



TREATMENT
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Massachusetts:

An Assessment on the Commonwealth's Access to Treatment for Persons with Severe Mental Illness

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Research from the Treatment Advocacy Center



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The Treatment Advocacy Center is a national nonprofit organization dedicated exclusively to eliminating barriers to the timely and effective treatment of severe mental illness. The organization promotes laws, policies and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

FAST FACTS: SEVERE MENTAL ILLNESS IN MASSACHUSETTS

- Untreated population with schizophrenia: 37,284
- Untreated population with severe bipolar disorder: 58,486
- Estimated number of homeless with severe mental illness: 4,999 (30% of 16,664) ⁱ
- Incarcerated with severe mental illness:
 - 7.26 % of the male inmate population identified as having serious mental illness. ⁱⁱ
 - 24% of men in prison have open mental health cases; 18% on psychotropic medication. ⁱⁱⁱ
 - 24.9% of the female inmate population identified as having serious mental illness. ^{iv}
 - 59% of women in prison have open mental health cases; 49% on psychotropic medication. ^v
- Estimated number of suicides in mentally ill population per year: 265.66
In 2011, 553 suicides occurred in Massachusetts, a rate of 8.3/1000^{vi}. Of these, 48% were reported to have a current mental health problem.
- Quality of Massachusetts treatment laws: F
 - Law provides access to treatment for people who are gravely disabled but unable to seek treatment? Yes, with severe limitations
 - Law provides access to treatment on the basis that treatment is needed in the absence of grave disability or danger? No
 - Law provides access to treatment via a citizen petition to the court for evaluation of an individual with mental illness who appears dangerous and is unable to seek treatment? No
 - Law provides an initial period of commitment to psychiatric treatment of 14 days or longer? Yes
 - Law provides access to mandated treatment in the community as a less-restrictive alternative to hospitalization No
- Public psychiatric beds per 100,000 people: 10.6 beds per 100,000 people (estimated beds to meet inpatient treatment need: 50 per 100,000)
- State ranking nationwide in beds per 100,000: 31
- Public psychiatric bed reductions 2005-2010: 31%
- Likelihood of being jailed vs hospitalized for symptoms and behaviors associated with untreated severe mental illness (2008 data): 1.2x. (Because of hospital bed reductions since this data was developed, likelihood of being jailed vs hospitalized has increased.)
- Percentage of Massachusetts population living where mental health courts are available to divert qualifying individuals with severe mental illness from jail into treatment: 13%
- Percentage of Massachusetts population living where law enforcement officers receive specialized training in handling criminal suspects with mental illness symptoms: 3%
- State grade for diverting people with severe mental illness from criminal justice system to treatment: F

I. INTRODUCTION

Massachusetts is home to an estimated 37, 284 people with untreated schizophrenia and 58,486 people with untreated severe bipolar disorder, two disabling severe mental illnesses.vii The Commonwealth prides itself on its progressive public policies yet the state consistently fails most measures of providing access to treatment for the small but costly segment of its population that suffers from untreated severe mental illness and is unable or unwilling to access treatment without assistance.

Individuals in this population are at high risk for the consequences of non-treatment that affect their ability to engage in the recovery process and to live safely and successfully in the community. These consequences include homelessness, arrest, incarceration, victimization, violence including suicide, unemployment, associated medical problems, family and other issues that reduce their quality of life and increase demand for social services.

This report on the Commonwealth's provision for this population includes the following:

- **Historical context**
- **Legal provisions determining access to treatment**
- **Relevant research**
- **Case examples**
- **Recommendations**

II. HISTORICAL CONTEXT

Deinstitutionalization, the name given to the policy of moving people with serious brain disorders out of large state institutions and then permanently closing part or all of those institutions, has been a major contributing factor to increased homelessness, incarceration and acts of violence in Massachusetts and nationwide.

Ironically, the public outcry against putting people with mental illness into jails and prisons began in Massachusetts in the early 19th century.viii Louis Dwight, a Congregationalist minister was shocked by what he saw when he began taking Bibles to prisoners in jails. In response to Dwight's advocacy, the Massachusetts state legislature in 1827 appointed a committee to investigate. The committee recommended that confinement in jails of mentally ill persons be

made illegal and that those in jails be transferred to hospitals. Shortly thereafter, the legislature approved the erection of the State Lunatic Asylum at Worcester for 120 patients.^{ix}

