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December 10, 2025

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

The Honorable Lydia Edwards
Chair, Joint Committee on Judiciary
24 Beacon Street, Room 413-A
Boston, MA 02133

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

Re: Testimony in opposition to H.1801/S.1115, An Act to provide a continuum of care for severe mental illness

On behalf of the Massachusetts Association for Mental Health (MAMH), I write to respectfully submit this testimony in opposition to the above-referenced bill, heard by your Committee on November 18, 2025.

Formed over a century ago, MAMH is dedicated to promoting mental health and well-being, while preventing behavioral health conditions and associated disability. We are committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. We seek to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers to the protections and benefits of citizenship due to their race, ethnicity, gender identity, or disability status. It is these principles and commitments that drive our concerns about provisions of H.1801/S.1115, as written, where vulnerable people living with disabling behavioral health conditions may be further subjected to discriminatory and marginalizing practices.

MAMH shares the palpable concerns of those testifying in favor of this bill, recognizing their rightful concerns about historical delays in response to persons in need of immediate care and challenges in navigating access and accountability of the behavioral health system. We, too, have family members living with complex and disabling behavioral health conditions, which informs how MAMH strives to

improve access to evidence-based mental health services for people across the Commonwealth. We recognize the stress placed on individuals and their families when services feel out of reach or mismatched. Addressing that disconnect is a key part of our work.

We know that the Committee is receiving many excellent submissions from individuals and organizations testifying in opposition to H.1801/S.1115, a bill which allows a range of persons to petition courts to force medication and other treatments and services upon individuals with mental health issues who are living in the community. H.1801/S.1115 allows courts to sanction those who do not comply with such treatment with further treatment orders or curtailment of liberty through involuntary hospitalization. Rather than include all the compelling arguments against involuntary outpatient commitment (IOC) here, we will focus in this testimony on a description of *existing, emerging, and potential services* that we believe do a much better job of meeting individual needs for care than IOC generally and this bill specifically. For a broader reflection of our concerns with IOC, please see this fact sheet and this Policy Paper, both the products of a broad coalition of advocates, people with lived experience, and family members who oppose IOC in favor of more assertive and accountable voluntary care for individuals who do not meet civil commitment criteria. We direct you particularly to the discussion in the Policy Paper regarding the disparate racial impact of IOC. Additional information can be found on MAMH's IOC webpage.

Our current, emerging, and potential service systems afford the opportunity to serve us all while relying on voluntary, evidence-based practices

Our Massachusetts behavioral health system ***has current services, emerging services, and the capacity to add new evidence-based services*** that can well serve people facing serious and disabling mental health issues. We should invest available resources in making sure these services are fully and effectively implemented, rather than adding a new and expensive layer of state executive and judicial branch control required by involuntary outpatient commitment as written in this bill.

Current services

In recent years, our behavioral health system has increasingly championed these principles to best promote recovery for persons with mental health issues.

- **Voluntary, community-based services.** As the state closed decaying and outdated public hospital buildings, it shifted funding to the community system, funding residential and supportive services though the DMH Adult Community Clinical Services (ACCS) program. This program allows people to live integrated into their communities. The ACCS program assists in fulfillment of our state's Olmstead Plan and is a better way to promote recovery than long-term institutional care. At the same time, the state appropriately maintained acute inpatient care and chronic care capacity for those in need of such level of care. That level of care should be reserved for those most in need and the length of stay should be as long as clinically required. Our principal goal is to promote voluntary services in the community, without using the threat of institutionalization as a mechanism to achieve treatment compliance. Because safe housing is an essential element of successful care and treatment. we can further this end by supporting funding for DMH's Safe Havens (low threshold housing for chronically homeless individuals) and Rental Subsidy Program (rental voucher for DMH clients coupled with supportive clinical and tenancy services).

- **Peer support services.** Massachusetts now has formal mechanisms for the certification of peer specialists who have lived experience with mental health recovery. Peers are increasingly a part of the provision of mental health services, including in community service programs, inpatient facilities, respite programs, and even at Bridgewater State Hospital. The state's Recovery Learning Communities are peer-run networks of self-help/peer support, information and referral, advocacy and training activities. There is the potential to expand the use of peers and peer services. Peers have, for example, proposed a bill to establish a peer respite in each county.[1] MAMH supports this important and effective initiative.
- **Housing First models.** These are housing models that do not require sobriety, treatment compliance, or service participation before providing access to safe and supportive permanent housing. The Massachusetts Housing and Shelter Alliance, which has championed Housing First, reports that since 2006, its Housing First programs across the commonwealth have housed more than 2,100 people who were chronically homeless and living with behavioral health conditions. Continuing to fund Housing First programs is essential.

