Wildflower Alliance

Formerly known as the Western Mass Recovery Learning Community

187 High Street, Suite #202
Holyoke Ma 01040
Toll free 866.641.2853
Fax 413.536.5466
Voice/TTY {413} 539-5941
www.wildfloweralliance.org
info@wildfloweralliance.org

November 18th, 2025
Joint Committee on the Judiciary
In Opposition to H.1801/S.1115, "An Act to provide continuum of care for severe mental illness"

Senator Edwards, Representative Day, and members of the Judiciary Committee:

My name is Fern Fairchild, and I am the Director of Wild Ivy Social Justice Network and part of the Wildflower Alliance. Wildflower Alliance is a peer support and harm reduction community based in Western Massachusetts which supports healing and empowerment for our broader communities and people who have been impacted by psychiatric diagnosis, trauma, extreme states, homelessness, problems with substances and other life-interrupting challenges. Much of our work specifically supports people who have experienced oppression at the hands of the psychiatric system, in the forms of involuntary or coerced commitments, forced drugging and other interventions, use of restraints, and general loss of autonomy over one's own mind, life, and body. People who are most impacted by this type of psychiatric oppression are often multiply marginalized on the basis of race, gender, sexuality, disability, class and more. Wild Ivy Social Justice Network as a part of the Wildflower Alliance seeks to build community power as a basis for the liberation of all people impacted by psychiatric oppression and connected struggles.

I am writing to you on behalf of Wildflower Alliance, in opposition to **H.1801/S.1115, "An Act to provide continuum of care for severe mental illness"**

Currently, Massachusetts is one of two states which protects people's right to autonomy when they do not wish to participate in outpatient treatment. This bill seeks to change that by introducing Involuntary Outpatient Commitment (IOC), misleadingly referred to by proponents as "Assisted Outpatient Treatment" (AOT). Simply put, IOC is a legal process which violates bodily autonomy and coerces outpatient psychiatric treatment, against the will of the person receiving it.

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In this testimony, I will:

1. Define Involuntary Outpatient Commitment
2. Describe how IOC violates autonomy and deprives people of their liberties
3. Answer whether IOC and the use of force are effective (they are not) and describe some of the harms that can come from them
4. Describe the disparate impact of IOC and other forced and coercive policies on marginalized people
5. Describe voluntary alternatives to IOC

1. What is Involuntary Outpatient Commitment? (a.k.a Assisted Outpatient Treatment):

Involuntary Outpatient Commitment, as outlined in this bill, is a legal process which allows various clinicians, DMH, a person's family members, spouses, the police, and others to petition courts to coerce, and essentially commit individuals to outpatient treatment, against their will, **under the threat of possibly being involuntarily committed to a psychiatric facility** and removal from their community if they do not comply with harsh probation- or parole-like treatment conditions, such as:

- Forced drugging
- Forced attendance at a day program or in person therapy, multiple times per week, preventing people from working
- Living in a group home
- Not being allowed to leave the state

2. IOC is a violation of autonomy and deprivation of liberties:

The decision to pursue an IOC order is not made (and diagnostic labels not ascribed) based on the use of any biologic test—rather, psychiatric diagnoses and the deprivations of liberties that follow them are ascribed on the basis of subjective opinion.

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Some supporters of Involuntary Outpatient Commitment claim that these orders are voluntary. This could not be further from the truth. IOC relies on court orders. Not complying (whether intentionally or not) with the conditions of an IOC order carries the threat of being dragged back to court and possibly being committed to a psychiatric facility under Section 12. Because of this, this bill also represents an expansion of the criteria for which someone could be committed under Section 12.

Notably, because common conditions of IOC orders include things such as:

- Mandatory in-person attendance at a day program or therapy
- Living in a group home
- Not leaving the state
- Forced drugging

Should this bill pass, simple noncompliance with these strict conditions or mistakenly missing any of these things could be reason for a court to consider committing a person under Section 12. This is a gross expansion of our involuntary commitment statutes, and is bad public policy.

