

Thank you chairpersons and members of the committee:

My name is Howard Trachtman and I am a mental health advocate. I am also a Certified Peer Specialist, a Certified Psychiatric Rehabilitation Practitioner and a Certified Older Adult Peer Specialist. As a peer (a person with mental health issues), 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.1801/S.1115, 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 and that the bill would create an unfunded mandate. As such, because it expands the criteria for commitment, it will likely expand the number of people who will be involuntarily committed by adding to the number of people subject to court orders. Judges' powers would be expanded to allow them to order specific treatments which the state would be obligated to provide.

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. 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 be forced to prioritize precious resources to people who actively seek to avoid, rather than seek, treatment?

What we need instead of more involuntary coerced treatment is an expansion of peer operated services- services we know can reach and support people who have resisted engagement in the traditional mental health system. The five Recovery Learning Communities (RLCs) that the DMH funds help peers through support groups, one on one support, peer support lines 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.

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. These mandatory treatment plans would be monitored by clinicians and enforced by judges. At the least, this is a gross misuse of limited clinical treatment resources and is contrary to important therapist-patient relationships.

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.

Howard D. Trachtman, BS, CPS, CPRP, COAPS
776 Main Street #541481
Waltham, MA 02454-5448

November 2025