The Commonwealth of Massachusetts
Supreme Judicial Court
MENTAL HEALTH LEGAL ADVISORS COMMITTEE

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Testimony of
Mental Health Legal Advisors Committee

In Opposition to
S. 980/H. 1694 an Act to Provide Critical Community Health Services

before the Joint Committee on the Judiciary

July 18, 2023

The Mental Health Legal Advisors Committee urges that S. 980/H. 1694, which would establish involuntary outpatient commitment in Massachusetts, not be released from Committee. MHLAC is a state agency charged with advancing the rights of individuals with mental health conditions in the Commonwealth. Our clients would be irreversibly harmed and further traumatized by the passage of these bills.

These bills would allow broad categories of persons to petition a district court for an order requiring a person with a mental illness to submit to involuntary outpatient treatment, including forced medication, in the community. Failure to comply with the court order could lead to a court hearing or involuntary hospitalization.

We believe these bills would codify bad public policy and raise serious legal questions related to the limits of state intervention under Massachusetts law. Passage of these bills would involve the judiciary in cumbersome proceedings and would deflect much-needed resources away from treatment approaches that have been proven more effective than coercion.

Bills that advance the agenda of outsiders intent on establishing involuntary outpatient commitment in Massachusetts have repeatedly failed to gain legislative support. Relying chiefly on the unjustified inference that terrible outcomes in specific cases could have been avoided if only courts were able to force treatment on people, supporters rarely even try to sustain what ought to be, as proponents of a major, expensive change in social policy, their burden—to show evidence that the change will generate positive outcomes.[1]

[1] Proponents also cite to the fact that most other states have adopted IOC, as if this is a good reason to follow suit. There are many examples of states *en masse* endorsing wrongheaded and now discredited

But proponents cannot meet this burden. The legislature should continue to reject involuntary outpatient commitment for at least four good reasons:

- It is ineffective and unsupported by research. In fact, it would likely deter more persons from receiving treatment than increase the number who receive it.
- Voluntary treatment, on the other hand, is demonstrated to be effective.
- The infrastructure necessitated by an outpatient commitment law would require funding better used to provide effective community-based treatments, particularly in light of the new "roadmap" for accessing care.
- Involuntary outpatient commitment would duplicate existent proceedings for protecting individuals at risk of harm and conflict with settled constitutionally based law that forbids forcing treatment on individuals deemed incompetent.

I. Research shows that involuntary outpatient commitment is ineffective and paradoxically deters participation in treatment.

Involuntary outpatient commitment does not achieve intended ends.

Involuntary outpatient commitment is bad policy for the Commonwealth because it is not effective. Researchers conducting a 2016 meta-analysis of clinical literature around the globe found that involuntary outpatient treatment schemes did not achieve their stated goals of keeping people in treatment and out of hospitals.[2] These researchers found that forced community treatment orders significantly increased the time individuals spent under coercion, but did not improve patient outcomes or yield clinical or social benefit. The authors also cast doubt over the use and ethics of forced treatment orders.

Other research examining involuntary outpatient treatment likewise has found that these judicial interventions do not improve patient outcomes.[3] The treatment orders did not reduce hospitalization and there was no evidence of cost-effectiveness. Further, court-ordered

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fixes of perceived social problems, such as long prison sentences for drug crimes and enhanced penalties for youthful "super predators," which anticipated a trend that never occurred, to name only a few.

[2] J. Rugkasa, *Effectiveness of Community Treatment Orders: The International Evidence.* The Canadian Journal of Psychiatry (2016), https://journals.sagepub.com/doi/full/10.1177/0706743715620415. (reviewing past systematic reviews of studies as well as newer studies, with a particular focus on randomized controlled trials and meta-analyses).