Dorothea Dix, the most famous and successful psychiatric reformer in American history, continued Dwight's advocacy work. During 1841 and 1842, she visited every jail in Massachusetts and documented the mistreatment of mentally ill prisoners. The following year, she presented her findings to the state legislature: "Men of Massachusetts, I beg, I implore, I demand ... raise up the fallen; succor the desolate; restore the outcast; defend the helpless."^x

Dix extended her crusade to many other states and by 1847 had visited 300 county jails and 18 state prisons. At the time, America provided 14 public beds for psychiatric treatment per 100,000 people. The efforts of Dix and fellow reformers led to a burst of hospital construction. By 1955, the peak of psychiatric hospitalization before the widespread availability of effective antipsychotic medications and vast reduction in the number of people hospitalized for conditions other than mental illness, there were 300 beds per 100,000 people. Today, the estimated number of public beds required to meet the need for hospital intervention is 50. By way of comparison, England had 62 beds per 100,000 people in 2008.

In 2010, Massachusetts offered 10.6 public psychiatric beds per 100,000 of its people and ranked 31st among the states.

Nationwide, the number of beds per 100,000 had dropped to 14.1 – essentially what it was before the humane treatment of mental illness was embraced in the 19th century.

III. LEGAL PROVISIONS DETERMINING ACCESS TO TREATMENT

Massachusetts civil commitment laws are among the most restrictive in the country. Their restrictiveness has the effect of limiting treatment of mental illness to individuals who are sufficiently stable to seek treatment.

The Treatment Advocacy Center in its forthcoming report, "Mental Health Commitment Laws: A Survey of States," will give Massachusetts an F for the quality of its laws.

The state's *only* statutory option for mandated treatment is involuntary hospitalization. To meet the state standard for involuntary hospitalization, a person must be a danger to self/others or be at a very substantial risk of physical impairment or injury because they are unable to protect themselves in the community.^{xi} The state has failed to recognize conditions other than danger to self or others or "very substantial risk" of same as grounds to providing access to treatment via the courts.

Massachusetts makes *no* statutory provision for mandated treatment in the community for qualifying individuals with severe mental illness with a history of struggling to adhere to treatment and an elevated risk for consequences of non-treatment. Only four other states (Connecticut, Maryland, New Mexico and Tennessee) have rejected assisted outpatient treatment (AOT) as a treatment option for so-called "revolving-door" patients. This has effectively restricted treatment access to those who are already evidently dangerous or are sufficiently well to seek treatment.

III. RELEVANT RESEARCH

1) Public hospital bed access

"No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals" (Treatment Advocacy Center, 2012) reported that the number of public psychiatric beds in Massachusetts decreased by 31% from 1,015 beds in 2005 to 696 beds in 2010. Additionally, state hospitals were discharging patients after shorter durations of treatment due to budget cuts.^{xii}

Massachusetts appears to be effectively terminating a public psychiatric treatment system that has existed for nearly two centuries. The system was originally created to protect both the patients and the public, and its termination is taking place with little regard for the consequences to either group. Although they constitute a small subset of all persons diagnosed with mental illness, the most severely ill patients are in dire need of the specialized, intensive treatment that has been delivered since the early 1830s through state hospital systems. The elimination of these systems is producing significant public and personal consequences in communities. In the absence of needed treatment and care, individuals in acute or chronic disabling psychiatric crisis increasingly gravitate to hospital emergency departments, jails and prisons. They also

became vulnerable to victimization and suicide; a small subset (estimated at 1%) became at risk to commit acts of violence.

2) Criminalization

“More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States” (Treatment Advocacy Center, 2010) reported that individuals with severe mental illness nationwide were three times more likely to be in jail or prison than in a hospital.^{xiii}

In Massachusetts, there were 1.2 more seriously mentally ill persons in jails and prisons than in hospitals, a number that has almost certainly increased since the report due to additional hospital bed closures.^{xiv}

The Massachusetts Department of Corrections in March 2003 reported 20.85% of the state’s prison population was suffering a severe mental illness. In 2012, males with serious mental illness comprised 7.26% of the male criminally sentenced custody population.^{xv} 24% of men in prison had open mental health cases with 18% on psychotropic medication.^{xvi} Comparatively, approximately one quarter (24.90%) of females in the criminally sentenced custody population were identified as having serious mental illness.^{xvii} 59% of women in prison in Massachusetts had open mental health cases with 49% on psychotropic medication.^{xviii}

Jails and prisons were not designed as mental health facilities nor are their personnel trained as mental health workers. Given those realities, it is unsurprising that inmates with severe mental illness suffer and exert consequences of incarceration not associated with the general jail/prison population.

