Testimony to Joint Judiciary Com. By Daniel B. Fisher,MD,PhD, President of NEC
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Thank you, Chairs Eldridge and Day and committee members.

My name is Dr. Daniel Fisher and I am testifying in opposition to H. 1801/S.1115, An Act to Provide Continuity of Care.

As a board-certified psychiatrist with 45 years of community practice, a person with lived experience of recovery from schizophrenia, and a member of the White House Commission on Mental Health, I am a strong advocate for community-based, voluntary services. Research on recovery has shown that trust and collaboration are the cornerstones of recovery (See www.power2u.org). AOT actually interferes with recovery because it creates a coercive, mistrustful relationship between clinicians and clients. Furthermore, Mass. already has a Rodgers Guardianship which enables involuntary medication for clients in the community.

I want to critique an unsupported concept used by proponents of AOT, ANOSOGNOSIA, (pronounced A-NO-SOG-NO-ZI-AH). This is a neurological term meaning lack of awareness of damage to a side of one's body after a stroke of the parietal area of opposite side of the brain. Even in such neurological cases, the anosognosia is temporary (personal communication, Dr. Danica Mijovic-Prelec, MIT). Proponents of AOT contend that there are similar pathophysiological reasons persons with MI permanently lack insight into their psychological condition. However, like with the most severe mental health conditions, the proponents have not been able to provide structural evidence for a lack of insight by clients into their condition. Instead, they conjecture that there is some yet to be found deficit which creates an "inability for patients to update their self-image." (Anosognosia, Aninda B. Acharya; Juan Carlos Sánchez-Manso. STAT Pearls, 2023.)

In contrast, in my experience as a community psychiatrist, I showed that building trusting, empathetic relationships between clinicians and clients is the basis of recovery from severe mental health issues. I was presented with several clients who were reluctant to engage in treatment. DMH wanted me to put them under a Rogers Guardianship, but I requested my

team be given 2 months to build trusting, therapeutic relationships. In each instance, they were able to gain insight and engage in successful treatment on a voluntary basis.

As an alternative to AOT, I recommend the following combination of voluntary approaches:

1. Peer support
2. Emotional CPR, a training for treatment teams and families based on what people in recovery find most helpful
3. Open Dialogue, a highly successful, non-blaming form of family therapy from Finland
4. Peer-run respites, voluntary alternatives to hospitalization.

I am submitting with my written testimony the case of a young man I worked with in Poland who had been hospitalized 15 times, but when offered a voluntarily a combination of 1-3 was able to recover a life of fulfillment in the community which has lasted 6 years. (Biernat, M., Zawisza, M., Biernat, M., & Fisher, D. 2024. Combining peer support, emotional CPR and open dialogue facilitates recovery from schizophrenia. In A. Cantú, E. Maisel, & C. Ruby (Eds.), *Practical Alternatives to the Psychiatric Model of Mental Illness: Beyond DSM and ICD Diagnosing* (pp. 207–216). Ethics International Press.)