

INVOLUNTARY OUTPATIENT COMMITMENT: A Legal and Policy Analysis



Center for Public
Representation

Mental Health Legal Advisors Committee



DISABILITY LAW CENTER, INC.



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EXECUTIVE SUMMARY

Involuntary outpatient commitment laws that compel people with mental health conditions to accept medication and treatment in the community do not increase safety or improve care. Not surprisingly, the involuntary outpatient commitment of people who have not been charged with a crime is among the most controversial and intrusive interventions experienced by those involved in mental health systems. This paper, prepared by the Center for Public Representation, the Mental Health Legal Advisors Committee, the Committee for Public Counsel Services, and the Disability Law Center, addresses key problems with involuntary outpatient commitment laws.

Involuntary outpatient commitment neither promotes recovery nor enhances public safety.

Nearly 25 years of research has demonstrated the shortcomings of outpatient commitment schemes. Studies have repeatedly found that coerced outpatient treatment orders did not lower rates of crime or hospitalization and did not promote compliance with suggested treatment. Moreover, researchers have found no strong evidence suggesting that compelled community treatment reduces hospital readmissions or length of hospital stay.

Even studies that have claimed to show positive outcomes following the introduction of involuntary outpatient commitment schemes often emphasize that the beneficial outcomes cannot be ascribed simply to the treatment mandate but instead are more likely associated with the expansion of community mental health services enacted in conjunction with involuntary outpatient commitment legislation. Indeed, researchers suggest that major investments in additional community mental health services are likely the primary factor associated with any positive outcomes of involuntary outpatient commitment. Continued and increased investment in Massachusetts' recovery-oriented community-based voluntary services is the best way to promote recovery.

Involuntary outpatient commitment would disproportionately impose coercion on communities of color.

Research strongly suggests that involuntary outpatient commitment will be used disproportionately on Black, Indigenous, and people of color (BIPOC) community members, who continue to lag behind whites with respect to access to mental health services. In fact, the experience in New York in implementing Kendra's Law over 20 years proves that outpatient commitment orders will be used disproportionately with persons of color. Research in other jurisdictions confirms this.

Involuntary outpatient commitment pulls public funds away from mental health services that work.

While states with involuntary outpatient commitment differ widely in their standards for its use, implementation has required a substantial infusion of non-treatment related resources just to administer and enforce court orders. Funding is needed to establish a judicial process and protect procedural due process rights, as well as to pay clinical and administrative costs. In Maryland, the most recent state to enact a system of outpatient commitment, the bill was accompanied by a \$3 million fiscal note and an estimate that each county would incur

implementation costs from between \$250,000 to \$5 million. And California, which budgeted hundreds of millions of dollars to fund its new outpatient and mental health court program, is now being forced to cut programs and delay implementation due to fiscal challenges and loss of federal dollars. States have learned that monitoring and enforcement of court orders imposes ongoing, expensive burdens on the judiciary, public defenders, and on public mental health agencies and their contractors. At a time when these systems are facing difficult budgets and staffing shortages, involuntary outpatient commitment would divert resources further from these systems.

Involuntary outpatient commitment proposals make little sense in the context of the current Massachusetts mental health system.

Involuntary outpatient commitment is not a wise investment of resources in Massachusetts, where the focus has been on providing community-based supports to people with serious mental health issues. First, non-coercive community mental health programs are becoming increasingly available in Massachusetts, but still require further investments. Second, Massachusetts pilot projects which have experimented with coercive models have apparently rejected an involuntary approach in practice, similar to the many states that have involuntary outpatient commitment but do not regularly use it. Third, it is a misconception that people with mental illness are inherently dangerous and in need of containment. Fourth, Massachusetts has recently implemented a comprehensive initiative to address systemic deficiencies in the Massachusetts behavioral health system, the Roadmap for Behavioral Health Reform, which invests in voluntary services and does not rely on involuntary outpatient commitment.

Involuntary outpatient commitment is contrary to well established fundamental legal rights enjoyed by individuals in Massachusetts.

The Commonwealth has been a national leader in developing laws and judicial standards that recognize the fundamental rights to bodily integrity, informed consent, and autonomy regarding medical treatment decisions. To comply with our State's Constitution, individuals with mental illness may be ordered to accept invasive mental health treatment, such as antipsychotic medication, only if they are found by a court, with appropriate due process, to be incompetent; and if the court, pursuant to a substituted judgment analysis, determines that the person would accept treatment if they were competent. Further, Massachusetts law provides, again after Constitutional due process and within Constitutional parameters, for involuntary civil commitment and confinement of individuals with mental illness who present a risk of serious harm to themselves or others.

Involuntary outpatient commitment schemes proposed in Massachusetts not only is inconsistent with provisions of our Constitution but also is likely to result in protracted litigation challenging such rules as unconstitutional.

I. INTRODUCTION*

Involuntary outpatient commitment laws that compel people with mental health conditions to accept medication and treatment do not increase safety or improve care. Not surprisingly, the involuntary outpatient commitment of people who have not been charged with a crime is among the most controversial and intrusive intervention in mental health systems.

This paper addresses: (1) the research regarding the effectiveness of involuntary outpatient commitment, which demonstrates that coerced treatment is neither effective in promoting recovery or enhancing public safety; (2) the clinical, policy, programmatic, and fiscal costs inherent in administering a system of involuntary outpatient commitment which collectively undermine the very goals of that system; and (3) the fundamental legal rights and procedures in Massachusetts which are inconsistent with involuntary outpatient commitment.