Mentally ill offenders re-offend – and are re-incarcerated – at higher rates. Since the county and state corrections systems are separate from, and usually not coordinated with, the mental health system, most mentally ill persons leaving jails and prisons receive little, if any, psychiatric aftercare. As a result, the recidivism rate is thought to be higher than it is for other released prisoners. In jails and prisons, repeat offenders are commonly referred to as “frequent flyers.” In the Los Angeles County Jail, for example, 90% of mentally ill inmates are repeat offenders, with 31% having been incarcerated ten or more times.

Mentally ill inmates cost more. Mentally ill inmates cost more than inmates without mental illness for a variety of reasons, including increased staffing needs. In Texas, for example, prisons “the average prisoner costs the state about \$22,000 a year,” but “prisoners with mental illness range from \$30,000 to \$50,000 a year.”

Mentally ill inmates are incarcerated longer. Many mentally ill inmates are incarcerated for a greater period of time than inmates without serious mental illness because they find it difficult to understand and follow jail and prison rules. In New York’s Riker’s Island Jail, the average stay for all inmates is 42 days; for mentally ill inmates, it is 215 days. In one study, jail inmates were twice as likely (19 % versus 9 %) to be charged with facility rule violations.

Mentally ill inmates create inmate management problems. Because of their impaired thinking, many inmates with serious mental illnesses are major management problems.^{xix} One byproduct is that they are much more likely to be in isolation than other inmates. An estimated 25,000 of the 75,000 inmates nationwide who are in solitary confinement are mentally ill.

Mentally ill inmates are more likely to commit suicide. Multiple studies have shown that approximately half of all inmate suicides are committed by inmates who are seriously mentally ill. The prison suicide rate in Massachusetts is four times the national average, with a significant increase in prison suicides since 2005^{xx}. In 2011 there were 553 suicides that occurred in Massachusetts, a rate of 8.3/1000^{xxi}. 48% of those suicide victims had a current mental health problem.

3) “Prevalence of Mental Health Diversion Practices: A Survey of the States”

Massachusetts’ criminal justice officials have been forced to respond to the colossal failure of their mental health counterparts. Through the process of “diversion,” law enforcement agencies and the court system seek to identify individuals whose criminal acts are clearly attributable to untreated mental illness and connect them to needed treatment rather than punishment – in other words, to divert them out of the world of criminal justice and into the mental health system that should have addressed their needs in the first place.

Diversion is not itself a practice but an umbrella term encompassing a host of practices with a shared objective that includes parole and probation, which have long been used to prevent recidivism by linking mentally ill offenders to stipulated community-based treatment. Mental health courts and crisis intervention team (CIT) policing are two diversion practices that have proved to reduce inappropriate criminalization of people with mental illness.

Mental Health Courts

A mental health court links offenders who would ordinarily be prison-bound to long-term community-based treatment. The mental health court system relies on mental health assessments, individualized treatment plans and ongoing judicial monitoring to address both the mental health needs of offenders and public safety concerns of communities. Only three mental health courts operate in Massachusetts (Springfield, Plymouth and Boston). Together, they make this diversion strategy available to only 13% of Massachusetts' total population.^{xxii}

Crisis Prevention Team (CIT) policing

CIT entails a police department intensively training a cadre of officers on the nature of various forms of mental illness; the ways that these illnesses are likely to manifest in the community; the treatments known to relieve suffering and allow people with mental illness to function safely; the community-based resources available to connect people with these treatments; and proven techniques to communicate with and calm an agitated person in acute psychiatric crisis. Through this training and their own on-the-job experience, CIT police officers become mental health specialists.

Nationwide, 49% of the population lives in a county where CIT policing is in effect. In Massachusetts, CIT training has been provided to law enforcement in Berkshire County, Fitchburg and Taunton. The combined population of these jurisdictions represents roughly 3% of Massachusetts' total population.^{xxiii}

IV. CASES IN POINT

Government agencies tasked with tracking social and criminal trends officially and persistently ignore the factor of mental illness in their collection of data. As a result, official statistics relevant to many social, safety and law enforcement issues are unavailable.

The Treatment Advocacy Center combs media reports of mental illness associated with acts of violence to operate its Preventable Tragedies Database as an alternate source of information and a memorial to those whose deaths and injuries might not have occurred if access to effective and timely treatment were more widely available.

