



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

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Testimony by Dr. Michael Norko, MD
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Before the Public Safety and Security Committee
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Good morning Senator Hartley, Representative Dargan, and distinguished members of the Public Safety and Security Committee. I am Dr. Michael Norko, Director of Forensic Services for the Department of Mental Health and Addiction Services (DMHAS), and I am writing to express our concerns regarding **HB 6162 AN ACT CONCERNING INELIGIBILITY FOR A PERMIT TO CARRY A PISTOL OR REVOLVER OR AN ELIGIBILITY CERTIFICATE BASED ON A PRIOR HOSPITALIZATION.**

I would like to provide you with some background information that may be helpful to you as you make decisions in this area. In 1993, Congress required the creation of the National Instant Criminal Background Check System (NICS) for firearms transfers. Various categories of individuals were prohibited from being able to transfer firearms, such as those convicted of felonies. In addition, individuals were prohibited from firearms transfers for various mental health reasons when they had been: found not competent to stand trial, found not guilty by reason of insanity, or involuntarily committed to a psychiatric hospital or appointed a conservator of person or estate by a court order. The General Assembly directed compliance with NICS in 2005, including instructing DMHAS, the Department of Public Safety (now Emergency Services) and the Judicial Branch to enter into an MOU with the FBI regarding NICS reporting. That MOU became effective in November 2006 and since then we have provided this information as required without releasing protected health information to other agencies or the public.

HB 6162 expands the prohibition for a gun permit that is currently based on civil commitment by a probate court to hospitalizations that occur without any adjudication. The result would be that all persons hospitalized for psychiatric disabilities would be ineligible for a firearms permit, which would include voluntary hospitalizations and hospitalizations by physician emergency certificate. We believe there are multiple problems with this change.

First, it creates a public health problem. By including any psychiatric hospitalization in the prohibition, the change creates a barrier for individuals seeking hospital care for their mental health problems. If this change is enacted, notice will have to be given to any prospective patient about the effect on firearms permits as part of the informed consent process for voluntary hospitalization. Notice will also have to be given to all patients about the various new ways in which the information about hospitalization will be released without further consent from the patient. DMHAS has concerns about any legislation that though well intended, may create additional barriers to psychiatric treatment, especially when it may be most needed.

Second, it creates a logistical problem. The inquiry in 29-38b(a) by the Department of Emergency Services and Public Protection (DESPP) to DMHAS is only able to produce information about civil commitments because the probate courts are directed to notify DMHAS of all civil commitment orders in 17a-499. DMHAS does not receive information about civil commitments from hospitals. DMHAS is only aware of hospital admissions when they occur in DMHAS facilities. There is no existing infrastructure to produce reports from every hospital that provides inpatient services for psychiatric disabilities to DMHAS for every admission and no existing statutory requirement or even permission to do so. These admissions represent confidential and protected information, and nothing authorizes hospitals to provide this information, absent the patient's release of information, to anyone, except under specific circumstances.

Third, it creates a fiscal problem for the state and private hospitals. Even if statutes were created to permit or require the notification of all admissions to DMHAS, it would be burdensome for hospitals to produce those reports, and would require hiring of additional staff in DMHAS to receive and process that information. Connecticut has acquired more than \$600,000 in federal grant money to create a system to automate the one step of computerizing probate court records of civil commitments and conservatorships and uploading that data to DMHAS. There is no existing IT infrastructure to accommodate a similar development for all hospitals. It is difficult to even estimate the cost of trying to get all of those systems to communicate with DMHAS in an automated way to process this information.

Finally, it creates a perception of enhanced discrimination toward people with mental illness. The denial is based on a perceived danger represented by any person who has entered a psychiatric hospital for any reason without the need for any evidence of the person's actual dangerousness. This would also include individuals who voluntarily sought help and those who were hospitalized on the basis of a physician's determination at a single point in time that the individual needed to be in the hospital.

We also believe that it is problematic to target household members of those individuals who have been hospitalized for psychiatric care. If the real issue is the presence in the house of individuals who should not have access to firearms then why single out individuals with psychiatric disabilities when there may be just as much concern about someone in the home with any number of other concerns?

Thank you for your time and attention to this matter.