II. RESEARCH DEMONSTRATES THAT INVOLUNTARY OUTPATIENT COMMITMENT IS NOT EFFECTIVE IN PROMOTING TREATMENT OR PROTECTING SAFETY.

Studies have shown that involuntary outpatient commitment is not effective at meeting its proponents' goals of treatment compliance and reduced rates of hospitalization. Indeed, there is “[n]o strong evidence suggest[ing] that compelled community treatment reduces hospital readmissions or length of hospital stay, or increases contact with mental health services or compliance with medication. Additionally, the studies with the strongest research designs are unanimous in finding no significant effect in patient outcomes including general mental state, psychopathology, social functioning, quality of life, offenses resulting in arrest, homelessness, or career satisfaction.”¹

Rather, nearly 25 years of research has demonstrated the shortcomings of outpatient commitment. For example, one of the first studies, the 2001 “Bellevue Study” in New York, which compared a group of individuals under involuntary outpatient commitment to a control

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

group, found that court orders did not lead to lower rates of crime or hospitalization, or promote compliance with treatment.² This finding has been replicated time and time again.³

Even studies that have claimed to show positive outcomes following the introduction of involuntary outpatient commitment often emphasize that the beneficial outcomes cannot be ascribed simply to the treatment mandate but instead are more likely associated with the significant expansion of community mental health services. Mandates for outpatient commitment are often enacted as part of a broader package of reforms containing an array of new services. Researchers have been unable to isolate the coercive commitment provision as the cause for any clinical outcome, and instead suggest that major investments in additional community mental health services is likely the primary factor associated with any positive outcomes.⁴ In fact, these

² 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 reinforced earlier findings that involuntary outpatient commitment does not increase compliance, reduce hospitalization rates, or keep down costs. Jorun Rugkasa, *Effectiveness of Community Treatment Orders: The International Evidence*, 61 CANADIAN J. OF PSYCHIATRY 1 (2016) (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).

³ See Rugkasa, *supra* note 2 (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* note 2 (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) (“RAND Report”); Steve R. Kisely *et al.*, *Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders*, 3 COCHRANE DATABASE OF SYSTEMATIC REVIEWS 3 (2017), Rachel Churchill *et al.*, *International Experiences of Using Community Treatment Orders* (2007), <https://psychrights.org/research/digest/OutPtCmmtmnt/UKRptonCTO.pdf> (there is currently no robust evidence about either the positive or negative effects of CTOs on key outcomes, including hospital readmission, length of hospital stay, improved medication compliance, or patients’ quality of life).

⁴ See Marvin Swartz *et al.*, *A Randomized Controlled Trial of Outpatient Commitment in North Carolina*, 52 Psychiatric Services 325, 329 (2001); Sharon Carpinello, Office of Mental Health NY, *Kendra’s Law Final Report on the Status of Assisted Outpatient Treatment*, (2005); Marvin Swartz *et al.*, Office of Mental Health NY, *New York State Assisted Outpatient Treatment Program Evaluation* (2009); see also RAND Report, *supra* note 3, 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 137, 137 (2010) (although there were “modest” improvements in lives of test subjects, given “treatment and other enhancements” included in outpatient program, evidence does “not support the expansion of coercion in psychiatric treatment”); Marvin Swartz, *Assisted Outpatient Treatment (aka Involuntary outpatient commitment): The Data and the Controversy* (2017 presentation)

studies have instead identified a wide range of harms, including increased distrust of services, trauma, physical injury due to police enforcement of court orders, and broader negative systemic impacts.⁵

A 2022 meta-analysis of outpatient commitment studies from around the world has specifically attributed positive outcomes to enriched community services sometimes associated with involuntary outpatient commitment, rather than the involuntary outpatient commitment system itself.⁶ Reviewing studies that measured the impact of involuntary outpatient commitment on mortality risk, the meta-analysis concluded that mortality risk to patients subject to outpatient commitment was influenced by service utilization rather than by the fact of having a treatment order. These conclusions were reinforced when the author examined another study within the meta-analysis; in that study, after controlling for service-utilization, the cohort of patients subject to involuntary outpatient commitment showed no overall reduced risk for injury as compared to the non-committed cohort. The researcher stressed it was the access to services that the outpatient commitment system brought that had efficacy.

Other telling examples from this meta-analysis contradict the claims of advocates of involuntary outpatient commitment. For instance, outpatient commitment was associated with increased access to acute medical care for non-psychiatric conditions. However, once individuals (with and without outpatient commitment orders) received entry into the medical service system, they received equal access to medical procedures for health conditions requiring emergency room or hospital admission. Thus, the only benefit of involuntary outpatient commitment was in facilitating *access* to acute medical care; it did not improve health outcomes for those who had such access.

The same meta-analysis also looked at medication compliance, comparing the compliance of patients subject to outpatient commitment orders with the compliance of patients hospitalized but not subject to outpatient commitment. The study found equal levels of compliance for these two groups. And the meta-analysis also concluded that research could not substantiate claims that involuntary outpatient commitment reduces hospital stays.⁷

(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").