1) South, Boston, MA. Source – The Boston Globe, 7/23/13

On July 23, 2013, Amy E. Lord spent 47 minutes driving between five banks in Boston early Tuesday after being kidnapped in her South Boston neighborhood. The kidnapping ended with Amy being murdered and dumped in the Stony Brook Reservation in Hyde Park. The alleged perpetrator is Edwin Alemany, who has a history of untreated mental illness and criminal charges. Alemany is also charged with nonfatal attacks on two additional women which occurred early on the mornings of July 23 and July 24. Edward Alemany spent several stints in psychiatric hospitals as a teenager and has a history of refusing treatment.

2) Ashland, Middlesex, MA. Source – Citizen.com, 12/11/10, 12/17/10; The Boston Globe

On December 9, 2010, 35-year-old Fearrie Ray fatally stabbed 52-year-old Kevin Doane. According to the owner of the building where Doane was living, Ray had been staying with him for about a month. Doane, who had found Ray soaking wet behind a local store, had given her some dry clothes and attempted to find her a place to live. When police arrested Ray, she told them her name was Clair Jax, a name derived from the names of two of the main characters on the soap opera General Hospital: Clair and Jax. Ray's family in Buffalo, NY had reported her missing in August. Ray's mother said her daughter, who had been diagnosed with paranoid schizophrenia in her teens, had stopped taking her medication last summer. Ray, who was living in Buffalo with her son, who has sickle cell anemia, withdrew all her money from the bank and flew herself and her son to Boston. After she arrived in Boston, Ray threw away her identification. When they arrived at the airport, the paranoid Ray flagged a police to report someone was trying to kill her. Police noticed that her son, who hadn't been treated in months, was ill and took them both to Massachusetts General Hospital. Ray walked out the same day and disappeared.

3) Somerville, Middlesex, Source – MA, Somerville News Blog, 7/23/10

On July 23, 2010, 33-year-old Carol Lynn Kingsley was fatally shot after stabbing three Somerville police officers. Kingsley had suffered with mental health and substance issues for years before she was killed. Kingsley had been released from psychiatric care shortly before the

attack. Police were initially called to Kingsley's home at 3:30 a.m. She was taken to a Cambridge hospital but returned home in a taxi shortly after. It was unknown why she was released from care. At 6:30 a.m., police were called back to her home when Kingsley set fire to her boyfriend's clothes. When officers attempted to locate and question Kingsley, she allegedly brandished at least one knife and attacked the three responding officers. Two of the officers suffered serious wounds; one officer suffered stab wounds to his back, shoulder and arm and the other suffered stab wounds to his back and arm. Kingsley's substance abuse coincided with a history of violence, including attacks against police. A decade ago, she was charged with attacking a woman for no reason at a bus stop in Somerville. The case was continued without a finding after she served probation for six months. The prior year, she allegedly broke into a woman's house in Somerville at random, accused the woman of stealing her bag and attacking her. She then allegedly attacked the police officers who arrested her and spat at them. Kingsley was also taken into police custody in June for allegedly acting disorderly and assaulting police officers. While in custody, she allegedly threatened to blow up the police station. She was never charged; instead police brought her to Cambridge Hospital to undergo a psychiatric evaluation. According to a spokesperson, Somerville police had planned to seek criminal charges against Kingsley.

4) Fairhaven, Bristol, MA. Source – New Bedford Standard Times, 10/16/09

On October 14, 2009, Stephen Wilson was arrested and charged with the noontime attack of a young woman who was walking along the Fairhaven bike path. Wilson had a long history of schizophrenia and had not been taking his medications. Wilson was sent to Bridgewater State Hospital for a mental health evaluation to determine his competency to stand trial. It was reported that Wilson attacked the woman, he picked up the woman's iPhone that had fallen to the ground and gave it back to her, and she then used it to call 911. Wilson has been a client of the Massachusetts Department of Mental Health. Wilson has been hospitalized in the past and is on multiple medications, of which he has admitted to missing dosages. Wilson's prior criminal record consists of a 2006 assault and battery charge that was dismissed and a pending destruction of property case in Wareham District Court.

