



STATE OF CONNECTICUT
OFFICE OF PROTECTION AND ADVOCACY FOR
PERSONS WITH DISABILITIES
60B WESTON STREET, HARTFORD, CONNECTICUT 06120-1551

TESTIMONY OF NANCY B. ALISBERG, MANAGING ATTORNEY
STATE OF CONNECTICUT
OFFICE OF PROTECTION AND ADVOCACY FOR PERSONS WITH DISABILITIES

IN OPPOSITION TO Raised Bill 5531, An Act Concerning the Care and Treatment of
Persons with a Mental Illness or Substance Use Disorder.

JUDICIARY COMMITTEE, PUBLIC HEARING 3/18/16

Senator Coleman and Representative Tong and members of the Judiciary Committee:
Thank you for this opportunity to comment in opposition to Raised Bill 5531, An Act
Concerning the Care and Treatment of Persons with a Mental Illness or Substance Use
Disorder. I am testifying on behalf of the Office of Protection and Advocacy and on behalf of
the Advisory Board of OPA which also opposes this bill.

Imagine that you are leaving a hospital after receiving treatment for a mental illness. You
are feeling much better and are ready to resume your life and your job. But imagine, that
instead of being able to leave and go on with your life, the doctors there who barely know you
have decided that you have to take a certain medication. You don't want to take that
medication. You've taken it before and experienced devastating side effects. You are able to
provide informed consent. You have been informed why your provider wants you to take
medication and the type of medicine the provider wants you to take. You have been told the
advantages and disadvantages of the medication, whether there are medically acceptable
alternatives medications, the risks of the medication, and the risks of not taking the
medication. Yet, you have made an informed decision that you don't want to take that
medication.

Now imagine being told that your decision doesn't matter. That a judge who doesn't know
you has decided that somebody else who doesn't know you can decide that in fact you have
to take that medicine, no matter what you say. And further imagine that despite this order
you decide not to take the medicine because you know how it's going to make you feel.
Therefore, your conservator, who you met only once at the court hearing, calls the police who
come and pick you up at your job as a State Representative at the Legislative Office Building
and take you to by ambulance to an emergency room where a doctor waits to give you a shot
containing the medicine that you begged not to be forced to take. Imagine all this. Because
this is precisely what could happen if this bill is enacted.

This Bill would create a mechanism whereby conservators could be appointed and
authorized by Probate Courts to consent to the administration of psychotropic drugs for up to
120 days following a person's discharge from a facility when that person either refuses to
give consent to take psychotropic drugs, or has a history of not taking prescribed drugs. It
would authorize the conservator to call police and/or an ambulance to have the person
transported to a location where drugs could be forcibly administered. As James
McGaughey, the previous Executive Director of the Office of Protection and Advocacy stated

in 2012, our Office opposes this measure because its provisions would interfere with building the types of trusting, respectful relationships between treatment providers and their clients that are essential in order for real treatment and recovery to occur, and because it would undermine efforts of our mental health service system to escape reliance on coercive practices and to embrace the far more progressive and, ultimately more successful approaches that are the hallmarks of a recovery-oriented health care system. Mr. McGaughey's 2012 testimony is just as relevant today as it was in 2012, and I cannot do any better than repeat what he said then.

It is important to understand that "treatment" is not synonymous with prescribing psychotropic medication, and "recovery" is not synonymous with a willingness to take them. The notion that people with psychiatric disabilities get into trouble if they are "off their meds" is an unfortunate oversimplification. Often, people find themselves in difficulty because some other aspect of their lives has fallen apart – they have lost their home or job or an important relationship. While many people who experience mental illness do, indeed, benefit from medications, the truth is that individuals vary considerably in their responses to psychiatric drugs, and in their susceptibility to side-effects, some of which can have serious consequences for one's health. Not infrequently, people come to an informed decision about taking a particular medication only after attempting various alternatives, including living without medications. Optimally, they are able to work with responsive psychiatrists and other treatment professionals as they discover what works best for them. This is especially important in the area of psychiatric medication because there are so few "biological markers" available to clinicians to assess the effectiveness of the drugs they are prescribing. They must rely on candid feedback from their patients, and they must give credence to that feedback. Too often, however, interactions with professionals are short, infrequent and insensitive to individuals' concerns. This leads to a superficial focus on things like "medication compliance" and formulaic approaches for "management of your illness/disease", rather than on gaining a holistic understanding of the person and encouraging efforts to achieve genuine recovery. Because it focuses narrowly on the question of medication compliance, the provisions of this Bill would contribute to this unfortunate and ultimately counter-productive dynamic.