⁵ Deborah Corring *et al.*, A Systematic Review of the Views and Experiences of Subjects of Community Treatment Orders, 52 INT'L J. OF L. & PSYCHIATRY 74 (2017) abstract and section snippets available at <https://www.sciencedirect.com/science/article/abs/pii/S0160252716301583>; Marie-Hélené Goulet, *et al.*, Community Treatment Orders: A Qualitative Study of Stakeholder Perspectives, 89 INT'L J. OF L. & PSYCHIATRY 101901 (2023) abstract and section snippets available at <https://www.sciencedirect.com/science/article/abs/pii/S0160252723000444>.

⁶ Steven P. Segal, *Protecting Health and Safety with Needed-Treatment: The Effectiveness of Outpatient Commitment*, 93 PSYCHIATRY Q. 55 (Mar. 2022).

⁷ See also Steven P. Segal, *Hospital Utilization Outcomes Following Assignment to Outpatient Commitment*, 48 ADM. POLICY MENTAL HEALTH 6, 942-61 (Nov. 2021) (explaining this same outcome, this study notes that when involuntary outpatient commitment is associated with Assertive Community Treatment or some form of aggressive case management, it will be associated with reducing re-hospitalization numbers, but when outpatient services are more limited, involuntary outpatient

There is no dispute that “intensive community treatments produce good outcomes.”⁸ However, before investing in a huge and expensive involuntary outpatient commitment enforcement infrastructure, it is critical to determine if the data demonstrate any positive impact from programs that employ coercion in tandem with services. The research to date demonstrates that there is not any benefit from imposing a system of coercion on our community services and, conversely, that absent a significant expansion of community services, there is no discernible benefit from involuntary outpatient commitment.

This imperative becomes even more urgent when the negative impact of coercion is factored. A study of the impact of “Kendra’s Law” in New York concluded that “perceived coercion has [negative] consequences.”⁹ It is “significantly associated” with involuntary hospitalization and has “detrimental effects on perceived stigma, quality of life, and self-esteem.”¹⁰ Indeed, studies affirm that individuals subject to compelled outpatient commitment often experience it as stigmatizing and disempowering.¹¹

The full body of research on involuntary outpatient commitment to date, therefore, gives little reason to question the 2003 findings of the President's New Freedom Commission on Mental Health. The report called for dramatic increases in community mental health services but urged that these services be delivered on a voluntary basis.¹²

There is no shortage of alternatives to forced treatment. In 2018, with a grant from the United Nations, scholars from the University of Melbourne published a 216-page survey of the worldwide literature on such alternatives.¹³ Massachusetts already provides a variety of recovery-oriented community-based voluntary services.

commitment is associated with rapid return to hospital and therefore increased “total-hospital-days and readmissions when compared to a comparison group. The study cites other examples of mixed results as well.)

⁸ RAND Report, *supra* note 3, at 99.

⁹ Phelan, *supra* note 4, at 142.

¹⁰ *Id.*

¹¹ Professor E. Lea Johnston cites these studies as some examples of the stigmatizing impact of compelled community treatment: “Lisa Brophy & David Ring, The Efficacy of Involuntary Treatment in the Community: Consumer and Service Provider Perspectives, 2 SOC. WORK APPROACHES HEALTH & MENTAL HEALTH 157, 158, 171 (2004) (finding a “common area of agreement” between individuals ordered to treatment and mental health professionals that orders “had the propensity to be stigmatizing and disempowering”); Karen Schwartz *et al.*, Community Treatment Orders: The Service User Speaks. Exploring the Lived Experience of Community Treatment Orders, 15 INT’L J. PSYCHOSOCIAL REHAB. 39, *8 (2010) (reporting that participants described the experience of stigmatization as feeling feared by, isolated from, and judged by community members).” E. Lea Johnston, The Constitutionality of Assisted Outpatient Treatment, 86 OHIO ST. L. J. ____ (2025), available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5021136.

¹² 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).

¹³ Piers Gooding *et al.*, *Alternatives to Coercion in Mental Health Settings: A Literature Review* (2018), available at https://figshare.unimelb.edu.au/articles/report/Alternatives_to_Coercion_in_Mental_Health_Settings_A_Literature_Review/21128083?file=37478731.

Moreover, forced acceptance of services creates legal obligations that can distort the distribution of such services among those who need them. In *Youngberg v. Romeo*, the Supreme Court held that when a person is involuntarily committed, the state has, among its duties, to ensure that the person is provided minimally adequate treatment.¹⁴ Thus, involuntary outpatient commitment arguably creates a legal entitlement to community-based mental health treatment, including all services 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 for the general population, and particularly the subset of people with mental health conditions who need and are voluntarily willing to participate in community treatment but cannot obtain that care.

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 both unfair and potentially illegal. Although Massachusetts has invested in community-based services, it is generally acknowledged that these services plainly do not meet the need, as evidenced by long waiting lists for mental health programs and overburdened emergency departments. Creating a new entitlement to services for some persons may well result in a reduction of services to those who do not have such an entitlement. 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, likely, the concomitant reduction in care for those individuals who most want it. This has been the case in New York. Implementation of Kendra’s law has drawn resources away from “affordable, culturally competent, and evidenced based voluntary mental health services.”¹⁵

III. THE INTRODUCTION OF INVOLUNTARY OUTPATIENT COMMITMENT WILL EXACERBATE ALREADY EXISTING DISPROPORTIONATE USE OF COERCED TREATMENT IN COMMUNITIES OF COLOR.

Research strongly suggests that since involuntary outpatient commitment targets persons who have not accessed mental health services, it will be used disproportionately on Black, Indigenous, and people of color (BIPOC) community members. In fact, the experience in New York proves that outpatient commitment orders will be used disproportionately with persons of color.