5) Weston, Middlesex, MA. Source – The Boston Globe, 3/17/09

On March 15, 2009, police say that James M. Clark, 22, went to the Weston home of his grandmother, 80-year-old Eleanor Clark, and used a folding knife to repeatedly stab her and slit her throat, killing her. Later, Clark apologized to the officers who arrested him for "making us

look at his grandmother" and asked "that we give him a gun so he could shoot himself". James M. Clark began suffering psychotic breaks shortly after graduating from high school four years ago. He drank heavily and bounced from psychiatrist to psychiatrist. During one explosive episode, he threatened his mother. At her wits' end in January, Catherine Clark sought a restraining order against her son, writing that James "is in the midst of a psychotic break, is very angry at me, and has been burning items in my house." After the incident, Catherine Clark said in an interview that her son had been sick for a long time. "The person who killed her was not James Clark. It was this very, very sick person who refused help," she said. "All the caseworkers who saw him, all the social workers who saw him said he's psychotic. Two years ago, he saw a psychiatrist at Arbour Hospital in Jamaica Plain, but his mother said she was "absolutely distraught when he let my son go, because James took that as permission to be without mental healthcare." He went once to Carney Hospital in Dorchester, complaining of sleeplessness and anxiety. Recently, he had been living at New Horizon House, a Dorchester halfway house, and had once frightened his mother by erupting in anger and moving toward a cutlery drawer at her home in Quincy. He went voluntarily to Arbour-Fuller Hospital in South Attleborough "but signed himself out" soon after.

V. RECOMMENDATIONS

Deinstitutionalization was well-intentioned, but the failure to provide for the treatment needs of the patients has turned this policy into one of the greatest social disasters of the 20th century. As states like Massachusetts continue to close psychiatric hospital beds, it becomes a bigger problem.

If Massachusetts were to pass a law allowing for assisted outpatient treatment (AOT) and to use that law effectively, the state would help those most in need, and it would mitigate the strains that untreated mental illness are exerting on families, law enforcement officers, your jails and prisons and your hospital ERs.

Provide an adequate number of public psychiatric beds

An estimated 50 public psychiatric beds per 100,000 people are needed to provide minimally adequate inpatient psychiatric care to Massachusetts' population. The state needs to restore sufficient beds to meet the needs of its population and stop closing beds immediately.

Authorize assisted outpatient treatment

Assisted outpatient treatment (AOT) is court-ordered treatment (including medication) for individuals with severe mental illness who meet strict legal criteria, e.g., they have a history of medication noncompliance.

Passing House Bill 1792/ Senate Bill 906, introduced by Representative Kay Khan and Senator Ken Donnelly, would ensure that assisted outpatient treatment (AOT) is used in Massachusetts and provide access to less-restrictive treatment for the small but vulnerable and costly subset of the population that struggles to stay in treatment and is at risk for consequences of non-treatment. This legislation would align Massachusetts with the 45 other states that already have provided a statutory option for assisted treatment in the community.

A substantial body of research conducted in diverse jurisdictions over more than two decades establishes the effectiveness of assisted outpatient treatment in improving treatment outcomes for people with serious mental illness.^{xxiv} This includes decreasing hospital admissions, rates of homelessness, arrests and violent episodes.

Among the studies verifying the effectiveness of AOT is the 2009 Duke Study in North Carolina, which found that long-term AOT combined with intensive routine outpatient services was significantly more effective in reducing violence and improving outcomes for severely mentally ill individuals than the same level of outpatient care without a court order. Results from that study showed a 36% reduction in violence among severely mentally ill individuals in long-term AOT (180 days or more) compared to individuals receiving AOT for shorter terms (0 to 179 days). Among a group of individuals characterized as “seriously violent,” 63.3% of those not in long-term AOT repeated violent acts, while only 37.5 % of those in long-term AOT did so. Long-term AOT combined with routine outpatient services reduced the predicted probability of violence by 50%.^{xxv}

Reform the treatment laws

Individuals with mental illness should be able to access treatment before they become dangerous or commit a crime, not after. Many times, it is this very dangerousness standard that necessitates law enforcement involvement. About half the nation’s states include the need-for-treatment standard among their other civil commitment standards. Need-for-treatment standards are particularly relevant for individuals who lack insight into their illness (a symptom of the brain

condition known as “anosognosia”) because they focus the court’s attention on needless personal suffering and/or deterioration, from which the person is incapable of seeking relief without assistance. In addition to authorizing AOT, Massachusetts should reform its mental health treatment laws to create treatment access for those who need treatment before they become dangerous and even if they cannot seek treatment.

Use mental health courts

Mental health courts give qualifying criminal offenders a choice between following a treatment plan (including the taking of medication) or going to jail. The court thus becomes the *de facto* treating authority, a task originally assigned to the failed psychiatric outpatient clinics and community mental health centers. Studies have shown that mental health courts are effective in diverting individuals at risk for criminalization from incarceration. Massachusetts 5th to last among the nation’s 50 states in making mental health courts available. Increased implementation of this diversion strategy would reduce criminalization.

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