October 6th, 2025

The Honorable Senator John C. Velis, Chair
Joint Committee on Mental Health, Substance Use and Recovery
State House, Room 513
24 Beacon St
Boston, MA 02133

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

Re: Testimony in Support of H.2199: An Act ending unnecessary hospitalizations

Dear Senator Velis, Representative Domb, and Members of the Joint Committee on Mental Health, Substance Use and Recovery:

I am writing to express the National Alliance on Mental Illness of Massachusetts' (NAMI Mass) strong support for **H.2199,** *An Act ending unnecessary hospitalizations.* This bill reduces the use of traumatic and ineffective involuntary hospitalizations by mandating the prioritization of appropriate community alternatives.

NAMI Mass is a grassroots nonprofit whose base includes individuals with mental health conditions, their families, and caregivers. We have firsthand knowledge of the trauma and stigma that stem from unnecessary hospitalization, as well as the challenges faced in accessing appropriate and effective treatment. That is why we advocate for a crisis system that tends to the individual needs of those living with mental health conditions with person-centered, equitable care that promotes well-being and recovery.

Section 12 of the Massachusetts General Law C.123, commonly known as Section 12, enables specified health professionals and police officers to request the hospitalization of a person experiencing a mental health crisis, if they determine that the individual poses a risk of serious harm to themself or others. Once a Section 12 application is filed, the person in crisis is transported to a hospital emergency department, where they are evaluated for admission.

Massachusetts residents who are experiencing a mental health crisis are taken to hospitals pursuant to Section 12 approximately 55,000 times every year.[1] It is our belief that many of these hospitalizations are unnecessary and that their frequency can be lessened in favor of referral to other services. During a study conducted by the Middlesex County Restoration Center Commission, only 41% of individuals who were subject to a mobile crisis intervention and then sent to the emergency department were thereafter admitted to an inpatient hospital.[2] Combined with personal experiences shared by our community, this statistic indicates an overreliance on Section 12 as the universal response to a person experiencing a mental health crisis.

Curtailing the unnecessary use of Section 12 would go a long way towards redressing the ongoing harms originating from or exacerbated by these hospitalizations. A history of psychiatric hospitalization is correlated with increased shame, self-contempt, and stigma, each of which can inhibit recovery.[3] The use of restraint and seclusion, which may occur during these hospitalizations, is likewise associated with strong emotional responses, including trauma.[4] In a study of youth and young adults who have been involuntarily hospitalized, three quarters of those interviewed shared that their experience contributed to distrust in future care, brought on by their perception of the hospitalization as punitive, staff being more judgmental than empathetic, and hospitalization failing to meet therapeutic needs.[5]

Mitigating these harmful outcomes, H.2199 requires that prior to making use of involuntary hospitalization, it must be determined that no appropriate community alternative exists for an individual in crisis. These alternatives include, but are not limited to:

- Mobile Crisis Intervention (MCI)
- Behavioral Health Urgent Care (BHUC),
- Community Crisis Stabilization (CCS)
- The Behavioral Health Helpline (BHHL)
- The 988 Lifeline
- Peer-run programs, such as peer respite

Community-based alternatives provide timely, quality care that addresses individual needs. Each alternative is designed to support people living with mental health conditions by way of specialized services. These are offered in various modalities, including in-person and virtual, clinical and peer-run, crisis stabilization and crisis counseling. The services are culturally and linguistically responsive, meeting the preferences of those receiving care. Treatment in the community has been

---

[1] Massachusetts Department of Mental Health. (2022). *Final Report on the Impact of Chapter 249 of the Acts of 2000: An Act to Reform the Civil Commitment Process for Persons with Mental Illness*. https://www.mass.gov/doc/2022-dmh-civil-commitment-annual-report/download

[2] *Middlesex County Restoration Center: Strategic Consensus Building - The Foundation for Feasible Implementation of a Crisis Diversion Facility* [PowerPoint Slides].

