Testifying in opposition to H.1694.

Good afternoon Chair Eldridge, Chair Day, and members of the committee. As Executive Director of Disability Policy Consortium, Massachusetts' primary disability civil rights advocacy organization, I am here to express the disability community's strong opposition to H.1694. I will be referring throughout this testimony to data from the legal analysis conducted by the Center for Public Representation, Mental Health Legal Advisors Committee, Disability Law Center, and the Committee for Public Counsel Services. I believe this was submitted to the committee, and I urge you to read it carefully while making your decision.

This is a civil rights issue. Let's call this what it is: forcing people to participate in treatment, and often take medication against their will. Yet again, this bill treats people with mental health diagnoses as criminals in waiting, even if they have committed no crime beyond having a medical condition. There is absolutely no data showing that people with mental health diagnoses are more likely to commit violent acts towards others than people who do not have mental health diagnoses. However, there is data showing that people with mental health diagnoses are more likely to be victims of violence.

I want to be clear—I'm not in any way opposed to psychiatric medication. I take medication to manage my own depression and anxiety, as did my mother and her mother, who was bipolar and a professor of psychiatry at Harvard Medical. But what I am opposed to is violating people's bodily autonomy by forcing them into treatments they do not consent to and subjecting them to involuntary institutionalization if they do not comply, particularly based on a vaguely defined notion of someone being "gravely disabled," which opens the door for stigma and bias.

A substantial share of mental health diagnoses result from trauma, and this carceral approach will only further traumatize them and erode trust between them and the medical system. The reliance on family members to request people be treated involuntarily also fails to account for the fact that the trauma that causes mental health issues in the first place can be caused by abuse perpetrated by family members. This bill also does not make clear who will pay for the treatment, running the risk that people will wind up burdened with medical debt for treatment they did not consent to receiving.

Multiple high quality studies of these involuntary treatment program show that they are not effective. The Bellevue study of New York's system, for instance, found that it did not reduce crime rates, hospitalization rates, or compliance with treatment. Most importantly, these studies have not shown that involuntary outpatient treatment improves patient outcomes whatsoever. To the extent that any benefits ensue from these practices, a 2022 meta-analysis showed that these ensued solely from increased access to and in investment in services, not in forcing people to use them. That frankly makes sense; no law can give a court the ability to stand over someone's shoulder and stick their medication down their throats. Instead, this bill relies on the carceral approach of punishing people for non-compliance, somehow simultaneously proposing that people are so irrational that it is impossible to build a consensual treatment relationship with them and yet sufficiently rational that they will take medication to avoid de-facto incarceration in an institution. What data does show, however, is that involuntary outpatient treatment has ""detrimental effects on perceived stigma, quality of life, and self-esteem."

Providing more medical resources in the community is welcome; indeed, Massachusetts took important steps in this direction with the passage of the behavioral health roadmap. Making more care coordination available in the community is something we'd be highly supportive of. Expanding peer services and particularly peer respites, which are more effective than traditional mental health care for many people with complex mental health diagnoses, is long overdue and sorely needed. Investing in greater access to mental health care in the community is likewise absolutely welcome, as is providing care coordination. However, none of these require involuntary outpatient treatment; on the contrary, it consumes a vast quantity of resources that could better be used in expanding access. Fundamentally, successful mental health treatment requires building relationships of trust between people with mental health diagnoses and providers, and providing services that are culturally competent and responsive to the needs of individuals and their families. As with any kind of health condition, treatments are far more effective when the person being treated wants to be treated. Let's not significantly erode civil rights in the name of treatments that haven't even been shown to work.