INVOLUNTARY OUTPATIENT COMMITMENT

A Legal and Policy Analysis

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I. INTRODUCTION

This memorandum addresses the legal principles relevant for analysis of involuntary outpatient commitment in Massachusetts, the clinical, policy, programmatic, and fiscal considerations inherent in a system of involuntary outpatient commitment, and the national experience with involuntary outpatient commitment in terms of preventing violence and promoting recovery. Based upon these factors, and particularly the existing legal context in Massachusetts, it is doubtful that any form of an involuntary outpatient commitment law that would primarily address the issue of people not taking medication or refusing to accept mental health treatment would achieve the goals of increasing safety and improving care.

II. THE CONTEXT OF INVOLUNTARY TREATMENT IN MASSACHUSETTS.

Massachusetts has long recognized the common law and constitutional bases for an individual's right to refuse medical treatment. *Shine v. Vega*, 429 Mass. 456, 463 (1999). *See also Norwood Hosp. v. Munoz*, 409 Mass. 116, 121 (1991); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 430 (1986). Even in an emergency situation, a competent person's refusal of treatment may not be overridden. *Shine*, 429 Mass. at 467. Furthermore, the Supreme Judicial Court has recognized the general right of all persons, whether competent *or incompetent,* to refuse medical treatment. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 745 (1977) (emphasis added).

The general right to refuse unwanted medical treatment applies broadly to all citizens, including individuals with mental illness. *Guardianship of Roe III,* 383 Mass. 415, 434-435 (1981). All citizens in Massachusetts are presumed to be competent to consent to medical and psychiatric treatment. That presumption can only be overridden by a judge after a hearing. G.L. c. 190B §§ 5-101, 5-306A; *Guardianship of Roe III*, 383 Mass. at 442; *Rogers v. Commissioner of Dept. of Mental Health*, 390 Mass. 489, 491 (1983). This presumption extends even to individuals who have been civilly committed after a judicial finding that they are mentally ill and that there is a risk of serious harm to themselves or others. G.L. c. 123, § 8B; *Guardianship of Roe III*, 383 Mass. 435 at n. 15; *Rogers,* 390 Mass. at 491.

Accordingly, individuals with mental illness can only be forced to accept invasive mental health treatment such as antipsychotic medication, if: (a) they are found by a court to be incompetent; and (b) if a court, pursuant to a substituted judgment analysis, determines that the person would take the antipsychotic medication if he or she was competent. *Guardianship of Roe III*, 383 Mass. at 435. The substituted judgment determination is made by a judge, taking into consideration the individual's preference for each specific treatment, the risks and benefits of that treatment, and the consequence of not treating. In *Rogers,* the Court emphasized that an individual's expressed preference is a "critical factor" in the substituted judgment analysis because "it is the patient's true desire that the court must ascertain." *Rogers*, 390 Mass. at 505.

Notwithstanding the right to decline treatment, individuals with mental illness who present a risk of serious harm to themselves or to others are subject to restraint, detention and involuntary confinement in a secure mental health facility. Like every state, Massachusetts has a well-established and frequently used system of involuntary civil commitment – both in an emergency and for the long term. This process may be initiated by, among others, a mental health professional, a police officer or a family member. G.L. c. 123 §§ 7, 8, and 12.

The Supreme Court has declared that civil commitment involves a "massive curtailment of liberty." *Humphrey v. Cady,* 405. U.S. 504, 509 (1972). Consistent with this opinion, and beginning with its decision in *Commonwealth v. Nassar* more than 40 years ago, the Supreme Judicial Court has required that the statutory objectives of G.L. c. 123 be accomplished in the least restrictive manner possible, including a legal determination that there are no less restrictive, voluntary treatment alternatives. *Commonwealth v. Nassar*, 380 Mass. 908, 917 (1980).