When compared to other groups, racial and ethnic minorities have less access to mental health services than whites.¹⁶ Cultural misunderstandings between patient and clinician, clinician bias, and a fragmented mental health system are some of the reasons for this disparity.¹⁷

¹⁴ 457 U.S. 307, 324 (1982).

¹⁵ New York Lawyers in the Public Interest, *Implementation of Kendra’s Law Continues to be Severely Biased* (2025), available at <https://www.nylpi.org/wp-content/uploads/2025/03/Implementation-of-Kendras-Law-Continues-to-be-Severely-Biased-Report-1.pdf>.

¹⁶ Thomas G. McGuire *et al.*, *New Evidence Regarding Racial and Ethnic Disparities In Mental Health: Policy Implications*, 27 HEALTH AFFAIRS 393, 396 (Mar./Apr. 2008).

¹⁷ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY—A SUPPLEMENT TO MENTAL HEALTH; A REPORT OF THE SURGEON GENERAL* (2001), at Chapter 2, Introduction.

In addition, it takes longer for members of BIPOC communities to be referred by a primary care provider to specialty psychiatric care.¹⁸

Likewise, results of an important study published in an American psychiatric journal in 2021 showed that Black Canadians of Caribbean or African descent experiencing a first-episode of psychosis were “significantly more likely to be coercively referred and coercively treated than non-Black individuals.” This was shown to be especially true for legal coercion with court involvement.¹⁹

When members of communities of color do receive care, it is likely to be of poorer quality than that provided to white people.²⁰ Research shows that, in clinical practice settings, BIPOC people are less likely than white people to receive treatment that adheres to treatment guidelines.²¹ Additionally, for African American people, mental health services most often occur in emergency rooms and psychiatric hospitals because of the barriers to community mental health services.²²

Disparities in accessing voluntary, quality, community-based care raise concerns that BIPOC community members would be more likely to be placed under involuntary outpatient commitment than other groups. The research demonstrates that this is precisely what happens. New York studies have found that, statewide, outpatient commitment is imposed on African American people five times more frequently than white people.²³ Black and Hispanic people make up 17.6% and 19.3% of New York’s population, but comprise 38% and 27% of those under outpatient commitment, respectively.²⁴ Involuntary outpatient commitment reinforces and aggravates already existing disparities; effectively establishing a separate mental health system in communities of color that costs people their agency and causes them to experience the stigma of coerced treatment.

This is the case for 20 years in New York’s implementation of Kendra’s Law. According to the New York Lawyers in the Public Interest, there were 3,674 individuals subject to outpatient commitment orders in New York as of February 25, 2025. Thirty-eight percent of those individuals were Black, although Black people constitute on 17.7% of the state’s population. Twenty-six percent of the individuals were Hispanic (19.8% of the population).

¹⁸ 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 202, 204 (June 2012).

¹⁹ Sommer Knight *et al.*, *Ethnoracial Differences in Coercive Referral and Intervention Among Patients with First-Episode Psychosis*, 73 PSYCHIATRIC SERVICES 2 (2021) available at <https://psychiatryonline.org/doi/10.1176/appi.ps.202000715>.

²⁰ Thomas G. McGuire *et al.*, *supra* note 16, at 396.

²¹ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 17, at Chapter 2, Evidence-Based Treatment and Minorities.

²² *See, e.g.*, National Disability Rights Network, Bazelon Center on Mental Health Law - Murphy Bill Impact Based On Race - 2013 (2013), https://www.ndrn.org/images/PAIMI/Bazelon_Murphy_bill_-_impact_based_on_race_-_2013.pdf.

²³ Jeffrey Swanson *et al.*, *Racial Disparities in Involuntary Outpatient Commitment: Are They Real?* 28 HEALTH AFFAIRS 816 (May/June 2009).

²⁴ Victoria M. Rodríguez-Roldán, *The Racially Disparate Impacts of Coercive Outpatient Mental Health Treatment: The Case of Assisted Outpatient Treatment in New York State*, DREXEL L. REV. 945 (2020).

White people represent 54% of New York’s population, but only 31% of the persons under Kendra’s law orders.²⁵

Moreover, multiple studies have confirmed that racial and cultural bias contributes to misdiagnosis of mental health conditions for certain populations, particularly African Americans.²⁶ In particular, research has established the presence of significant racial disparities in the diagnosis of schizophrenia.²⁷ Considering that the vast majority of those under outpatient commitment are likely to have a schizophrenia diagnosis – e.g., 72% of participants in New York²⁸ – diagnostic bias foreshadows the potential for an alarming overrepresentation of BIPOC individuals in any Massachusetts program.

Additionally, involuntary outpatient commitment is particularly problematic for BIPOC communities because members of those communities are already overrepresented in restrictive settings such as mandated psychiatric services, jails, and prisons. BIPOC community members are more often treated as inpatients and are four times more likely to be legally mandated to treatment than their white counterparts.²⁹ There is also a greater likelihood that the police are involved in the hospital admissions of BIPOC community members for psychiatric care than for other community members.³⁰ Imposing involuntary outpatient commitment on BIPOC communities contributes to the narrative that these populations need more governmental policing – here, in the mental health realm – while shifting needed resources from addressing the root problem, which is discrimination in the provision of access to inclusive community mental health care resources.

