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April 9, 2026

The Honorable Michael J. Rodrigues
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Chair, Senate Committee on Ways and Means
24 Beacon Street, Room 212
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The Honorable Joanne M. Comerford
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Vice Chair, Senate Committee on Ways and Means
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Dear Chair Rodrigues, Vice Chair Comerford and Members of the Senate Committee on Ways and Means:

Re: Our opposition to S. 2973, An Act to provide a continuum of care for severe mental illness

On behalf of the Massachusetts Association for Mental Health (MAMH), I respectfully submit this letter in opposition to the above-referenced bill.

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 S.2973, where vulnerable people living with disabling behavioral health conditions may be further subjected to discriminatory and marginalizing practices.

MAMH shares the concerns of people who support the bill regarding delays in access for people in need of immediate mental health care and challenges in navigating the behavioral health system. We, too, have family members living with complex and disabling behavioral health conditions, which along with our knowledge of the current policy, research, and service delivery environment, informs how MAMH strives to end disparities and improve access to evidence-based mental health services in the Commonwealth. We recognize the stress placed on individuals and their families when services feel out of reach or mismatched to needs. Closing those gaps is a key part of our work. The bill, however, will not solve these problems and may well exacerbate access problems.

In summary, the bill would allow an expanded range of persons to petition courts to force medication and other treatments and services on individuals with mental health issues who are living in the community. If enacted, S. 2973 would allow courts to sanction those who do not comply with involuntary outpatient treatment by issuing further treatment orders or by curtailing the person's liberty through involuntary hospitalization. This process is known by several names – assisted outpatient treatment (AOT), outpatient commitment, and, the more accurate descriptor, involuntary outpatient commitment (IOC). Moreover, at least in some cases, it would engage unlicensed case managers to assess compliance and report to the court on matters of compliance with clinical care, acting more like a probation officer than a clinical services manager.

Our concerns about IOC are set out in detail in a Policy Paper, the product of a broad coalition of advocates, people with lived experience, and family members who oppose IOC. The paper reviews legal, policy, fiscal, and program issues. We note as well the discussion in the policy paper regarding the disparate racial impact of IOC.

We expect that your Committee is receiving excellent submissions from many individuals and organizations in opposition to S. 2973. Several will direct your attention to the very recent research on IOC, published by Dr. Nev Jones in February 2026. She has concluded that "[n]o study has demonstrated that involuntary court-ordered treatment adds value beyond the enhanced services and system accountability that accompanies it. Meanwhile, intensive voluntary services such as [P]ACT and Housing First have a well-established evidence base for improving outcomes for individuals with serious mental illness."[1] (We will discuss PACT and Housing First later in this letter.)

Rather than include all the compelling arguments against IOC we will focus this letter on a description of services and programs that do a much better job of meeting individual needs for care than IOC generally and this bill specifically.

Our Massachusetts behavioral health system ***has existing 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 treatment compliance control required by IOC.

The administrative costs of IOC will be high and in the current fiscal climate will not only compete with but will surely deplete investment in services, at a time when we are not meeting the presenting demand for care. Of course, part of the reason some people are calling for compulsory services is that it is too often difficult to obtain a timely and appropriate response to meet an individual's need for mental health treatment and recovery support services. This is because we lack sufficient investment in community-based behavioral health services. Ironically, redirecting investment in IOC, with its high, court and administrative costs, will further limit care remaining for those not under involuntary treatment orders, leaving them at risk and potentially subject to IOC as more individuals and families

[1] Dr. Jones has an in depth description of her research in this PowerPoint presentation to Roots Up, an advocacy group in Western Massachusetts.

struggle to access care in the further depleted civil system. Again, we note that IOC outcome studies find the only value is in the increased services funded and increased provider accountability required.