The SJC has consistently reaffirmed the principle that an individual subject to constraints on his or her fundamental right to liberty under G.L. c. 123 has the "right to receive the least restrictive or least burdensome control necessary to pursue rehabilitation." *Commonwealth v. Rosenberg*, 410 Mass. 347, 360 (1991); *see Williams v. Steward Health Care System,* 480 Mass. 286, 292-293 (2018), quoting *Nassar*, 380 Mass. at 917-918; *Matter of E.C.*, 479 Mass. 113, 121 (2018). The Court recently held that detailed findings are constitutionally mandated, and an essential due process protection, when individual liberty interests are at stake. *See Matter of a Minor*, 484 Mass. 295, 307, 309-310 (2020)(requiring detailed findings regarding the evidence credited in support of a legal conclusion that statutory criteria for a substance abuse commitment order are met.)("For G. L. c. 123, § 35, to be constitutional as applied, the hearing judge must find, by clear and convincing evidence, that there are no appropriate, less restrictive alternatives that adequately would protect a respondent from a likelihood of imminent and serious harm.")

Given this analysis, it would be unconstitutional to order involuntary treatment until and unless a court concluded, and made detailed factual findings, that there were no appropriate voluntary community programs/supports. Since these decisions were rendered in the context of the Commonwealth's entirely voluntary community mental health system, they strongly suggest that involuntary treatment should be limited to inpatient hospitalization.

As this important body of caselaw demonstrates, Massachusetts has a lengthy history of recognizing the fundamental right to bodily integrity, informed consent and autonomy with regard to treatment decisions, including all forms of treatment for mental illness. The well-established judicial procedures for determining whether an individual is incompetent, and if so, whether the individual's substituted judgment is to accept a proposed mental health treatment, apply equally to mental health care in facilities and in the community. Thus, in order to pass constitutional muster, any involuntary outpatient commitment law would need to include provision for a judicial procedure that is comparable to *Rogers* and inpatient commitment proceedings.

These established rights and statutory procedures provide the context for analyzing any involuntary outpatient commitment proposal.

III. THE BASIC ELEMENTS OF INVOLUNTARY OUTPATIENT COMMITMENT.

A. Involuntary Outpatient Commitment Standards

States with involuntary outpatient commitment differ widely in their standards for its use. While some states have some form of dangerousness requirement that is similar to the inpatient commitment standard (*i.e.* risk of harm), other states, such as North Carolina and Michigan, use a much lower involuntary outpatient commitment standard, such as a need for mental health treatment. In the former, the number of individuals subject to involuntary outpatient commitment is relatively small, since the law focuses on persons who may not quite satisfy inpatient commitment standards at a specific point in time. In those states that have adopted relatively low standards, the number of persons who can be involuntarily treated is significantly larger than those who are subject to inpatient commitment, with the concomitant cost and complexity of constructing a much larger judicial process and many more state-operated or monitored treatment programs. Despite some fundamental differences, most states that have involuntary outpatient commitment require findings that: (1) the person is able to live safely in the community; (2) the person is not so dangerous that inpatient commitment is necessary immediately; (3) there is an available community program; (4) the court has approved a detailed treatment plan; and (5) the person will cooperate with the plan.

B. Involuntary Outpatient Commitment Process

There are significant procedural requirements that must be included in any involuntary outpatient commitment process. At a minimum, there must be a full judicial hearing, with adequate notice, the right to counsel, access to an independent expert, a written decision, and a right to appeal. Most jurisdictions require that mental health clinicians attend the hearing and present evidence that the individual meets the involuntary outpatient commitment standard for commitment and that the mental health services set forth in the proposed treatment plan are necessary and available. At a minimum, this clinical opinion must be set forth in an affidavit and be subject to cross-examination at a hearing. Given the full range of procedural requirements demanded by due process when an individual's freedom is curtailed or treatment is compelled, all states that have implemented involuntary outpatient commitment have had to devote considerable legal, judicial, and fiscal resources to implementation. Inasmuch as our courts have interpreted the Massachusetts Constitution to require significant due process protections in mental health cases, it is likely that any involuntary outpatient commitment system here would have to include protections equal to or greater than those in any other state.

