Rep. Anne Donahue
Testimony on H. 573, House Health Care, Feb. 24, 2026

Hello, and thank you for asking me to testify.
I do have some concerns about this bill, although I also do think it needs to move forward.
At the high level, it is important to recognize the degree of the rights at stake here. This is almost the only time that a person can be stopped from leaving and be locked in a facility that is not based on charges of committing a crime. When a crime is committed, there must be probable cause established, and bail can only be withheld for allegations of extremely serious offenses – harm that has occurred, not the potential risk of future harm.
We balance this in society based upon the altruism of providing care, but it is a serious infringement of rights.
For those protections, we have what I consider three parts to the process:
Getting someone to the hospital against their willing; holding them in the ED for a psychiatric examination; and then involuntary admission based upon that evaluation. This bill only addresses the second part, the "first certification that authorizes holding someone in the ED for the psychiatric exam (the "second certification.")
The problem with a bill only addressing the middle part is that the three are interconnected. I would eliminate barriers to just get someone to a hospital, keep a firm standard for holding someone in the ED, and put the most weight on the question of admission, which is the most significant infringement of rights. Unfortunately, right now, that third level is badly impaired by the lack of enough psychiatrists to be there in person, meaning that the question of the need for an involuntary admission is often reviewed through a video evaluation – something I believe is grossly inadequate for an appropriate assessment on such a crucial question. Regrettably, given the workforce shortage in this area, there is little that can be done at this point in time to remedy this. It is deserving of more review to look at options for improvement.
So I take caution with reducing the level of expertise in the person conducting the first certification. This is not only for an initial review of psychiatric status, but also for assessment of possible physical reasons for the psychiatric appearances of a health crisis. There is a serious problem with diagnostic overshadowing caused by an implicit bias that someone with a psychiatric history or presenting symptoms is complaining about unfounded physical symptoms. I had a sister-in-law who died that way. She was sent home from the ER several times with her physical symptoms dismissed and died in her bed of internal bleeding. Implicit bias in addressing psychiatric patients is a well-recognized issue but has only begun to be addressed in more recent years, and I hope that ED practitioners are well aware of this. These issues also call for strong medical diagnosticians for these exams.
I do believe that adding trained physician assistants to those permitted to do these first certifications is a necessary step forward. They likely have more time to attend to a patient's symptoms, and EDs are struggling with workforce issues. The alternative of a longer wait for an evaluation while being held involuntarily is not beneficial. My last psychiatric ED admission involved a wait of 5 or 6 hours, despite being there seeking help voluntarily (as are 90% of all admissions.) It was horrific. That was years ago, and now the waits can be days instead of hours. Six hours would be considered speedy.
This bill also establishes that the initial application must be completed by a trained mental health professional, not anyone who qualifies as an "interested party," which is an important standard. And it ensures that those doing the first certification be trained in the key requirements. So I do support this bill but urge the committee to look further in the future into the issues involved in its three-part process, not leaving just one in isolation.