

Eastern Regional Mental Health Board, Inc.

The citizen's voice in mental health policy.

**Testimony before the Judiciary Committee
SB 452 - Outpatient commitment won't help
Robert E. Davidson, Ph.D.**

Outpatient commitment, like prohibition, is a well-intentioned but ineffective solution to a problem we are lucky enough not to have much of in Connecticut. Many people don't want to take medications—some of whom have mental illnesses—but we have better ways than forced medication to persuade them to do it.

Outpatient commitment is popular in states with *bad* mental health services because it makes providers *give* the meds as well as making the client take them. In some places, it is the only way to get off waiting lists. If you can't get services here, we have an effective grievance procedure, Regional Mental Health Boards, and a whole array of consumer advocates to help.

A judge cannot make you take the meds. He can issue an order, but he will not *track* you down and then *hold* you down while you 'comply.' That is up to a treater, most of whom are ambivalent about forced medication. Those who are not *will* be after seeing it done. And when the order expires in 120 days, clients will have to re-establish trusting relationships with people who forced them to do something they saw as unpleasant, unnecessary, and coercive.

Moreover, forced meds are a slippery slope, the last refuge of a burned out treater who wants to shift the blame to the patient for a service plan that doesn't fit. It is a new hammer, but it will make more people look like nails. It starts with people who you think will shortly become dangerous, then extends to people who will just "do better." It is the worst kind of "substituted judgment," a substitution of *values*, not just capacity.

So, the main problem with outpatient commitment is that it does not work. But it also damages treatment relationships, makes it *less* likely that the client will comply in the future, and violates people's rights. It punishes people for what they *might* do in the future. The argument is that they have *demonstrated* that they will decompensate if left to themselves, that they really don't want to be psychotic and they will thank us afterwards. Maybe. I hope so. But a service plan *that works* must respect the rights and dignity of the patient.

Meds have side effects. They slow you down and make it harder to deal with people without cognitive impairments. You gain weight. You *feel* worse, not better. You drink Red Bull and Mountain Dew. Yes, you may become psychotic, but you won't know that until later. One goal of services is to associate the consequences with the cause, and that will be much easier *without* an overlay of coercion.

We call clients of the mental health system "consumers." That implies that they have a *choice* of services, like you have a choice of brands in a store. DMHAS is committed to "person-centered planning," which is the *antithesis* of outpatient commitment. Every use of outpatient commitment *discredits* treatment among a naturally suspicious group of people whose encounters with the courts and treaters have not been positive. People refuse meds for good reasons. We can counter those reasons, but only by convincing them that things have changed. If this proposal passes, that task becomes impossible.

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