Because of this, this bill also represents several expansions of the use of force, violations of autonomy, and other pathways toward the use of force, including those not related to IOC:

- The above-mentioned de-facto expansion of the Section 12 criteria to include simple violations of IOC orders.
- These orders would allow for the involuntary, court ordered psychiatric drugging outside of inpatient settings or psychiatric facilities.
- Many of the conditions typically required by IOC orders interfere with a person's ability to attend work, school or otherwise live their life in an autonomous way—for example, if attendance at a day program is mandated, a person cannot attend school, work, or otherwise during regular hours.

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- This bill also amends the definition of grave disability (which is used as a criteria for an IOC order) to include the vague term "serious demonstrates psychosis". This is discriminatory against voice hearers, people who see visions, or have unusual beliefs which may not necessarily or at all be related to the reason for a prior hospitalization. Yet, should this bill pass, these could be used as criteria for involuntarily committing someone to outpatient treatment. This definition has far broader impact, however, and could lead to more instances of the above people being arbitrarily committed or having force used against them through other means than IOC alone. This represents a significant violation of autonomy for people labeled vaguely with psychosis (who are disproportionately Black and brown).

Additionally, this bill represents serious violations of privacy and autonomy. The list of people authorized to petition a court for an IOC order under this bill is lengthy, and invites a concerningly large number of people and systems into the decision making about a person's private information and treatment. While we believe that IOC is carceral and abusive in itself, the bill includes a concerning number of interested institutions and persons who are likely to abuse this power: the department of mental health, the superintendent of a medical facility or residence where the individual receives medical care, or the medical director of the Bridgewater state hospital, qualified health professionals, or the spouse, blood relative, legal relative, legal guardian, any responsible adult or individual partner in a substantive relationship, a parole officer or probation officer. We have a number of concerns about this, namely:

- **Spouses, parents and relatives, intimate partners, and legal guardians have the ability to apply for IOC orders in furtherance of domestic abuse, giving these individuals another level of power to wield over victims.** Too often, the oppression of forced treatment closely resembles previous traumas and oppression that a person has experienced, including at times the events which led to their involvement with the psychiatric system. Survivors of sexual violence or intimate partner violence, for example, often report being retraumatized by the lack of bodily autonomy and the violations of their body when told by force where they may or

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may not go, forcibly drugged, and when their abusers are allowed to wield the power of IOC orders over them.

- Clinicians, hospital superintendents, Bridgewater State Hospital and the Department of Mental Health are inclined to petition for an IOC order, and regularly petition to use force on the basis of grave disability. Often these are accompanied by arbitrary determinations about a person's own awareness of their present mental state. Notably, where forced treatment is sought by facilities and clinicians, the most common factor for this type of determination is that the person disagrees with the facility or provider's recommendations. **This gives facilities more pathways to override a person's autonomy and consent in cases where they disagree with their provider and do not consent to treatment.**
- The probation and parole systems are particularly punitive, regularly reincarcerating people for minor violations. Therefore, involving these systems and actors within them in IOC order petitions would likely result in even more psychiatric incarcerations resulting from violations of the conditions set forth in an IOC order.

In disability and psych survivor communities, there is a simple but powerful saying: **"Nothing about us without us".** IOC proceedings invite others in our lives to speak about us, be part of the decision making process about us, and potentially commit us to treatment under the threat of locking us away in a hospital. Processes such as IOC, and conversations about us which do not include us are disempowering and traumatizing, and represent a removal of our autonomy. Evidence shows that coercion leads to long term harm, as described in the next section.

3. IOC and other forms of forced treatment are harmful and DO NOT WORK:

Evidence does not support IOC or the treatment methods often used in them. (Bou-Rhodes et al. 2025, Kisely, Campbell & Reilly 2017, Ridgely, Borum & Petrila 2001, Steadman et al. 2001)

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- There is a growing body of evidence that suggests that the use of force increases the risk of suicide and other negative outcomes (Grossmann, et al. 2026, Callaghan, Ryan & Kerridge, 2013)
- The treatments that IOC would most commonly be used to force are often ineffective and sometimes harmful (Van Dulman et al. 2007)
- Researchers preparing a report on Kendra's law for the NY legislature have shared that IOC does not improve outcomes.
- For many people who are aware of what psychiatric treatment entails, this means avoiding seeking support entirely, driving people away from the system.

