July 18th, 2023

The Honorable Senator James B. Eldridge
Joint Committee on the Judiciary
24 Beacon St.
Room 511-C
Boston, MA 02133

The Honorable Representative Michael S. Day
24 Beacon St.
Room 136
Boston, MA 02133

RE: Written Testimony on S.980/H.1694, An Act to provide critical community health services

Dear Chair Eldridge, Chair Day, and members of the Joint Committee on the Judiciary,

I am writing to express the National Alliance on Mental Illness of Massachusetts' (NAMI Mass) concerns regarding **S.980/H.1694**, An Act to provide critical community health services. The services in this bill are more commonly referred to as Assisted Outpatient Treatment (AOT).

NAMI Mass is a grassroots organization, and our members are individuals with mental health conditions as well as their family members, loved ones and caregivers. We strive to create societal conditions that promote health, advance justice, and prevent physical and psychological distress. As NAMI members and families, we are often the people on the front lines dealing with the mental health system and encountering barriers to accessing mental health services.

Mental health services like AOT, also known as 'involuntary outpatient commitment' or 'community treatment orders,' are civil court orders that mandate a person living with a mental health condition to adhere to community-based treatment. The individuals receiving AOT are often individuals with 'serious mental illness' who have experienced repeated hospitalizations with little to no success. At NAMI Mass, we honor and are all too familiar with the concerns that our family members have for their loved ones living with a mental health condition, particularly those who do not believe they need help. These concerns are valid and real and continue to be a challenge for families as they navigate the mental health system.

However, here at NAMI Mass, we also acknowledge the challenges that individuals living with a mental health condition encounter as they can be more vulnerable to discrimination and violations of their human rights in our current systems. To address human rights violations, it is of the utmost importance that people living with a mental health condition are given the opportunity to exercise human rights, including the right to make complex and multi-layered personal decisions about their own healthcare.

Additionally, we recognize that people's intersectional and social identities influence their experience with mental health and that AOT will impact communities differently. Human rights violations are often associated with adverse mental health outcomes and could lead to increased levels of depression, anxiety, trauma, and other stressor-related conditions. In fact, there are many, many stories about the trauma experienced by individuals living with a mental health condition when they are subjected to involuntary treatment, or AOT. Incidences of traumatization and oppression directly shape a person's health and we strive to address these stressors for individuals living with mental health conditions and their families.

AOT is implemented in 47 states. The only states without AOT are Massachusetts, Maryland, and Connecticut. Because it is so widely implemented, there are strong alternatives, studies, and discussions on AOT, which Massachusetts can utilize to evaluate this proposed treatment. Below I will discuss these alternatives and studies to show why Massachusetts should not enact **S.980/H.1694**.

Alternatives to AOT

NAMI Mass believes we should and must support individuals living with a mental health condition and their families who are struggling and refusing support. We also believe we should support programs that meet individuals where they are, including when they don't think they need any help. Rather than focusing on forced treatment, we might consider a non-coercive relentless outreach, peer-led approach. In Westchester County, NY, such a program has been established as an alternative to AOT, called INSET (Intensive and Sustained Engagement Team).[i] Again, rather than pass AOT in Massachusetts, let's build specific capacity for this exact population through a peer-led, peer respite-style program. Families will have a place to turn and get the help they need to support their loved one's path to recovery. Individuals will be in control of their engagement voluntarily.

Here at NAMI Mass, we believe in relationship building. We seek to improve the quality of life for people living with mental health conditions, their families, and their caregivers. Our programs, Helpline, policies, and advocacy are centered around providing free information, connection, ideas, resources, and support to help those in Massachusetts while navigating our mental health system. Utilizing a relentless outreach approach would promote our values of building connections and providing non-judgmental support to individuals when they are ready. We know building trust takes time, but the reward of community-based peer led support is a holistic and humanistic approach to mental health care.

It takes patience to meet people where they are. There are no quick fixes. When resources are scarce, even considering a relentless outreach approach, which can require months of building a connection, seems impossible. However, we know it is not.[ii]

Coercive to voluntary community services

In 2019, *Mad in America* published an article on AOT twenty years after Kendra's Law was passed in NY which authorized compulsory outpatient treatment.[iii] Detailing the reasoning behind the support and opposition of AOT, the article highlighted that as of 2019 only three randomized clinical trials, which are widely viewed as the "gold standard in medical research," have been conducted on AOT.[iv] The first study conducted in New York City in 1990 identified that "no statistically significant differences were found" among the 142 patients--some of whom received AOT and others who received only enhanced services.[v] The second study in North Carolina also showed no significant differences at the end of the 1-year

study.[vi] The last study, done in the UK, "found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty."[vii]

All three of these studies researched individuals receiving AOT versus individuals receiving community care without a compulsory requirement, and all three studies showed no significant difference. The evidence of AOT being the impetus that puts an individual on the path to recovery is murky at best. It begs the question, "what is the point of forced treatment"? To date, these studies and data do not show AOT as an overarching success.

