Judiciary Committee Public Hearing

S.B. No. 452 (Raised)

March 29, 2012

Hon. Robert K. Killian, Jr.

Judge of Probate, District of Hartford

First, may I express unequivocally, the tremendous respect I have for the Commissioner of the Department of Mental Health and Addiction Services and the outstanding job she and her colleagues have done over the past few years in converting our mental health programs from an undue reliance on inpatient treatment to a much-needed focus on outpatient services. The Commissioner was good enough to come to a meeting with me last week, also attended by many representatives of patient's advocates groups, to discuss the bill before this committee today. I must report to you that in a room full of people whom I have come to know over the past thirty years as thoughtful, caring and highly motivated advocates for their clients, I was a lonely voice in support of many of the provisions of this bill.

Allow me, Mr. Chairman, to put this into context. The Commissioner reported at that meeting, in response to my question, that approximately one-half of one percent of her client base faces hospitalization every year. Put in a positive light, that means 99.5% are not subject to involuntary confinement during the course of a year. I believe this bill is focused on the one-half of one percent representing the Commissioner's client base, together with other individuals, many of whom suffer from dementia and reside in nursing homes prior to their hospitalization, but who require a hospitalization to achieve a medical adjustment. Finally, I see a smaller number of people who are not DMHAS clients, but who enter the hospital as the result largely of family initiatives. What all of my customers have in common is the fact that they are in a hospital and do not want to be there or they are incapable of consenting to a hospital stay. This is an important sub-set, albeit a very small one, of the total population who have a psychiatric diagnosis and are in treatment for it. But, it is that part of the population with mental illness upon which we focus the most attention; upon whose lives we intrude most significantly; and upon whom we spend a disproportionately large amount of the capital committed to treatment of these illnesses.

My belief is that there are inadequate tools to address the very special needs of this very special segment of the mental health population. I'm over 29 years as a Judge. Unfortunately, during that extended tenure, I have come to know many of the clients who I see in commitment hearings on a first name basis, and generally know as much about their history as anyone in the room. Some of these clients, I see multiple times a year. Many have illnesses characterized by strong fixed delusions which often lead to bizarre community behaviors which bring them to the attention of the authorities or in an even smaller percentage of the population, lead them to engage in assaultive or suicidal behaviors. In virtually all of the cases that I see, forced medication is authorized, usually by the outside consultant Court bypass route, and mercifully, these individuals respond quickly and well to the reinstitution of medications and are discharged. Their rampant recidivism, however, is a function of the fact that upon their discharge from the hospital, they soon discontinue their medications, decompensate, and end up coming anew to the authorities' attention.

Now, to the bill.

There really are four changes inherent in this bill. One of them, the proposal to reduce the number of outside reports filed by Court-appointed physicians from two to one, I would characterize as procedural and insignificant, although reducing the cost of the commitment process by approximately 40%.

The second, the proposal to allow for hearings to authorize psychotropic medications to be held in a nursing home for patients currently residing there, I see as humanitarian and a huge cost saver. If a nursing home resident is refusing medication necessary for treatment of a physical condition, a conservator may be appointed to authorize the administration of such medications. The conservator can also authorize surgery, establish a patient's code status, even authorize amputation of a limb. But the conservator cannot authorize recommended psychotropic medications in a nursing home setting. Under current law, a conservator may be authorized to approve psychotropic medications if someone is in a hospital as opposed to a skilled nursing facility setting. This, of course, requires a Court hearing and the Court must specifically grant the authority to a conservator. A patient in a nursing home is transferred to a hospital for such medication decisions to be made. Particularly in the case of those who suffer a dementia, this dislocation can be extraordinarily troubling. Additionally, we have problems because nursing homes often take advantage of the discharge (to a psychiatric hospital) of an

un-medicated patient, who is often assaultive or aggressive, to justify a decision not to allow that patient to return from the hospital to the nursing home. I have no doubt that psychiatrists in nursing homes can authorize appropriate medications and that the psychiatrists and staff are capable to see to their proper administration and closely monitor the patient for undesirable reactions to the medication.

The third proposal is intended to address a glaring problem with our current practice, which, in the guise of patient's rights and confidentiality, hamstrings doctors and hospitals attempting to evaluate a patient and implement an appropriate treatment protocol. There is no question these are significant medications and there is no question that you don't want to administer one to which a patient has already demonstrated an adverse reaction or waste time trying a medication that proved ineffective in the past. Similarly, without talking to community supports, it is very difficult to develop the discharge plan which it is the duty of the hospital to develop starting virtually at the moment of admission.

Finally, and especially troubling for many who see little merit in any part of this bill, I have proposed what has, erroneously I submit, been dubbed an outpatient treatment provision which allows a conservator to approve psychotropic medications in the community for up to 120 days after an involuntary hospitalization. There is no question this is a significant limitation on the current right of a community-based patient to refuse medications. By the same token, for the patient who yo-yos back and forth between hospital and community, it holds the promise of extending significantly the time the patient will be in the community. I believe most psychiatrists will tell you that it takes significant time for most psychotropic medications to reach their maximum effectiveness. Hospital stays are short and growing shorter. That's good news. But, it means that the patient being discharged with the hope that they will continue their meds, long before the meds have developed maximum effectiveness for that patient. This would allow community caseworkers to arrange for a patient who is refusing medications to be required to take them either in their home setting or by transportation to an appropriate clinical setting.

There is no question that the patient's advocates took violent exception to this and to my surprise, the Commissioner also showed no enthusiasm for this. I understand that it flies in the face of the current best practices in mental health treatment to try to ensure voluntary compliance with a treatment protocol. But it is directed, remember, at a very small segment for

whom such voluntary support was not successful, resulting in an involuntary hospitalization and a discharge to the community in which necessary medications were immediately stopped. Over 80% of the states have adopted some form of outpatient commitment and what is proposed here is less extensive than virtually any of those states. I also understand that it will not totally eliminate recidivism nor will it keep people totally on their medications because there are limitations on forcible medication. However, I believe that for a significant percentage of this very small sub-set, it could dramatically extend the benefit of the hospitalization and increase the likelihood that there could be a community treatment plan that works for a much longer period of time.

Nothing creates greater problems for a mentally ill person than a psychiatric episode that brings the patient to the attention of authorities and results in an involuntary hospitalization. These are the situations that lead to evictions and housing is the nexus to community-based treatment. These individuals are those who have the most challenging housing problems, which, remember, our Courts also deal with under the conservatorship statutes.

If the resistance to this proposal is such that you determine not to report out a bill with this component in it, I hope you, just as I hope the U. S. Supreme Court on health care, will not choose to throw out the entire bill because you believe one part of it requires additional thinking. I would submit to you that the other three changes called for in this bill are worthy of your support, will benefit patients and will also achieve considerable resource savings and I hope such savings will be re-directed to other much-needed improvements in our community-based care system.