Much of the research touted by proponents to promote IOC includes measures which could be addressed without the use of force. For example, the housing outcomes supporters point to could be achieved through other means, such as better funding for housing vouchers: **one longstanding criticism of IOC is that it creates individual mandates for people to receive unfunded services and basic needs, such as housing.**

Furthermore, much of what is used as evidence for IOC are measures such as medication adherence, which have nothing to do with quality of life outcomes. (Swartz et al. 2009)

4. Forced and Coercive measures such as IOC have a disparate impact on marginalized people:

We have to remember that the diagnoses that the proponents of IOC talk so much about are just words on a page. They are socially constructed illnesses and diagnostic criteria. What is also true, however, is that the manner in which these criteria are constructed always has the potential to do harm. For example:

Black people are 4x more likely than white people to be diagnosed with 'psychotic disorders'; Latiné people are diagnosed at a rate 3x higher than white people. (Schwartz & Blankenship 2014) Of course, there is no biological basis for this and to say as much would rightly be considered bigoted race science. Instead, the reason for the disparate racist

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application of these diagnoses has more to do with the history of white supremacy and white backlash to movements for Black liberation in the 1960s and 70s, including by institutions such as the American Psychiatric Association (APA). In *The Protest Psychosis: How Schizophrenia became a Black disease*, psychiatrist Jonathan Metzl traces the disparate psychiatric incarceration and use of force against Black people to the APA's altering of the diagnostic criteria for schizophrenia to include criteria which racistly targeted Black and brown people, including for their political views and understandable fear of state violence. (Metzl, 2010)

Because of this, Black people are disparately targeted by some of the most violent, carceral and coercive psychiatric levers—police detentions and transport to hospitals, section 12 involuntary commitment applications, use of restraint, and more. Notably, Black people are subjected to Involuntary Outpatient Commitment orders at over twice the rate they are represented in the overall population.

- A 2009 study by Schwartz et al. of New York's 'Kendra's law' found that 42% of people under IOC orders were Black, meaning that Black individuals were twice as impacted by IOC as they are represented in NY's population. This trend has been consistent for the over 25-year duration of NY's IOC statute, and the disparate racial impact of the statute has not been ameliorated in that time.
- By comparison to Boston, A 2025 study by Simon et al. found that Section 12 applications disproportionately targeted Black Bostonians, who comprised 41% of all Section 12 applications despite only constituting 23% of Boston's population. Black people were targeted at a rate almost twice that of their representation in the city's population. Considering this, and that this bill includes the term "serious demonstrates psychosis" without definition in the criteria for an IOC order, and that Black people are disproportionately more likely to be labeled with a 'psychotic disorder', **it is foreseeable that IOC would have the same systemically racist impacts here in MA as it does in NY.**

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Furthermore, while proponents of IOC argue that it decreases rates of hospitalization, it does not address the above disparate racial impact, does not address the reasons why psychiatric hospitalization doesn't work, and does not address the following systemic violence which is disproportionately used against Black and brown people.

- Despite claims about decreases in hospitalization rates, it's worth noting that where IOC exists, the disparate racial impact of both hospitalizations and IOC orders has remained.
- A 2024 study by Chang-Sing et al. found that people who were transported to the hospital by police were 550% more likely to be restrained.
- A 2023 meta-analysis by Eswaran et al. found that Black people face a significantly higher rate of restraints than people of any other racial background.

It is foreseeable that psychiatric force will be further weaponized against marginalized people under the Trump administration, more so than it already is. Trans people and Immigrants have been targets of fascistic campaigns and policies built on hate and eradication. The Trump administration has already prioritized the use of force and carceral approaches, it also happens that these groups are pathologized by the psych system at disproportionate rates. For example:

- Trans people are significantly more likely than cis people to be diagnosed with Borderline Personality Disorder or other personality disorders, (Rodriguez-Seijas, Morgan & Zimmerman, 2024) due to cisgender bias in the diagnostic criteria.
- As discussed above, Black and Latiné people respectively are about 4x and 3x more likely than white people to be diagnosed with a "psychotic disorder".
- These diagnoses would be considered criteria for an IOC order, and almost certainly will be used to target BIPOC people, immigrants, and trans people.

