

To: Members of the Judiciary Committee
From: Sheila B. Amdur
Re: SB 452: AN ACT CONCERNING THE CARE AND TREATMENT OF PERSONS WITH
PSYCHIATRIC DISABILITIES
Date: March 29, 2012

I am testifying today against SB 452. My testimony is based on my experience of being the CEO of two large mental health centers in the state, and also for the last 12 years, serving in leadership roles in both the state and national Boards of Directors of the National Alliance on Mental Illness. The fundamental issue of so-called "treatment resistant" persons is the lack of effective outreach and engagement services to help that individual deal with their own health issues. There is no other illness for which we would presume that we should use legal force to make someone take medications. In fact, about 50% of people who are prescribed heart medications do not take them or take them erratically, but no one would even think we would use the intervention of the court and health care "police" to make them do so. The same applies to people who have diabetes and many other chronic health conditions. Not taking care of one's blood pressure, heart conditions, diabetes, and many other disorders could result in someone causing a car crash that would injure others, erratic behavior, and self harm. However, it would be unthinkable to do the following that this bill prescribes:

"A conservator of the person appointed pursuant to subsection (b) of this section may request that state or local police or a licensed or certified ambulance service assist in transporting the patient to a designated location for purpose of administering the medication."

I have spent 40 years of my life as a provider of mental health services and now as an advocate for individuals with serious mental illnesses. I have been responsible for organizing and overseeing community outreach teams who worked with people who were homeless, who refused to come to our clinic, and who did not want traditional treatment. I can only recall one person in all those years who we could not engage, and she chose to disappear, in all likelihood going to another city. The issue is not forced outpatient treatment, but rather outreach, engagement, and non-traditional services that *do not give up on people*. This, of course, requires that the state fund these services, some of which could be Medicaid reimbursable.

When I was the President of NAMI-CT in 2000, the Board of Directors passed the following: *It was the consensus of the NAMI-CT Board of Directors that an outpatient commitment bill, which may be introduced in this session, is an ill-conceived solution to the problems in the Connecticut mental health system. There is no evidence that involuntary outpatient commitment is an effective intervention to prevent violence, and a recent New York study showed no difference between two similar groups of clients who each received intensive outreach and treatment services with one group receiving the services involuntarily. Involuntary outpatient commitment will not do away with the gridlock in the current mental health system, and is not a substitute for the necessary resources for effective treatment. It was the concern of the NAMI-CT Board that an emphasis on outpatient commitment will detract from the necessity of funding assertive outreach programs, housing, and other basic community services, the withering away of which have led to the current problems.*

Nothing has changed since that time, except that Connecticut has addressed some of these issues. Let's be sure that we continue to address them and reach the people who are the most vulnerable.