IV. IMPLEMENTING AN INVOLUNTARY OUTPATIENT COMMITMENT INFRASTRUCTURE WOULD REQUIRE AN VERY SIGNIFICANT INFUSION OF NEW RESOURCES.

While states with involuntary outpatient commitment differ widely in their standards for its use, it is clear that implementation of any such commitment process will require a substantial infusion of resources just to administer and enforce involuntary commitment orders, diverting funds from needed expansions of mental health treatment services.

²⁵ New York Lawyers in the Public Interest, *Implementation of Kendra’s Law Continues to be Severely Biased* (2025), available at <https://www.nylpi.org/wp-content/uploads/2025/03/Implementation-of-Kendras-Law-Continues-to-be-Severely-Biased-Report-1.pdf>.

²⁶ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 17, at Chapter 2, Clinician Bias and Stereotyping.

²⁷ C. M. Olbert, A. Nagendra, & B. Buck, *Meta-Analysis of Black vs. White Racial Disparity in Schizophrenia Diagnosis in the United States: Do Structured Assessments Attenuate Racial Disparities?* 127 J. OF ABNORMAL PSYCHOLOGY 104 (2018).

²⁸ Rodríguez-Roldán, *supra* note 24.

²⁹ Galon, *supra* note 18.

³⁰ *Id.* at 205.

A. *The Judicial Process for an Involuntary Outpatient Commitment Will Require a Substantial Expenditure of Resources.*

To pass federal and state constitutional muster, there are significant procedural requirements that would have to be included in any involuntary outpatient commitment process. A significant and costly infrastructure will be necessary to design, monitor, and enforce an involuntary outpatient commitment system. 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. Due process demands a full range of procedural protections when there is the possibility that an individual's freedom will be curtailed or treatment will be compelled. Thus, all states that have implemented involuntary outpatient commitment have had to devote considerable legal, judicial, and fiscal resources to implementation.

For instance, Maryland is the most recent state to establish a system of outpatient commitment. The law requires a care coordination team—specified as a psychiatrist, a case manager, and a certified peer specialist—and the bill carried a \$3 million fiscal note.³¹ In addition, the Maryland Association of County Health Officers has estimated that each of Maryland's 23 counties will spend from \$250,000 to up to \$5 million annually on associated costs.³² If the average associated cost for the 23 counties was just \$1 million, that would be a total statewide cost of \$26 million.

Inasmuch as our courts have interpreted the Massachusetts Constitution to require significant due process protections in mental health cases (see section VI below), it is likely that any involuntary outpatient commitment system here would have to include protections equal to or greater than those provided 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. Moreover, an individual subject to an involuntary outpatient commitment petition will have a constitutional right to counsel, requiring increased resources for the Committee for

³¹ Mental Health-Assisted Outpatient Treatment Programs, S. 453, 446th Leg. (Md. 2024), May 22 2024. https://mgaleg.maryland.gov/2024RS/fnotes/bil_0003/sb0453.pdf. The law is “generally effective” in July 2025; new programs must be implemented by July 2026.

³² Dinah Miller, Outpatient Civil Commitment: A Look at Maryland's New Legislation, 41 Psychiatric Times (2024), available at <https://www.psychiatristimes.com/view/outpatient-civil-commitment-a-look-at-marylands-new-legislation>.

Public Counsel Services.³³ This is particularly alarming given the Committee’s difficulty finding counsel -- both private panel attorneys and state agency staff persons -- to take mental health cases.³⁴ A fiscal analysis by the Maryland Department of Legislative Services projected an increased cost to the state’s public defender program of \$3,356,543 to provide representation to clients subject to that state’s new outpatient commitment law. This estimate, which assumed 1,500 cases, was significantly less than the public defenders’ own estimate.³⁵

Involuntary outpatient commitment 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. However, 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.³⁶ 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.

When courts mandate treatment, states and their agents, like mental health providers, are obligated to provide that treatment, as prescribed by the judge. Courts may not have the information to balance competing demands upon resources in the way that state agencies and

³³ At the federal and state level, courts and legislatures have recognized a right to counsel in a range of contexts that are similar to involuntary outpatient commitment proceedings with respect to the loss of liberty. In *In re Gault*, the Court found a Constitutional right to counsel for youth in delinquency cases. Additionally, the First Circuit Court of Appeals has found a Constitutional right to counsel in sexually dangerous person cases under Chapter 123A. *Sarzen v. Gaughan*, 489 F.2d 1076, 1085–86 (1st Cir. 1973) (“The assistance of counsel should be offered to indigent inmates soon after the filing with the court, during the 60-day commitment, of a report of sexual dangerousness by the examining psychiatrists”). In *Vitek v. Jones*, 445 U.S. 480 (1980), the Supreme Court held that a prisoner being involuntarily transferred to a mental health facility was entitled to “independent assistance” due to the stigma of civil commitment.

By statute, Massachusetts provides for a right to counsel in civil commitment cases, sexually dangerous person cases, some guardianship proceedings, and in Section 35 civil commitments for substance use treatment cases. The SJC has required appointment of counsel in involuntary treatment cases for individuals both in the community and in facilities, *see Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728 (1977); *Guardianship of Roe III*, 383 Mass. 415 (1981); *Rogers v. Commissioner of Dept. of Mental Health*, 390 Mass. 489 (1983), and for parents in guardianship custody cases. *Guardianship of V.V.*, 470 Mass. 590 (2015). In all states, legislatures have passed statutes providing a right to counsel in most civil commitment cases and in a few states, state courts have found a constitutional right to counsel in such cases. *See* John Pollock, *The Case Against Case-by-Case: Courts Identifying Categorical Rights to Counsel in Basic Human Needs Civil Cases*, 61 *DRAKE LAW REV.* 763, 815 (2013). Finally, the right to counsel should attach to involuntary outpatient commitment proceedings not only due to the potential loss of liberty, but also due to the potential to lose the right to make one’s own medical decisions.

