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

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November 19, 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 Honorable Members of the Joint Committee:

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

On behalf of the Mental Health Legal Advisors Committee (MHLAC), I submit this testimony in in opposition to H.1801/S. 1115*, An Act to provide continuum of care for severe mental illness*, heard by the Joint Committee on November 18, 2025.

MHLAC provides legal and policy advocacy throughout the Commonwealth for people with mental health issues. A state agency, MHLAC's priority is to help our clients live full and independent lives. We seek to protect against unnecessary loss of liberty and to ensure access to appropriate treatment in the least restrictive setting possible.

This testimony highlights serious concerns regarding this bill's potentially broad scope and unmanageable expense. For a fuller analysis of the many concerns about this legislation, please see Involuntary Outpatient Commitment: A Legal and Policy Analysis (June 23, 2025), prepared by the Center for Public Representation, MHLAC, the Disability Law Center, and the Committee for Public Counsel Services, at https://mamh-web.files.svdcdn.com/production/icons/OPC-Policy-Paper-June-23-2025-FINAL.pdf?dm=1750785442. We particularly direct you to the discussion of the twenty years of research demonstrating the disparate impact of involuntary outpatient commitment on BIPOC communities.

The bill's scope is exceedingly broad in terms of the people affected and the power to be exerted over them

This bill is troubling in its breadth – both with respect to the range of persons potentially affected and the control it gives courts over their daily lives.

The bill could force treatment on many people for insufficient reasons

The bill would permit judges to require an adult with alleged "severe mental illness" to accept "critical community mental health services," including, very often, antipsychotic medication. A judge would need to find that that the person is "gravely disabled," but that is loosely defined in the statute and could be applied to literally anyone a mental health provider believes is not taking adequate care of themself. The judge would also need to find that the person had been involuntarily hospitalized or incarcerated in the past three years OR had made one or more acts of serious violent behavior or threats of, or attempts at, serious physical harm. Both these criteria would bring very many individuals within the bill's reach. (The remaining criteria for an order – services would prevent serious harm to the individual or others, likelihood of benefit, and lack of voluntary participation in outpatient services – are subjective and would be easy to allege and hard to refute.)

We believe that this bill would affect many who, under current law, could not be deemed incompetent to make treatment decisions. Since what constitutes a threat of serious physical harm is not defined in the bill, a wide range of conduct or statements that could be perceived as threatening would justify involuntary treatment, particularly in light of the deference courts typically afford psychiatric opinion. A person who has been diagnosed with a major mental illness, correctly or not, who has threatened serious physical harm to themself and is not taking medication could be a candidate for an order. So might a person who was hospitalized three years ago and is currently not receiving outpatient mental health care. And medications could be forced on a homeless person deemed a threat to self who was assaulted in a shelter and prefers to live outdoors in the winter despite the cold. The General Court should not enact legislation that would permit such serious impingements on individual autonomy.

The bill proposes oversight that should frighten those who believe in personal autonomy and privacy

With respect to the scope of oversight, the court-ordered treatment plan, which is the bill's centerpiece, can be extremely intrusive. A court's power would not be limited to ordering compliance with medication. Plans could set requirements for mental health supervision, employment, diet, clothing, and shelter as well. Importantly, the bill does not require that the court-ordered mental health services, employment, or housing actually be available or indicate who will provide or pay for them. Thus, the bill would empower courts to require people to engage in activities without any assurance that the person so ordered can comply because services may not be accessible or even exist. A person could be charged with violations of their court-ordered plan for reasons beyond their control.

Non-compliance can result in harsh penalties. Once an involuntary treatment plan is in place, a judge who finds a person non-compliant could require an evaluation of whether failure to hospitalize would create a likelihood of serious harm, potentially resulting in involuntary hospitalization. This means that people who, under current law, could not be involuntarily admitted to a psychiatric hospital could be forcibly transported and institutionalized against their will pursuant to this bill. Once institutionalized in a psychiatric facility, we know that oversight is even more expansive and intrusive.

Involuntary outpatient commitment schemes, such as that proposed in this bill, require substantial fiscal investment, yet much of that investment does not benefit people with mental health issues

Mandated judicial processes will be very expensive

Due to the potential for curtailment of individual freedom, the federal and state constitutions mandate significant procedural requirements to ensure against the arbitrary imposition of involuntary outpatient commitment orders. A significant and costly infrastructure will therefore be necessary to design, monitor, and enforce the imposition of treatment orders. At a minimum, full judicial hearings will follow petitions, with rights to counsel, independent experts, written decisions, and appeals. All jurisdictions that have enacted and then moved forward to impose a system of involuntary outpatient commitment have devoted considerable legal, judicial, and fiscal resources toward implementation.

Significant costs in other states are borne by various governmental entities. For instance, in Maryland, the most recent state to establish a system of outpatient commitment, the law requires a care coordination team—specified as a psychiatrist, a case manager, and a certified peer specialist—and the bill carried a $3 million fiscal note.[1] In addition, the Maryland Association of County Health Officers estimated that each of Maryland's 23 counties would spend from $250,000 to up to $5 million annually on associated costs.[2] If the 23 counties spent $1 million each, the bill will cost $26 million.

