

TESTIMONY IN OPPOSITION TO H.B. 7015

3/17/15

Dear members of the Judiciary Committee:

My name is Nicole Stacy. Some of you may know me as Public Policy Assistant of the Family Institute of Connecticut, but today I am primarily speaking on my own behalf.

I would like to register my **strong opposition to H.B. 7015**, for many reasons, but most personally because of my experience being diagnosed with and treated for clinical depression as a college senior. As I lost my ability to cope with the normal slings and arrows of life, I found myself in the bizarre position of watching myself gradually lose my grip on reason, being aware, yet not being able to do anything to stop it. That is making a long story very short. I now consider myself not cured, but in remission.

On March 12, 2014 I listened to John Rowland's radio program (which is no longer available) with a guest spokesperson from Compassion & Choices. A question was asked about people suffering from depression, and the spokesperson responded that such individuals should "seek medical help." As I recall, that was the extent of the answer.

As a fellow human being I have nothing against him. Frankly, though, I found it to be a risible remark because it is so distant from reality and shows me that depression is still poorly understood. Telling depressed people to get help, leaving the onus on them, is not enough. They need social structures that facilitate their getting help, and caring individuals to show some initiative. It is incredibly lonely and difficult to be your own advocate when you can barely conceive of getting in a car and going somewhere, but your illness is invisible.

Why is it so hard for depressed people to get help? I have identified several barriers:

- Lack of Education. I took a semester of psychology in high school and two college psychology courses. It is hard enough to understand what is happening to you with a background like that; it stands to reason that if you do not know very much about depression and other mental illnesses, it's harder. In *Depression in primary care. Why do we miss the diagnosis?*, which appeared in the journal *Canadian Family Physician*, one learns that "many patients do not recognize a depressive mood change in themselves. In some cases, on direct questioning, patients acknowledge a change in mood, but attribute it to their physical symptoms."¹
- Culture of the Pep Talk. In America, we are supposed to pull ourselves up by our bootstraps, a message many of us have unconsciously absorbed from birth. Clinically depressed people can't do that; they try hard, and almost inevitably fail, which makes them feel worse. When they finally gather the courage to tell someone how they feel, they may get *the Pep Talk*: any one of myriad variations on self-motivation, accepting criticism, counting one's blessings, glass half full, et cetera. Well-meaning people try to remind them how good they have it – which, again, makes them feel more miserable for being so ungrateful. This experience is not unique to me; I've heard about it over and over.

- No Questions Asked. When I started showing up late to class because I lacked the motivation to do anything, perhaps coincidentally, our entire class received an angry e-mail from the professor. I perceived it, of course, as directed squarely at me. I considered saying something, only to have the sudden revelation: “Your professors do not want to hear about your personal problems.” Maybe they did, and maybe they didn't. However, there was no deeper inquiry.
- Doctors. Yes, that's right! Specifically, primary care doctors. I was fortunate that my family doctor had an adjacent psychiatry practice. The same study I referenced above notes that “primary care practices are characterized by a large number of short visits”; “physicians are often unaware that psychosocial problems can underlie presenting somatic complaints and that depression can amplify symptoms of chronic illnesses”; and “the authors speculate that diagnosis was missed because the patients' emotional distress was ascribed to time-limited situational factors.” Given that the article is 20 years old, I would like to think things have significantly improved, but as of 2009 the *Lancet* was still reporting on incorrect diagnoses in primary care.²
- Treatment Itself. Two people given the same medication can have very different responses. The first one I tried made it impossible for me to sleep. I found something else that worked fairly quickly. Had I tried two or three medications with unpleasant side effects, or been less patient, I might have given up.
- Society. In a November article, the Manchester Journal-Inquirer³ quoted town officials speaking resentfully about the amount of resources being expended on mental health-related calls and making long-discredited assertions about property values. Smoke may actually have come out my ears when I thought about the potential effect of that piece (depressed people aren't necessarily illiterate). Mental health services are, unfortunately, often at the mercy of the state budget.⁴

I want to make very clear that I am not blaming anyone – not my immediate family, not my friends, not my teachers. I did not make it easy for other people to see what was really going on. That's kind of the point: depression needs to be diagnosed by a professional. That can't be skipped when someone presents with suicidal inclinations. Under Oregon's “Death With Dignity” law, the model for every subsequent law in this country including our own H.B. 7015, it is skipped 97% of the time as of the most recent report.⁵

I bristle when I hear that the terminally ill have a good reason to be depressed: it's the other side of the *Pep Talk* coin, and just as wrong. Depression is more than having bad feelings, it is a medical condition which some people develop and some people don't. It tends to run in families. It *causes* suffering as much as it may be *triggered by* suffering. It is simply irresponsible to make psychiatric evaluation just another option when the result will be fatal...as it was for the first patient to die under Oregon's law.⁶

At this point you may be wondering if changing that provision in the H.B. 7015 would satisfy me. Again, I have many reasons for opposing it. It is the apparent lack of concern for the fate of those 102 patients who never saw a psychiatrist, at least some of whom may very well have had treatable depression, that particularly bothers me. In three years, there have been hours upon hours plus hundreds of pages of testimony. I am not breaking new ground. If it was taken seriously, why in three years has it not been changed already? Consider the main advocacy group's glamorization of the death of a

beautiful young woman, and the fact that the “My Death, My Choice” poster campaign is back up in the Capitol concourse again where it can be viewed by school children, in spite of real, serious, and long-recognized concerns we and our allies have raised about the phenomenon of suicide contagion.⁷ I am very careful never to assume bad motives on anyone's part, but over time, I've come to the sad conclusion that the best word for it is “indifference.”

It is unacceptable for people with depression or other mental illnesses to become collateral damage in someone else's march to autonomy. Please reject H.B. 7015 today, once and for all.

Sincerely,

Nicole Stacy
Hartford

1. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2380010/>
2. <http://www.medscape.com/viewarticle/706714>
3. http://www.journalinquirer.com/towns/manchester/manchester-to-look-at-impact-of-emotionally-distressed-people/article_2fd39324-758f-11e4-bcfb-f7fab3273c34.html
4. <http://www.nhregister.com/health/20150221/malloy-has-mental-health-agencies-reeling-over-proposed-budget-cuts>
5. <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>
6. <http://dredf.org/public-policy/assisted-suicide/spurious-safegaurds/>
7. <http://www.cdc.gov/mmwr/preview/mmwrhtml/00031539.htm>