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July 18, 2023
(via electronic submission)

Senator James B. Eldridge, Senate Chair
Representative Michael Day, House Chair
Joint Committee on Judiciary
State House
24 Beacon St.
Room 136
Boston, MA 02133

Re: Written testimony in opposition to H.1694 / S. 980, *An Act to Provide Critical Community Health Services*

Dear Senator Eldridge, Representative Day, and Members of the Committee:

On behalf of the Disability Law Center (DLC) we are writing to express our strong opposition to H.1694 / S.980, a bill to be heard before the committee on Wednesday, July 18, 2023.

As the designated Protection and Advocacy (P&A) agency for the Commonwealth of Massachusetts, DLC operates pursuant to a federal mandate and legislation that gives us unique access to facilities that serve people with disabilities, including people in mental health facilities such as state psychiatric hospitals, rehabilitation centers, nursing homes, and prisons and jails. We also assist people with disabilities living in both community and institutional settings. Since 1986, designated P&A agencies in every state and territory have been working as part of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program to protect and advocate for the human

and civil rights of persons with serious mental health conditions, to monitor facilities that provide care or treatment to persons with serious mental illness, and to investigate reports of abuse and neglect.

Executive Summary

H.1694 / S.980 is essentially an involuntary outpatient commitment (IOC) bill. Like almost all organizations within the disability rights community, including all peer advocacy and peer recovery organizations, the Committee for Public Counsel Services (CPCS), the Center for Public Representation (CPR) and the Mental Health Legal Advisors Committee (MHLAC), we oppose involuntary outpatient commitment ("IOC") because **coercive and threatening measures** used within a community treatment plan **lack proven effectiveness and adversely affect therapeutic relationships.** In addition, IOC programs are **expensive and inefficiently consume scarce mental health resources** and **intrude upon the human rights and personal dignity** of people who receive mental health services. Moreover, as explained in the research paper jointly submitted to the Committee by DLC, CPR, CPCS and MHLAC, the use of involuntary outpatient commitment has **disproportionately affected marginalized communities of color.** Finally, the debate around outpatient commitment itself is **extremely destructive to the disability justice community**, pitting a small group of family members and mental health professionals against people with lived experience in the mental health system, other family members and other mental health professional and providers.

Discussion

We write to underscore four overriding concerns that are the core of our opposition:

1. **IOC Lacks Proven Effectiveness, Compared with Alternatives.**

IOC has not been proven to be an effective treatment approach. The prevailing conclusion in clinical literature is that in those situations where it has been used in states that also achieved improved levels of care, the improvement could not be correlated to IOC. Involuntary outpatient commitment has no possibility of working if it is not accompanied by services to which people may be committed. Therefore, there is the risk (and here, the likelihood) that any **positive outcomes are attributable only upon the infusion of substantial additional funding** in the form of expanded community services, not the use of coercive tactics. And so, studies of the effects of outpatient commitment have been unable to unravel whether any successful results were caused by coercive measures, or only the presence of expanded community services, such as intensive mental health services, supportive housing, or employment. And of course, expanded community services may just as equally be offered without coercive tools. As a result, many states that have IOC do not use it.[1] Involuntary

[1] See e.g., Solomon, "Forced Mental Health Treatment Will Not Prevent Violent Tragedies" in Jackson, *Social Policy and Social Justice,* (Univ. of Penn. Press, 2017) at 100-103.

outpatient commitment imposes extraordinary costs on an already strained system, draining existing financial resources through additional expenses for district court proceedings, independent medical examinations, appointed counsel and paid treatment monitors.

Meanwhile, the Department of Mental Health's Roadmap for Behavioral Health Reform and its service delivery model, Adult Community Clinical Services (ACCS) are working **to strengthen person-centered community-based alternatives**, while issues with wage rates and retention of direct support staff remain. If Massachusetts institutes involuntary outpatient commitment, **funds would be taken away from these operating resources**. We would encourage instead that the legislature provide the resources to fund fully community programs and clubhouses, rectify staffing shortages, create more peer respites, the hire more peer engagement specialists, increase positions of case managers, support diversion programs, and fund mobile crisis intervention and community crisis stabilization services. **The peer recovery community should be active partners in prioritizing and apportioning these resources**. Extensive studies show that people with mental health disabilities in their lives have the most success when they are actively involved in, if not leading, the decision-making process about their own health and recovery.

2. IOC Misallocates Resources and Does So in a Manner That Reflects Social Stigma.

It makes little sense to move resources away from those who voluntarily use them, and to use those resources to force treatment upon others against their will. This is especially so while there are waiting lists and not enough services for people who *do* want them. The individuals on waiting lists for services who have disabilities are no less significant.

This misallocation of resources is often **influenced by negative** attitudes towards people with mental health disabilities. This includes a readiness to use coercion on people who decline mental health treatment to their own detriment, while we readily accept poor decision-making among patients with physical disabilities such as diabetes or heart disease.[2]

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[2] One commentator notes that IOC may stigmatize individuals with mental illness, barring them further from achieving a life with individual choice by creating a double standard for healthcare. If an individual with a heart condition fails to follow prescribed medical protocol, there are no legal consequences. The doctor does not ask if the patient is "at-risk" for harming him or herself, despite the fact that this may well be the case. State agencies are not concerned with patients who choose to ignore their physical health because such a diagnosis of physical disability does not carry the stigma that mental illness holds. See Ezra E. H. Griffith and Daniel Papapietro, *Ethics Challenges in Forensic Psychiatry and Psychology Practice* (Ezra E. H. Griffith et al. eds., 2018) 120-122. One illustration of this is the way in which we managed the risks associated with the COVID pandemic. Here we readily embraced values of personal autonomy,