The court system would also incur substantial costs. Since our courts have interpreted the Massachusetts Constitution to require significant due process protections in mental health cases, it is likely that the implementation of any involuntary outpatient commitment system here would require processes as or more elaborate than any other state, with concomitant expense. In Massachusetts, due process requirements for necessarily complex and nuanced evidentiary hearings will place considerable demands on our courts. Moreover, an individual subject to an involuntary outpatient commitment petition has a constitutional right to counsel, requiring increased resources for the Committee for Public Counsel Services. A fiscal analysis by the Maryland Department of Legislative Services projected an increased cost to the state's public defender program of more than $3M. This estimate, which assumed 1,500 cases, was significantly less than the public defenders' own estimate.[3]

Further, since due process requirements apply equally to new and subsequent orders, each time a commitment order expires the state will be obliged to devote the same resources again in order to extend orders.

Monitoring and enforcement will be resource-intensive

One of the most significant demands on an involuntary outpatient commitment scheme is the system of monitoring and enforcement. Many states with involuntary outpatient commitment grapple with the problem of how to ensure compliance with orders. Jurisdictions also struggle to determine which agency should bear the ongoing and considerable costs of enforcement.

In states that rely on court probation departments for enforcement, there are significantly increased costs and administrative burdens on a system that is usually already overburdened. Unless funding for probation departments is substantially increased, outpatient commitment enforcement will leave less time for probation officers to perform their normal public safety job – ensuring criminal offenders' compliance with judicially-imposed conditions of release.

Were the state mental health agency to assume responsibility for monitoring and enforcement, there would be similar concerns. In Massachusetts, the Department of Mental Health (DMH) currently has limited case management capacity. Existent capacity is vulnerable; the Governor's FY 2026 budget called for eliminating half of DMH's case managers for adults. While this funding was eventually restored, the Governor's proposal was in response to serious budgetary concerns. issues for the agency – which are ongoing. And as federal cuts continue to impact DMH, the availability of dollars to implement an

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[1] Mental Health-Assisted Outpatient Treatment Programs, S. 453, 446th Leg. (Md. 2024), May 22 2024. https://mgaleg.maryland.gov/2024RS/fnotes/bil_0003/sb0453.pdf. The law is "generally effective" in July 2025; new programs must be implemented by July 2026.

[2] Dinah Miller, Outpatient Civil Commitment: A Look at Maryland's New Legislation, 41 Psychiatric Times (2024), available at https://www.psychiatrictimes.com/view/outpatient-civil-commitment-a-look-at-marylands-new-legislation.

[3] Mental Health-Assisted Outpatient Treatment Programs, S 453, 446th Leg (Md 2024). May 22, 2024. https://mgaleg.maryland.gov/2024RS/fnotes/bil_0003/sb0453.pdf.

involuntary outpatient commitment program, through case managers or other staff, will be even more questionable.

Delegating monitoring and enforcement to a mental health treatment provider raises other fiscal concerns. Mental health providers are facing serious workforce shortages.[4] Adding this responsibility will increase demand for provider staff, creating further pressure to increase consistently low wages. Those costs would be borne by the Commonwealth.

Much of the funding needed to implement involuntary outpatient commitment will not go to direct services for those in need

This bill would divert funds that could be used for mental health services to a system of adjudication, administration, and policing of compliance. We would do better to fully fund emerging and promising mental health services, including:

- The Massachusetts Behavioral Health Roadmap, which sets out a broad range of community-based behavioral health services provided in Community Behavioral Health Centers (CBHCs), including culturally and linguistically responsive interventions for individuals who are in crisis, require urgent care, or need longer term services.
- Peer services, which are evidence-based care alternatives, including peer respites, peer supports embedded in traditional services, peer-led Recovery Learning Communities, Living Room programs, and peer recovery coaches (for people with substance use needs).
- Voluntary forms of treatment, which include traditional and alternative mental health and substance use services, housing, and other social supports.

We applaud the Legislature for funding such measures as the first 24 hours of CBHC crisis services, peer respites and peer providers, substance abuse services through the Department of Public Health, and programs outlined in the Affordable Homes Act. The Legislature could continue and expand on these initiatives by requiring private insurance coverage of CBHC services, funding additional geographically dispersed peer respites, expanding access to stabilization services after detox, and increasing funding for rental assistance, the safe haven program, and supportive housing. Each of these actions would expand access to behavioral health services and provide an entry way to engagement for presently disconnected individuals. Funding these efforts a much better use of funds than involuntary outpatient commitment. For all the above reasons, MHLAC respectfully requests that you **decline** to report this bill out of Committee. Thank you for your consideration.

Sincerely,

Jennifer Honig

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[4] Massachusetts Taxpayers Foundation, Behavioral Health Workforce Shortage Continues to Create Challenges for Individuals Seeking Care (Dec. 5, 2024), available at https://www.masstaxpayers.org/sites/default/files/publications/2024-12/MTF%20The%20Behavioral%20Health%20Challenge%20Press%20Release.pdf.