Alexej Gundy
Boston, MA 02115

20th November, 2025

———

The Honorable Senator Lydia Edwards, Chair
Joint Committee on the Judiciary
Massachusetts State House
Boston, MA 02133

The Honorable Representative Michael S. Day, Chair
Joint Committee on the Judiciary
Massachusetts State House
Boston, MA 02133

Dear Chair Edwards, Chair Day, and members of the Joint Committee of the Judiciary,

My name is Alexej Gundy, and I am a Boston resident and mental health advocate writing to express my opposition to Bill S.1115. My opposition centers around the adverse outcomes associated with involuntary psychiatric services, the subjective and low bar for forced treatment established by the bill, and the concerns with the bill's funding.

First, involuntary outpatient treatment is not an effective solution to support individuals diagnosed with serious mental illnesses, nor does it have the intended outcomes of the bill.

Extensive research has demonstrated that involuntary outpatient services do not lead to better patient outcomes; rather, the opposite is more common. A 2025 nationwide meta-analysis[1] showed that results of assisted outpatient treatment (AOT) had no meaningful impact on "general mental state, psychopathology, social functioning, quality of life, offences resulting in arrest, homelessness, or career satisfaction." It also noted a lack of substantial evidence demonstrating that AOT reduces hospitalizations or promotes long-term engagement or compliance with treatment.

Involuntary outpatient treatment lowers the threshold for civil commitment, causing disparities between those affected and the general public.

This risk to well-being is emphasized by the bill's lowering of the standards of involuntary inpatient commitment to individuals affected by the bill — a lack of "adherence" with the mandated treatment plan can lead to forced inpatient commitment, even if they do not meet the standard civil commitment criteria.

Involuntary inpatient commitment is associated with severe adverse outcomes that would further undermine the intended impacts of the bill.

---

[1] E. Lea Johnston, Assisted Outpatient Treatment: A State-by-State Comparison, 73 CLEV. S. L. REV. 723, 796 note 69 (2025).

It is well-documented that suicide risk and attempts spike following involuntary commitment, particularly for those who reported experiencing coercion.[2] More broadly, individuals who were committed involuntarily are less likely to report improvement as a result of hospitalization than those voluntarily hospitalized.[3] Additionally, individuals who have experienced involuntary commitment are shown to be reticent to voluntarily seek out treatment due to fear of repeat commitments, additionally undermining the bill's aim of long-term engagement with behavioral health services.[4]

As people of color, primarily Black and Hispanic individuals, as well as people who are homeless, are disproportionately involuntarily placed into both outpatient and civil commitment, this legislation also holds a strong risk of exacerbating structural discrimination within the mental health system, and reducing checks against discriminatory civil commitment procedures.

The bill's eligibility criteria for forced outpatient services is concerningly vague, subjective, and easy to manipulate to force an individual into a "critical community health service treatment plan."

Number (ii) of Criterion 3 allows for actions from up to 36 months before petitioning to be considered, an incredibly far-reaching scope that cannot be assumed to hold bearing on present well-being or engagement with treatment. It additionally links these experiences to "lack of adherence with treatment", an undefined and problematic metric — individuals are currently not able to be compelled into a specific outpatient treatment plan in Massachusetts (hence the introduction of this bill) — so patients are free to stop seeing a therapist or psychiatrist, refrain from taking a medication, and generally choose to pursue as much or as little mental health support as they desire.

This part of the criteria additionally incorporates events from involuntary hospitalizations to "threats of… [causing] serious physical harm to self." I find it entirely unreasonable that a person who indicated that they were planning to end their life — but never acted on this plan — nearly three years ago should be at risk of losing their rights to dictate their own involvement (or lack thereof) with behavioral health services, and be eligible for civil commitment, if they decline to engage with any portion of a mandated treatment plan.

Number (iii) requires that the individual is "in need of ... critical community mental health services in order to prevent a relapse or deterioration that would likely result in serious harm to the individual or others." There is no clear burden of proof established, and even the best psychiatrist cannot definitively predict the future. Being forced into a long-term, unwanted treatment plan is not appropriate when there is no imminent risk.

---

[2] Jordan JT, McNiel DE. Perceived Coercion During Admission Into Psychiatric Hospitalization Increases Risk of Suicide Attempts After Discharge. Suicide Life Threat Behav. 2020 Feb;50(1):180-188. doi: 10.1111/sltb.12560. Epub 2019 Jun 4. PMID: 31162700.

