July 16, 2023
By email
michael.musto@mahouse.gov

The Honorable Michael Day
Chair, Joint Committee on Judiciary
24 Beacon Street, Room 136
Boston, MA 02133

The Honorable James Eldridge
Chair, Joint Committee on Judiciary
24 Beacon Street, Room 511-C
Boston, MA 02133

Re: Opposition to H.1694/S.980, An Act to provide critical community health services

Dear Chair Day, Chair Eldridge, and Members of the Joint Committee on the Judiciary:

I write in strong opposition to H.1694/S.980. These are bills which would create an unnecessary and ineffective system to allow courts to force individuals with mental health diagnoses to undergo involuntary medication and other treatment in the community. These bills will neither increase public safety nor improve care.

I write from almost 50 years of experience providing legal representation to people with mental and emotional challenges. I am now retired from the practice of law, but I remain deeply concerned about how the law impacts the lives of people with mental illness and committed to ensuring that everyone who needs and wants help is able to get it. I know from experience that when well-meaning people try to solve deeply rooted problems by increasing the use of force and coercion, failure is the outcome. It is instructive that these bills are opposed by people who have direct experienced the mental health system, as well as by respected metal health advocacy organizations, by many family members, and by legal advocacy organizations. I urge you to review Sera Davidow's recent MassLive op-ed[1] and the materials posted on the Massachusetts Association for Mental Health's website.[2]

As you will hear at the hearing on the bills on July 18, 2023, and as you can read in materials provided to you at the hearing, research demonstrates that coerced treatment is neither effective in promoting recovery or enhancing public safety; the clinical, policy,

[1] Sera Davidow, *What's Missing from Talk of Assisted Outpatient Care*, MassLive, June 6, 2023. https://www.masslive.com/opinion/2023/06/whats-missing-from-talk-of-assisted-outpatient-care-commentary.html.
[2] https://www.mamh.org/advocacy/take-action/involuntary-outpatient-commitment.

programmatic, and fiscal costs inherent in administering a system of involuntary outpatient commitment will undermine the professed goals of the system; fundamental legal rights guaranteed by the Massachusetts Constitution and laws are inconsistent with involuntary outpatient commitment; and, the coercive system and its sanctions are very likely to be used disproportionately against persons of color.

The research shows that involuntary outpatient commitment does not work. Proponents of these bills will no doubt tell you that research supports their claims that involuntary outpatient commitment produces good outcomes and enhances public safety. The truth is that researchers have been unable to isolate coercive commitment provisions of outpatient commitment schemes as the cause for any positive clinical outcome. Instead, not surprisingly, it is major investments in additional community mental health services that are likely the primary cause of any positive outcomes.[3] In other word, what works is making services available, not coercion.

Involuntary outpatient commitment will likely be used disproportionately against persons of color. A New York state study found that outpatient commitment is imposed on African Americans five times more frequently than white people.[4] Black and Hispanic people make up 17.6% and 19.3% of New York's population, but comprise 38% and 27% of those under outpatient commitment orders, respectively.[5] Accordingly, we can predict an overrepresentation of BIPOC individuals in any Massachusetts program. This would be contrary to the state's efforts and obligations to provide mental health care without discrimination.

The fiscal and policy costs of administering a new system of coercion will undermine the goals of Massachusetts' mental health system. There are important Constitutionally protected procedural rights that must be included in any involuntary outpatient commitment process. Therefore, a significant and costly infrastructure will be needed to operate an involuntary outpatient commitment system and to monitor and enforce court orders. At a minimum, there must be a full judicial hearing, with adequate notice, the right to counsel, access to an independent expert, and a right to appeal. Involuntary outpatient commitment significantly increase the burden on judicial resources.

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[3] *See*, e.g., Steven P. Segal, *Protecting Health and Safety with Needed-Treatment: The Effectiveness of Outpatient Commitment*, 93 Psychiatry Q. 55 (2022) (positive outcomes are attributable to enriched community services rather than the involuntary outpatient commitment system itself) and Jo C. Phelan *et al*., *Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State*, 61 Psychiatric Services 137 (2010) (although there were "modest" improvements in lives of test subjects, given "treatment and other enhancements" included in outpatient program, evidence does "not support the expansion of coercion in psychiatric treatment").

[4] Jeffrey Swanson *et al*., *Racial Disparities In Involuntary Outpatient Commitment: Are They Real?* 28 Health Affairs 816 (2009).

[5] Victoria M Rodríguez-Roldán, *The Racially Disparate Impacts of Coercive Outpatient Mental Health Treatment: The Case of Assisted Outpatient Treatment in New York State,* 13 Drexel L. Rev. 945 (2020).

Moreover, individuals, their clinicians, and providers will surrender a significant degree of clinical discretion and decision-making to judges. Courts, not the the Department of Mental Health (DMH), will prioritize how and to whom services are delivered. Treatment resources will be allocated to those who least want them, with, likely, the concomitant reduction in the availability of care for those who most want them. DMH has recently started a new care system which emphasizes immediate access to voluntary community-based care. That promising system-- called the Roadmap for Behavioral Health Reform – will be undermined by outpatient commitment.

Massachusetts has a *de facto* system of outpatient commitment. The fact is that a new involuntary outpatient commitment would be redundant. Massachusetts already has a *de facto* system of involuntary outpatient commitment-- the frequently used substituted judgment guardianship process which results in what are known as "Rogers orders." In the Rogers process, a court orders compliance with a treatment plan, just like in these bills. If proponents of these bills are arguing that the Rogers process does not work, they will be arguing that their own scheme will not work either.

The bills are contrary to well established fundamental legal rights. Massachusetts has long recognized both common law and constitutional rights to refuse medical treatment. Even in an emergency, a competent person's refusal of treatment may not be overridden. Therefore, individuals with mental illness may only be forced to accept invasive mental health treatment, such as antipsychotic medication, if they are found by a court to be incompetent; and if the court determines that the person would accept treatment if they were competent.[6] These bills make no provisions for determinations of capacity. Nor do they respect the other rights that are part of Massachusetts' legal heritage. We have a lengthy history of recognizing fundamental rights to bodily integrity, informed consent, and autonomy regarding treatment decisions. These bills are contrary to that tradition.

For these reasons and for all the reasons presented by opponents of these bill, I urge you not to report them favorably. Thank you.

Sincerely,

Robert D. Fleischner
Bob.Fleischner@gmail.com

[6] *Guardianship of Roe III*, 383 Mass. 415, 435 (1981).