

November 18, 2025

The Honorable Senator Lydia Edwards, Chair  
Joint Committee on the Judiciary  
Massachusetts State House  
Boston, MA 02133

The Honorable Representative Michael S. Day, Chair  
Joint Committee on the Judiciary  
Massachusetts State House  
Boston, MA 02133

**Re: Testimony in opposition to S1115/H1801 *An Act to provide continuum of care for severe mental illness***

Dear Chair Edwards, Chair Day and Members of the Joint Committee on the Judiciary,

Helping people with serious mental illnesses is a difficult and complex task. I have 40 years of experience as a psychiatrist primarily working with people with psychosis, severe trauma, substance abuse, incarceration, and homelessness. For 27 years I was the medical director of a very successful, award winning, comprehensive, person-centered, recovery-based, integrated services agency, the Village, in Long Beach California. I also worked as a street psychiatrist with the same population; I retired from that job last year.

Our experience at the Village demonstrates how integrated services and creating Full Service collaborative partnerships can work where involuntary measures couldn't:

*Olivia was unceremoniously dropped off on the sidewalk outside the Village with a pillowcase full of her belongings by her family. They couldn't handle her anymore and didn't know what else to do. They'd given her medications, but she'd always stop them. One time, in the hospital, when they tried to hold her down to make her take a shot, she thrashed around so much, while cursing them in Spanish, that the needle broke in her rear end. After that, she was even more uncooperative, especially with shots. They gave her several courses of Electroshock treatments, but they just made her quiet down for a while. It wasn't just that she thought God was talking to her. Her family could've handled that. But her behavior was so erratic and outrageous. She would fry pages of the Bible in oil on the stove. She'd spread her religious messages all over the house and even around town. Once, she even threw the refrigerator, that was much bigger than she was, down the stairs because she could hear the Devil hiding making noises behind the refrigerator. She'd take*

*other people's clothes without caring who they belonged to, which was bad enough, but sometimes she'd shred them up saying God had told her too. She even got run over by a car standing in the street talking to herself, so she had a serious limp.*

*Our first priority was to get Olivia off the streets and somewhere to live. There was no way she could survive on the streets or in a shelter. We paid for a room of her own at a sober living, but she walked away from it. We helped her get Social Security and a small apartment in a building we owned near the Catholic Church. We turned off the stove and secured the appliances so she couldn't start a fire or destroy anything. We got the Spanish speaking woman who managed the building to feed her sometimes and dole out money. She stayed there. Gradually she developed a routine.*

*One day Olivia came up to the table where I was eating at the Village cafe. I invited her to sit down with me. Between my broken Spanish and her broken English, I came to understand that she didn't have enough money from her SSI check to buy candles at the Catholic church and she wanted to be given a job washing dishes at the Café to make some more money.*

*Most psychiatrists would've answered something like, "We'd love to have you work here, but you're not ready yet. First you have to cooperate with medications and follow directions and then we'll see about a job."*

*But, we actively support people's goals instead of giving them a bunch of preconditions that are our goals, because everyone is more motivated to do what they want to do more than what someone else thinks is good for them. That's true regardless of how much insight they have or don't have.*

*So, we gave her a job in our Café, but she was every bit as stubborn at that as at everything else, insisting she knew how to do it her own way. Nonetheless, a couple weeks later she came up to my table again, this time wearing her white apron. She told me that she was having trouble focusing on her job, remembering what she was supposed to be doing. "You're always trying to get me to take medications. Do you have any medicine that might help with my memory?"*

*Now I had a chance to connect medications to her goals.*

*And that's how she ended up taking long acting injections, but only from me, and only in her arm, while praying to Jesus, making me afraid I'd break a needle too. It's also how she began a stable part of her life, even though she didn't hold her job long, living in her own apartment and as a regular Church goer. She'd learned from her dishwashing experience that she could use medications to be a stronger self, a*

*different context and motivation from how she'd ever viewed medications, or herself, before.*

For medications to help someone rebuild a life, coercion isn't the missing ingredient, integrated empowering services are: "people, places, and purpose" all funded and provided together.

In contrast, AOT is a "simple" solution to a complex problem that directly addresses our grief and our frustration while supporting our prevailing medical model: Unfortunately, in practice in many states, my impression is that its success has been quite limited, to the point where it's unclear if the coercive component adds anything other than greater availability of services.

AOT at its most basic "commits" a person with serious mental health to treatment, usually forced medications. Realistically, however, there are at least five parties involved in this commitment:

1. The person who needs help
2. The mental health system / program that is mandated to help them (there are other systems that may or may not partner with them)
3. The court that creates and oversees the mandate (and the police that enforce it)
4. The state government that funds the mandated services and the courts (there are other levels of government that may or may not contribute)
5. The community where the person is expected to receive services and live.

Meeting any given party's needs will impact the other parties. The process being used around the country to implement AOT focuses entirely on the person who needs help – their characteristics and eligibility for the program, their compliance with the court orders, and their punishment (usually locked hospitalization) for non-compliance. If any of the partners don't meet their commitments, the patient is the one who suffers the consequences.

In California, we've seen real implementation problems after passing Laura's Law in 2001. Typical problems include,

- Mental health programs have refused to accept people referred to them
- Mental health systems have refused to implement AOT programs because they don't want the burden and liability of these programs
- Trained mental health staff aren't available to hire.
- Programs and staff have implemented services in coercive, repressive ways that don't produce the engagement, empowerment, growth- oriented risk taking, and

community integration needed for people to develop in these programs enough to be “graduated” successfully.

