STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

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Testimony of Patricia A. Rehmer, MSN, Commissioner
Department of Mental Health & Addiction Services
Before the Judiciary Committee
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Good morning, Senator Coleman, Representative Fox, and distinguished members of the Judiciary Committee. I am Patricia Rehmer, Commissioner of the Department of Mental Health and Addiction Services (DMHAS), and I am here today to comment on **SB 452** ***AN ACT CONCERNING THE CARE AND TREATMENT OF PERSONS WITH PSYCHIATRIC DISABILITIES.*** Our Department has serious concerns regarding the issue of outpatient commitment and I will use this testimony to lay out what we see as problems should this bill be implemented. I would also like to acknowledge that we met with Judge Killian regarding this issue last week and while it was a very good meeting, we have agreed to disagree about this issue.

Let me start out by stating that in 1996, DMHAS proposed an outpatient commitment bill. It was during the height of hospital closings, and the Department viewed it as a tool that would continue to allow individuals with psychiatric disabilities to live in the community. Our thinking over the years has evolved into an approach that is increasingly person-centered and recovery-oriented. We now understand that the relationship between the caregiver and the individual is a collaborative one that is founded on mutual and thoughtful respect. Our experience has shown that if you have a discharge plan for an individual leaving the hospital that is tailored to his or her needs, the individual is much more likely to stay in treatment

Outpatient commitment makes a significant departure from the recovery movement for persons with psychiatric disabilities. It removes the more desirable possibility of an individual's full participation in decisions regarding medication administration. It is paternalistic and it does not guarantee that the services individuals with psychiatric disabilities need in the community will be available or effective. It can create distrust between clinicians and their patients, and in some instances, can be perceived as an easy out for someone whose needs are more complex. There are many of us, I am sure, who have not taken medications or have not followed their doctors orders on diet and exercise for high blood pressure, or cholesterol or diabetes because of side effects, or the difficulties we encounter when trying to make life changes. We are not punished—even if we show up in emergency rooms with high glucose levels or heart attacks. Instead, the medical community looks to provide incentives to help people reach their goals. Outpatient commitment goes in the opposite direction.

The field of psychiatry has changed considerably over the last 15 years and Connecticut has adopted many policies and programs to allow for individuals to lead productive lives in their communities, to find meaningful employment, to enjoy social activities that they never had access to in

our state psychiatric hospitals, to live in supported housing, and to have access to quality primary and behavioral health care.

We have established Jail Diversion programs that are a national model; we have Community Intervention Teams with local police departments that de-escalate problems in the community; and we have Supportive Housing Programs that offer safe and affordable housing to our population. We offer community support services, medication management and peer supports. All of the services I referenced emphasize an individual's right to live in the community and to enjoy the privileges of an autonomous citizen.

There are a number of states that have adopted an outpatient commitment statute in recent years. Many of these states have not used the statute because ethically as treaters, they would need to be sure that every service needed for the individual is in place before an outpatient commitment statute is used. Literature also suggests that outpatient commitment when used in other states is more commonly applied to persons of color. In Connecticut, which has a comparatively rich service system, there are still services that may not be readily available to someone who is leaving the hospital and is in need of very intensive services.

Outpatient commitment statutes may disrupt the collaborative relationship between caregivers and individuals and take resources away from recovery-oriented treatment planning which in turn creates discord within the treatment environment. It is not an effective solution. We ask that you not act favorably on the legislation before you.

I also have some concerns regarding the information-sharing language. I believe that a patient's consent should be considered first and foremost when we are talking about psychiatric records, and this language fails to capture the confidentiality protections afforded persons with psychiatric disabilities in sections 52-146 of the CT General Statutes.

We have also submitted written testimony on HB 5555 AN ACT CONCERNING DIVERSIONARY PROGRAMS. The Judicial Branch and DMHAS staff met over the summer and fall to address concerns raised last year about the Pretrial Drug Education Program and the Community Service Labor Program. We believe that sections 1 and 2 of HB 5555 will address the issues raised last year. There are some technical changes we are seeking in the bill and those changes are included in the written testimony.

I thank you for your time and attention to these matters and would be happy to answer any questions you may have.