

CONNECTICUT LEGAL RIGHTS PROJECT, INC.

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JUDICIARY COMMITTEE

**TESTIMONY OF THOMAS BEHRENDT IN OPPOSITION TO
HOUSE BILL No. 5531, AN ACT CONCERNING THE CARE AND TREATMENT OF
PERSONS WITH A MENTAL ILLNESS OR SUBSTANCE USE DISORDER**

March 18, 2016

Senator Coleman, Representative Tong, and members of the Judiciary Committee:

I am Thomas Behrendt, Counsel Emeritus with the Connecticut Legal Rights Project (CLRP), a legal services organization that advocates for low-income adults who have, or are perceived to have, psychiatric disabilities.

Involuntary Outpatient Commitment (IOC), as set forth in this bill, violates fundamental rights of a broad group of people who are not currently a danger to themselves or others, and have not been found incompetent to make their own medical decisions by forcing court ordered medical treatment. The bill has no requirement that the court make a finding that the individual is dangerous or lacks decision-making capacity. A conservator would be authorized to seek assistance of police or an ambulance service to have the individual medicated involuntarily. Persons diagnosed with psychiatric disabilities are singled out for this loss of rights.

IOC is inconsistent with Connecticut's mental health system and DMHAS's recovery-oriented system of care. HB 5531 is antithetical to our "recovery core values" and would divert resources and attention from community-based mental health approaches with proven track records – such as peer support, proactive outreach and engagement, subsidized and supportive housing programs, advance directives, and counseling. It would damage good will and drive a wedge between treatment providers and the clients that they serve, turning clinicians into enforcers.

Fiscal Impact – Outpatient Commitment is costly. New York State's Office of Mental Health budgets more than \$32 million annually for its IOC program.¹ The state's actual expenditures are considerably higher than that amount.² The bill would "commit" community mental health agencies to allocate scarce resources for something that they are not funded to do.

¹ Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment Resources to Provide Court-Ordered Services. ("more than \$32 million for operation of services in support of Kendra's Law") This amount was from the 2005-06 budget, the most recent year reported on the website of the New York State Office of Mental Health; the amount has surely increased with the numbers of AOT petitions filed in the years since. http://www.omh.ny.gov/omhweb/kendra_web/finalreport/resources.htm.

² E.g., the \$32 million figure does not include court staff and their time and does not include costs of state-funded legal representation of nearly 4,000 respondents via the state's Mental Hygiene Legal Service, nor does it include cost of police, EMTs, and more. In addition, OMH's budget includes over \$125 million in expanded services (Assertive Community Treatment, housing, and related costs).

Racial Disparities: African Americans and Latinos are over-represented as subjects of IOC orders in New York State, where an IOC law, known as “Kendra’s Law,” has been in place for just over a decade. New York’s law is widely regarded as the model for outpatient commitment in the United States. African American clients are nearly five times as likely as whites, and Latinos twice as likely as whites, to be the subject of court-ordered treatment, based on data reported in 2005 and 2009³. Implementing IOC in Connecticut would invite a comparably discriminatory application of court-ordered treatment. Connecticut commitments take place exclusively in probate court, in closed proceedings with no oversight and little ability to track impact.

IOC’s use of coercion drives people away from treatment⁴ and re-traumatizes clients who already have a high prevalence of trauma.⁵ Outpatient commitment can cause harm and result in dangerous situations by pushing people away from mental health treatment they would otherwise seek.

- HB 5531 would change current law, creating a system that allows for forced treatment orders for anyone treated by a mental health “facility.” (“Facility” is broadly defined to include virtually any mental health program: “any inpatient or outpatient hospital, clinic, skilled nursing facility or other facility for the diagnosis, observation or treatment of persons with psychiatric disabilities.”) The proposed law would have no requirement that the court make a finding that the individual is dangerous or lacks decision-making capacity.
- Under the proposed law, a conservator would be authorized to seek assistance of police or an ambulance service to have the individual restrained and forcibly medicated with powerful psychotropic drugs.
- At present, the availability of court-ordered authorization for forced medication is limited to inpatients in psychiatric hospitals. The existing law has “procedure[s] governing decisions concerning involuntary medication treatment for inpatients,” and applications for court authorized involuntary medication must be made by “the head of the hospital.”
- Under the proposed law, competent individuals living in the community would be stripped of their right of informed consent. They would lose the right to make their own decisions about taking powerful, mind-altering drugs in consultation with their physicians. This amounts to blatant discrimination – only people diagnosed with psychiatric disabilities would be singled out in this manner.

³ See, M. Cooper, “Racial Disproportion Seen in Applying ‘Kendra’s Law,’” New York Times, April 7, 2005; New York Lawyers for the Public Interest, 2009.

⁴ The Well-Being Project: Mental Health Clients Speak for Themselves, Campbell, Jean; Schraiber, Ron; California Network of Mental Health Clients, California Department of Mental Health, 1989. (IOC’s use of coercion risks driving people away from treatment altogether.)

⁵ Mueser, K.T., Salyers, M.P., Rosenberg, S.D., Goodman, L.A., Essock, S.M., Osher, F.C., et al. (2004). Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: Demographic, clinical, and health correlates. *Schizophrenia Bulletin*, 30, 45-57.

- Although proponents assert that outpatient commitment is a measure reserved for only a very small number of individuals, this is belied by the experience elsewhere in the country. For example, in New York State, nearly **2,800** individuals are currently under active outpatient commitment ("assisted outpatient treatment") orders, with a total of **3,925** individuals under these orders over the past 12 months.¹

Outpatient commitment would change the nature of community mental health in Connecticut to a criminal justice model, demonizing people with mental health disabilities and violating their civil rights. It would replace the present system of care into one driven by force, coercion, distrust, and fear, and it would discourage people in distress from seeking out needed help and services.

I urge you vote against HB 5531. Thank you for your attention to this matter and for the opportunity to testify.

⁶ See New York State Office of Mental Health, Program Statistics (<http://bi.omh.ny.gov/aot/statistics?p=under-court-order>).