Current services

In recent years, even when faced with limited financial resources, the behavioral health system has championed these principles to best promote recovery for persons with mental health issues:

- **Voluntary, community-based services.** As the state closed decaying and outdated state mental hospitals, it shifted funding to the community system, establishing residential and supportive services though the DMH Adult Community Clinical Services (ACCS) program. The ACCS program is a better way to promote recovery than long-term institutional care. At the same time, the state has maintained acute inpatient care and chronic care capacity for those in need of such levels of care. MAMH's goals are to promote voluntary services in the community without using the threat of institutionalization to achieve compliance, and to ensure that ACCS and other services are adequately funded even in times of fiscal restraints.
- **Peer support services.** Massachusetts has formal mechanisms for the certification of peer specialists who have lived experience with mental health recovery. Peers are a vital part of the provision community service programs, inpatient facilities, respite programs, and even at Bridgewater State Hospital. Peer services, including peer respite, should be supported and expanded. (We support another bill in your Committee, S. 1383, sponsored by Senator Comerford, which would promote the establishment of peer respite programs across the Commonwealth.)
- **Housing and Housing First models.** Because safe housing is an essential element of successful care and treatment, we support 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). The Massachusetts Housing and Shelter Alliance reports that since 2006, Housing First programs have housed more than 2,100 people who were chronically homeless and living with behavioral health conditions. Fully funding DMH housing and Housing First programs is essential.

Emerging services

EOHHS Roadmap for Behavioral Health Reform

The Commonwealth launched the Roadmap for Behavioral Health Reform 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:

Perhaps the most important initiative is Behavioral Health Urgent Care. There are almost 80 Behavioral Health Urgent Care Providers, behavioral health clinics that have met urgent care requirements

established by MassHealth, which offer same or next day evaluation, psychopharmacology appointments within 72 hours of an initial evaluation, and extended evening and weekend hours. Individuals can also receive urgent access to behavioral health care at 30 clinic sites operated by 25 Community Behavioral Health Centers (CBHCs) across the state. Each CBHC site provides day, night, and weekend hours, to see known clients/patients within the same day of presentation or new clients the next day for assessment, treatment initiation, and referral to ongoing treatment. The CBHCs, covering every city and town in the state, opened 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 also provide these services, without regard to insurance coverage:

- Mobile Crisis Intervention, services for anyone experiencing a mental health or substance use crisis provided by trained professionals who can travel to the person;
- Community Crisis Stabilization, 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.

The Roadmap also includes a Behavioral Health Help Line (BHHL), through which clinicians provide, on a 24/7 basis, individualized clinical evaluation, support, and referral to behavioral health services in the community. Through December 2025, the BHHL has handled 38,273 calls.

While the full promise of these Roadmap services has not yet been realized, we advocate for continued investment and commitment to complete the implementation and reap the rewards for individuals, families, and communities. In fact, Roadmap services like the BHHL, Urgent Care, Mobile Crisis Intervention, and Crisis Stabilization Units are critical to providing individuals in distress and their families with timely, accountable access to care.

Establishment of an IOC system and bureaucracy will divert resources and 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. Moreover, courts may appoint unlicensed individuals to act as case managers to assess compliance and report to the court on matters of compliance with clinical care, acting more like probation officers than a clinical services managers.

Middlesex County Restoration Center Pilot

On March 31, 2026, Vinfen with Spectrum Health Systems launched the Greater Lowell Restoration Center. Its launch represents the culmination of a thoughtful and intensive planning process by the Executive Office of Health and Human Services (EOHHS) and the Middlesex County Restoration Center Commission established by the Massachusetts General Court. The Restoration Center expands community capacity for mental health and substance use treatment and supports ongoing law enforcement diversionary efforts across New England's most populous county. Law enforcement can now bring people needing mental health and substance use treatment to the Center, diverting them

from costly and traumatic stays in hospitals and jails. Ambulances can now drop people off at the Center as diversion from busy hospital EDs, providing a direct alternative to costly ED boarding and acute inpatient admissions. The Restoration Center offers behavioral health crisis assessment, intervention, and stabilization; care coordination with individuals' behavioral and medical care providers; connections to peer specialists and recovery coaches; connections to offsite detox for substance use; a 10-bed Respite Care Program for short-term admissions; sober support for individuals who are intoxicated; and peer-led Living Room services with access to case management, showers, and laundry. The Restoration Center is an exciting model for the rest of the state and should be replicated.