[3] P. Barnett *et al.*, Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: a systematic review and meta-analysis, Lancet Psychiatry (2018); T. Burns *et al., Coercion in mental health: a trial of the effectiveness of community treatment orders and an investigation of informal coercion in community mental health* care, Programme Grants for Applied Research, No 4.21 (2016), available at haps://www.ncbi.nlm.nih. uov/books/NBK401969/; S. Kisely *et al., Compulsory community and involuntary outpatient treatment for people with severe mental disorders,* Cochrane Database of Systematic Reviews (2009); M. Ridgely *et al., The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States,* RAND Instit. for Civil Justice (2001).

community treatment had no significant impact on patients' health-related quality of life or capabilities. In fact, the authors concluded that such orders did not deliver clinical or social functioning benefits for patients, and that, in the absence of further trials, their use should be restricted or stopped.

Forced treatment is ineffective because it strips away a person's autonomy, which is key to the treatment process. The mere perception of coercion in treatment has been linked to an increase in the risk of suicide attempts.[4] In one study of the impact of coercion, patients explained that their symptoms were rooted in trauma or spiritual problems, and that coercive treatment neglected that context, eroding patient self-confidence.[5] This is troubling because patient satisfaction is not simply a goal in itself; it is also associated with better treatment outcomes.[6]

Recovery from or productive coexistence with mental illness is quite possible but almost always requires the patient's voluntary participation in treatment. Being treated with respect, empathy, and understanding is a significant element in getting well from or living with all kinds of severe mental health disorders. Effective treatment involves individuals "in genuine decision-making," as "self-empowerment…is seen as essential to the recovery process."[7]

Involuntary outpatient commitment deters people from seeking treatment.

Involuntary outpatient commitment not only does not help—it likely hurts, by causing people to avoid seeking out or accepting necessary mental health care. In a seminal study, researchers found that slightly more than half of a group of Californians diagnosed with serious mental illness avoided *voluntary* treatment, even when they believed it might benefit them, for fear of attracting the attention of treatment providers who might thereafter petition to force treatment.[8] Similarly, a clinician working in a shelter said that when he informed his

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[4] J. Jordan & D. McNiel, *Perceived Coercion During Admission Into Psychiatric Hospitalization Increases Risk of Suicide Attempts After Discharge*, 50(1) Suicide & Life Threatening Behavior 180 (2020).

[5] O. Nyttingnes *et al.*, 'It's unbelievably humiliating' - Patients' expressions of negative effects of coercion in mental health care, 49 Int. J. Law Psychiatry 147 (2016).

[6] J. Strauss *et al.*, Adverse impact of coercive treatments on psychiatric inpatients' satisfaction with care, 49 Community Mental Health J. 457 (2013) (finding that consumer satisfaction with inpatient mental health care is a key predictor of functional and clinical outcomes, while lower satisfaction is associated with involuntary admission and perceived coercion during hospitalization).

[7] *S. Samuelsen et al.,* Re-establishing and preserving hope of recovery through user participation in patients with a severe mental disorder: the self-referral-to-inpatient-treatment project, 3 Nursing Open 222, 224 (2016).

[8] J. Campbell & R. Schraiber, *In Pursuit of Wellness: The Well-Being Project*. California Department of Mental Health, Sacramento, CA, 1989; *see also* SAMHSA Study, *supra* (7% of adults cited fear of commitment or forced treatment as reason for not pursuing such care).

male clients of their potential eligibility for involuntary outpatient commitment, almost all fled the shelter and were not seen again.[9]

While the fear of involuntary treatment is powerful, so is the trauma incurred from such treatment. As researchers have observed, forcing people to engage in treatment may prompt avoidance of mental health care entirely: "coercion in most definable and measurable forms is not associated with improved outcomes and may negatively affect the individual. It may be traumatic, dissuade people from further treatment, increase the risk of non-adherence or increase further involuntary treatment."[10]

The antidote, these researchers suggest, is a system that provides non-coercive alternatives: "The trend over recent years of pursuing increasingly coercive measures that lack evidence is damaging patient care. It would be more humane, just and effective to implement alternatives that serve to reduce experienced and actual coercion, promote the wider involvement of people in their care, and potentially improve outcome[s]."[11]

II. Voluntary treatment promotes engagement and is effective.

Importantly, there are better options, with demonstrated success rates, available to support the voluntary treatment of individuals who struggle with mental health concerns. Those options include supported housing and touch therapy. In particular, models that rely on peer-to-peer support are effective because they provide an empathic entryway into treatment. For example, peer respite centers offer an alternative to forced outpatient commitment and offer supportive environments to assist individuals weathering a mental health crisis.[12] There is legislation pending (S. 1238/H. 3602), which MHLAC supports, that would establish a peer respite center in each county throughout the Commonwealth.

