



STATE OF CONNECTICUT

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Testimony of the Office of Protection and Advocacy for Persons with Disabilities
before
The Joint Committee on Human Services

Presented by: James D. McGaughey
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Good morning Senator Doyle, Representative Walker and Members of the Committee. Thank you for the opportunity to comment on a bill that is quite important to our Office, and, even more importantly, thank you for raising it. I am referring to **Raised Bill No. 893, An Act Concerning Notification to the Office of Protection and Advocacy for Persons with Disabilities of Department of Mental Health and Addiction Services Client Deaths.**

As the title of the bill suggests, this legislation would require the commissioner of DMHAS to report deaths of people who are receiving inpatient psychiatric care to our Office.

As many of you know, our Office was established to safeguard the civil rights of people with disabilities, with a particular emphasis on protecting fundamental human rights. In addition to providing advocacy services, protection and advocacy agencies are authorized to conduct investigations, monitor conditions, review internal investigations and quality assurance data, and to review reports from peer review proceedings. An important aspect of this assignment involves reviewing and investigating the circumstances surrounding client deaths. As sad as this work is, it can yield useful information that directly leads to improved safeguards for others.

However, because our resources are limited, we cannot be constantly present in every environment where people are housed and receive treatment. In order to fulfill our responsibilities to people living in institutional environments – people who often feel isolated and closed off from the world - we need to receive reports about conditions or events that might raise questions about possible abuse, neglect or other rights violations. State statutes already require that we receive notification of serious injuries resulting from use of restraint and seclusion. Creating a similar mechanism to reliably notify us of deaths of DMHAS's inpatient psychiatric clients will better enable us to do our job.

Based on our discussions with DMHAS, I understand that that agency supports this measure as it applies to persons with psychiatric disabilities receiving inpatient behavioral health care services. However, the language in line 8 suggests that the death of a person with substance use disorders would also have to be reported. DMHAS objects to that language and we do not need it. So, I would respectfully request that it be deleted.

Again, I thank the Committee for raising this important bill, and urge you to act favorably on it.

I also wanted to comment briefly on two other bills on your agenda today:

Raised Bill No. 955, An Act Concerning Authorization of a Treatment Plan for a Child's Outpatient Psychiatric Counseling Services directs the Department of Children and Families to not require a child to authorize or sign his or her treatment plan when a parent or guardian has done so.

I understand that DCF's regulations currently require the child's signature, which can prove problematic when the child refuses to sign. As the statement of purpose suggests, requiring the child's signature can fuel an "atmosphere of discord between the guardian and the child which may inhibit needed treatment." No doubt, that is sometimes true. However, it has been our Office's experience that effective treatment usually requires taking some level of responsibility for one's own recovery, and that those who successfully provide help must observe a deep respect for the rights and personal autonomy of the individual being treated. This is no less true of treatment modalities for children - particularly older children - than it is of those geared toward adults.

Rather than simply directing the Department to not require the child's authorization when a parent or guardian has signed off, I would urge you to consider adding language to the effect that the Department "shall not require a child to authorize or sign a treatment plan for psychiatric or counseling services when the child's parent or legal guardian has authorized the treatment on the child's behalf and the treating clinician has documented specific reasons why, in the clinician's professional judgment, requiring the child to authorize or sign the plan would be detrimental to the child's progress in treatment."

Committee Bill No. 5416, An Act Concerning the Transition of Care and Treatment of Children and Youth from the Department of Children and Families to the Department of Mental Health and Addiction Services calls for the development of interagency agreements between DCF and DMHAS, the development of a pilot housing program and the establishment of various oversight and monitoring mechanisms. Based on our Office's experience working with a number of youth with psychiatric disabilities who are aging out of the DCF system, we support this effort to improve interagency coordination and successful transitions.

However, more is at stake than information sharing, referral processes and interagency planning. Some of the young people we have worked with were surprised to learn that they had been referred to DMHAS. Not having been consulted or informed, it is not surprising that they were not very interested in accepting adult services. Others who had formed trusting relationships with providers affiliated with the DCF system were dismayed to learn that they could not continue to see the same treaters once they had become clients of the adult service system. And then there are families that have sometimes been through quite difficult times seeking, and ultimately finding help from the children's mental health service system, only to learn that their son or daughter does not meet the eligibility requirements to get help from the adult system. So, the discontinuity between systems is more than about bureaucratic structure and communications processes - it also has a profoundly human dimension.

One way to minimize discontinuities, encourage participation in transition planning, and ensure that individual decisions are well informed, would be to empower people to participate in decisions and to raise complaints when something they don't think is right is about to happen to them. At several points the bill refers to hearing mechanisms through which an individual or family can contest decisions affecting eligibility, levels of service and the components of transition plans. DMHAS also has a comprehensive, multi-step client grievance policy. However, successfully navigating the steps of administrative grievance and hearing procedures can be a daunting task. Most people need help, especially if they are new to the process. To strengthen the bill, I would urge you to consider adding language requiring DCF to provide young people being considered for transition, and, where appropriate their families, with a list of advocacy services that can advise and assist them to participate in treatment planning, and to pursue inquiries, grievances and complaints.

Thank you for your attention. If there are any questions, I will try to answer them.