# THE CONNECTICUT PSYCHOLOGICAL ASSOCIATION, INC.

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Mental Health Services Working Group
Public Health Committee
State of Connecticut
Legislative Office Building
300 Capitol Avenue
Hartford, CT 06106

Working Group Members,

Thank you for this opportunity to share my comments regarding the future course and direction of mental health services in the State of Connecticut, both in light of our current fiscal realities and our profound reactions to the violent actions against innocent lives at Sandy Hook Elementary School last month. As concerned citizens we look in many places for means to prevent such a tragedy from ever recurring here, including restrictions on guns and ammunition, on violent movies and video games, and today on the rights and liberties of persons with psychiatric disabilities. In searching for answers, I strongly urge the members of our legislature to oppose the enactment of proposed legislation in Connecticut that promotes involuntary outpatient commitment of persons with psychiatric disability in the hope that this would be the answer to our common concerns.

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 this work group today on behalf of my clinical psychology colleagues in our State. But, perhaps most importantly, my comments 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 treatment is a court-ordered mandate to community-based treatment for individuals with severe psychiatric disability. Although it is sometimes euphemistically labeled "assisted outpatient treatment," it is an inherently coercive process that uses loss of liberty and freedom as a threat to engage adults in treatments that they have refused to engage in voluntarily. Such approaches may be well-intentioned efforts to provide treatment to individuals before they require psychiatric hospitalization for symptom management. However, 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 new services to which the individual would not have otherwise been afforded. The issue thus remains whether the court order adds anything positive to the expanded provision of services which would address the individual's needs in a less coercive manner.

My concerns over involuntary outpatient commitment are also generated by the impact of coercion in the lives of individuals who are already skeptical of the public mental health system. If the possibility of a court order looms over a person who is ambivalent about

coming forward for help, the expected response is to avoid seeking help even longer. Our State is not made any safer by spending tax dollars to enact a process that will legitimize one more barrier to treatment for those who might be most in need. Please also consider what we lose by shifting more funding away from treatment to pay for enforcement. Although it is true that many states have enacted involuntary outpatient commitment legislation, Connecticut has resisted this option in favor of a recovery-oriented mental health system which is a recognized leader in our nation.

It is also noteworthy that many states which have enacted laws permitting involuntary outpatient commitment have done so because of their more restrictive inpatient commitment laws. That is, many states permit involuntary psychiatric hospitalization only on the basis of danger to self or others. Connecticut has a more liberal law that additionally permits involuntary psychiatric hospitalization on the basis of grave disability. Adding more threats of hospitalization would not nearly be as helpful here as would protecting funding for outreach and recovery.

I commend our governor and legislators for their thoughtful consideration of all efforts to make our communities both safer and more inclusive. I ask that you resist the argument to provide a false sense of security that might be engendered by involuntary outpatient commitment legislation. Let us instead promote those efforts that reduce barriers to treatment and engage individuals with services that have been shown to promote recovery and quality of life.

Thank you for your consideration of my testimony.

Sincerely,

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