July 18, 2023

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

By email to michael.musto@mahouse.gov

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

Re: OPPOSITION - H. 1694/S. 980 An Act to Provide Critical Community Health Services (involuntary outpatient commitment)

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

We write on behalf of the Center for Public Representation to express our opposition to House Bill 1694, Senate Bill 980, "An Act to Provide Critical Community Services." This bill would establish a system of involuntary mental health commitment in the community. Outpatient commitment schemes like the one proposed by H. 1694/S. 980 may be well-intentioned but are fundamentally flawed. We recognize the underlying issues that the Act is designed to address, but believe that a more effective solution would be to develop and fund an array of high quality, voluntary community mental health services and supports.

A detailed analysis of the issues, and the reasons we oppose this bill, is set forth in the paper we jointly submitted with other advocacy organizations, *Involuntary Outpatient Commitment: A Legal and Policy Analysis* (June 2023). In summary, we oppose H. 1694/S. 980 because:

- Outpatient commitment is a **very costly** program of court ordered treatment that is **not effective.**

- Outpatient commitment **requires courts to commandeer mental health professionals** and non-profit agencies and require them to provide, fund, monitor, and enforce a program of involuntary treatment, and then compel the individual, family, or Commonwealth to pay the cost of potentially unlimited treatment.

- Coercion in the mental health system through outpatient civil commitment **undermines the therapeutic relationship** between client and treatment provider and **often causes individuals to avoid treatment** altogether.[1]

[1] Campbell, J. and Schraiber, R. *In Pursuit of Wellness: The Well-Being Project*. California Department of Mental Health, Sacramento, CA, 1989 (study finding trend of people with serious mental illness avoiding voluntary treatment when there was fear that such treatment would draw attention of a provider who could potentially petition for forced treatment).

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- **Limited mental health dollars** are better spent on creating a robust system of **voluntary services** in the community, which are severely lacking.

We write to articulate some additional reasons that Massachusetts should not establish a system of outpatient commitment, as set forth in H. 1694/S. 980:

1. **The bill would impose a substantial programmatic, personnel, and financial burden on the courts and the mental health system.**

First, by some estimates, outpatient commitment could cost as much as $30,000 per person, given that the typical needs of individuals include clinical treatment, intensive case management, housing, medication, and therapy, in addition to the cost to the judicial system.[2] By this estimate if 1,000 people were subjected to outpatient commitment in Massachusetts, the costs could well exceed $30 million dollars. Massachusetts is better served investing in more effective voluntary services.

Further, the bill would strain already overburdened courts by requiring that they oversee all aspects of the court ordered treatment plans, including modifying and enforcing the plans. The court would have to hold an evidentiary hearing *each time* there was a proposed change to a treatment plan, a change to an individual's condition, an issue with enforcement, or a motion to terminate the order of commitment. This would place a substantial strain on the judicial system in Massachusetts.

2. **Research shows that courts disproportionally impose involuntary outpatient commitment on people of color.**

Research into the involuntary outpatient commitment law in New York (commonly referred to as "Kendra's Law") showed significant racial disparities in its implementation. One study found that courts were five times as likely to impose outpatient commitment on African American people versus white people and two and a half times as likely to impose civil commitment on Hispanic people versus white people.[32] This is compounded by the fact that Black, Indigenous, and people of color community members are already disproportionately overrepresented within U.S. institutions such as mandated psychiatric services, jails, and prisons. The pandemic has also put BIPOC community members at greater risk of experiencing a mental health crisis precisely because of an inability to access needed medical care.[4]

Implementing an additional involuntary civil commitment system is likely to widen existing racial disparities BIPOC communities experience when accessing mental health treatment.[5]

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[2] Association of State Mental Health Program Directors, Medical Directors Council Technical Report, https://www.nasmhpd.org/sites/default/files/NASMHPD%20Medical%20Directors%20Council%20Technical%20Report%20on%20Involuntary%20Outpatient%20Commitment%20-%20October%209%2C%202001.pdf (recommending funding of voluntary services as opposed to coercive services).

[3] New York Lawyers for the Public Interest, "Implementation of 'Kendra's Law' Is Severely Biased," April 7, 2007, https://www.prisonpolicy.org/scans/KendrasLaw04-07-05.pdf.

3. The bill creates a scheme for outpatient commitment, but does not require or fund the development of an array of community treatment options as a less restrictive alternative.

