



CONNECTICUT
LEGAL
RIGHTS
PROJECT, INC.

TESTIMONY OF KATHLEEN FLAHERTY, ESQ.
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MASSACHUSETTS JOINT JUDICIARY COMMITTEE
JULY 18, 2023

In opposition to: S 980, An Act to provide critical community health services.

Good afternoon. My name is Kathy Flaherty and I am a lawyer and the Executive Director of Connecticut Legal Rights Project (CLRP), a statewide non-profit agency that provides legal services to low-income adults with serious mental health conditions. CLRP was established in 1990 pursuant to a Consent Order which mandated that the state of Connecticut provide funding for CLRP to protect the civil rights of clients of the Department of Mental Health and Addiction Services who are hospitalized, as well as those clients who are living in the community. I am also a former Massachusetts resident, having attended both college and law school in the Commonwealth. I am someone subjected to involuntary inpatient care at a Massachusetts psychiatric hospital via civil commitment and who engaged later in voluntary treatment, on both an inpatient and an outpatient basis. I am here to testify against S. 980 because it simply will not accomplish its stated purpose. This bill would divert state funding to create a structure to enable coerced treatment instead of using state dollars to meet the need for a broader range of voluntary services and supports. Instead of helping people with mental health conditions, this bill would hurt them. I urge the committee to reject this bill.

Your colleagues in the Connecticut state legislature have considered, and rejected, various proposals to institute involuntary outpatient commitment over the last quarter of a century. In 1996, a public act established a task force to study involuntary outpatient commitment in Connecticut. Their report was issued in January 1997 and can be found here: <http://www.narpa.org/reference/task.force.report> Notably, the task force did not

recommend either adoption or dismissal of the concept of involuntary commitment. They noted that “[t]he question remains, "Is there a case for some form of involuntary outpatient commitment for a very narrow target population considered to represent a risk of violence in the community?"”

In 2000, Connecticut’s Judiciary Committee held public hearings on two bills and referred them to Appropriations, where they died. In 2012, the Judiciary Committee raised a bill for a public hearing; that bill never made it out of committee. In 2013, the Young Adult Behavioral Task Force issued their report and could only encourage “further study” of IOC. The Sandy Hook Advisory Commission (on which I served) stated in its final report, issued in 2015, that it was “unable to arrive at a recommendation concerning adopting IOC as an option short of involuntary hospitalization in Connecticut.” In 2016, yet another bill had a hearing in the Judiciary Committee, and never made it out of committee. In 2020, the Public Safety & Security Committee raised a bill and had a public hearing. That bill died when the 2020 session ended due to the Covid-19 pandemic. Bills proposed by individual legislatures in the sessions since then have not even made it to a public hearing.

Three times the Connecticut legislature requested research reports from the Office of Legislative Research: in 2001 (2001-R-0866), 2011 (2011-R-0438), and 2013 (2013-R-0105) on what other states do regarding involuntary outpatient commitment. Much time and effort has been expended on examining IOC, only to have the legislature reject it each time it is proposed.

This bill does not require that any services be made available to an individual made subject to an order to accept “critical community health services,” nor does it indicate who will actually provide such services or who will pay for them. The bill creates a position for a “supervising mental health professional.” At a time when the behavioral health workforce is experiencing such significant shortages, removing someone who otherwise could be providing direct care services into a supervisory role seems counter-intuitive to the expansion of available services.

While the bill itself does not specifically define “critical community health services” as including the forced administration of psychiatric medication, it implies that continuing medication may be part of the critical community health service treatment plan, as is submission to testing “or other reasonable conditions.” Failure

to comply with the plan can result in petition for a “service plan non-compliance hearing” and if the court finds the person non-compliant, it could require an evaluation of whether failure to hospitalize the person would create a likelihood of serious harm. The bill thus expands the existing bases for involuntary commitment to a psychiatric facility.

Expansion of involuntary medication to the community is a step backward.

It has long been recognized that all people have a constitutional right to bodily integrity, which includes the right to refuse medical treatment including psychiatric medications. “An individual has a constitutionally protected liberty interest in avoiding involuntary administration of antipsychotic drugs. . .” Sell v. United States, 539 U.S. 166, 178-79 (1992). When forced medication is used “to alter the will and the mind of the subject, it constitutes a deprivation of liberty in the most literal fundamental sense.” Washington v. Harper, 494 U.S. 210, 237-38 (1990).

Presently, the law allows for involuntary medication in a psychiatric hospital under certain limited circumstances and with strict due process protections. It mandates procedures that protect patients’ rights, including notice to the patient of available advocacy services, advance notice of any proceedings, the right to representation and the right to question witnesses.

Expansion of involuntary medication into the community is not only a limitation of constitutional rights; it is unnecessary. Massachusetts has other options available that include peer support, recovery learning communities, advance directives and Housing First models. Forced medication in a community setting would be counter to a patient-centered approach. The bill language says that the plan should be prepared in consultation with, when possible, “those familiar with the individual, the superintendent or physician in charge of the care of the individual, or those familiar with the case history of the individual” (lines 46-48). Who is not expressly included on that list? The individual that would be subject to the order. We have a saying in the disability community “nothing about us without us.” Not involving the person who the plan is about in the development of the plan virtually guarantees that the plan will fail, because it does not respect the humanity and dignity of the person.