It is important to note that there are successes under AOT and to stress that we value the importance of families who feel supported by AOT and its outcomes. However, without more trials and understanding of the broader impacts of AOT, we might consider a non-coercive approach with enhanced community support. In fact, in 2021, the World Health Organization (WHO) released guidance on promoting person-centered and rights-based approaches to community mental health services.

The guidance found that "community-based mental health care that is both respectful of human rights and focused on recovery is proving successful and cost-effective."[viii] In the guidance, WHO recommended that mental health services be in the community and support day-to-day living through access to accommodations, education, and employment services. WHO also affirmed that "mental health care must be grounded in a human rights-based approach"[ix] and included examples of community-based mental health services, such as "crisis support, mental health services provided within general hospitals, outreach services, supported living approaches, and support provided by peer groups."[x] Of most concern, WHO estimated that less than 2% of designated government health funds are used on mental health services. As a result of their findings, WHO advocates for a transition from coercive treatment to voluntary community services worldwide.[xi]

As endorsed by WHO, NAMI Mass also promotes peer support and education through our own support groups and classes led by people living with mental health conditions including NAMI Peer-to-Peer classes and NAMI Connection Recovery Support Groups. We also uplift the work of other groups, such as Recovery Learning Communities, Young Adult Access Centers, peer support warmlines, and peer-led crisis programs, among others. At NAMI Mass, we center the voices of individuals and families with lived experience and draw from their wisdom to shape our priorities, policy agenda, and programs. Additionally, we view a person's mental health as synonymous with a person's overall health.

We applaud WHO for upholding the importance of peer led support groups and community-based mental health services. As our vision statement positions, "NAMI Mass envisions a society that humanizes the experience of mental health challenges, promotes the values of respect, agency, and self-determination, non-coercion, and non-violence, and supports individuals and families wherever they are in their journey of healing and recovery." We are in steadfast agreement with WHO that mental health services should be grounded in a human rights-based approach.

We are also concerned by WHO's findings on the lack of governmental spending on mental health services. This spending gap in our current system does not support the health and wellbeing of individuals living with a mental health condition and requires us to call for systemic changes. We need more resources, financial support, and community engagement to make sure we are meeting people living with mental health conditions where they are and addressing current inequities in the mental health system. The residents of the Commonwealth living with a mental health condition deserve more than 2% of financial support, they deserve enhanced community-based services.

Racially disparate impacts of coercive outpatient mental health treatment

While we are finally beginning to understand and acknowledge the impact institutional biases have had on historically marginalized groups in our society, the mental health system needs to operate with a stronger social justice lens. Furthermore, this shift could lead to better outcomes for communities of color across the mental health field. It is important that we view and evaluate all mental health policies from a social justice lens to ensure our active participation in anti-racist policy making.

In 2021, the Drexel Law Review published an article by Victoria M. Rodriguez-Roldan on the racially disparate impacts of AOT. She determined that a 2009 study that found no evidence of racial bias in AOT, failed to analyze and acknowledge the "surrounding context of systemic racism within the medical field, courtroom, and society in general."[xii] "Structural racism is the societal system that continually confers social benefits on some groups while imposing burdens on others, principally, people of color."[xiii] Ultimately, the 2009 study failed to consider and flat out ignored the impact of systemic inequality shaped by implicit bias on those who received coercive outpatient mental health treatment.