Reforms required by Chapter 177 of the Acts of 2022

An omnibus mental health law, Chapter 177 of the Acts of 2022, provided a range of important improvements and reforms to mental health services. We should invest available resources in ensuring their implementation. It hardly makes sense to layer another broad service delivery model (especially one of questionable efficacy like IOC) on top of a system that is required to implement these measures. Some examples of the requirements of Chapter 177 that will positively impact access to behavioral health services and will not be helped by or even be consistent with forced IOC include:

- Enhancements to the 911 system including adding members with knowledge of and experience with the mental health system to the 911 Commission and requiring training for 911 telecommunicators on identification of and response to callers experiencing behavioral health crises;
- Requiring Public Safety Answering Points (PSAPs) to be equipped to respond to requests for emergency services from individuals with mental health or substance use conditions;
- Requiring health insurers to maintain coverage on a parent's insurance plan for dependent persons over 26 years of age who are mentally or physically incapable of working due to disability and to provide insurance coverage for medically necessary emergency services programs (ESPs) including mobile crisis intervention;
- Requiring MassHealth and its contractors to comply with state and federal mental health parity laws; and,
- Directing the Commissioner of Insurance to implement and enforce federal and state mental health parity laws.

988 Suicide and Crisis Lifeline

- The nationally-mandated 988 Suicide and Crisis Lifeline serves anyone in emotional distress or suicidal crisis or anyone who is worried about a loved one and not sure how to support that person or where to turn for help. Lifeline specialists provide free, confidential emotional support to all callers. In place since July 2022, use of the 988 Lifeline in Massachusetts is growing. As with other behavioral health services, fulfillment of this service will require the state to address workforce challenges.

Evidence-based behavioral health services Massachusetts could pursue

Many of the proponents of IOC have seen family members suffer problems in access because of the discriminatory practices of their insurance companies, which fail to cover the treatments justifiably needed and scientifically proven to effectively treat emerging mental health conditions. Coverage of these evidence-based services would likewise support more widespread dissemination of these services by providers across the state. Requiring commercial insurance plans to fully cover these services could provide needed relief for individuals, families, and providers alike. Among such services are:

- 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.4896, *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 use. 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. These are individuals whom the proponents of S. 2973 say the bill is intended to benefit.
- Long established evidence-based and promising psychosocial treatments for schizophrenia, including supportive employment, family psychoeducation, cognitive behavioral therapy for psychosis, and other practices.
- Services that allow for the diversion of people from hospital level care. Such reforms would improve overall access to immediate and longer-term behavioral health care. For instance, H.2199, *An Act relative to ending unnecessary hospitalizations*, 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.

In addition, reforming the competency to stand trial process can open up access to continuing inpatient care, solving one of the concerns of proponents of the bill. Establishing entities to conduct community-based observation and examination for competency to stand trial and criminal responsibility, and for competency restoration would open up space in facilities for non-forensic patients requiring an acute inpatient setting or continuing inpatient care and would improve movement through the continuum of care.

Response to some arguments in favor of the bill

We also take this opportunity to briefly respond to arguments presented by supporters of this bill at the hearing before the Joint Committee on Mental Health and Substance Use and Recovery on November 18, 2025.

The bill, in fact, is not narrowly drafted. Despite the apparent efforts of the proponents to narrowly tailor the bill, its sweep is actually quite broad in several important and concerning ways. First, It would expand the legal criteria for civil commitment by adding a "gravely disabled" element. Lowering the civil commitment standard to grave disability would include a substantially larger group of people who would be subject to civil commitment, which is a significant curtailment of liberty and which the law recognizes as a severe infringement of rights.[2]

Second, it would allow a wide range of individuals to seek involuntary 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. This will include an unknown but certainly significant number of people including those with limited connection with the person. Persons whose interests may not be aligned with those of the person subject to the order will have standing to file petitions.