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5. Voluntary Alternatives to IOC:

Wildflower Alliance and our broader communities offer several supports which represent voluntary, human rights based alternatives to Involuntary Outpatient Commitment. In particular:

- Our first peer respite, Afiya was recognized by the World Health Organization's Quality Rights Initiative in 2021 (World Health Organization, 2021), and we opened the world's first Trans and Queer peer respite this past spring. Peer respites are voluntary, homelike environments in which people can stay during hard times and crisis. **Evidence shows that peer respites reduce the chance of subsequent hospitalizations by 70%, (Croft and Isvan, 2015) which is ostensibly one of the goals of this bill.** People who stayed at Wildflower's peer respites also report overall high satisfaction. (Afiya FY25 Exit Surveys, Wildflower Alliance, 2025, available upon request) There is another bill, **H.2231/S.1383,** which the legislature is considering which would establish 18 peer respites in Massachusetts, including two BIPOC peer respites and two LGBTQIA+ peer respites.
- Our community and hospital bridging teams and mobile supports support people in their communities and prior to coming out of hospitalization.
- Our Alternatives to Suicide and Hearing Voices groups support people in navigating these experiences through a harm reduction approach—these approaches are used throughout our supports.
- Our community centers support people through resource navigation and access to basic needs.
- **All of these supports are voluntary.**
- In addition to these, IOC creates unfunded mandates for various services such as housing. Instead of investing in involuntary commitment orders, the legislature could invest more funding into housing vouchers, etc. and utilize a housing first approach, rather than conditioning someone's ability to live in the community on compliance with harsh treatment orders.

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In conclusion, we strongly urge you to take no further action on H.1801/S.1115.

Thank you for the opportunity to submit testimony.

Solidarity,

Fern Fairchild (she/her)

Director, Wild Ivy Social Justice Network, Wildflower Alliance
fern@wildfloweralliance.org
wildfloweralliance.org/wild-ivy

STOP H.1801/S.1115 INVOLUNTARY OUTPATIENT COMMITMENT IN MASSACHUSETTS

H.1801/S.1115, "An Act to provide continuum of care for severe mental illness" seeks to violate bodily autonomy and coerce psychiatric treatment, against the will of the person receiving it.

Currently, Massachusetts is one of two states which protects people's right to autonomy when they do not wish to participate in outpatient treatment.

FORCED TREATMENT IS TRAUMATIZING!

This bill seeks to change that by introducing a pathway to Involuntary Outpatient Commitment/IOC (misleadingly called "Assisted Outpatient Treatment" or "AOT" by proponents). Involuntary Outpatient Commitment is a legal process which allows various clinicians, DMH, a persons family members, spouses, the police, and others to petition courts to **coerce, and essentially commit individuals to outpatient treatment, against their will,** under the threat of possibly being involuntarily committed to a psychiatric facility and removal from their community if they do not comply.

FORCED TREATMENT DOESN'T WORK!

Conditions of this "treatment" could include things like:

- Forced drugging
- Forced attendance at a day program or in person therapy, multiple times per week, preventing people from working
- Living in a group home
- Not being allowed to leave the state

*Instead of forcing people into complying with expensive treatment orders they did not agree to and diverting money away from proven alternatives, **Massachusetts should invest in voluntary supports like Peer Respite, and strengthen the 6 fundamental rights** of people in DMH licensed, funded, and operated facilities!

HELP ISN'T HELP IF IT DOESN'T HELP

"BUT IT'S VOLUNTARY" (NO IT'S NOT)

If you were given the choice between being incarcerated in your own home or in a prison, would you feel that your decision represented a voluntary choice which you made on your own? Or would that decision be coerced?

This is essentially the choice given to people under IOC orders.

IF YOU'RE GIVEN THE OPTIONS TO KEEP SOME OF YOUR FREEDOM OR NONE, YOU'RE STILL LOSING YOUR FREEDOM.

IOC ORDERS RELY ON FEAR FROM THE THREAT OF HOSPITALIZATION.