³⁴ Email correspondence from Laura Sanford, Director, Mental Health Litigation Unit, Committee for Public Counsel Services to Jennifer Honig and others, Mass. Ass’n for Mental Health (Apr. 5, 2023).

³⁵ *Mental Health-Assisted Outpatient Treatment Programs*, S 453, 446th Leg (Md 2024). May 22, 2024. https://mgaleg.maryland.gov/2024RS/fnotes/bil_0003/sb0453.pdf.

³⁶ *See 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”).

providers typically do. 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. And the court might well issue an order with respect to the individual that does not reflect what is actually available.

Moreover, each time a commitment order expires, due process requirements apply equally to any new order or any extension of an existing commitment order. Each new hearing demands the concomitant resources, including the petitioner's resources, appointed counsel, judicial attention, and administrative activities, discussed further in the next section.

B. Monitoring and Enforcement of Involuntary Outpatient Commitment Will be Resource-Intensive.

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 how to ensure compliance with orders and with assigning responsibility for this job. Jurisdictions also struggle to determine which agency should bear the ongoing and considerable costs of enforcement and how to promote treatment compliance and engagement without doing substantial harm through coercion. Enforcement is undeniably costly. “States that have not invested in meaningful and costly enforcement mechanisms have found that involuntary outpatient commitment is not useful or widely used.”³⁷

In those states that rely on court probation departments for enforcement, there are significantly increased costs and administrative burdens on a system that is already overburdened. These costs and burdens leave less time for probation officers to engage in their traditional responsibility of ensuring criminal offenders' compliance with judicially imposed restrictions. Additionally, probation officers do not have the training or resources to work effectively with people with psychiatric disabilities, so the burden of monitoring often falls on treatment providers who also simply “do not have the resources to provide high levels of supervision.”³⁸ In Massachusetts, it is unclear who would have the capacity to assume this responsibility. DMH has very limited case management capacity.³⁹ Moreover, both DMH and their contracted providers are facing serious workforce shortages.⁴⁰

³⁷ RAND Report, *supra* note 3.

³⁸ *Id.* at 64.

³⁹ As of early June 2025, the future of DMH's case management program was uncertain. The Governor's FY 2026 budget called for eliminating half of the agency's case managers for adults. The House version of the budget forbids reducing the number of case managers, but does not restore the funds cut by the Governor. The Senate budget appears to have restored some or all of the funding. Presumably, if the House language remains in the final budget, the funds for case managers will have to come from other adult services.

⁴⁰ Massachusetts Taxpayers Foundation, Behavioral Health Workforce Shortage Continues to Create Challenges for Individuals Seeking Care (Dec. 5, 2024), available at <https://www.masstaxpayers.org/sites/default/files/publications/2024-12/MTF%20The%20Behavioral%20Health%20Challenge%20Press%20Release.pdf>.

Delegating monitoring and enforcement to a mental health treatment provider who would then have competing responsibilities as patients' therapeutic support and involuntary outpatient commitment order monitor threatens the therapeutic alliance and, thus, the effectiveness of mental health treatment, which can ironically result in increased non-compliance.⁴¹ This clinical consequence is a substantial non-fiscal cost of involuntary outpatient commitment.⁴²

V. INVOLUNTARY OUTPATIENT COMMITMENT PROPOSALS RAISE SERIOUS DESIGN AND IMPLEMENTATION CONCERNS.

A. *Persons Who Would Benefit from Involuntary Outpatient Commitment Would Likely Participate in a Well-designed Voluntary Program of Services, which is a Less Expensive Alternative.*

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."⁴³ 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 individuals.

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

As described in more detail below, Massachusetts already has a process, endorsed by the SJC, for community-based court-ordered medication. The substituted judgment guardianship process has been widely used to require individuals to take psychotropic drugs and other treatment when they have been deemed incompetent to make treatment decisions.⁴⁴

While advocates have expressed concerns about the substituted judgment guardianship process on the grounds that it results in too many guardianships and has a high rate of approval for the administration of potentially risky antipsychotic medication, there is no criticism of the substituted judgment process as being too rigorous or resulting in too few approvals of involuntary treatment orders for medication. There is no reason to conclude that the system in our Commonwealth is not working or should be discarded. Thus, the real question is whether involuntary outpatient commitment, given its cost, risk, and limited use, is necessary, is worth

⁴¹ See, e.g., Mark J. Cherry, *Non-Consensual Treatment is (Nearly Always) Morally Impermissible*, 38 J.L. MED. & ETHICS 4, 789-98, at 791-792 (2010).

⁴² See Jennifer L. Strauss et al., *Adverse impact of coercive treatments on psychiatric inpatients' satisfaction with care*, 49 CMTY. 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.)

⁴³ Honig & Stefan, *supra* note 12.