The bill, in fact, is punitive. Notwithstanding proponents' intentions to help people get care and statements that the bill is not punitive, from the point of view of many individuals living with mental health conditions, it is; they see threats to their liberty and being forced to accept treatment they do not want as harmful. This is so not only with respect to the initial order and implementation of a service plan contrary to the individual's will, but also upon non-compliance with a service plan, which can trigger new treatment requirements or an evaluation of whether an emergency involuntary psychiatric hospital admission is warranted. The fact is that many people who experience these consequences experience them as punitive, regardless of how they are intended.

The proponents rely on pseudo-science to justify involuntary medication. There are many reasons why some people refuse powerful psychiatric medications. These reasons include past experience, concerns regarding harmful side effects of some drugs that include life-shortening metabolic and cardiac illnesses, the questionable efficacy of some medications, long-term risks of cognitive decline or liver/kidney failure, and withdrawal responses. There are also individuals for whom earlier traumatic experiences make submission to forced medication administration, particularly injectable medication, frightening and retraumatizing.

The proponents' claim that refusal to accept certain treatments is caused by "anosognosia" is misleading and is based on what many experts refer to pseudo-scientific use of the term.

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[2] *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).")

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 applied the concept to people who refuse mental health treatment without scientific evidence. As Dr. Sue E. Estroff has written in a commentary on anosognosia, "[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 misplaced focus on external events oddly discounts the significance of well-established social and environmental determinants of mental health.

The BOAT program is not IOC. Your Committee may be 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 legal standard, 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. If involuntary hospitalization is warranted, BOAT participants are afforded the same due process and subject to the same legal standards as any other citizen – not the lesser standards in S. 2973.

There are existing court processes for involuntary treatment. There are existing judicial processes to compel treatment, both in facilities and in the community. In facilities, courts may order mental health treatment in conjunction with an order for civil commitment.[3] Individuals in the community may be subject to a treatment order approved by the Probate Court, known as a *Rogers* order.[4] DMH estimates that 2,700 DMH clients are now subject to court ordered and monitored treatment at any given time.

Case managers provided for in S. 2973 will function as treatment probation officers. One of the professed advantages to IOC is that committed individuals will receive a case manager. However, given the judicial process and mandated reporting to the court, case managers overseeing the treatment plan would be treatment probation officers rather than a trusted sources of support. The bill's provision that the court may designate any suitable person (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.

A more judicious use of the Commonwealth's resources would be to ensure that people with disabling mental health conditions can receive timely and effective case management services in light of recent reform efforts. For instance, in March 2026 DMH restructured its case management model, including onsite staff to assist individuals on a drop-in basis and prioritization of rapid engagement to address critical needs as they emerge. The FY26 General Appropriations Act (GAA), required DMH to provide the Legislature with data on how this model is working. Since the model just launched, no data is available

[3] G.L. c. 123, § 8B.
[4] G.L. c. 190B, § 5-306A; *see also*https://www.mass.gov/info-details/learn-about-rogers-guardianships.

yet. Furthermore, the Governor's FY27 state budget proposal cuts MassHealth case management services in half, and no longer requires Accountable Care Organizations (ACOs) to contract with Behavioral Health Community Partners (BH CPs). MAMH is concerned about the lack of direction to ACOs for managing the reduction to limit negative impacts on individuals. At a time when access to behavioral health case management is under transition and uncertain, repurposing case managers as treatment compliance reporters and overseers for a court under IOC is a misuse of resources.

The Commonwealth should prioritize, authorize, and account for timely care to individuals most in need and at risk, targeting the individuals and families for whom involuntary outpatient care is sought in the bill. For all of the above reasons, as well as those available in the additional resources we have referenced, MAMH supports fulfilling the implementation of behavioral health system reforms, including plans to prioritize care to persons most at risk, with complex and co-occurring conditions, leading with outreach and engagement followed by assertive community treatment and recovery supports. We underscore that Massachusetts already has a procedure for determining when and how someone in need of such care and refusing it can be presented in a *Rogers* petition to the court for substituted judgement and treatment orders. Therefore, we respectfully oppose S. 2973. Thank you for your consideration.

Sincerely,

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