OLR RESEARCH REPORT

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OLR BACKGROUNDER: 2012 OUTPATIENT CIVIL COMMITMENT BILL

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This backgrounder summarizes Section 5 of SB 452, raised by the Judiciary Committee during the 2012 legislative session. This section of the bill, which was not voted out of committee, created a comprehensive outpatient civil commitment procedure for forcibly medicating people with mental illnesses who posed safety risks to themselves or others when they failed or refused to take medication prescribed to control their symptoms.

SUMMARY

Section 5 of Senate Bill 452 creates an outpatient forced medication protocol for soon-to-be released psychiatric patients in specified facilities whose symptoms can generally be controlled by medication but who (1) if mentally competent, withhold informed consent, as defined in the bill, to its administration or (2) have a history of failing to take it.

Under the bill, the outpatient commitment process begins prior to discharge when the facility director, or a designee, and two qualified physicians determine that a patient's history of refusing or failing to take medication falls into one of the above categories. The director may then file a Probate Court petition asking that a conservator be appointed and given authority to consent to the administration of the medication on the patient's behalf.

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The Judiciary Committee held a public hearing on the bill on March, 29, 2012. Probate Judge Robert K. Killian, Jr. was the only one of approximately 100 witnesses who spoke in its favor. Opposition focused principally on the bill's effect on patients' civil rights, interference with relationships between patients and their clinicians, conflict with the state's recovery-based approach to treating mental illness, likelihood of diverting funds and resources from the state's person-centered, recovery-based care approach; and its punitive and paternalistic features.

MEDICAL FINDINGS

The bill applies to patients in inpatient or outpatient hospitals; clinics; and skilled nursing facilities and others that diagnose, observe, or treat people with psychiatric disabilities. Before instituting a Probate Court action, the facility director or designee and two physicians must agree that (1) the patient has previously failed to take prescribed psychiatric medication or, if competent, refuses to give informed consent to its administration, (2) forced medication is the least intrusive beneficial treatment and (3) without it, the patient's psychiatric disabilities will continue unabated and threaten to place the patient or others in direct threat of harm. These determinations must be documented by objective medical and other factual evidence and indicate a high probability that the patient will inflict substantial harm on him- or herself or others if the condition goes untreated.

Under the bill, informed consent" means permission given competently and voluntarily after a patient has been informed of the reason for treatment, its nature and advantages or disadvantages, medically acceptable alternatives, the proposed treatment's risks and benefits, and risks associated with foregoing it. "Direct threat of harm" means that the patient's clinical history demonstrates a pattern of serious physical injury or life-threatening injury to him- or herself or others which is caused by the patient's diagnosed psychiatric disabilities.

PROBATE COURT FINDINGS

Once the threshold findings have been made, the facility head or designee may apply to the local Probate Court for the appointment of a conservator authorized to consent to the administration of psychiatric medication over the patient's objection. Before granting a petition, the judge must find, by clear and convincing evidence, that the patient falls within one of the two categories above and that medication is necessary for the patient's treatment. If the judge grants the petition, the resulting conservatorship can last up to 120 days.

MEDICATION ADMINISTRATION

Under the bill, the conservator may consent to the administration of forced medication if the discharged patient fails or refuses to take it. The medication must be administered in a manner and place that, in the prescriber's best judgment, is clinically appropriate, safe, and consistent with the patient's dignity and privacy. The bill authorizes the conservator to request that State or local police or a licensed ambulance service provider assist in transporting the patient to a designated location where the medication can be administered.

PUBLIC HEARING TESTIMONY

Favorable Testimony

Judge Robert Killian, who had requested that the Judiciary Committee raise the bill, was the sole witness to testify in its favor. In his view, a commitment that allows medication to be given in outpatient rather than inpatient settings is much less intrusive on a patient's (1) life, (2) employment and housing arrangements, and (3) relationships and interactions with family and the criminal justice system. He also pointed out that many states have adopted outpatient commitment laws and that medication administration in outpatient settings is much more cost effective than when administered on an inpatient basis.

Unfavorable Testimony

Approximately 100 witnesses testified in opposition to the bill. Groups represented included current and former psychiatric patients and their families, mental health professionals, and organizations advocating for the rights of those with mental illness. Two state agencies — the Department of Mental Health and Addiction Services and the Office of Protection and Advocacy for Persons with Disabilities — also argued against the bill.

The principal reasons advanced by the opposition were the bill's

1. substantial curtailment of psychiatric patient's privacy and liberty rights;

2. mandatory and coercive aspects that conflict with the state's adoption of recovery-based systems of care;

3. interference with the building of trusting, respectful relationships between patients and health care providers, which is essential for recovery;

4. punitive and paternalistic approach; and

5. potential to take resources away from recovery-oriented treatment planning.

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