

Written testimony of Michael Rowe, Ph.D.
for the Connecticut Judiciary Committee
March 18, 2016

IN OPPOSITION TO
Raised H.B. No. 5531 AN ACT CONCERNING THE CARE AND TREATMENT OF PERSONS
WITH A MENTAL ILLNESS OR SUBSTANCE USE DISORDER

Senator Coleman, Representative Tong and members of the Judiciary Committee, I am an Associate Professor of Psychiatry at the Yale School of Medicine and Co-Director of the Yale Program for Recovery and Community Health. I was also the Principal Investigator for a study of a 2000-2002 Connecticut Legislature-funded project, the Peer Engagement Specialist Project (PESP), a prospective alternative to outpatient commitment. Thank you for this opportunity to submit testimony in opposition to H.B. No. 5531.

Introduction

Research on outpatient commitment has produced mixed findings, with no clear, consistent, and convincing evidence of its effectiveness. In addition, research on outpatient commitment often sidesteps or fails to address the social, institutional, and historical context of coercion of persons with mental illnesses, as well as the foundational American value of personal freedom. Given the lack of solid evidence of its effectiveness, lack of attention to promising alternatives, and the high bar that should be set for any intrusion on personal liberty in our democratic society, outpatient commitment is bad public policy.

Arguments *for* outpatient commitment are that it can be an effective means of providing mental care to persons who are refusing care ^[1] and can help to identify people at risk of violence against self or others, thus reducing acts of violence committed by members of this group. ^[2] Proponents also argue that outpatient commitment may encourage clinicians to provide coordinated and attentive care to mandated clients ^[2] and provide a less restrictive alternative to inpatient commitment for those who refuse outpatient treatment. ^[3]

Arguments *against* outpatient commitment are that it: unfairly targets persons with mental illnesses, as most of this group does not commit acts of violence ^[2] (80% of mass or serial killings are committed by persons seeking revenge, not persons with histories of mental illness); ^[3] may wrongly assess individuals as being at risk for violence, since psychiatrists have poor track records for predicting violence in their patients; ^[1] may drive people with psychiatric disorders away from treatment; ^[3] and draws attention and resources away from far more important issues in mental health care in the U.S., including lack of access to care due to fear of being stigmatized, and underfunded systems of care. ^[1, 4] It may also unfairly target African Americans ^[5-6] who, for example, were overrepresented in New York State among recipients of outpatient commitment after passage of 'Kendra's Law'. ^[7]

Systematic reviews of outpatient commitment studies by the Rand Corporation in 2001 ^[8] and the Cochrane Collaborative in 2013 ^[9] concluded that evidence for the effectiveness of outpatient commitment apart is lacking or cannot be distinguished from the provision of intensive outpatient care. Both reviews recommended further research on outpatient commitment and consideration of alternative approaches.

Coercive treatment should be undertaken with reluctance, with protections against abuse, and only when there is clear evidence of benefit to the individual, to society, or to both. ^[10-11] Evidence of the effectiveness of outpatient commitment is lacking, inconclusive, or compromised by study limitations. Evidence based alternatives for engaging people with serious

mental illness in care, which may be effective with the target group for outpatient commitment, are available. They include peer engagement, mental health outreach to people who are homeless, and citizenship interventions.

Peer engagement. In 2000, the Connecticut General Assembly, considering passage of an outpatient commitment law, responded positively to advocates' proposed alternative approach by allocating funds for a statewide community-based intervention, the Peer Engagement Specialist Project (PESP). Peers (persons with lived experience of mental illness) were hired and trained to provide support and engagement services to persons who were not engaged in treatment and who would have been subject to outpatient commitment had it been enacted in Connecticut. Specifically, these persons had been diagnosed with serious mental illnesses and had histories of violence or the threat of violence against themselves or others.