Promoting recovery involves many types of supports and connections. People with psychiatric disabilities have the same fundamental human needs as everyone else: we all need a place to call home, food to eat, some kind of income, physical security, healthcare, meaningful work and opportunities to learn and contribute in the world. And we all very much need relationships with others. In fact, human beings are hard-wired to heal in relationships - relationships with friends, neighbors, family members and with peers who have been through similar experiences and can act as guides. Relationships with therapists and professional supporters can also be tremendously important for people who have lost their place and are struggling to recover it. Yet those relationships can be irretrievably harmed, or never even develop in the first place if the person who is in need of help feels betrayed by those who are supposed to be helping. Unfortunately, the provisions of this Bill would encourage, and even legitimize practices that, from the perspective of the person struggling with a mental illness, would amount to such a betrayal. It is difficult to imagine how divulging confidential treatment information without the person's permission, or setting up a situation where a conservator would be authorized to call in the police and ultimately employ force to administer medication could be anything but destructive to the type of trusting relationship that people need to have with their treatment providers.

Over the years, our Office has represented hundreds of people at hearings about "forced medication" in psychiatric hospitals. Often, hospitals feel pressured by insurance and managed care organizations to initiate medication quickly, short-circuiting essential processes of communications and relationship-building. Sometimes, people refuse to consent because they have had prior bad experiences with medications; sometimes they just need time to come to terms with their circumstances. I can attest that, amongst those who request hearings, much of the resistance to taking medication is rooted in a failure by others to listen to and credit their feelings and concerns. Nothing can produce resistance quicker than attempts to over-ride personal autonomy and force a person to take powerful, mind-altering drugs into their body. It is not an experience people soon forget. I seriously doubt that subjecting someone to 120 days of involuntary medication will result in insight, gratitude and ultimate success; it is more likely to produce resentment, further wounding and future avoidance of treatment.

Much of the alienation that so called "non-compliant" individuals demonstrate can be traced to one or more experiences where they were disrespected as human beings and subjected to some form of coerced "treatment". Indeed, for decades, the blunt instruments of confinement, coercion and over-sedation were the principle tools relied on by our mental health system. We are now realizing that engaging people in treatment is a much more successful approach – one that leads to positive expectations and significantly higher levels of recovery. For treatment providers, acquiring the competencies necessary to genuinely engage people is critically important. That means, among other things, helping to empower people by forging real partnerships, instead of dis-empowering them by focusing on "compliance" and manipulating the legal levers of coercion. From a systems reform perspective, the goal is to develop treatment and support options that are viewed as relevant and trustworthy – ones that people will want to approach because they are affirming and useful; not ones they will seek to avoid because they worry that they will be subjected to judgmental, coercive practices. The last thing this reform effort needs is an invitation, written in statute, for those who provide services to seek judicial orders which disregard personal rights and actually expand the coercive options available to them.

In addition to our concerns about the provisions of this Bill that would authorize involuntary outpatient medication orders, our Office also has concerns about expanding the definition of "facility" to include nursing homes. Although there are a significant number of people with primary psychiatric diagnoses living in nursing homes, it is our view that nursing homes are generally not appropriate facilities for treating or housing people with psychiatric disabilities. While it may be tempting to apply all the statutorily protected rights of persons with psychiatric disabilities being treated in psychiatric facilities to nursing homes, doing so in the manner proposed in the Bill (e.g. by simply enlarging the definition of the term "facility") could also subject those people to the statutory provisions that allow for forced administration of psychiatric medication. Those provisions were enacted with hospitalized patients in mind, and their application should continue to be limited to hospital settings.

Thank you for your attention. If there are any questions, I will try to answer them.