Involuntary outpatient commitment laws create a greatly expanded role for the courts and a significantly increased burden on judicial resources. Due process requirements for complex and nuanced evidentiary hearings, with expert opinions and predictions concerning future behavior, proposed treatment plans, and evidence of the availability of mental health clinicians and programs willing to provide involuntary treatment, place considerable demands on courts already struggling with limited resources. Moreover, there can be little doubt that an individual subject to an involuntary outpatient commitment petition will have a constitutional right to counsel. This will almost certainly require increased resources for the Committee for Public Counsel Services.

Involuntary outpatient commitment clearly requires a judicial determination about what is necessary and appropriate treatment, with judicial approval of a treatment plan. For clinicians, providers and Department of Mental Health (DMH) officials, involuntary outpatient commitment means surrendering a large degree of clinical discretion and decision-making to judges. In many other situations, including community placement and institutional conditions cases, courts are reluctant to make treatment decisions that are arguably more properly within the purview of doctors and mental health professionals, *Olmstead v. L.C.*, 527 U.S. 581, 610 (1999) ("The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference"). But involuntary outpatient commitment invests the court with the final authority to make detailed decisions about the type, intensity, and frequency of mental health treatment. In a system with limited resources, judicially mandated treatment frequently results in the perverse allocation of the greatest treatment resources to those who least want them, and the concomitant reduction in care for those who most want it. When courts mandate treatment, states and their agents, like mental health providers, are obligated to provide that treatment, as

prescribed by the judge. Courts are not obliged to be sensitive to resource constraints in mental health programs; they might well order what they believe the individual needs, rather than just what is available. Moreover, since judges understandably focus on the individual before the court, they are not in a position to assess the competing needs or priorities of other mental health consumers, and particularly those who voluntarily engage in community mental health services.

Finally, the arguable benefits achieved by involuntary outpatient commitment are often short-lived, and inarguable costs increased, as states limit the duration of commitments under involuntary outpatient commitment and provide even more procedural opportunities for periodic review and reversal of involuntary outpatient commitment orders as patients' circumstances and conditions change. States vary in the length of time for which someone can be committed under involuntary outpatient commitment. However, each time a commitment order expires, due process requirements apply equally to any new order or any extension of an existing commitment order, with the concomitant resources, including appointed counsel, demanded at each new hearing.

C. Monitoring and Enforcement

One of the most significant challenges for any involuntary outpatient commitment system is the need to construct an efficient monitoring and enforcement scheme. Many states with involuntary outpatient commitment grapple with the problem of who is responsible for monitoring and enforcing an involuntary outpatient commitment order, how to ensure effective oversight and compliance with the order, which agency should bear the ongoing and considerable costs of enforcement, and how to promote treatment compliance and engagement without undue coercion.

Enforcement is undeniably costly, at least if it has any possibility of being effective. "States that have not invested in meaningful and costly enforcement mechanisms have found that involuntary outpatient commitment is not useful or widely used." M. Susan Ridgely, Randy Borum & John Petrilla, *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, 69-70 (2001) (the *"RAND Report"*).

In those states that rely on court probation departments for enforcement, there are significant increased costs and administrative burdens on a system that already has great responsibilities. These costs and burdens leave less time for probation to ensure community safety, demand compliance of criminal offenders with judicially imposed restrictions, and take prompt action when confronted with noncompliance. Probation departments, including in Massachusetts, have historically been focused on these tasks. Accordingly, probation officers are ill-equipped and not trained to deal with people with psychiatric disabilities. Given the reasonably anticipated resistance of probation

departments to assume the responsibility for monitoring and enforcing involuntary outpatient commitment orders, the burden of monitoring orders will likely fall on the treatment providers. One study found that most treatment providers simply "do not have the resources to provide high levels of supervision." *RAND Report* at 64. In Massachusetts, monitoring and enforcement of involuntary outpatient commitment would likely become the responsibility of DMH's case management, a community service which has been greatly scaled back as a result of budget cuts.