- Courts haven’t devoted the resources to mental health courts and the training and role changes within them needed to make them work
- Courts and mental health systems haven’t collocated and worked collaboratively
- Police have refused to respond to mental health calls for help and enforcement (because “they’re mental health’s problem now”)
- States have made AOTs “unfunded” or underfunded mandates
- Necessary support services -especially supported, subsidized housing, employment, and community integration have not been allocated, funded, or integrated with AOT
- Communities have forced out welcoming programs that serve these people, because they’re “magnets” and they don’t want these people in their community.
- Landlords, businesses, and employers actively exclude these people
- Governments don’t fund or give tax breaks to “social cooperatives” who could engage these people
- Programs and housing are set up in the least desirable, most dangerous areas (or sometimes remote areas of the city) away from people’s communities of origin

California’s experience implementing AOT has demonstrated that:

- Unfunded AOT wasn't implemented. Funded AOT is barely implemented.
- AOT is far more popular among policy advocates than among staff and people being served.
- Funding intensive outreach is likely more cost effective than funding courts
- These people use a wide range of psychosocial rehabilitation services, that tend to be neglected and underfunded in Medicaid systems and not well integrated into our mental health system.
- Substance misuse needs to be expected and planned for.
- Creating and funding Full Service Partnerships has been far more widely implemented in California than AOT.
- Full Service Partnerships would never have existed without the direction of the California legislature over decades of proven success

See more details and data in support of these bullets in the Appendix.

**Bottom line: Given limited funding, the Massachusetts legislature should be promoting Full-Service Partnerships and other Recovery Model services instead of AOT.**

Legislators should go beyond the simple strategy, by taking into account these, and other emerging complexities, to try to pass legislation that mitigates these problems and incentivizes positive commitments. Rather than pass S1115 and H1801, I urge the legislature to fund non-coercive, Full-Service approaches that work, are able to retain the interest of those at the center of concern and respect the human dignity of everyone involved. I appreciate the opportunity to share my experience and submit these comments to the Committee.

Sincerely,

*Mark Ragins, MD*

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## Appendix:

### Results from AOT in California

What actually happened in California 20 years after AOT was passed? I attached the most recent AOT outcomes report. Here are the highlights:

- It took from 2002 to 2008 to implement AOT even in the one county where the original killing occurred. No other county implemented it until 2013 when funds were diverted from the Mental Health Services Act to use for AOT.
- Even with funding, about half the counties opted out of participating, and that led to mandating them to do so in 2023.
- When people are heavily outreached (average 12 contacts over 52 days) 80% accept voluntary services. Outreach is generally not funded by Medicaid, or anyone else, so it can easily be argued that if you want to help these people, fund intensive outreach instead of courts.
- Even within the court ordered group the "compliance" was only fair - 58% "adhered to their treatment", 71% maintained contact with the program (average 281 days).
- The services that the counties used were more often psychosocial services than medication oversight (89% housing, 74 % education, 70% employment, 63% transportation, 59% case management, vs. 56% med management). These numbers may reflect what services legislators, families, or TAC thinks people need, but just like we found at the Village they are what's really needed. These services are generally not funded by Medicaid, so the counties had to use other funding sources from the state including MHSA funding to provide what people actually need.
- Substance abuse is very pervasive, 85% of counties used substance abuse treatment and the decrease in usage was reported as only 30% (so "make them stop using drugs" is generally not a realistic outcome of AOT)
- The three target outcomes (16% reduction in homelessness, 52% reduction in hospitalizations, and 41% reduction in law enforcement contacts) are all much less impressive than the Village or the original Full Service Partnerships (generally about 70% reduction in all three areas), most likely because of worsening housing shortages in California that undermines all efforts (and is why last year California

diverted even more MHSA money to housing and treatment beds (Note that 50% of the AOT group entered as homeless).

## The Village

The Village was established as a demonstration program by the California state legislature in 1990 to “show us the best we can do.” We integrated the best practices available, clubhouse, psychosocial rehabilitation, ACT teams, dual -diagnosis services, payee services, supported housing, employment, and educations, and community integration. By altering our focus from treating illnesses to helping people have better lives and from compliance to collaboration we got stunning results for people like Olivia (described above). The Village program began the Full Service Partnership movement in California which has spread throughout the state serving about 50,000 people today.

Statewide success of about 70% reduction in hospitalizations, homelessness, and incarceration led to expanding the program. In 2003 the Mental health Service Act was passed to get ongoing flexible state mental health funds.

### SERVICE EXPENDITURE PATTERNS:<sup>1</sup> VILLAGE vs. COMPARISON GROUP (1990-1994)

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	<b>Village</b>	<b>Comparison</b>
<b><u>Type of Service</u></b>	<b><u>Percent of Total</u></b>	Percent of Total
Case Management	40.6	10.1
Day Treatment	0.2	1.0
Medications	11.2	10.2
Residential	0.3	2.1
Socialization	11.6	1.2
Outpatient Therapy	4.7	23.2

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<sup>1</sup> In Lewin-VHI, Inc., with Meisel, J., & Chandler, D. The Integrated Service Agency Model: A Summary Report to the California Department of Mental Health, June, 1995.

Vocational	25.1	1.3
Acute Hospital	5.1	27.9
Long Term Care	1.3	23.1

**The three largest areas of expenditure for the Village members were in case management, employment services and socialization services. The three greatest areas of expenditure for the control group were acute hospitalization, outpatient therapy, and long-term care.**