In her advocacy for court-ordered outpatient commitment — also known as involuntary outpatient commitment — Dr. Jhilam Biswas ignores the heavy long-term psychic cost of forcing treatment on those she finds short on self-awareness ("State’s mental health law is missing a key treatment," Opinion, Dec. 19). And if there is a missing link in the Massachusetts mental health care system, her fear-mongering piece fails to identify it.

Annual legislative testimony for involuntary outpatient commitment tends to rely on
outlier stories. Conspicuously absent from these cases, as well as from Biswas’s op-ed, is analysis of how adding this treatment to existing means for addressing the most extreme cases of acute psychiatric conditions would make a difference. The conduct described in these stories is typically serious enough to justify inpatient commitment.

Instead of funding officers to enforce involuntary treatment orders, we should continue efforts to bolster a system of community-based services to make it as various as the needs of the people who may be inclined to accept and thus benefit from such services. This should include increased funding for services that are effective in engaging people in recovery, such as peer respite — temporary supportive housing for people in acute need — and other model programs such as Housing First, which gets people off the streets without imposing impossible conditions.

The state’s recently established Roadmap for Behavioral Health Reform is designed to make a wider array of services more accessible. Investing in the delivery of indisputably effective services makes a great deal more sense than diverting substantial resources for the claimed but inadequately demonstrated benefits of involuntary outpatient commitment (the nonrandomized study cited by Biswas, according to its own authors, has serious limitations; more recent research finds involuntary outpatient commitment ineffective).

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Quincy