Furthermore, the tension between the competing responsibilities of a mental health treatment provider, as both a therapeutic support and monitor of an involuntary outpatient commitment order, has its own negative consequences for the effectiveness of mental health treatment. Involuntary treatment, generally, undermines the provider/patient relationship and actually results in increased non-compliance. *See*, *e.g.*, Mark J. Cherry, *Non-Consensual Treatment is (Nearly Always) Morally Impermissible*, 38 J.L. Med. & Ethics 789, 791-792 (2010). This clinical reality is one of the greatest non-fiscal costs of involuntary outpatient commitment. *See also* Jennifer L. Strauss *et al.*, *Adverse impact of coercive treatments on psychiatric inpatients' satisfaction with care*, 49 Community Mental Health J. 457 (2013) (Consumer satisfaction with inpatient mental health care is a key predictor of functional and clinical outcomes; lower satisfaction is associated with involuntary admission and perceived coercion during hospitalization.)

D. Services and Programs

Several studies have demonstrated that involuntary outpatient commitment is ineffective and unnecessary, particularly without a broad array of intensive community mental health services. The Bellevue Study, which compared a group of individuals under involuntary outpatient commitment to a control group, found that court orders did not lead to lower rates of crime, hospitalization or compliance with treatment. Henry J. Steadman, *et al.*, *Assessing the New York City Involuntary outpatient commitment Pilot Program*, 52 Psychiatric Services 330, 335-36 (2001).

More recent studies have confirmed the findings that involuntary outpatient commitment does not increase compliance, reduce hospitalization rates, or keep down costs. *See* Jorun Rugkasa, *Effectiveness of Community Treatment Orders: The International Evidence*, Canadian Journal of Psychiatry (2016), https://journals.sagepub.com/doi/full/10.1177/0706743715620415 (2016 meta-analysis of clinical literature around the globe found that outpatient treatment schemes do not achieve their stated goals of keeping people in treatment and out of hospitals); Tom Burns *et al.*, *Coercion in mental health: a trial of the effectiveness of community treatment orders and an investigation of informal coercion in community mental health care,* NIHR Journals Library (Dec. 2016) (involuntary commitment orders did not reduce hospitalization and there was no evidence of cost-effectiveness); Phoebe Barnett *et al.*, *Compulsory community treatment to reduce readmission to hospital and*

increase engagement with community care in people with mental illness: a systematic review and meta-analysis, Lancet Psychiatry (Dec. 2018) (no consistent evidence that compulsory community treatment reduces hospital readmission or length of inpatient stay, although it might have some benefit in enforcing use of outpatient treatment or increasing service provision, or both).

Studies also have found that involuntary outpatient commitment fails to improve patient outcomes. *See* Rugkasa, *supra* (community treatment orders significantly increase the time individuals spent under coercion, but do not improve patient outcomes or yield clinical or social benefit, with the sole exception being a reduction of likelihood of falling victim to crime); Tom Burns *et al.*, *supra* (involuntary outpatient commitment did not improve patient outcomes). *See also* M. Susan Ridgely *et al.*, *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States,* RAND Instit. for Civil Justice (2001); Steve R. Kisely *et al.*, *Compulsory community and involuntary outpatient treatment for people with severe mental disorders,* Cochrane Database of Systematic Reviews (2009).

Even studies that have shown some positive outcomes from involuntary outpatient commitment emphasize that it is only one aspect of a broad-based package of reforms which include significant increases in resources that enable the delivery of a comprehensive array of community health services. Marvin Swartz *et al*., *A Randomized Controlled Trial of Outpatient Commitment in North Carolina,* 52 Psychiatric Services 325, 329 (2001); Sharon Carpinello, *Kendra's Law Final Report on the Status of Assisted Outpatient Treatment*, Office of Mental Health NY (2005); Marvin Swartz *et al., New York State Assisted Outpatient Treatment Program Evaluation*, Office of Mental Health NY (2009). *See also RAND Report* at 99 ("There is no evidence that simply amending the commitment statute to add an outpatient commitment program will make benefits accrue to persons with severe mental illness"); Jo C. Phelan *et al*., *Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State*, Psychiatric Services 61:137-143, 137 (2010) (study found "modest" improvements in lives of test subjects, but given "treatment and other enhancements" included in outpatient program, evidence does "not support the expansion of coercion in psychiatric treatment"). *See also* Marvin Swartz, *Assisted Outpatient Treatment (aka Involuntary outpatient commitment): The Data and the Controversy* (2017 presentation) (available upon request) (summarizing findings of a study of the New York State program, noted that benefits of involuntary outpatient commitment may derive from the prioritization of patients with court orders over those without them, as a court order "exerts a critical effect on service providers").