Even when providers and their patients rely on medications, there are better ways to engage patients and produce good outcomes than coercive approaches. For example, a randomized study showed that persons involved in a peer-led, medical self-management program showed increases in patient activation compared to treatment without peer support. These persons had higher rates

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[9] M. Rowe, *Alternatives to Outpatient Commitment*, J. Am. Acad. Psychiatry & Law, 41: 3: 332-336 (Sept. 2013), http://www.jaapl.org/content/41/3/332.full.

[10] A. Molodynski *et al., Coercion in mental healthcare: time for a change in direction,* 13 B.J. Psych. Int'l 1, 1 (2016) (citations omitted).

[11] *Id.* at 2.

[12] A randomized controlled trial of a peer-run crisis respite found that the average rate of improvement in symptom ratings was greater in the alternative than in the hospital comparison group. The cost was significantly less: $211 per day for a peer respite versus $665 per day for hospitalization. The study authors concluded that this alternative was "at least as effective as standard care" and a "promising and viable alternative." T.K. Greenfield *et al., A Randomized Trial Of A Mental Health Consumer-Managed Alternative To Civil Commitment For Acute Psychiatric Crisis.* Am. J. of Community Psychology, *42(1),* 135-144 (2008).

of visits to primary care providers, medication compliance, physical activity, and also enjoyed better physical health and thus quality of life.[13]

No one person's path to recovery is the same as another, and any of these options might work best for some individuals but not others. Government best promotes treatment when it offers a wide array of treatment choices that increase individuals' willingness to get help while also addressing basic human needs which, when left unaddressed, can exacerbate mental health issues.

III. Outpatient commitment is costly and draws funding away from treatments proven to be effective.

Outpatient commitment would be costly.

Implementation of outpatient commitment would generate substantial costs for judicial proceedings and enforcement. The proposed legislation would require courts to conduct judicial hearings on the initial petitions, approve treatment plans, and engage in compliance monitoring and enforcement. Significant resources would be spent in preparation for these hearings. The bill would engage, not only court officers, defense attorneys, and treatment monitors in ongoing legal proceedings, but also service providers who will spend time in court that they could better use to assist their clients. The State has been undergoing a mental health epidemic, aggravated by the COVID-19 pandemic, and many individuals seeking treatment face wait lists. Now is not the time to divert precious treatment resources away from helping people and into funding a counterproductive approach to mental health care.

Funding is better spent providing treatment and addressing care barriers with services known to be effective.

Cost of services is a significant barrier to treatment. In 2011, the United States Department of Health and Human Services surveyed 69,500 adults from all 50 states, asking why they hadn't received mental health treatment over the preceding year. Costs or lack of insurance coverage were the most often cited reason.[14] Instead of making treatment more affordable and available, spending on a system of coercion will only exacerbate this problem.

Scarce mental health treatment funding should be spent on voluntary, community-based services. We know that these services are effective in engaging, treating, and supporting individuals with serious or complex conditions. In 2001, the Medical Directors Council of the National Association of State Mental Health Program Directors examined forced community-based treatment.[15] The Medical Directors didn't endorse coercion. Instead, they concluded that

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[13] B. Druss *et al.*, The Health and Recovery Peer (HARP) Program: A Peer-Led Intervention to Improve Medical Self-Management for Persons with Serious Mental Illness, 118 Schizophrenia Res. 264 (2011), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2856811/.

[14] SAMHSA, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, https://www.samhsa.gov/data/sites/default/files/2011MHFDT/2k11MHFR/Web/NSDUHmhfr2011.htm.

