign=Campaign%20Name%20Association.

⁶ See, e.g., SAMHSA, *supra* note 2, at 10 (discussing "[t]he ever-escalating cost of inpatient healthcare for individuals who are unable to access needed community-based services in a timely manner.").