There is no dispute that "intensive community treatments produce good outcomes." *RAND Report* at 99. Before investing in a huge involuntary outpatient commitment enforcement infrastructure, however, it is critical to sort out the reason for any positive impact from programs including coercion in tandem with services, particularly in Massachusetts, where coerced treatment already options exist.

Moreover, coercion has a serious potential negative impact. The most recent study of the impact of "Kendra's Law" in New York concluded that "perceived coercion has [negative] consequences." Phelan, *supra*, at 142. This perception is "significantly associated" with involuntary hospitalization and otherwise has "detrimental effects on perceived stigma, quality of life, and self esteem." *Id.*

Subsequent research, therefore, offers little reason to question the findings of the President's New Freedom Commission on Mental Health, which in 2003 issued a report calling for dramatic increases in community mental health services, stipulating that all be delivered on a voluntary basis. Jennifer Honig & Susan Stefan, *New Research Continues to Challenge the Need for Outpatient Commitment,* 31 New Eng. J. on Crim. & Civ. Confinement 109, 119 (2005), citing *President's Freedom Commission, Report of the Subcommittee on Rights and Engagement* (2003).

The Supreme Court has made clear that when a person is involuntarily committed, the state has a duty to ensure the person is safe, is free from unnecessary restraint, and is provided minimally adequate treatment. *Youngberg v. Romeo,* 457 U.S. 307, 324 (1982). Thus, involuntary outpatient commitment arguably creates an entitlement to community mental health treatment, as well as a legal and financial duty to provide and fund all court-ordered treatment services to which an individual may be committed or which may be included in a court-ordered treatment plan. This obligation obviously intensifies the already-existing challenges of meeting the need for community mental health services at any time, and particularly in difficult financial times. In states that lack adequate community mental health services or that are unwilling to create an entitlement to these services for involuntarily committed persons, involuntary outpatient commitment is deeply problematic and legally quite risky. In Massachusetts, where intensive community-based services such as case management, mobile outreach and Assertive Community Treatment have been substantially reduced by DMH, involuntary outpatient commitment is particularly problematic and not likely to be effective.

IV. OTHER DESIGN AND IMPLEMENTATION CONSIDERATIONS.

A. There Are Not Enough People Who Would Benefit From Involuntary Outpatient Commitment to Justify the Necessary Investment in Judicial and Mental Health Resources.

Outpatient commitment is not a wise investment of resources because most people who would be subject to such an order would likely voluntarily participate in a well-designed and respectfully implemented non-coercive community mental health program. Indeed, the President's New Freedom Commission on Mental Health's Subcommittee on Rights and Engagement found that "[t]oo often, the services absent

from a community's mental health care continuum are precisely those services that would most likely engage the consumer in voluntary treatment." Honig & Stefan, *supra.* It makes far more sense to invest resources in less expensive voluntary services than to create an entirely new and expensive system for a few persons.

B. Massachusetts Already Has a Process for Court-Ordered Psychiatric Medication and Related Mental Health Treatment.

As discussed above, Massachusetts already has a process, endorsed by the Supreme Judicial Court, for community-based court-ordered medication. The *Rogers* guardianship process has been widely used in many communities to require individuals to take psychotropic drugs and other treatment, when they have been deemed incompetent to make treatment decisions. *See* Marylou Sudders, *Commitment Law Won't Help Mentally Ill,* Boston Globe, June 12, 2002 at A23. ("Although Massachusetts does not have an outpatient commitment law, more than 4,500 people in the Commonwealth take their psychiatric medications under court orders. Known as Rogers guardianships, these orders specify which medications are prescribed and how often they are taken.")