Additionally, the 2009 study that found no racial bias existed in AOT admitted that the AOT program "primarily treated those who are more likely to live in poverty, lack private insurance and access to private physicians, have been incarcerated, and/or have experienced homelessness."[xiv] Based on New York State population statistics in 2019, which showed that 48% of prison sentences were given to Black adults and that 59% of adult homeless shelter occupants identified as Black,[xv] affluent and/or white community members are less likely to live in poverty, experience homelessness, and to be incarcerated. They are also more likely to have private insurance and access to private physicians. Essentially, individuals who can afford private treatment or support will be afforded the opportunity to participate in mental health treatment on their terms and won't be subjected to coercive practices. This is an equity problem that proponents of AOT cannot ignore and must address before implementation in Massachusetts. The AOT system, while not intentionally racially biased, sits within a broader system that is and has created a "punitive and segregated system for the mental health treatment of low-income, Hispanic, and Black" individuals.[xvi]

Therefore, we need to continue to push conversations on mental health forward and demand these inequities be addressed across all communities and systemic levels. The racial inequities in our systems run deep and changing them will take all of us to pledge our allegiance to social justice initiatives. We cannot, in good faith, continue to promote and enact legislation that disparately impacts Black and Brown communities. While the idea of AOT working at its best isn't racially motivated, the systems in which AOT will live are still rooted with inherent racism. We need to evaluate alternatives, as suggested above, that do not place more restrictions on Black and Brown communities, but instead serve as a model to support all individuals living with a mental health condition. We also need to consider what policies we are enacting and how they may adversely impact our Black and Brown community partners.

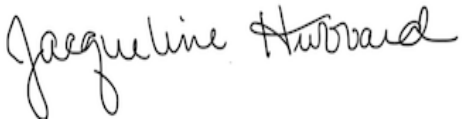
Conclusion

NAMI Mass supports implementing evidence-based practices that equitably aid individuals and families. Based on the research presented above, adopting AOT in Massachusetts as it is currently proposed in **S.980/H.1694** would not equitably support individuals and families**.** Given we do not want this legislation to pass as is, we do believe the intricacies of AOT require us to have a public, more inclusive

conversation on AOT and its alternatives. We hope this will not only support individuals and families in understanding the myths and realities of AOT in practice but also help drive Massachusetts toward more equitable solutions.

We would be honored to help facilitate further discussions in Massachusetts regarding AOT, its challenges, and alternative options, so that individuals, their families, and caregivers can be heard. As a grassroots organization with members who have mental health conditions as well as members who identify as family members, loved ones and caregivers of individuals with mental health conditions, we are uniquely situated to promote this conversation and ensure diverse attendance and perspectives shared. Convening family members, experts, advocates, and individuals with lived experience would enable us to have open discussion regarding current data on AOT that includes its racially disparate impact and the identification of strong alternatives.

Thank you,



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[i] https://www.mhawestchester.org/our-services/treatment-support/intensive-and-sustained-engagement-team

[ii] Roca has effectively used relentless outreach to engage with hard-to-reach, at-risk youth. They have a decade of data illustrating the effectiveness of such an approach.

[iii] Whitaker, Robert, and Michael Simonson . "Twenty Years after Kendra's Law: The Case against Aot." *Mad In America*, 14 July 2019, www.madinamerica.com/2019/07/twenty-years-kendras-law-case-aot/.

[iv] *Id*.

[v] *Id*.

[vi] *Id*.

[vii] *Id*.

[viii] "New Who Guidance Seeks to Put an End to Human Rights Violations in Mental Health Care." *World Health Organization*, 10 June 2021, www.who.int/news/item/10-06-2021-new-who-guidance-seeks-to-put-an-end-to-human-rights-violations-in-mental-health-care.

[ix] *Id*.

[x] *Id*.

[xi] *Id*.

[xii] Rodriguez-Roldan, Victoria M. (2020). The Racially Disparate Impacts of Coercive Outpatient Mental Health Treatment: The Case of Assisted Outpatient Treatment in New York State. *Drexel L. Rev*., 13, 945.

[xiii] *Id*. Citing William M. Wiecek*, Structural Racism, and the Law in America today: An Introduction*, 100 K.Y. L.J. 1,4 (2011).

[xiv] *Id*. See also, in 2019, Black adults, who represent 15% of the adult New York State population, received 48% of total prison sentences in New York State. N.Y. STATE DIV. OF CRIM. JUST. SERV., NYS ADULT ARRESTS AND PRISON SENTENCES BY RACE/ETHNICITY IN 2019 (Aug. 31, 2020), https://www.criminaljustice.ny.gov/crimnet/ojsa/comparison-population-arrests-prison-demographics.html (click

on “2019”), see also, in 2019, 59% of single adult homeless shelter occupants in New York City identified as Black (non-Hispanic). COAL. FOR THE HOMELESS, STATE OF THE HOMELESS 2020, at 11 (March 2020), https://www.coalitionforthehomeless.org/advocacy-library/research-and-policy/state-of-the-homeless-archive/ (click on first prompt that says “Download the complete report here”).

[xv] *Id*.

[xvi] *Id*. at p. 5