Involuntary Outpatient Commitments place people under harsh treatment conditions, similar to a probation.

If a person does not comply with even just one of these strict conditions, (like missing a therapy session, or leaving the state even briefly) that could lead to a petition being filed to commit them to a psychiatric facility under Section 12.a, against their will.

THIS REPRESENTS AN EXPANSION OF THE CRITERIA THAT COULD LEAD TO A SECTION 12 COMMITMENT

RESULTS AND COMPLIANCE BASED ON FEAR AND THREATS ARE NOT A SIGN THAT A TREATMENT WORKS!

For more information, please contact fern@wildfloweralliance.org

Click here or scan the QR code for citations & to get involved

IOC/"AOT" DOES NOT WORK.

Evidence does not support IOC or the treatment methods often used in them. (1-4)

- There is a growing body of evidence that suggests that the use of force increases the risk of suicide and other negative outcomes (5, 6)
- The treatments that IOC would most commonly be used to force are often ineffective and sometimes harmful (7)
- Researchers preparing reports on Kendra's law for the NY legislature have shared that IOC does not improve outcomes (9)
- Many of the studies proponents of IOC point to only measure outcomes such as compliance with medication and reduced hospitalization, **but do not measure outcomes related to quality of life** (10)

IOC DISCRIMINATES.

IOC orders target marginalized people who are already overdiagnosed and pathologized—Trans people, Disabled people, BIPOC, etc. (11) Due to bias in how the diagnostic criteria are manufactured:

- Black people are **4x more likely** to be diagnosed with a 'psychotic disorder' than white people (12)
- Trans people are more likely to be diagnosed with Borderline Personality Disorder (13)

Where IOC exists, it is disproportionately and racistly used against Black and Brown people. A study of New York's 'Kendra's law' found that **42% of people under IOC orders were Black,** meaning that Black individuals were twice as impacted by IOC as they are represented in NY's population. (10)

Abuse survivors are especially vulnerable to this as a tactic of control when their spouse or family member can petition for an IOC order.

Wildflower Alliance / Wild Ivy Social Justice Network Involuntary Outpatient Commitment (IOC) Fact Sheet - Citations & Notes

1. Involuntary Outpatient Commitment: A Legal and Policy Analysis, Bou-Rhodes et al. 2025 https://www.centerforpublicrep.org/news/cpr-contributes-to-opc-white-paper-involuntary-outpatient-commitment-a-legal-and-policy-analysis/
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6. Risk of suicide is insufficient warrant for coercive treatment for mental illness, Callaghan, Ryan & Kerridge, 2013 https://www.sciencedirect.com/science/article/pii/S0160252713000757
7. Patient adherence to medical treatment: a review of reviews, Van Dulman et al. 2007 https://pubmed.ncbi.nlm.nih.gov/17439645/
8.
9. Human Services Research Institute is conducting research on IOC/AOT outcomes in New York for the NY State Legislature, and has indicated preliminary findings which are not favorable to IOC.
10. Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program, Swartz et al. 2009 https://psychiatryonline.org/doi/10.1176/ps.2010.61.10.976
    a. Note: While other findings of this study seem at first glance to indicate that IOC is effective, it is important to ask, effective at what? The measures being studied are measures that one would expect to see increase with an IOC law in place—compliance with medication increased when that medication was forced, hospitalization decreased when strict outpatient services were coerced under the threat of hospitalization. These measures DO NOT make any indication about outcomes such as improvement to a person's quality of life, independence, coping strategies, etc. This makes us question: is the purpose of an IOC order to coerce treatment for life?
11. The Protest Psychosis: How schizophrenia became a Black disease, Metzl 2010
12. Racial disparities in psychotic disorder diagnosis: A review of empirical literature, Schwartz & Blankenship 2014 https://pmc.ncbi.nlm.nih.gov/articles/PMC4274585/
13. Transgender and Gender Diverse Patients Are Diagnosed with Borderline Personality Disorder More Frequently Than Cisgender Patients Regardless of Personality Pathology, Rodriguez-Seijas, Morgan & Zimmerman, 2024 https://pubmed.ncbi.nlm.nih.gov/39735379/