While advocates have expressed concerns about the *Rogers* guardianship process on the grounds that it results in too many guardianships and has a high rate of approval for antipsychotic medication, there is no criticism of the *Rogers* process as being too rigorous or resulting in too few approvals of involuntary treatment orders for medication. There is no evidence, then, that this system is not working or that it should be discarded. Thus, the real question is whether, given the cost, risk and limited use of involuntary outpatient commitment, is it necessary, is it worth it, and will it result in more effective care? In Massachusetts, where there is already a *de facto* system of involuntary outpatient commitment through the *Rogers* guardianship process, the answer appears to be no.

C. *Potential for Racial Bias Should Lend Pause to Any Adoption of Involuntary Outpatient Commitment*

Involuntary outpatient commitment produces a disparate impact on Black, Indigenous, and people of color (BIPOC) community members who already disproportionately do not have access to nondiscriminatory, culturally appropriate, and high-quality mental health services. Racial and ethnic minorities have less access to mental health services than whites have, are less likely to receive needed care, and are more likely to receive poor-quality care when treated. Thomas G. McGuire *et al*., *New Evidence Regarding Racial And Ethnic Disparities In Mental Health: Policy Implications*, 27 Health Affairs 2 (Mar./Apr. 2008). Multiple studies over the last decade have confirmed trends in racial and cultural bias when identifying mental health

symptoms as well as inadequate access and referrals to mental health services. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY—A SUPPLEMENT TO MENTAL HEALTH; A REPORT OF THE SURGEON GENERAL, AT 18 (2001), https://www.ncbi.nlm.nih.gov/books/NBK44243/pdf/Bookshelf_NBK44243.pdf.

As a result, outpatient commitment rates are influenced by "upstream" social and systemic variables and BIPOC community members are more likely to be placed in involuntary outpatient commitment. A New York study found that outpatient commitment affects African Americans three to eight times more frequently than it affects whites—about five times more frequently, on average, statewide. Jeffrey Swanson *et al*., *Racial Disparities In Involuntary Outpatient Commitment: Are They Real?*, 28 Health Affairs 3 (May/June 2009). Greater funds to involuntary outpatient commitment will likely do very little to assist BIPOC communities with mental health needs other than further remove their agency and increase stigmatization. Pathways to psychiatric services are already considerably more complex for BIPOC communities, as it takes longer for them to be referred by a primary care provider to specialty psychiatric care. Patricia A. Galon *et al*., *Influence of Race on Outpatient Commitment and Assertive Community Treatment for Persons With Severe and Persistent Mental Illness*, 26 Science Direct 3, 204 (June 2012). Bringing most of the attributes of coercion and institutionalization into community-based programs through involuntary outpatient commitment would further reproduce and intensify the health care disparities already experienced by BIPOC community members.

Involuntary outpatient commitment also fails to contextualize coercive, mandated mental health treatment within BIPOC community members who are already disproportionately overrepresented within U.S. institutions such as mandated psychiatric services, jails, and prisons. BIPOC community members are already more often treated as inpatients and are four times more likely to be legally mandated to treatment than their white counterparts. Galon, *supra*. There is also a greater likelihood that the police are involved in the hospital admissions of BIPOC community members for psychiatric care. Galon, *supra*, at 205. Creating a cumbersome, expensive, and controversial involuntary outpatient commitment program contributes to the narrative that BIPOC community members need mandated medical intervention with court oversight within their community, when access to inclusive community mental health care programs in the first instance remains a root challenge nationwide and specifically within Massachusetts. For African Americans, for example, mental health services most often occur in emergency rooms and psychiatric hospitals because of the barriers to community mental health services. *See, e.g.,* National Disability Rights Network, Bazelon Center on Mental Health Law - Murphy Bill impact based on race - 2013 (2003), https://www.ndrn.org/images/PAIMI/Bazelon_Murphy_bill_-_impact_based_on_race_-_2013.pdf. Involuntary outpatient commitment is counterintuitive to supporting people with mental health needs, especially within BIPOC communities already struggling with access to mental health services.

D. Many States with Involuntary Outpatient Commitment Do Not Regularly Use It & Massachusetts Pilots Experimenting with this Model Appear to Reject Coercion As Well.