In some situations, the willingness to default to **coercion is rooted in a misconception** that individuals with mental health disabilities are inherently dangerous. Solomon, "Forced Mental Health Treatment Will Not Prevent Violent Tragedies" in Jackson, *Social Policy and Social Justice*, (Univ. of Penn. Press, 2017). This reflects a fundamental misunderstanding of mental health. Every individual living with a mental illness, and even those living with the same diagnosis, experience and exhibit drastically varying symptoms, few of which are violence. In fact, people with mental illness are five times more likely to be the victim of violence than a person without mental illness. Only 3 to 5.3 percent of violent crime is attributable to a person with a mental illness.[3]

3. IOC Leads to Troubling Changes to the Roles of Judges and Treatment Providers

The bill would **move us to a dysfunctional system of having individual judges allocate scarce resources** under "critical community health services" including court-

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even to the extent of allowing people with serious pre-existing conditions to deny the existence or risks associated with COVID, which would "likely result in serious harm" (See line 43-44 of H. 1694), and in some cases refusing medical treatment after they became infectious. Yet, even during a pandemic and a public health emergency declared by the Governor, there were no consequences.

[3] Ari Ne'eman and Morgan C. Shields, *Expanding Civil Commitment Laws is Bad Mental Health Policy,* Health Affairs Blog (April 6, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180329.955541/full/.

We acknowledge that IOC is supported by many people with good intention, including family members who have loved ones with mental health struggles that are treatment-resistant, or who have difficulty consistently accepting and complying with effective treatment regiments while in the community. Our office devotes considerable resources to advocating on behalf of these individuals for better discharge planning and higher quality community programs that will keep persons served engaged in respectful, patient-centered and effective approaches to treatment. We differ in maintaining that literature and practical experience demonstrate that coercion in community programs is not effective, financially sound or reflective of the human rights of the individuals it purports to benefit. Many of the results sought by IOC states (namely compliance with medication protocols in treatment programs) can be achieved through continuous, direct, person-centered engagement and respectful dialogue; innovative approaches such as certified peer specialists and peer respites; as well as mobile crisis intervention and community crisis stabilization services.

In addition, we find debate surrounding IOC, particularly when influenced by national organizations unfamiliar with Massachusetts, to be **injurious in and of itself.** It divides portions of the community, including some family members, treating professionals, providers, and individuals with lived experience -- forcing people should be natural allies into disagreement -- while more important issues of mutual concern remain unaddressed.

ordered outpatient treatment based on individual cases. This is extraordinarily expensive, consuming scarce state resources devoted to mental health for expenses that do not improve results. Instead, allocation of resources should be managed by individuals working together with agencies, treating professionals, and providers. We need a holistic agency policy and comprehensive criteria for allocating scarce resources rather than haphazard, individual *ad hoc* decisions made by district court judges from the bench.

Just as it enlists judges to make policy decisions about allocating mental health resources, IOC **forces clinicians to take part in judicial enforcement.** In so doing, IOC **undermines relationships between mental health professionals and the persons for whom they provide care and treatment.** It involuntarily enlists clinicians to take over probation officer functions. This violates the necessary trusting, long-term relationship that patients need with their clinical professionals to achieve their personal milestones.

4. H. 1694 Raises Confusing and Problematic Drafting Issues.

The bill empowers any spouse, blood relative, legal relative, legal guardian or individual partner on a substantive dating relationship" to institute file a petition to restrict the freedom and personal autonomy of a patient. There are **no limitations requiring that such a person be free of conflicts of interest or even have any familiarity with the present life of the individual.**

The petitioning party, who may have no training or qualifications whatsoever. is permitted to prepare "the written critical community health services treatment plan." In doing so, the petitioning party need only consult "when possible" with those familiar with the individual, or the individual's family, or their physician, or those familiar with their case history. **Any requirement or expectation that the individual themselves be consulted is omitted.**

Once the matter is quickly brought before a judge, **the court appoints a "supervising mental health professional" who may not be a professional at all.** As that term is defined in the bill, the court may empower any person "deemed suitable" to serve in this role, notwithstanding the absence of any license, education, training, or other credentials. From there, this person is empowered to begin enforcement proceedings against the individual **by accusing the individual of not complying with any aspect of the service plan** (including medication, reporting, testing, or services to be provided for employment, food, clothing, or shelter) which may end with involuntary hospitalization. Those proceedings are rushed forward on an accelerated schedule **without basic due process standards and well-established procedures required**

by Massachusetts law, particularly a determination that one is not competent and a substituted judgment inquiry.[4]

Conclusion

We urge you to oppose H.1694 / S.980. Involuntary outpatient commitment undermines the basic ideas of liberty, autonomy, dignity, and choice that define what it means to live in the community. Instead, it creates yet another institutional parallel to the correctional system, where individuals with mental illness are forced into a cycle of being admitted, held, released, and then, with outpatient commitment, placed under probation.

Overall, court ordered outpatient commitment plans are a deeply flawed short-term approach to a systemic failure to adequately fund community mental health programs. **Research indicates that effective solutions come from individualized, respectful, community supported care**. Resources should be allocated instead to supporting and creating more services that fit these criteria.

Thank you for the opportunity to comment on and express our strong opposition to this measure. If we may be of any assistance to the Committee, please do not hesitate to contact Rick Glassman at rglassman@dlc-ma.org.

Very truly yours,

Richard M. Glassman
Director of Advocacy

Barbara L'Italien
Executive Director

[4] In addition, an involuntary outpatient commitment procedure is **unnecessary** in light of the existing civil commitment process, which provides that individuals who are dangerous to themselves or others be civilly committed, and the existing *Rogers* guardianship process, which allows for forced medication orders. Massachusetts state law chapter 123, section 12 already provides a process for people to be held in a psychiatric facility following a finding by any number of clinical professionals or a police officer - - all without going to court.