



Why We All Oppose An Act to Provide Critical Community Health Services (H.1694/S.980)

What this involuntary outpatient commitment bill does: This bill would allow a judge to order a person to participate in involuntary medical treatment while the person lives in the community. Individuals could be ordered to accept “critical community health services,” an undefined term which most often would mean antipsychotic medication. Judges could impose a mandatory service plan on anyone whom they determine is “gravely disabled” – another vague term that could apply to anyone a mental health provider believes is not taking adequate care of themselves, including people who are unhoused. Non-compliance with the plan would trigger a hearing. If the court finds the person non-compliant, it could order an emergency evaluation to determine whether failure to hospitalize would create a likelihood of serious harm. This provision would expand the existing bases for involuntary commitment to a psychiatric facility. The bill does not address what services must be made available or who will provide or pay for the services, and it does not require that the services be made available. The burdens appear to fall on the individual as opposed to the care system.

Massachusetts has just launched a reform initiative to make behavioral health services more accessible and effective. This bill will divert funding better used to meet the well-acknowledged need for a broad range of voluntary services. This bill will not help, but instead will hurt, people with mental health conditions.

Involuntary outpatient commitment is bad public policy:

- Studies of outpatient commitment *do not show* that it improves mental health outcomes, results in more people receiving more care, or reduces homelessness.
- Multiple studies *do show* that whatever benefits may come from outpatient commitment laws derive not from its coercive nature, but from the expansion of those services and supports that may be established at the same time.
- Studies *do show* that BIPOC communities are disproportionately subjected to involuntary treatment orders, exacerbating their negative experiences with an already discriminatory mental health system.
- Involuntary outpatient commitment relies on coercion. Fear of forced (and thus traumatizing) treatment will dissuade people from seeking voluntary mental health services.
- People who live with behavioral health conditions and with disabilities widely oppose outpatient commitment as it threatens autonomy, dignity, and liberty and is not consistent with fundamental precepts of disability rights and recovery movements.
- Adding a new legal standard for involuntary treatment and a new judicial enforcement procedure is an inefficient and costly way to provide services. Outpatient commitment will place extensive burdens on courts, hospitals, and law enforcement.
- Involuntary outpatient care will divert money, resources, and precious workforce from the roll out of the urgent care, outpatient, and crisis resolution services of the Roadmap for Behavioral Health Care and from implementation of the mental health omnibus law, Chapter 177 of the Acts of 2022.
- The bill raises significant constitutional law issues and may well ultimately be deemed illegal.

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FAQ on Involuntary Outpatient Commitment in Massachusetts

Will involuntary outpatient commitment help people who refuse to take antipsychotic medication?

Outpatient commitment forces antipsychotic medication on people, but not necessarily to positive effect. Those so compelled may have legitimate reasons for not accepting powerful and potentially detrimental forms of treatment. For the following reasons, outpatient commitment will not necessarily cause people who are refusing medication to change their minds or benefit them if they do:

- Antipsychotic medication may have been tried and found ineffective or caused intolerable side effects and/or withdrawal symptoms.
- Alternative forms of treatment are often more effective than forced medication.
- Underlying social, economic, or legal problems at the root of emotional distress may be successfully resolved if effectively addressed (e.g., by providing housing).
- Many people with mental health conditions have experienced the trauma of forced medication and state intervention in the past, with harmful outcomes. Forcing treatment again may deter such people from seeking care that would meet their individual needs.
- Therapeutic alliances between health providers and their patients, which are documented as the key to treatment acceptance and adherence and have well-established healing potential, are placed at risk when caregivers get involved in forcing patients to accept treatment.

What alternatives to involuntary outpatient commitment exist for people not engaging in treatment?

- The EOHHS Roadmap sets out a broad range of never before available behavioral health services devised after extensive listening sessions, including culturally and linguistically responsive interventions for individuals who are in crisis, require urgent care, or need longer term services. The provision of new urgent care and crisis resolution services can address the problems of poor or delayed access to care that now drive some individuals' deterioration and disaffiliation from providers. We need to give the Roadmap reforms the opportunity to provide the promised solutions.
- Peer services, including peer respites, peer supports embedded in more traditional services, peer-led Recovery Learning Communities, Living Room programs, and peer recovery coaches (for people with substance use needs).
- Voluntary forms of treatment such as traditional and alternative mental health and substance use services, housing, and other social supports.

Are there alternatives for people who really do need protection or compelled treatment due to likely serious harm to self or others arising from mental illness?

- When failure to hospitalize would create a likelihood of serious harm by reason of mental illness, there already are processes in Massachusetts for emergency detention and for civil commitment.
- Outpatient commitment forces antipsychotic medication on people, but for people found incapable of making medical treatment decisions including use of antipsychotic medication, there already is a substituted judgment decision-making process in Massachusetts.

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