Many states that have involuntary outpatient commitment do not regularly make use of it. *RAND Report* at 69. For example, some states with involuntary outpatient commitment use the process primarily for discharge planning purposes rather than an alternative to hospital-level care. *Id.* Another reason cited for low utilization rates is provider concerns about liability. The RAND Report found that in North Carolina, community mental health providers considered individuals under involuntary outpatient commitment to be high-risk and were reluctant to accept such individuals into their programs due to liability concerns. *Id.* at 70. The umbrella of risk created by involuntary outpatient commitment is broad and results in increased liability to clinicians and other providers for numerous issues ranging from treatment to safety. The result, of course, is an increase in insurance costs, something many community mental health providers may unwilling or unable to assume.

The implementation in Massachusetts of two programs labeled as "assisted outpatient treatment" illustrate this point. The first is an "Enhanced Outpatient Treatment Pilot" (formerly known as the "Assisted Outpatient Treatment Pilot"), financed under an outside section of the budget and administered by Elliot Community Human Services since at least 2015. To our knowledge, this program has never involuntarily hospitalized its participants merely for not complying with a community treatment or service plan. On the contrary, each of the annual reports note that "Engagement is the core strategy to deliver services...." *See, e.g.,* DMH, Enhanced Outpatient Treatment Pilot Fiscal Year 2020, https://www.mass.gov/doc/enhanced-outpatient-treatment-pilot-status-report-fy2020/download.

The second is a program developed by Boston Medical Center and the Boston Municipal Court, with federal funding from SAMHSA, called "Boston Outpatient Assisted Treatment Program" or BOAT. It is an involuntary outpatient commitment program in name only, operating without any new authority under Massachusetts General Laws, and illustrates the latitude afforded by existing law within the Commonwealth. While marketed as Assisted Outpatient Treatment, the program is actually an extension of mental health services provided by Boston's Mental Health Courts. *Compare* Trial Court Awarded Two Federal Grants to Expand Court-Based Mental Health and Substance Use Disorder Services for Specialty Courts in Boston and Springfield, MASS.GOV (July 28, 2020), https://www.mass.gov/news/trial-court-awarded-two-federal-grants-to-expand-court-based-mental-health-and-substance-use ("The [Boston Municipal Court] partnership with Boston Medical Center breaks new ground in providing the first demonstration of Assisted Outpatient Treatment in Massachusetts.") *with* MASS. ADMIN. OFFICE OF THE TRIAL COURT, Abstract for

SAMHSA Funding Opportunity Announcement No. SM-20-006, at 1 (Jan. 10, 2020) (unpublished abstract) (on file with DLC) (BOAT's "population of focus is individuals who have come to the attention of the Mental Health Diversion Initiative (MHDI) of the Boston Municipal Court.")

Participants may choose to enroll in BOAT as part of their probation if they have a pending criminal case in Boston Municipal Court or if they already completed Mental Health Court and need additional services. Information Sheet, BOSTON MED. CTR., https://www.bmc.org/sites/default/files/Patient_Care/Specialty_Care/Psych/BOAT/Information_Sheet_BOAT.docx. The statute authorizing SAMHSA to fund BOAT defines Assisted Outpatient Treatment as "medically prescribed mental health treatment that a patient receives while living in a community under the terms of a law authorizing a state or local court to order such treatment." Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, 128 Stat. 1040, 1084 (2014). Since participants will continue receiving BOAT services as long as they have an open criminal case, the relevant law for SAMHSA funding is Boston Municipal Court's legal authority as a criminal trial court. *See* MASS. ADMIN. OFFICE OF THE TRIAL COURT, *supra*. Thus, BOAT's legal authority does draw from the civil commitment and forced medication statutes that typically authorize involuntary outpatient commitment. For this reason, BOAT is best described as an extension of Boston's Mental Health Courts rather than as an example of involuntary outpatient commitment.

E. Involuntary Outpatient Commitment Is Often Rooted in the Misconception that Individuals with Mental Illness are Inherently Dangerous.