[3] Bonsack C., Borgeat F. Perceived coercion and need for hospitalization related to psychiatric admission. International Journal of Law and Psychiatry 2005; 28: 342–347

[4] Swartz M. S., Swanson J. W., Hannon M. J. Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals. Behavioral Sciences & the Law 2003; 21: 459–472

(v) specifies that eligible individuals are "unlikely to voluntarily participate in OP treatment." For example, if an individual objects to a forced treatment plan that they do not play a role in developing, this can be construed as meeting the criteria, even though objections to forced participation in a plan over which they have no control is entirely understandable. The term "unlikely" is also undefined, making this a highly subjective criteria that, based on AOT laws in other states, is easily exploited.

I additionally want to draw attention to the provided definition of "gravely disabled" within the bill, specifically the bolded portion.

> "Gravely disabled", a condition evidenced by behavior in which a person, as a result of a severe mental illness, is at substantial risk of inflicting serious harm to self or others, **or is in danger of serious demonstrates psychosis**; and has shown an inability to provide for his or her basic physical needs, including medical and psychiatric treatment and shelter, and live safely in the community because of the severe mental illness.

This indicates that solely "demonstrating psychosis" is a sufficient risk to be eligible for coerced treatment; the second element is scarcely relevant due to the widespread, inaccurate belief that individuals with psychotic symptoms cannot live safely in the community. Countless individuals with psychotic-spectrum disorder diagnoses live safely and independently, and function without medication or conventional forms of psychiatric treatment.[5] The wording also appears to have a grammatical error, deleted word(s), and/or other inaccuracies, which is concerning for such a high-stakes bill that puts the rights and freedom of vulnerable individuals at risk.

Finally, the question of funding raised by the bill would cause further harm to vulnerable communities and undermine effective programs.

The bill does not have any clear plans for funding, noting only that services may be paid for by the Commonwealth or by the estate of the patient.

This bill contains language placing individuals who are homeless under particular threat, particularly the criteria including "inability to provide for his or her basic physical needs, including … shelter."[6]

I regularly work with Boston's unhoused community members as a volunteer, and have heard countless stories of challenges with existing, voluntary services that would otherwise remedy their "inability to provide for his or her basic physical needs." Many report having their case workers fall out of contact, extended delays in promised housing timelines, fear of going to doctors due to discrimination and threat of commitment, or lacking consistent access to a phone or computer to identify resources or communicate with support systems.

---

[5] Harrow, Martin; & Jobe, Thomas H. (2007). "Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study." Journal of Nervous and Mental Disease 195(5): 406–414

[6] Note that this language has been used to permit horrific rights violations of homeless individuals, such as Utah's isolated, locked "homeless campuses", which the National Homelessness Law Center has compared to Japanese detention camps and Nazis' "rounding up" Jewish individuals.

Many of these individuals may end up placed into involuntary treatment plans when they would voluntarily obtain support if these programs were improved. However, the most likely source(s) of funding for this bill would be existing housing and community mental health services, including The Massachusetts Behavioral Health Roadmap, which is developing new voluntary, community-based behavioral health services.

Housing-first initiatives, person-centered planning, and non-coerced treatment are proven effective.[7, 8, 9] AOT laws are not — recall the data on poorer outcomes in comparison to voluntary forms of community support and treatment. **Improving existing services is an easier and more effective option than launching a new program with no plans for funding, that is proven to cause adverse outcomes, and decreases the likelihood of voluntarily seeking out services in the future.**

In short, there are many effective ways of supporting individuals experiencing mental distress on their own terms — we should focus on expanding and improving these options, not resorting to forced treatment.

Thank you for your time, and I respectfully ask you not to pass this bill out of committee.

Sincerely,
Alexej Gundy

---

[7] Mackelprang, Jessica L.; Collins, Susan E.; & Clifasefi, Seema L. (2014). "Housing First is Associated With Reduced Use of Emergency Medical Services." *Prehospital Emergency Care* 18(4): 476–482.
National Alliance to End Homelessness, "Data Visualization: The Evidence on Housing First" (website).

[8] Miller, E., Stanhope, V., Restrepo-Toro, M., & Tondora, J. (2017). Person-centered planning in mental health: A transatlantic collaboration to tackle implementation barriers. *American journal of psychiatric rehabilitation,* 20(3), 251–267. https://doi.org/10.1080/15487768.2017.1338045

[9] Mosher, Loren R. (1999). "Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review." *The Journal of Nervous and Mental Disease* 187(3): 142-149. National Empowerment Center, "Evidence for Peer-Run Crisis Alternatives" (website)