Massachusetts resources would be much better spent increasing access to supportive housing and other voluntary community treatment and support options, such as peer-run respites.

No Magic Pills

It is important to note that while psychotropic medications help some people, there are others for whom they are not helpful. The diagnosis and treatment of psychiatric conditions is not an exact science. It may take trial and error over time to discover an effective regimen. As with any medical condition, sometimes something that was once working stops working. Some people are accused of not taking their medication when in fact, it is a matter of their medication simply not working. Sometimes people develop adverse effects that require changes in medications. Psychotropic medications are powerful and can cause severe and irreversible side effects. It is therefore not unreasonable for an individual to refuse to take medication in accordance with a doctor's clinical recommendation. Failure to comply is not a psychiatric symptom or evidence of a psychiatric disorder.

Despite the fact that Connecticut does not have involuntary outpatient commitment, I had to comply with my psychiatrist's recommendations for treatment because my admission to practice law in Connecticut was conditional on my compliance with mental health treatment. I note for the record that neither Massachusetts nor New York subjected me to any such condition. For nine years, I had to submit an affidavit every six months saying that I remained compliant with treatment, and my psychiatrist had to submit a letter as well. I took the medications my psychiatrist recommended, even though they often did not work. I also attempted suicide several times during that time frame. Thankfully, I did not succeed. Eventually, the conditions on my admission were removed and I had true freedom to make choices about my psychiatric care.

Trusting and respectful relationships encourage sharing of these concerns and discussions of options. Forcing treatment encourages avoidance of treatment providers.

Discrimination

This bill singles out people with psychiatric disabilities for loss of self-determination with no proven benefits to them or to the public. I understand that there are some people whose conditions are difficult to treat and whose situations frustrate and worry their family members, treatment providers and judges. However, sacrificing the rights of many people to deal with a few complex situations, using an ineffective methodology, is wrong. It is also likely to increase health disparities. There is substantial evidence that involuntary outpatient commitment is used disproportionately against Black and Brown people.

International Law from the United Nations has found that forced psychiatric treatment may amount to torture.

I am someone who has been subjected to forced psychiatric treatment, including forced hospitalization, seclusion, restraint, and forcible medication. That intervention occurred more than 30 years ago. The trauma that resulted from that intervention still remains. It is not merely psychiatric survivors who say that forced treatment is harmful: The U.N. Special Rapporteur on Torture recently submitted a report on torture and other cruel, inhuman or degrading treatment or punishment. In paragraph 37 of the report, the following was noted (emphasis added)

37. **It must be stressed that purportedly benevolent purposes cannot, per se, vindicate coercive or discriminatory measures.** For example, practices such as involuntary ... psychiatric intervention based on “medical necessity” of the “best interests” of the patient (A/HRC/22/53, para.20, 32-35; A/63/175, para.49), ... generally involve highly discriminatory and coercive attempts at controlling or “correcting” the victim’s personality, behaviour or choices and almost always inflict severe pain or suffering. In the view of the Special Rapporteur, therefore, if all other defining elements are given, such practices **may well amount to torture.** (Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment - A/HRC/43/49, available at: https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session43/Documents/A_HRC_43_49_AUV.docx)

Conclusion: The Joint Judiciary Committee should reject this bill.

S 980 is titled as an act to provide critical community health services but doesn't make any allowance for the actual provision of those services. It sets up a structure by which a plan can be developed (apparently without the input of the person who would be subject to it) which someone would be supervising, and a mechanism to bring the individual into court if they do not comply with the plan. If Massachusetts needs additional critical community health services, this legislature should focus on setting up that service delivery system first and build it in a way such that people will want to engage with it. Setting up the mechanism to force people into an already over-burdened system is backwards. You already have a Roadmap for Behavioral Health Care and a mental health omnibus law passed in 2022. Do not divert money, resources, and workforce from the rollout of that plan by implementing S 980.

It is unconscionable that in a time when people cannot access community-based services because they are not available as a result of lack of funding that there would be a proposal to set up a system in which treatment is forced on someone who doesn't want it, and depends on monitoring and supervision by under-resourced and over-stretched agencies to ensure an individual subject to an order of involuntary outpatient commitment takes their medication.

This bill does not center the people who need access to services and supports. I can guarantee you, as a former patient, that the likelihood of establishing rapport and earning trust when treatment is coerced is next to nil. Forced outpatient treatment does not work better than or in the absence of an influx of voluntary community services. Evidence increasingly shows that acts that include force actually increase risk of suicide, violence, and other poor outcomes.

Unless and until people have a legally enforceable right to the community-based services and supports they need, and until the state adequately funds the agencies that provide the services and supports, this state has no business instituting involuntary outpatient commitment. Please reject this bill.