



Take Away My Rights if I Lose My Mind Again—Because I Want to Live

A Peer Perspective on the Continuum of Care Act (S.2973)

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I have sat before legislative committees in the State House and said what most are too afraid to say: "Please, take away my rights if I ever lose my mind again—because I don't want to die; I want the chance to actually live."

I am a survivor of bipolar psychosis. I know what it is like to have your brain fail you—to be unraveled, disoriented, and lost in a reality that doesn't exist. Years ago, I was encountered by police while visibly psychotic. Because I wasn't "dangerous" yet, the law barred them from taking me for treatment. The system waited for me to hit a catastrophe, and because of that preventable delay, I later tried to take my own life.

The Myth of "Autonomy" in a Broken System

Critics of the Continuum of Care Act (S.2973) talk about protecting "civil liberties" and "self-determination." But as a peer, I have to ask: Where is the liberty in an early grave? Where is the self-determination in a jail cell?

To offer someone "freedom" while their brain is suffering from a stage-four medical emergency isn't compassion—it is a sanitized form of abandonment. In Massachusetts, we protect a "Right to be Sick" while ignoring the fundamental Right to be Well.

Witnessing the "Standard of Neglect": A Timeline of Failure

My perspective is forged by over thirty years of navigating a system that has, at times, felt like it was designed to fail. In 1992, while I was a graduate student at Harvard, I poured my heart out to a resident at the university's mental health clinic during a crisis. I walked back to my apartment only to receive a phone call from her saying, "I don't think I can help you." Shortly thereafter, following a suicide attempt born of that very abandonment, I woke up under the blinding ER lights of a Cambridge hospital only to hear a nurse look at me and say, "Lay still, you did this to yourself."

Years later, after graduating, the cycle repeated. I was found by my sister in the sprinklers during a psychotic break—an incident that occurred only a month after police had refused to detain me for treatment because I wasn't "dangerous" yet. The system's only answer was the ER. I was "boarded" for over 24 hours—a prisoner of bureaucracy—only to be moved by ambulance to a psychiatric facility at 4 AM, exhausted and broken. By then, I knew the system



had no interest in my recovery; they just needed the bed. I eventually learned to lie to the evaluators just to escape a process that offered nothing but a brochure and a discharge paper. From the ivy-covered walls of Harvard to the sterile tiles of the ER, the message has been consistent: Wait for tragedy, then blame the victim.

The Solution: AOT as the Hospital "Off-Ramp"

Critics argue that hospital systems are flawed—and they are. AOT is not a "fix" for a broken hospital system; it is a way to bypass it entirely. The trauma of "ER boarding" and "silent dismissals" is a direct result of waiting for a catastrophe to happen. Assisted Outpatient Treatment (AOT) is the clinical "off-ramp" that prevents this trauma. By providing mandated care in the community, AOT bypasses the need for traumatic hospital admissions and the "Standard of Neglect" found in overcrowded ERs.

Who is AOT For? Clearing the Misinformation

There is a growing fear among the peer community that AOT is a "dragnet" that will lead to the involuntary commitment of anyone with a diagnosis of schizophrenia or bipolar disorder. This could not be further from the truth. AOT is a specialized tool reserved strictly for the "clinical few" for whom voluntary treatment has repeatedly failed due to the biological reality of their illness.

Furthermore, critics often falsely frame AOT as a mechanism for "forced drugging." In reality, AOT is about mandated clinical engagement. It creates a legal framework that requires the system to stay at the table with the patient, and the patient to stay at the table with the doctor. The goal is to find a treatment plan that works in the community so the individual never has to set foot in a hospital or a jail cell again. If you are successfully managing your illness voluntarily, AOT does not apply to you. It is a safety net for those currently falling through the cracks of a system that expects them to perform miracles while in the depths of psychosis.

The Front Lines: ACT Teams and Anosognosia

Beyond my own survival, I have stood on the front lines as a Certified Peer Support Specialist on an Assertive Community Treatment (ACT) team. I have borne witness to the incredible, needless suffering of my SMI brothers and sisters. I have been the one offering a clinical hand and the keys to free housing, only to have those offers turned away.

Why would someone choose a freezing sidewalk over a warm bed? The answer is anosognosia—the physical brain damage that prevents a patient from knowing they are sick. When we give someone "autonomy" during a psychotic break, we aren't giving them freedom. We are handing them a map to a cliff and telling them it's their "right" to walk off it.

The AOT Reality: Implementation and Duration

Assisted Outpatient Treatment (AOT) is the bridge to recovery that 48 other states already use, but we must be honest: for AOT to work, it must be more than a temporary patch. The current



proposed durations are often nowhere near long enough to achieve lasting neurological stability. We are treating a marathon-level disease with a sprint-level solution. To truly stop the "revolving door," AOT must be clinically sustained for a duration that reflects the biological reality of SMI recovery—not the convenience of a court calendar.

The 99% Scandal: Jail is not a Hospital

Currently, 99% of our state psychiatric beds in Massachusetts are occupied by "forensic" patients—people who were only granted a medical bed after they were arrested. We have made the jail cell the only waiting room for a doctor. We are currently tracking 139 preventable tragedies in our Commonwealth—69 of which resulted in a needless loss of life. This is the human cost of "protecting" someone's right to remain untreated until blood is shed.

Conclusion: A Moral Duty to Act

S.2973 provides the clinical "off-ramp" that keeps patients stabilized in their own communities. AOT is not about "forced drugging"—it is about mandated medical accountability. We have a moral duty to assist those who cannot see the cliff they are walking toward. Let's stop protecting the "Right to be Sick" and start fighting for the Right to be Well.

Take Action: Move the Bill in Senate Ways and Means

- Contact the Committee Chair: Tell Senator Michael Rodrigues that "liberty" is not a medical treatment. Ask him to move S.2973 out of Committee.
 - Email: michael.rodrigues@masenate.gov
 - Call: 617-722-1114
- Share the Truth: Circulate this peer perspective and the NSSC Preventable Tragedies Tracker with your network. Download the Tracker at:
https://www.nationalshatteringsilencecoalition.org/nssc_press_room.html