Unless and until Massachusetts creates and adequately funds an array of community treatment options, there will not be a range of appropriate, less restrictive services to include in any forced treatment plan. Without such available services, outpatient commitment is neither legal nor reasonable. Further, from a clinical or practical standpoint, it is not reasonable to conclude that it is necessary to force people into treatment until we have offered people adequate treatment on a voluntary basis. In fact, the Commonwealth, led by former Secretary Sudders, has done a comprehensive analysis of the many gaps and disparities within the existing mental health system, highlighting the significant deficiencies in the existing system.[6] Significantly, her signature achievement, the Roadmap for Behavioral Health Reform authored by Executive Office of Health and Human Services, *does not* include involuntary outpatient commitment as a solution to the needs of the Commonwealth and was developed with substantial community input from almost 700 stakeholders, including families.

Oddly, the bill allows a court to decide who pays for the forced treatment. Subsection (p) provides that court-ordered community health services shall be paid for from the estate of the individual (presumably only if the individual is deceased), by the petitioner (usually the family or guardian), or the commonwealth. Unless the petitioner is willing and able to fund an unlimited amount of community health services, including housing, therapy, support services, and any other form of care needed to promote the health and welfare of the individual, the cost of court-ordered services will be borne by the Commonwealth. Significantly, there is no limit on the type, amount, duration, frequency, and cost of these services, allowing courts unrestricted discretion to compel the Commonwealth to pay whatever is needed for the individual.

4. The bill would effectively create a legal entitlement for community-based services.

Because H. 1694/S. 980 allows a court to order the provision of necessary community mental health services, the bill would create an entitlement to whatever services an individual needs as set forth in the court-approved treatment plan. This would subject the Commonwealth to individual injunctive or damages actions by the family and the individual to enforce a plan against the state if services described in the order were not provided. In addition, prioritizing funding for involuntary services, while neglecting voluntary services, creates perverse incentives for individuals to petition courts for treatment plans simply to gain access to needed mental health care, increasing the Commonwealth's legal exposure and the burden on its economic and judicial resources.

5. The bill would empower courts to compel health care providers to supervise and even fund forced treatment plans that they might not be able to oversee and/or do not believe are appropriate.

The bill commandeers local non-profit mental health providers and makes them responsible for providing, monitoring, and enforcing involuntary treatment orders. It allows a court to compel a mental health professional to supervise a treatment plan, and to require a director of a treatment program, and (presumably) a private provider organization to implement the plan—all without

their consent and even over their opposition. The mandated treatment order does not consider, and may well disregard, whether the mental health agency or individual provider has the resources to provide the treatment, whether they can do so safely, and even whether the agency or individual thinks the services are clinically appropriate.

Finally, forcing treatment providers into the monitoring and enforcement role undermines the therapeutic relationship between the individual and the treatment provider, and the efficacy of that treatment, by replacing trust and engagement with fear and coercion. This is inconsistent with recognized best practice, and the recommendations of organizations like National Alliance on Mental Illness (NAMI), the leading national organization of family members of people with mental illness, which has promoted engagement as the standard of care rather than coercion.[7]

6. The bill infringes on the constitutional right to privacy and property.

The bill allows mandatory involuntary testing (presumably blood and urine testing) without any standard, process or ability to object, thus contravening basic constitutional guarantees of bodily privacy. It discriminates against people with psychiatric disabilities by forcing them – and only them – to participate in a judicial regimen of forced medication, to accept court-ordered services, and to be subject to punishments including involuntary detention if they refuse.

For these reasons, the Center for Public Representation strongly opposes the passage of H. 1694/S.980 and associated legislation that would create a system of outpatient commitment. We do support legislation that would promote the expansion of voluntary mental health treatment.

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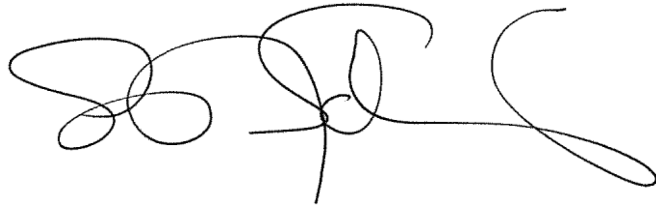
[4] *Building Toward Racial Justice And Equity In Health*, Office of Mass. Attorney General Maura Healey, at 11 (https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download.

[5] See in depth discussion in White Paper submitted as written testimony *Involuntary Outpatient Commitment: A Legal and Policy Analysis* (June 2021) at 10-11.

[6] See Roadmap for Behavioral Health Reform, https://www.mass.gov/service-details/roadmap-for-behavioralhealth-reform

Sincerely,



Steven Schwartz
Legal Director