Emerging services and/or Services in early implementation

Chapter 177 of the Acts of 2022 provisions

In 2022, the Legislature passed an omnibus mental health law, Chapter 177 of the Acts of 2022, that provided a range of improvements to mental health services. These reforms are ongoing. We should invest available resources in ensuring the implementation of these efforts and the completion of the required reports and commission work mandated by the law. It hardly makes sense to layer another broad service delivery model (especially one of questionable efficacy) on top of a system that is required to implement these recently enacted measures.

Some examples of the requirements of Chapter 177, which will positively impact access to behavioral health services and will not be helped by or even be consistent with forced outpatient treatment, include:

- Requiring the Secretary of EOHHS to designate at least one 988 suicide and crisis lifeline center that is available 24/7 to provide crisis intervention services and care coordination; the Secretary designated five.
- Enhancements to our 911 system:
    - Amending the membership of the State 911 Commission to include the Commissioner of the Department of Mental Health (DMH), an Association for Behavioral Healthcare representative/emergency service program provider, and a person with lived behavioral health experience and a history of interactions with the police (Section 6);
    - Requiring Public Service Access Points (PSAPs) to be equipped to respond to requests for emergency services from individuals with mental health or substance use conditions (Section 8);

[1] H.2231/S.1383, *An Act establishing peer-run respite centers throughout the Commonwealth*.

    - Directing the State 911 Department to update state regulations on certification requirements for enhanced 911 telecommunicators by integrating training on identification of and response to callers experiencing behavioral health crises (Section 81).
- Requiring health insurers and plans regulated by the Division of Insurance (DOI) to maintain coverage for dependent persons over 26 years of age on a parent's insurance plan who are mentally or physically incapable of earning their own living due to disability (Sections 52, 53, 57, 60, and 62);
- Requiring health insurers to provide insurance coverage for medically necessary emergency services programs (ESPs), which are 24/7 behavioral health crisis assessment, intervention, and stabilization services including mobile crisis intervention, emergency community-based locations, and adult community crisis stabilization services (Sections 27, 49, 51, 55, 58, and 61);
- Requiring MassHealth and any entity it contracts with to provide mental health and substance use condition benefits to comply with state and federal mental health parity laws by covering all behavioral health conditions and ensuring that any annual or lifetime dollar or unit of service limitation for behavioral health conditions is not less than any limitation for physical health conditions (Section 44);
- Requiring MassHealth and any entity it contracts with to provide mental health and substance use condition benefits to ensure that there are no separate non-quantitative treatment limitations that apply to behavioral health that do not also apply to medical/surgical services (Section 44);
- Requiring MassHealth to perform behavioral health parity compliance examinations on its contractors every four years and require its contractors to submit annual parity reports by July 1; Require MassHealth to submit an annual summary of all the reports that it receives to the Legislature by December 1 (Section 44); and,
- Directing the Commissioner of Insurance to implement and enforce federal and state mental health parity laws, including by performing behavioral health parity compliance market conduct examinations on each insurance carrier every four years; Allowing the Commissioner to impose penalties against carriers for violations, and require carriers to provide remedies if the violations resulted in denied access to behavioral health services; Requiring the Commissioner to evaluate and resolve consumer complaints alleging parity violations (Section 22).

Some reforms required by Chapter 177 directed agencies to take specific actions or commissions to form recommendations. All of these reforms are important to improving access to care and all require effort and coordination to implement.

EOHHS Roadmap for Behavioral Health Reform

As a result of listening sessions with nearly 700 individuals, families, providers and other stakeholders around the state, the Commonwealth introduced the EOHHS Roadmap for Behavioral Health Reform in 2021 and implemented it in 2023. The goal is to profoundly improve access to urgent, crisis, and ongoing care. The Roadmap's services adhere to these principals identified by stakeholders: 24/7 availability, integration of mental health and substance use services, integration of behavioral health care with medical care, and a reliance on voluntary, person-driven, culturally competent services. All of these initiatives will have a positive impact on access to mental health services.