⁴⁴ See Marylou Sudders, *Commitment Law Won't Help Mentally Ill*, THE 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.")

it, and will result in more effective care? In Massachusetts, where there is already a *de facto* system of involuntary outpatient commitment – the substituted judgment guardianship process – the answer is no.

C. *Many States with Involuntary Outpatient Commitment Do Not Regularly Use It and the 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.⁴⁵ Some states with involuntary outpatient commitment use the process primarily for discharge planning purposes rather than an alternative to hospital-level care.⁴⁶ Other states decline to use the mechanism due to provider concerns about liability. The RAND Report found that in North Carolina, for example, 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.⁴⁷ 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 be unwilling or unable to assume.

Two pilot programs in Massachusetts labeled as “assisted outpatient treatment” are sometimes cited as evidence of the outpatient commitment’s success. 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 entirely voluntary program has never involuntarily hospitalized its participants merely for not complying with a community treatment or service plan. On the contrary, each of the program’s annual reports note that “Engagement is the core strategy to deliver services...”⁴⁸ In other words, it is engagement with the individual, not coercion, that works.

The second is a program developed by Boston Medical Center and the Boston Municipal Court, with federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), called “Boston Outpatient Assisted Treatment Program” or BOAT. BOAT is involuntary outpatient commitment in name only. It is limited to people with criminal justice involvement and is used as a disposition alternative. It is actually an extension of mental health services provided by Boston’s Mental Health Courts.⁴⁹ Participants may *choose* to enroll

⁴⁵ RAND Report, *supra* note 3, at 69.

⁴⁶ *Id.*

⁴⁷ *Id.* at 70.

⁴⁸ See, e.g., DMH, Enhanced Outpatient Treatment Pilot Fiscal Year 2022 (Oct. 2022), <https://www.mass.gov/doc/enhanced-outpatient-treatment-pilot-legislative-report-fiscal-year-2022/download>.

⁴⁹ 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-disorder-services-for-specialty-courts-in-boston-and-springfield> (“The [Boston Municipal Court] partnership with Boston Medical Center breaks new ground in providing the first

in BOAT as part of their criminal probation if they have a criminal case in Boston Municipal Court.⁵⁰

D. 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.⁵¹

The willingness to default to coercion in the provision of services to individuals with mental health issues is rooted in a misconception that such persons are inherently dangerous.⁵² This belief reflects a fundamental misunderstanding of mental health. An individual living with a mental health condition may be affected in a range of ways from that condition, but violence is rarely among these symptoms. In fact, people with mental illness are five times more likely to be the victim of violence than a person without a mental illness. Moreover, only 3 to 5.3% of violent crime is attributable to a person with a mental illness.⁵³

Some proponents of involuntary outpatient commitment point to violent tragedies in support of their policy advocacy.⁵⁴ However, there is no evidence that involuntary outpatient commitment makes incidents of extreme violence less likely. Swartz and his colleagues, reviewing the empirical evidence for using involuntary outpatient commitment for violence prevention, concluded that “[d]espite the current interest in OPC as a means to reduce violence, rigorous empirical evidence to employ it on that basis is slim. ... the paucity of empirical evidence is marked if the goal is reduction of larger scale acts of extreme violence.”⁵⁵

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.”)

⁵⁰ Information Sheet, BOSTON MED. CTR.,

https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.bmc.org%2Fsites%2Fdefault%2Ffiles%2FPatient_Care%2FSpecialty_Care%2FPsych%2FBOAT%2FInformation_Sheet_BOAT.docx&wdOrigin=BROWSELINK.

⁵¹ 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. LAW & PUB. POL'Y 213, 221 (2009).

⁵² 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).

⁵³ 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/doi/10.1377/forefront.20180329.955541/full/>.

⁵⁴ 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 102 (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.”)

⁵⁵ *Id.*

E. *Recent Critical Reform of the Behavioral Health Care System -- the Roadmap for Behavioral Health Reform -- Would be Undermined by Involuntary Outpatient Commitment.*

The Commonwealth recently implemented a comprehensive initiative to address systemic deficiencies in the Massachusetts behavioral health system. That reform effort, the Roadmap for Behavioral Health Reform, does not include involuntary outpatient commitment.

The Roadmap was developed with substantial community input. The Executive Office of Health and Human Services (EOHHS) conducted a comprehensive review of community needs based on listening sessions and feedback from almost seven hundred individuals, families, providers, and stakeholders.⁵⁶ A call for involuntary treatment did not emerge from this extensive polling and had no place in the resulting reforms. Rather, the Roadmap largely focuses on creating new and expanding existing community behavioral health treatment options that promote choice, dignity, independence, and voluntary acceptance of services from a wider array of choices.⁵⁷ The Roadmap also makes extensive investment in the use of peers to provide support for those seeking mental health and substance use treatment services, employing peers as Recovery Coaches, Certified Peer Specialists, and as administrators and staff at peer-run respite programs.⁵⁸ The Roadmap's endorsement of voluntary and peer-led services reflects a conscious decision to adopt the strategy favored by both providers and those seeking treatment – to provide access to services that will “ensur[e] the right treatment when and where people need it.”

Nowhere in the entire Roadmap does EOHHS propose that the Commonwealth consider using involuntary outpatient commitment as a reform strategy. Former Secretary Marylou Sudders, whose long history in mental health services administration spans many years and multiple governorships, is the person most responsible for shepherding the Roadmap through to fruition. She has voiced both strong opposition to involuntary outpatient commitment and belief in the superior efficacy of a voluntary mental health system.

