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March 18, 2016

Sen. Eric Coleman  
Rep. William Tong  
Joint Committee on Judiciary  
State of Connecticut Legislative Office Building  
300 Capitol Avenue  
Hartford, CT 06106

Re: RB 5531 AAC the Care and Treatment of Persons with a Mental Illness or Substance Use Disorder

Dear Sen. Coleman and Rep. Tong,

Thank you for this opportunity to share my comments in opposition to **RB 5531: AAC the Care and Treatment of Persons with a Mental Illness or Substance Use Disorder**. Similar bills have been raised in the past for those diagnosed with a mental illness or substance use disorder to restrict their rights to refuse psychiatric medication upon discharge to the community. The current bill continues in the tradition of its predecessors to promote involuntary outpatient commitment (IOC) of persons diagnosed with psychiatric disability. As stated in the bill, this proposal focuses on an individual who "is capable of giving informed consent but refuses to consent to take medication for the treatment of the patient's mental illness or substance use disorder." It is a deeply flawed and dangerous concept to provide a Probate Court with the authority to appoint a conservator of the person expressly for the purpose of administering medication against the will of individuals who are otherwise competent to make their own decisions.

I present my testimony as a licensed clinical psychologist in Connecticut for over 25 years. I presently serve as the director of the Doctoral Program in Clinical Psychology at the University of Hartford, where I have taught and supervised over 500 psychologists now in practice from coast to coast. It is in my role as a former president of the Connecticut Psychological Association (2007-2010) that I address the Joint Committee on Judiciary today on behalf of my colleagues. My comments also draw on my prior service as a former State of Connecticut employee, having worked proudly for several years as a psychologist at the Capitol Region Mental Health Center, an outpatient setting where staff engaged in many innovative services to assist with the community integration and recovery of adults with serious psychiatric disabilities.

Involuntary outpatient commitment is an inherently coercive process that uses the threat of loss of freedom to force adults to accept medication treatments which they have refused to accept voluntarily. Although such approaches may reflect

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good intentions, a review of research on this process does not provide a clear indication that the court mandate itself is effective in increasing community tenure and quality of life. Much research has confounded the use of a court mandate with the provision of support services which the individual would not have otherwise received. If the court order does not add anything to treatment outcome, then a more humane and positive approach would simply involve providing the increased services without coercive use of medication.

A second concern involves the impact of coercion in the lives of individuals who are already skeptical of the public mental health system. When the possibility of a court order looms over a person who is ambivalent about coming forward for help, a likely response is for that person to avoid seeking help even longer. Our State is not made any safer by spending tax dollars to create one more barrier to treatment for those in need. It is more helpful to protect funding for outreach and recovery than to pay for "state or local police or a licensed or certified ambulance service (to) assist in transporting the patient to a designated location for the purpose of administering the medication."

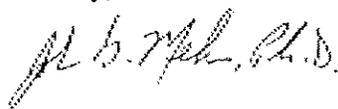
Many states which have enacted laws permitting IOC have done so because they have inpatient commitment laws which permit involuntary psychiatric hospitalization only on the basis of danger to self or others, requirements more restrictive than those in Connecticut. One reason that Connecticut has resisted IOC legislation is that we already have a more liberal law that allows for a 15-day physician's emergency certificate for involuntary hospitalization on the basis of grave disability, even if the person is not imminently dangerous to self or others. The selective use of emergency hospitalization provides a safety net for both the individual and the community, with its restriction of freedom as a temporary exception rather than the norm for an individual with a psychiatric disability.

In the wake of the tragedy at Sandy Hook Elementary School, it is reasonable to ask whether mandated medication is a procedure which might provide a safeguard against violence by young adults. Reviewing four published studies that are frequently cited in discussions of IOC, I have examined demographics of IOC participants from North Carolina, Florida, Oregon, and New York. Research shows the average age of individuals mandated for outpatient treatment to be about 40 years of age, with a standard deviation of 10-13 years in these studies. Given what is known about normal distributions of data, we can estimate that only 3-5% of all individuals mandated for outpatient commitment are age 20 or younger. Thus, IOC is an approach which is only infrequently employed for individuals the age of the Sandy Hook shooter. It is a procedure designated for individuals who, by virtue of older age and history of multiple hospitalizations, are much less likely to possess firearms or commit an act of mass violence.

Making our communities safe should not come at the expense of making them less inclusive of persons with disabilities. I ask that you oppose RB 5531 in favor of efforts that reduce barriers to treatment and engage individuals with services shown to promote recovery and quality of life.

Thank you for your consideration of my testimony.

Sincerely,



John G. Mehm, Ph.D.  
CPA President, 2007-2010