Roadmap services include:

- A Behavioral Health Help Line (BHHL), through which clinicians provide, on a 24/7 basis, individualized clinical evaluation, support, and referral to ongoing behavioral health services in the community, including setting up appointments and following up after to ensure satisfaction. The BHHL opened in January 2023. From January through September 2025, the BHHL has handled 27,469 calls (82% by phone, 9% by text, and 9% by chat).[2]

- Perhaps the most important initiative is Behavioral Health Urgent Care, now available at 25 Community Behavioral Health Centers (CBHCs) and an additional 70 plus clinics scattered throughout the Commonwealth, each of which attests to provide day, night, and weekend hours, to see known clients/patients within the same day of presentation or next day for assessment, treatment initiation, and referral to ongoing treatment. The 25 CBHCs, covering every city and town in the state, commenced operation in January 2023. For many individuals, these critical and innovative programs offer meaningful and easily accessible alternatives to emergency department admissions, inappropriate police interventions, and foregoing help entirely. CBHCs provide each of these services, without regard to insurance coverage:

    - Mobile Crisis Intervention (MCI) (services for anyone in Massachusetts experiencing a mental health or substance use crisis provided by trained professionals who can travel to your location);
    - Community Crisis Stabilization (CCS) (a less restrictive alternative to inpatient hospitalization for people in need of short-term, overnight crisis care); and
    - Three urgent care or outpatient visits within one 12-month period.

It is important to note that many of these service interventions were not available to individuals and families who testified compellingly to the challenges they encountered in the system over the years. And, while the full promise of these Roadmap for Behavioral Health Reform services has not yet been met, we advocate tirelessly for continued investment and commitment to complete the implementation and reap the rewards for individuals, families, and communities.

Establishment of an involuntary outpatient commitment system likely will divert funding from these critical programs, cause clinical staff to be redeployed to being treatment plan monitors and enforcers, and seriously undermine the mission of the CBHCs and of the urgent care centers.

988 Suicide and Crisis Lifeline

The nationally-mandated and coordinated 988 Suicide and Crisis Lifeline has the potential to serve a wide range of people in distress and offer connection to ongoing services. The line is intended for anyone in emotional distress or suicidal crisis or for an individual who is worried about a loved one and not sure how to support that person or where to get them help. Lifeline specialists are available to

[2] Behavioral Health Help Line (BHHL) Dashboard. *See* https://www.mass.gov/info-details/behavioral-health-help-line-dashboard.

provide free, confidential emotional support to all callers. Fewer than 2% of calls to 988 in MA require emergency intervention.

In place since July 2022, use of the 988 Lifeline in Massachusetts is growing. There was a 26% increase in 988 calls received and 96% increase in 988 calls answered between FY22 and FY23.[3] As with other behavioral health services, fulfillment of this service will require the state to address workforce challenges.[4]

Middlesex County Restoration Center Pilot

The Middlesex County Restoration Center pilot is based on the work of the 13-member Middlesex County Restoration Center Commission. The Commission, chaired by Middlesex Sheriff Peter J. Koutoujian and MAMH President and CEO Danna Mauch, is tasked with piloting a program to create a restoration center in Middlesex County. The center will help support ongoing law enforcement diversionary efforts across New England's most populous county while also expanding the community capacity for behavioral health (mental health and substance use) treatment. The Commission will launch a restoration center in 2026 in Lowell, operated by Vinfen and Spectrum Health Services.

The Center will serve as a community location for people in crisis to access services and avoid police or emergency room detention. It will be staffed by clinical professionals who can assess, treat, and connect people to voluntary services. The plan is that a pilot restoration center then could be replicated in other counties of the state. The Middlesex center will be a model for the rest of the state.

Evidence-based behavioral health services Massachusetts could pursue

There are evidence-based services that Massachusetts could establish and require commercial insurance plans to fully cover. These services include:

- Treatment for first episode psychosis, through a combination of two evidence-based services shown to be effective treatment modalities: Coordinated Specialty Care (CSC) and Program of Assertive Community Treatment (PACT). Currently, there is no requirement that private insurance plans cover these services. Pending legislation, H.1135/S.709, *An Act for supportive care for serious mental illness*, would require such coverage.
- INSET-Intensive and Sustained Engagement Team is a relatively new program that assists individuals who have been diagnosed with a mental health condition, have experienced multiple hospitalizations, and/or have a history of incarceration or substance abuse. INSET offers integrated peer and professional services to provide rapid, intensive, flexible and sustained interventions to those for whom prior programs of care and support have been ineffective. INSET is being implemented in multiple counties in New York State.

[3] *See* https://www.mass.gov/doc/988-commission-presentation-33023-0/download at 18.
[4] *See* https://www.mass.gov/doc/988-commission-presentation-33023-0/download at 13.

- Evidence-based psychosocial treatments for schizophrenia. These include, among other services, supportive employment, family psychoeducation, and trainings for people with serious mental illness in illness management and recovery.

