NAMI Connecticut
National Alliance on Mental Illness

Testimony before the Judiciary Committee
March 29, 2012
Opposing SB 452 - An Act Concerning the Care and Treatment of Persons with Psychiatric Disabilities

Good afternoon, Senator Coleman, Representative Fox and members of the Judiciary Committee. My name is Daniela Giordano, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). I am here today on behalf of NAMI-CT to strongly oppose SB 452 - An Act Concerning the Care and Treatment of Persons with Psychiatric Disabilities.

We know that people who need medications go without them for a variety of reasons including serious adverse side effects, stigma, denial, conditions of the illness leading to a lack of insight, and lack of access to services including access to medications and other community based treatments. **Although written with good intentions, this proposal will not help improve treatment for persons with psychiatric conditions, also for a variety of reasons**:

- Coerced treatment greatly damages future treatment relationships
- Relationships built on trust, not force, lead people to make good decisions regarding their health
- Denial and disapproval regarding the illness and medications is very common and usually a temporary stage of the illness and recovery process

Most people testifying today will have once been in that stage and moved passed it without an involuntary outpatient commitment.

Connecticut is not perfect but has come a long way. **Connecticut's mental health system and DMHAS's recovery-oriented system of care is client-centered** and has worked hard to get to this point. **IOC is inconsistent with this approach and direction. It is antithetical to our "recovery core values" and would divert resources and attention from community-based mental health approaches with proven track records** – *such as peer support and engagement, assertive outreach, subsidized and supportive housing programs, advance directives, and counseling.* **It would damage good will and drive a wedge between treatment providers and the people they serve.**

- A lot, if not most, of what works in mental health depends on relationships, particularly the relationships between the people dealing with mental health issues and their partners in recovery such as providers, family members and other social supports chosen by the individual. Forced treatment, including and in particular, forced medication administration, will make it less likely, now and in the future, that individuals will trust the people and systems around them to support and help them with their mental health conditions. This trust includes having conversations with people affected by mental illness and listening to their stories, their

preferences i.e. what medications have the least side effects and are effective for *that* individual, and their goals and dreams.

- In 2009, the National Alliance on Mental Illness (NAMI) published "Grading the States: A Report on America's Health Care System for Adults with Serious Mental Illness" which measures each state's progress in providing evidence-based, cost-effective, recovery-oriented services for adults living with serious mental illnesses. CT received a grade B out of only six B's and no A's in the nation. Even more noteworthy is CT's grade A (the only one in the nation!) in the subcategory of **Consumer & Family Empowerment**, which we surely would lose if SB 452 was implemented. This is not only an issue of losing an achievement but also tells people where the focus of our entire system is headed, namely away from being recovery and consumer-oriented and instead going backwards.

Involuntary Outpatient Commitment (IOC) violates the fundamental rights of autonomously choosing one's own path including treatment path, of a broad group of people who are not currently a danger to themselves or others. They have not been found incompetent to make their own medical decisions by forcing court-ordered medical treatment. IOC singles out people with psychiatric conditions for this loss of rights.

The proposal would limit **privacy rights and confidentiality** during inpatient commitment by allowing treatment providers to talk to anyone with whom the patient has lived in the previous year as well as parents, siblings or children of the patient. Sometimes people do not have good relationships with family members and possible trauma in those relationships causes them to not want to include those family members in their treatment planning. Applying a framework of the criminal justice system, where police are allowed to talk to neighbors, families and landlords when investigating a crime, is different from asking questions about a person with mental illness. Mental illness is not a crime, therefore different standards should apply.

- Using **Advance Directives** more often would allow individuals to choose who will be part of their treatment i.e. by appointing someone on one's behalf to make medical decisions when one is unable to make or communicate decisions about his/her medical treatment. This will make it more likely for treaters to have access to clients' networks when this is needed. Most Local Mental Health Authorities (LMHAs) have training in this recovery-oriented practice.

IOC remains unproven. No empirical evidence comparing court-ordered community mental health services and supports with comparable programs offered on a voluntary basis show any difference in outcomes. (Policy Research Assoc., 1998; RAND Corp., 2000; Steadman et al., 2001; Swartz et al., 2009).

IOC's use of coercion risks driving people away from treatment as they lose trust in the people and the systems those people represent (Campbell & Schraiber, 1989). **It re-traumatizes clients who already have a high prevalence of trauma** (Mueser et al., 2004).

Racial Disparities: For example, African Americans and Hispanics are over-represented as subjects of IOC orders in New York. African American clients are nearly three times as likely and Hispanics twice as likely as Anglos, to be the subject of court-ordered treatment, based

on data reported in 2005 and 2009 (NY Lawyers for the Public Interest). Implementing IOC in Connecticut would invite a comparably discriminatory application of court-ordered treatment. Connecticut commitments take place exclusively in probate court, closed proceedings with no oversight and little ability to track impact.

Outpatient Commitment is costly. As an example, New York budgets $32 million annually for its IOC program ("Kendra's Law"). Actual expenditures are considerably higher than that amount. Additionally, only 1.7% of the Office of Mental Health population in NY (NY's equivalent to CT's DMHAS), have been committed via Assisted Outpatient Treatment (AOT - NY's version of involuntary outpatient commitment). Those 1.7% are using 25% of the system's Assertive Community Treatment (ACT) services, thus leaving clients in voluntary services with fewer resources and services (Swartz et al., 2009).

What works is the continued and increased investment and enhancement of our community-based mental health system as there are still plenty of people who are being turned away from services they need, want, and request. ***Supportive housing*** *has been demonstrated to promote stability and engagement. Other services that work include peer support and engagement programs, assertive outreach programs, advance directives, counseling, as well as initial and ongoing training for people in the field, including conservators, court personnel and mental health treatment providers.*

Thank you for your time. I am happy to answer any questions you may have.

Respectfully yours, Daniela Giordano

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◊ *Final report.* Research Study of the New York City Involuntary Outpatient Commitment Pilot Project. Policy Research Associates, Inc. December 4, 1998. (Positive outcomes were the result of the enhanced services – and are not the court orders or involuntary treatment.)

◊ *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States,* RAND Corporation, 2001.

◊ Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., Mulvey, E., Roth, L., Grisso, T., & Banks, S. (2001). *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence.* New York: Oxford University Press. (The stereotypes, prejudices and irrational fears of "violent" mental health clients on which IOC is based are not consistent with the facts. Mental health clients without symptoms of substance abuse are no more prone to violence than others living in their communities who do not have symptoms of substance abuse.)

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◊ *The Well-Being Project: Mental Health Clients Speak for Themselves,* Campbell, Jean; Schraiber, Ron. California Network of Mental Heath Clients, California Department of Mental Health, 1989. (IOC's use of coercion risks driving people away from treatment altogether.).

◊ *Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: Demographic, clinical, and health correlates.,* Mueser, Kim T.; Salyers, Michelle P.; Rosenberg, Stanley D.; Goodman Lisa A.; Essock, Susan M.; Osher, Fred C.; Swartz, Marvin S.; Butterfield, Marlan I. (2004)., Schizophrenia Bulletin, 30(1), 2004, 45-57. http://psycnet.apa.org/journals/szb/30/1/45/

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