I was the principal investigator for a randomized controlled study of the PESP, which compared clients receiving peer specialist services with clients receiving current community-based case management services. Findings were that participants in the peer engagement condition had greater satisfaction with care and perceived higher positive regard, understanding, and acceptance from peer engagement specialists than did participants in the comparison condition from their case managers. In addition, positive regard from peer specialists in the early stages of enrollment was associated with participants' future motivation to receive care for psychiatric, alcohol, and drug use problems and attendance at Alcoholics and Narcotics Anonymous meetings.^[12] Finally, for participants in the peer specialist condition, even negative feedback from their peer specialists regarding their behavior was linked to improved quality of life and fewer obstacles to recovery.^[13] These findings suggest that peer providers can quickly forge therapeutic connections with and motivate to accept treatment those persons who are among the most disconnected from mental health care.^[12]

Mental Health Outreach. Mental health outreach was developed as a means of finding mentally ill homeless people who are not engaged in care, building their trust, and providing care, including mental health, housing, and rehabilitation services.^[14-15] Research on a nine-state, 18-site national study of services for this group found that mental health outreach engages the most severely psychiatrically impaired among persons living on the streets and that those engaged through street outreach showed significant improvements in several domains.^[16] While mental health outreach was developed to address the needs of people with mental illness who are homeless, many of these persons would also be subject to outpatient commitment, depending on state laws. In addition, the principle of outreach and engagement of mental health outreach teams need not be limited to persons who are homeless. Instead, it can apply to all persons who, for various reasons, refuse or lack access to mental health care or otherwise avoid contact with clinicians and case managers.

Citizenship-based approaches. Citizenship-based approaches support the recovery of persons with serious mental illnesses through efforts to enhance their sense of belonging and attainment of valued roles in their communities. A citizenship-based intervention, including community-oriented classes, valued role and giving-back community projects, and wraparound peer support, was evaluated through a randomized, controlled trial that I conducted. Participants with serious mental illness and criminal justice charges were randomized to the citizenship-based intervention plus current community mental health services or to current services. Citizenship intervention participants had statistically significant reductions in substance and alcohol use and increased quality of life on some subscales, compared with current service participants. In addition, arrests decreased significantly for both groups, perhaps suggesting that engagement in treatment, which occurred without outpatient commitment in this study, supported decreased criminal justice contacts for the target group.^[17-18]

These three interventions directly targeted persons who, otherwise, would be subject to outpatient commitment (peer engagement); persons who are homeless and are equally marginalized and hard to reach (mental health outreach); and persons who would be subject to outpatient commitment and others with serious mental illness and criminal justice charges (the citizenship intervention). The State of Connecticut has been a national leader in regard to each of these promising alternatives to coercive treatment. In addition to these potential alternatives to outpatient commitment, initiatives involving coordination of care, ongoing assessment, stigma reduction, mental health public education activities, and ongoing consultation from experts in forensic psychiatry should be regarded as part of a comprehensive alternative approach to work with the target group for coercive treatment.

Summing Up

In computer language, software programs come with 'default settings'—such as those annoying red squiggles that tell you you've misspelled a word—that always apply *unless* the user takes a specific action to change them—such as getting rid of those annoying red squiggles. In a similar but far more meaningful way, we can speak of individual freedom as the 'default setting' in our democracy. Freedom is 'the way things are' unless specific action is taken to modify or limit it. Changes to the default setting of freedom must be undertaken with great care and hesitation, and the benefit of the doubt should go to freedom. The default setting rule takes on special meaning with groups of people, such as those with psychiatric disorders who, historically, have been subject to coercive interventions and loss of individual rights. In mental health care, inpatient hospitalization, under certain conditions, is a limitation that can be placed on the freedom of a person diagnosed undergoing a mental health crisis. Outpatient commitment laws do *not* seek to replace involuntary inpatient hospitalization, but to extend the reach of coercion.

After more than 20 years of mandates and programs, outpatient commitment remains a costly, coercive, and unproven approach. More promising, and proven, practices are available. Through building on such practices and increasing the availability of services, effective mental health care can be provided to persons with serious mental illness who are not presently receiving care, including the very small percentage of those among this group who are at risk of violence toward others. In the Recovery Era, mental health in the U.S. should be moving forward, not backward, in its effort to assure 'a life in the community' for persons with mental illnesses. ^[19]

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