[15] National Association of State Mental Health Program Directors, Medical Directors Council Technical Report, available at

states' failure to provide a continuum of appropriate services was the real problem facing people with mental illness. The Medical Directors recommended that states add a range of community services to their treatment menus, including services addressing co-occurring disorders, better case coordination, outreach, and services otherwise designed to address root causes of problems by promoting consumer and family participation.

A diverse menu of services also works to keep people safe. Massachusetts has recently implemented the Roadmap for Behavioral Health Reform, which was developed with input from hundreds of individuals with lived experience, their family members, and providers. The Roadmap seeks to create a "front door" for mental health treatment and greatly expand treatment resources in the community. These resources are particularly directed at individuals who are in crisis, and include a behavioral health help line, community behavior health centers, and behavior health urgent care centers. Absent from the Roadmap is coerced treatment. The Roadmap points the Commonwealth in the right direction for the future of mental health care; involuntary outpatient commitment would represent a step in the wrong direction.

IV. Massachusetts has a statutory scheme to protect individuals with mental illness from harm and, when necessary and justified, to provide court-ordered treatment.

Existing procedures protect individuals with mental illness at risk of harm to self or others. Persons meeting this standard are subject to civil commitment and even forced medication orders under current law. And forcing individuals to accept medication under the proposed legislation could violate constitutional principles.

Massachusetts has an emergency admission process.

Our laws currently provide a mechanism for emergency hospitalization of people who pose a risk of harm to self or others due to mental illness. Section 12 of Chapter 123 offers a more effective recourse for addressing risks of serious harm than that contemplated in the proposed legislation. The law already provides for an emergency evaluation of whether there is a need for extended treatment. Thus, the proposed legislation is duplicative of existing measures.

Massachusetts has a process to authorize extraordinary treatment.

Further, legislation that allows for involuntary medication and confinement outside the section 12 process may well illegally circumvent due process protections. Massachusetts has a well-established legal process to provide for involuntary treatment under the SJC's decision in *Rogers v. Commissioner of Department of Mental Health*, 390 Mass 489 (1983). Before approving a treatment plan for antipsychotic medication, a judge must render two judgments: that the person is not capable of making informed decisions and, if they were capable, would choose to accept treatment. Notwithstanding these legal hurdles, petitioners for orders authorizing treatment with antipsychotics find that courts look sympathetically upon their requests; the rate of success for

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https://www.nasmhpd.org/sites/default/files/NASMHPD%20Medical%20Directors%20Council%20Technical%20Report%20on%20Involuntary%20Outpatient%20Commitment%20-%20October%209%2C%202001.pdf

such petitions is high. Since Massachusetts has a functioning process to authorize extraordinary treatment for those who cannot provide consent, new legislation is not needed.

Moreover, procedures enacted under the proposed bills could permit forced treatment of individuals capable of making their own decisions, in violation of *Rogers*. The State's high Court held that individuals have an interest in privacy that protects them from involuntary invasions of their bodily integrity. However, S. 980/H. 1694 would permit those types of invasions by allowing courts to order treatment for people even if they can make decisions on their own. Such orders could violate *Rogers*.

These bills upset the careful balance of societal interests and fundamental civil rights struck by the SJC in the *Rogers* case, thus denigrating principles of individual autonomy underlying the decision. A court reviewing the imposition of forced treatment and medication under this legislation may well invalidate the statute.

CONCLUSION

Although the desire to help people who are struggling with psychiatric challenges, as well as their families, is laudable, involuntary outpatient commitment will not effectively address the problems at hand. Rather, it will divert funding from services that actually promote recovery.

Rather than implementing costly and unsuccessful systems of coercion, we should ensure that people who want treatment have access to it and support, instead of forcing it on people. We urge the Committee to listen carefully to the voices of people with lived experience. They will likely offer differing accounts on what services have been helpful to them. Yet, these persons will likely uniformly state that people cannot be forced to get well.

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