Thank you chairpersons and members of the committee. .

My name is Howard Trachtman and I am the co-founder and President Emeritus of the NAMI Greater Boston Consumer Advocacy Network (NAMI GB CAN), a membership organization with over 300 members. I also serve as a chair of the NAMI National Advisory Committee on Restraint and Seclusion. I am also a Certified Peer Specialist and a Certified Psychiatric Rehabilitation Practitioner. As a peer, I have personal experience with treatment for behavioral health issues. I have spent 9 months in a state hospital and have endured numerous hospitalizations in other licensed facilities.

This bill, H.1694/S.980, is a bad idea for a number of reasons. These include, but are not limited to, the facts that the Commonwealth does not need outpatient commitment, that the bill would create an unfunded mandate, and that the bill will violate the civil rights of people with behavioral health issues.

First, Massachusetts does not need outpatient commitment. Existing laws and regulations are sufficient. Courts already have the right to involuntarily hospitalize individuals they deem to be a danger to themselves or others. Courts can also mandate needed medication for individuals in the community with a Rogers Order.

Second, from a purely economic viewpoint, the bill does not make sense because it would create an unfunded mandate. As such, it will expand the number of people who will be involuntarily committed by adding to the number of people subject to court orders. If Massachusetts already struggles to pay for adequate mental health care for people who seek treatment. These individuals have trouble finding doctors, therapists, and hospital care. Why should the state allocate precious resources to people who actively seek to avoid, rather than seek, treatment?

What we need is an expansion of peer operated services. The six Recovery Learning Communities (RLCs) that the DMH funds help peers through support groups, one on one support, and individual and systemic advocacy. RLCs also provide peer bridgers, people who go into hospitals to meet individuals before discharge, make a connection, and help them reintegrate into the community and continue to support them while there. We also need to fund warmlines: peer support phone lines that need to expand to provide 24/7 peer support. Massachusetts also needs more peer-run respites, places people can go to when in distress in lieu of hospitalization and at 1/4 the cost. While there is a peer-run respite operated by the Western Mass RLC there need to be many more.

Third, this bill would allow the courts to impose a mandatory treatment plan in the community that, if violated, could result in hospitalization. This mandatory treatment plan could force individuals to live in specific housing, attend specific programs, and associate with, or not associate with, specific people.

The peer recovery movement is a civil rights movement. Unlike other civil rights movements, however, our society tolerates widespread violation of the civil rights of people with behavioral health issues. This bill is draconian in its treatment of my peers, and this committee should report it out unfavorably.

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