In some states, such as New York, involuntary outpatient commitment has been adopted primarily, or at least in large part, because of a perceived need to prevent violence perpetrated by individuals with mental illness. Kathryn A. Worthington, *Kendra's Law and the Rights of the Mentally Ill: An Empirical Peek Behind the Courts' Legal Analysis and a Suggested Template for the New York State Legislature's Reconsideration for Renewal in 2010,* 19 Cornell J.L. & Pub. Pol'y 213, 221 (2009).

The willingness to default to coercion is rooted in a misconception that individuals with mental health issues are inherently dangerous. Phyllis Solomon, Forced *Mental Health Treatment Will Not Prevent Violent Tragedies* in John L. Jackson, Social Policy and Social Justice (Univ. of Penn. Press 2017). This belief 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. Rarely is violence among these symptoms. In fact, people with mental illness are five times more likely to be the victim of violence than a person without mental illness. Moreover, only 3 to 5.3 percent of violent crime is attributable to a person with a mental illness. Ari Ne'eman & 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/.

Some proponents of involuntary outpatient commitment point to violent tragedies in support of their policy advocacy. *See* Marvin S. Swartz *et al*., *Involuntary Outpatient Commitment and the Elusive Pursue of Violence Prevention: A View from the United States*, 62 Can. J. Psychiatry 2, 102-108 (Feb. 2017) ("Drawing on public opinion, political advocates of OPC in recent years have 'sold' OPC by capitalizing on the publicity surrounding sensational acts of violence by people with mental disorders—explicitly promoting involuntary outpatient treatment as a needed measure to ensure public safety.")

However, there is no evidence that involuntary outpatient commitment makes extreme violent incidents less likely. For example, the ten school shootings that took place in 2021 and the twelve school shootings that took place in 2020 all took place in jurisdictions with involuntary outpatient commitment. See *School Shootings This Year: How Many and Where* (June 21, 2021), https://www.edweek.org/leadership/school-shootings-this-year-how-many-and-where/2021/03.

F. Executive Office of Health and Human Services does not condone involuntary outpatient commitment in the Roadmap for Behavioral Health Reform

Moreover, Secretary Sudders recently led development of a comprehensive initiative to address systemic deficiencies in the Massachusetts mental health system that notably ***does not*** include involuntary outpatient commitment as a solution to the needs of the Commonwealth. The Roadmap for Behavioral Health Reform was developed with substantial community input: Executive Office of Health and Human Services conducted a comprehensive review of community needs based on listening sessions and feedback from almost 700 individuals, families, providers, and stakeholders. *Roadmap for Behavioral Health Reform*, Executive Office of Health and Human Services, https://www.mass.gov/details/for-health-reform, last accessed June 24, 2021. Based on this input, the Baker Administration proposed a wide range of reforms that largely focus on expanding voluntary community mental health treatment options that promote choice, dignity, and independence and encourage people to engage with services voluntarily. *See* "Roadmap for Behavioral Health Reform," Executive Office of Health and Human Services, at 10 (Feb. 2021) https://www.mass.gov/doc/presentation-on-the-roadmap-behavioral-health-reform/download. The purpose of the Roadmap is to "ensur[e] the right treatment when and where people need it" and yet ***nowhere*** in the entire Roadmap does the Executive Office of Health and Human Services propose, recommend, or suggest that the Commonwealth should even consider using involuntary outpatient commitment to address the problems the Commonwealth is facing. Secretary Sudders has herself also previously stated her opposition to involuntary outpatient commitment and belief that the state should instead prioritize funding the voluntary mental health system.

V. CONCLUSION

A comprehensive array of well-funded community mental health services helps to prevent bad outcomes. Involuntary outpatient commitment, without services, delivers empty promises and false hope about its ability to prevent violence and tragedy. In an economic climate where funding for many essential services is scarce, Massachusetts should spend the Commonwealth's limited resources to fund and develop voluntary community mental health services. Furthermore, in Massachusetts the *Rogers* guardianship process provides as good an avenue to providing care, monitoring and enforcement as any involuntary outpatient commitment statute could offer. Any duplication or parallel involuntary outpatient commitment process would merely add costs with no other clear benefits, procedurally or substantively.