VI. IN MASSACHUSETTS, AN INDIVIDUAL'S FUNDAMENTAL RIGHT TO REFUSE TREATMENT AND LIBERTY INTERESTS ARE CAREFULLY BALANCED AGAINST PROTECTIONS WHICH ALLOW FOR SUBSTITUTED JUDGMENT REGARDING TREATMENT AND CIVIL COMMITMENT.

A. *Massachusetts Law Recognizes and Vigorously Enforces a Fundamental Right to Refuse Treatment.*

⁵⁶ *Roadmap for Behavioral Health Reform*, Executive Office of Health & Human Services, <https://www.mass.gov/roadmap-for-behavioral-health-reform>.

⁵⁷ See Executive Office of Health & Human Services, “Roadmap for Behavioral Health Reform: Ensuring the right treatment *when* and *where* people need it” at 10 (Feb. 2021), <https://archives.lib.state.ma.us/bitstream/handle/2452/846228/on1259693110.pdf?sequence=1&isAllowed=y>.

⁵⁸ Executive Office of Health & Human Services, *Roadmap for Behavioral Health Reform: FAQs*, <https://www.mass.gov/info-details/roadmap-for-behavioral-health-reform-faqs>.

Massachusetts has long recognized both common law and constitutional bases for an individual's right to refuse medical treatment.⁵⁹ Even in an emergency, a competent person's refusal of treatment may not be overridden.⁶⁰ Supreme Judicial Court (SJC) precedent clearly recognizes the general right of all persons, whether competent or incompetent, to refuse medical treatment.⁶¹

The right to refuse unwanted medical treatment applies to individuals with mental illness.⁶² Indeed, Massachusetts residents are presumed to be competent to consent to or to decline medical and psychiatric treatment. The presumption of competence may only be overridden by a judge after a hearing.⁶³ Moreover, the presumption applies 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.⁶⁴

Accordingly, individuals with mental illness may only be forced to accept invasive mental health treatment, such as antipsychotic medication, if they are found by a court to be incompetent; and if the court, pursuant to a substituted judgment analysis, determines that the person would accept treatment if they were competent.⁶⁵ The judge makes the substituted judgment determination, taking into consideration the individual's preference for each specific treatment, the risks and benefits of that treatment, and the consequence of not receiving the treatment. In *Rogers v. Commissioner of Dept. of Mental Health*, the SJC 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."⁶⁶

B. Massachusetts Law Provides for Involuntary Civil Commitment for Individuals with Mental Illness Who Present a Risk of Serious Harm to Themselves or Others, While Recognizing Such Commitments as a Massive Curtailment of Liberty.

Individuals with mental illness who present a risk of serious harm to themselves or others may be 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 that can be pursued 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.⁶⁷

⁵⁹ *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).

⁶⁰ *Shine*, 429 Mass. at 467.

⁶¹ *Saikewicz*, 373 Mass. at 745.

⁶² *Guardianship of Roe III*, 383 Mass. at 434-435.

⁶³ G.L. c. 190B, §§ 5-101, 5-306A; *Guardianship of Roe III*, 383 Mass. at 442; *Rogers*, 390 Mass. at 491.

⁶⁴ G.L. c. 123, § 8B; *Guardianship of Roe III*, 383 Mass. at 442, n.15; *Rogers*, 390 Mass. at 491.

⁶⁵ *Guardianship of Roe III*, 383 Mass. at 435.

⁶⁶ 390 Mass. at 505.

⁶⁷ G.L. c. 123, §§ 7, 8, and 12.

The Supreme Court and the SJC have both described civil commitment as a “massive curtailment of liberty.”⁶⁸ Beginning with its decision in *Commonwealth v. Nassar* more than 40 years ago, the SJC has required that the statutory objectives of Chapter 123 of the General Laws be accomplished in the least restrictive manner possible, including by requiring a legal determination in commitment proceedings that there are no less restrictive, voluntary treatment alternatives to commitment.⁶⁹ Since then, the SJC has consistently reaffirmed that principle.⁷⁰

As this important body of caselaw demonstrates, Massachusetts has a lengthy history of recognizing the fundamental right to bodily integrity, informed consent, and autonomy regarding treatment decisions, including treatment for mental illness. These established rights and statutory procedures provide the context for analyzing any involuntary outpatient commitment proposal. Case law and statutes have established judicial procedures for determining whether an individual is incompetent to make mental health treatment decisions, and if so, whether the individual's substituted judgment would be to accept a proposed treatment. These procedures 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.

VII. CONCLUSION

It is a comprehensive array of well-funded community mental health services that can prevent bad outcomes for people with mental health conditions. Involuntary outpatient commitment, by contrast, delivers empty promises and generates false hope. Given the many pressing and still largely unmet needs of persons with mental health conditions (e.g., housing, physical health care, behavioral health services and supports, assistance with daily living activities, food assistance, and transportation), Massachusetts should direct limited behavioral health resources towards voluntary services. If coercion is necessary, the existent *Rogers* guardianship process offers as effective an approach to the provision of care, monitoring, and enforcement as any involuntary outpatient commitment statute. A duplicate or parallel involuntary outpatient commitment process would merely add costs without producing procedural or substantive benefit.

⁶⁸ *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’ ... 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).”).

⁶⁹ *Commonwealth v. Nassar*, 380 Mass. 908, 917 (1980).

⁷⁰ *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).