[3] Xu, Z., Lay, B., Oexle, N., Drack, T., Bleiker, M., Lengler, S., Blank, C., Müller, M., Mayer, B., Rössler, W., & Rüsch, N. (2019). Involuntary psychiatric hospitalisation, stigma stress and recovery: a 2-year study. *Epidemiology and psychiatric sciences*, *28*(4), 458–465. https://doi.org/10.1017/S2045796018000021

[4] Chieze, M., Hurst, S., Kaiser, S., & Sentissi, O. (2019). Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review. *Frontiers in Psychology, 10*(491). doi:10.3389/fpsyt.2019.00491

[5] Jones, N., Gius, B.K., Shields, M., Collings, S., Rosen, C., & Munson, M. (2021). Investing the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Social Psychiatry and Psychiatric Epidemiology, 56*, 2017-2027. https://doi.org/10.1007/s00127-021-02048-2

shown to reduce the stigma associated with living with a mental health condition as well as seeking help.[6] This type of care also promotes long-term connections with local service providers, facilitating continuous support that encourages recovery.

To ensure equity, promote transparency, and measure effectiveness, H.2199 also stipulates that the Department of Mental Health (DMH) collects information about all Section 12 applications. This data collection is especially imperative in monitoring potential ethnic and racial inequities, which have previously been observed in psychiatric commitment practices.[7] Applicants must document why no community alternative was deemed appropriate whenever they execute an involuntary hospitalization, offering clarity around the decision-making process. Knowledge of Section 12 usage and demographic trends will help to identify necessary process improvements or service gaps.

We acknowledge that some authorized applicants already do consider available alternatives prior to filing for Section 12, and that in some cases, involuntary hospitalization may be necessary. Accordingly, this bill does not prevent the use of Section 12 altogether. Instead, it ensures that people in crisis are being referred to the most appropriate service for their individual needs, which is not always the emergency department.

Holistically, promoting the use of community alternatives constitutes a step towards fulfilling the promise made by the Commonwealth's Roadmap for Behavioral Health Reform to "[connect] people with supportive services right in their communities."[8] Contrary to this goal, implementation challenges related to transportation, liability, and public awareness have meant that emergency departments continue to receive mental health patients whose needs could be better met with the person-centered care provided by community-based services[9] By mandating that community alternatives are considered prior to initiating an unnecessary hospitalization, H.2199 would contribute to the realization of a behavioral health system that links people with appropriate care in their own communities, reaffirming our state's investment in the successful implementation and expansion of these services.

I urge you to report favorably on H.2199. Limiting the use of psychiatric holds in favor of community alternatives would better serve every Massachusetts resident living with a mental health condition by connecting them with appropriate care when and where they need it.

Thank you for your attention to this matter.

---

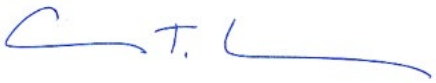
[6] Kearns, M., Muldoon, O. T., Msetfi, R. M., & Surgenor, P. W. G. (2018). The impact of community-based mental health service provision on stigma and attitudes towards professional help-seeking. *Journal of Mental Health*, *28*(3), 289–295. https://doi.org/10.1080/09638237.2018.1521928

[7] 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 (Washington, D.C.)*, *73*(12), 1322–1329. https://doi.org/10.1176/appi.ps.202100342

[8] Massachusetts Department of Mental Health. (n.d.). *Roadmap for Behavioral Health Reform*. https://www.mass.gov/roadmap-for-behavioral-health-reform

[9] Anthony, S., Boyes, E., Guyer, J., & Rozario, N. (2024). *Massachusetts Roadmap for Behavioral Health Reform: Overview and Implementation Update.* Blue Cross Blue Shield of Massachusetts Foundation. https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2024-08/BH_Reform_Roadmap_Aug2024_final_0.pdf

Sincerely,



Eliza T. Williamson
Executive Director
NAMI Massachusetts
331 Montvale Ave
Suite 200
Woburn, MA 01801