

CONNECTICUT LEGAL RIGHTS PROJECT
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JUDICIARY COMMITTEE

Testimony of Sally Zanger IN OPPOSITION TO S.B. 452
An Act Concerning the Care and Treatment of People with Psychiatric
Disabilities.

Senator Coleman, Representative Fox, members of the committee, I am a staff attorney with the Connecticut Legal Rights Project (CLRP), which is a legal services organization that advocates for low-income individuals in institutions and in the community who have, or are perceived to have, psychiatric disabilities. Part of our work is to advise and assist clients in matters regarding their rights to treatment and to refuse treatments and their rights under the Patients Bill of Rights. This bill adversely affects those rights by

1. Expanding involuntary medication of competent patients to the community and to nursing homes;
2. Permitting treating clinicians to communicate without permission with family members or other treaters;
3. Reducing the number of doctors required to file reports in involuntary commitment proceedings.

Privacy rights and rights to confidentiality

Connecticut has longstanding thoughtful protections of the confidential doctor patient relationship, in particular, psychiatrist/patient and psychologist/patient privileges. In the court context, this communication is privileged and whatever a patient says to a treatment provider cannot be repeated in court. Similarly, we protect the medical records, including psychiatric records, of all people, with limited exceptions.¹ We protect the privacy rights of all patients' medical information, to the extent that a hospital, any hospital, does not even confirm or deny that a person is a patient there without that person's permission. This is not always convenient, but it is a protection we have agreed is appropriate. There is no justification, other than discrimination, to deny that protection to a person being treated for a psychiatric condition. There is no justification for making an exception to this rule when a person is the subject of an involuntary commitment or involuntary medication proceeding and good reason to respect it if the ultimate goal is for a person in recovery to become able to work with his or her treatment team. This applies equally to respecting the right of all people to choose to share medical information with their family members or not, and to choose whether to share family members with their treatment team or not.

Due Process Rights

Involuntary commitment is a very serious intrusion by the state into the life and liberty of private citizens. Recognizing that, our commitment statute requires a court appointed attorney, two independent physicians, one of whom is a psychiatrist, and other

safeguards prior to involuntary commitment to a psychiatric hospital. Sometimes judges do not consider both reports and sometimes court appointed attorneys do not request that the examiners come to court. However, members of our staff attend probate court hearings in courts all over the state and find that it is not uncommon for the independent reports to disagree with the hospital that is petitioning for commitment or to disagree with each other. The diagnosis and treatment of psychiatric conditions is not an exact science, and the statutory standards are not crystal clear (what is gravely disabled??). It is never appropriate to reduce the safeguards to liberty.

Expansion of Involuntary Treatment

A Step Backward

Connecticut is in the forefront of mental health treatment with its system of community treatment and recovery oriented system of care. We have options available that include peer support, advance directives and housing first. Outpatient commitment as set out in this proposed statute is expensive and that money would be much better spent increasing access to supportive housing and other community treatment and support options.

Interferes with Recovery

Open and respectful relationships with treatment providers are key to recovery of individuals with psychiatric disabilities. Forcing treatment is the opposite of mutual respect and it interferes with open sharing of information that is essential to recovery.

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 working stops working. Sometimes people are accused of not taking their medication when in fact their medication just isn't working. Sometimes people develop side effects that require changes in medications. These medications are powerful and can cause severe and irreversible side effects. It is not necessarily irrational or a psychiatric symptom to refuse such medication; when an individual refuses to take medication, there are often good reasons. Trusting and respectful relationships encourage sharing of these concerns and discussions of options, while forcing treatment encourages avoiding treatment providers.

Discrimination

You would never be considering a bill that required cancer patients who are capable of giving informed consent to undergo chemotherapy or surgery, or obese patients with diabetes to undergo bariatric surgery. We would not legislate forcible injection of medication to lower their blood pressure or cholesterol into people who have high blood pressure or high cholesterol. Yet, both those groups of people, left untreated, have high risk of stroke and heart attack and are dangerous to themselves and others when driving cars. 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.

¹ Conn Gen. Stat. Sec. 52-146c et seq. There are exceptions for warnings of imminent danger, and similar to HIPPA, for subsequent providers of treatment (Conn. Gen. Stat. Sec. 52-146f). Notably in this context HIPAA permits disclosure without permission for treatment, but not for involuntary treatment, the use contemplated by this statute. See *Matter of Miguel M.*, 17 N.Y. 3d 37, 950 N.E. 2d 107:

“The treatment exception permits disclosure of protected health information “for treatment activities of a health care provider” (45 CFR 164.506 [c] [2]). “Treatment” is defined as:

“the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another” (45 CFR 164.501). “AOT—assisted outpatient treatment—is literally “treatment”—“the provision . . . of health care . . . by one or more health care providers.” But the thrust of the treatment exception is to facilitate the sharing of information among health care providers working together. We see no indication that the authors of the regulation meant to facilitate “treatment” administered by a volunteer “provider” over the patient’s objection. Disclosure for that purpose is a more serious invasion of privacy than, for example, the transmission of medical records from a patient’s primary care physician to a specialist—the sort of activity for which the treatment exception seems primarily designed. The treatment exception is inapplicable here.” *Miguel, supra* at 43, emphasis added.