Massachusetts could also pursue services that would allow for the diversion of people from hospital level care when services could instead be provided in the community. Such reforms would improve overall access to immediate and longer-term behavioral health care. Two pending bills seek this end.

H.1652, *An Act relative to reforming the competency to stand trial process,* would reform the competency to stand trial process by requiring that DMH contract with entities to conduct community-based observation and examination for competency to stand trial and criminal responsibility and community-based competency to stand trial restorations. This bill would open up space in facilities for non-forensic patients requiring an inpatient setting and would improve movement through the continuum of care.

H.2199, *An Act relative to ending unnecessary hospitalizations*, currently before the Joint Committee on Mental Health, Substance Use and Recovery, would require that mental health professionals explore and exhaust community-based treatment alternatives such as telehealth, one-to-one observation, mobile crisis intervention, urgent care, family involvement, and peer support, before seeking involuntary transport by law enforcement.

Both these bills would improve access to crisis and acute care for those who truly need it.

Response to testimony presented in favor of bill

We also take this opportunity to briefly respond to arguments presented by supporters of this bill at the hearing last session and at the hearing on November 18, 2025. We take issue with certain claims. As we outline below, this is a bill which: 1) would impact a large number of people; 2) imposes punishment on people identified as having a disability; 3) relies on a pseudo-scientific concept for why people might refuse treatment; 4) differs from an existing *voluntary* program for people facing criminal charges in Boston Municipal Court; 5) is unnecessary given existing Massachusetts law providing for medication guardianship orders; and 6) is a poor (and unneeded) substitute for available case management services.

Despite the apparent efforts of the proponents to narrowly tailor the bill, its sweep is actually quite broad in several important ways. It would allow a wide range of individuals[5] to pursue service plans for another wide range of people including, for example any "blood relative" or "partner in a substantive dating relationship," regardless of the quality of the relationship between the parties.[6] This will include

[5] This group includes "Any physician licensed pursuant to section 2 of chapter 112, the department of mental health, the superintendent of a medical facility or residence where the individual receives medical care, or the medical director of the Bridgewater state hospital, qualified health professionals, or the spouse, blood relative, legal relative, legal guardian, any responsible adult or individual partner in a substantive relationship, a parole officer, or probation officer assigned to supervise the subject of the petition."

[6] This group includes persons 18 or older who have a primary diagnosis of a serious mental illness, are gravely disabled (itself a broad definition) with a history of "lack of adherence with treatment for mental illness" which has

an unknown but certainly significant number of people including those with a limited connection with the person. We are also concerned that as the bill is written, some persons whose interests may not be aligned with those of the person subject to the order will have standing to file petitions.

Notwithstanding proponents' statements that the bill is not punitive, it is from the perspective of those who may suffer restrictive consequences. This is so not only with respect to the initial implementation of a service plan contrary to the individual's will, but again upon non-compliance with a service plan, which can trigger new treatment requirements or the evaluation of whether failure to hospitalize the person would create a likelihood of serious harm and, if so, an emergency involuntary psychiatric hospital admission. The fact is that people who experience these consequences experience them as punitive, regardless of how they are intended. Moreover, this provision of the bill expands the existing bases for involuntary commitment to a psychiatric facility – such commitment is a substantial curtailment of liberty, which is in law recognized as a severe infringement of rights.[7] Such restriction of liberty cannot be characterized as anything but punitive, even though it is not the expressed intent of the bill's supporters.

There are many reasons why some people refuse powerful psychiatric medications. These reasons include past experience, concern regarding side effects, the questionable efficacy of some medications, long-term risks, and withdrawal responses. There are also individuals for whom earlier traumatic experiences make submission to forced medication administration, particularly injectable medication, a frightening and retraumatizing scenario. Attributing refusal simply to "anosognosia" is misleading and pseudo-scientific. Anosognosia is a term some neurologists use to describe a syndrome in which a person, typically one who has suffered a stroke, has a profound lack of awareness of an obvious deficit. Until recently, the term has not been used in psychiatry. Supporters of forced treatment have tried to apply the concept to people who refuse mental health treatment, without scientific evidence. Proponents' attempts to label resistance to medication (or even something as basic as disagreement with a doctor about a diagnosis) as being rooted in a controversial supposed symptom that has not been scientifically proven, is a tool for proponents to ignore the range of reasons people may have for declining to accept treatment. Or, more broadly, as Sue E. Estroff has written in an essay on the use of anosognosia to deny the value of individual perception, "[b]y considering lack of insight as a sign of neurological impairment, we excuse ourselves from taking the time for and encouraging the emergence of an individual's formulations of him- or herself." Relatedly, proponents characterization of distress as a

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been "a significant factor" in the prior 3 years, in two hospitalizations or services in forensic/criminal legal facilities or a single act of "serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others; and needs such services to prevent relapse or deterioration that would likely result in serious harm to the individual or others; and would likely benefit from critical community health services. So much of this definition is vague or tautological; it could easily apply to a person with a mental illness diagnosis who has made a threat or attempt at harm to self or others in the prior three years.

[7] *Humphrey v. Cady,* 405 U.S. 504, 509 (1972); *Garcia v. Commonwealth*, 487 Mass. 97, 102–03 (2021) ("The right of an individual to be free from physical restraint is a paradigmatic fundamental right." (citations omitted); "We have previously described a temporary hospitalization as short as three days under G. L. c. 123, § 12, as a 'massive curtailment' of liberty (citation omitted). *Newton-Wellesley Hosp. v. Magrini*, 451 Mass. 777, 784 (2008)."

misplaced focus on external events oddly discounts the significance of well-established social and environmental determinants of mental health.

Your Committee has been told that the bill would replicate, for people who are not facing criminal charges, the Boston Municipal Court's Boston Outpatient Assisted Treatment Program (BOAT). While there are similarities, the most obvious difference between BOAT and the IOC bill is that participation in BOAT is voluntary. Further, unlike persons who fail to comply with a service plan under the proposed bill, who may be subject to involuntary hospitalization under a lower standard of what must be proven, enrollees in the BOAT program do not risk loss of liberty for declining to accept treatment. If BOAT enrollees end their participation in the program, they proceed with their pending criminal legal proceedings.

Importantly, we have a robust and functioning process in Massachusetts to compel treatment, both in facilities and in the community. In facilities, courts may pursue substituted judgment decision-making in conjunction with an order for civil commitment.[8] Individuals in the community may be subject to the well-established process to put in place a treatment order approved by the Probate Court pursuant to the guardianship code.[9] DMH estimates that 2,700 DMH community-based clients are subject to Rogers probate court guardianships – that is, court ordered and monitored treatment – at any given time.

Lastly, one of the professed advantages to IOC will be that committed individuals will receive a case manager. However, this bill, with its connection to a judicial process and required reporting to the court, would make those overseeing the treatment plan into a treatment probation officer rather than a trusted source of support. Further, the bill's provision that the court can designate anyone (not only a licensed clinician) to fill this role is dangerous. It potentially inserts an untrained, unlicensed individual into the role of treatment oversight and management.[10]

Additionally, there already are robust case management services available in Massachusetts, including both traditional case management and alternative models of peer support. These case management services include, but are not limited to, those provided by these providers:

- Behavioral Health Help Line (BHHL) clinicians. As discussed above, the BHHL is a new service implemented as part of the EOHHS Roadmap which provides, on a 24/7 basis, individualized clinical evaluation, support, and referral to ongoing behavioral health services in the community, including setting up appointments and following up after to ensure satisfaction.
- DMH case managers.
- Program of Assertive Community Treatment (PACT) team coordinators.

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[8] M.G.L. c. 123, § 8B.

[9] M.G.L. c. 190B, § 5-306A; *see also* https://www.mass.gov/info-details/learn-about-rogers-guardianships.

[10] The bill creates a position for a "supervising mental health professional," but it is not clear that this person will be a trained individual. The bill defines the term "supervising mental health professional" as "a mental health services provider who is required pursuant to such practice to obtain a license from the commonwealth **or who, at the discretion of the court, is deemed suitable to supervise a critical community health service treatment plan.**" (Emphasis added.)

- Adult Community Clinical Services (ACCS) primary clinician. ACCS services, available to DMH clients, provide a range of community-based services and supports. The ACCS primary clinician, assigned to all clients, is accountable for all service components provided by the ACCS team.
- Behavioral Health Community Partners (BH CPs). BH CPs are community-based entities that provide care management and coordination to certain members identified by MassHealth and others. Identified clients have significant behavioral health needs, including serious mental illness and addiction.
- Certified peer specialists. These are trained professionals who, by sharing their lived experience of mental health recovery and resilience, can guide an individual to healing.

Thus, there are a range of sources of case management and similar services available for those with mental health issues.

For all of the above reasons, as well as those available in the additional resources we have referenced, MAMH respectfully opposes H.1801/S.1115.

Thank you for your consideration.

Sincerely,

Danna Mauch, PhD
President and CEO