



**PA 18-86**—sSB 404  
*Public Health Committee*

**AN ACT CONCERNING WHITING FORENSIC HOSPITAL AND CONNECTICUT VALLEY HOSPITAL**

**SUMMARY:** This act makes various changes affecting Department of Mental Health and Addiction Services (DMHAS) facilities, principally Connecticut Valley Hospital (CVH) and Whiting Forensic Hospital (Whiting). Specifically, it:

1. establishes an eight-member task force to, among other things, (a) review and evaluate DMHAS facility operations and conditions and (b) evaluate the feasibility of creating an Office of Inspector General to receive and investigate complaints about DMHAS hospitals (§ 1);
2. establishes mandatory reporting of suspected patient abuse at DMHAS-operated behavioral health facilities and related reporting requirements and penalties (§ 2);
3. requires the DMHAS commissioner to investigate reports of suspected abuse of behavioral health facility patients and establishes related requirements, such as disclosure of and access to patient abuse reports and investigations (§ 3);
4. requires the Department of Public Health (DPH) to conduct an on-site inspection and records review of Whiting by January 1, 2019, and report the outcome to the Public Health Committee and DMHAS facility task force (§ 4);
5. subjects Whiting to DPH licensure and regulation, which it was previously exempt from, and makes minor, technical, and conforming changes to reflect the hospital's separation from CVH pursuant to 2017 Executive Order 63 (§§ 5-53); and
6. repeals obsolete provisions in various DPH- and DMHAS-related statutes (§ 54).

**EFFECTIVE DATE:** Upon passage, except that the provisions on (1) mandatory reporting of abuse at DMHAS-operated behavioral health facilities take effect October 1, 2018, and (2) DPH's inspection and review of Whiting take effect July 1, 2018.

**§ 1 — DMHAS TASK FORCE**

The act establishes an eight-member task force to evaluate various matters concerning DMHAS facilities, including CVH and Whiting.

*Duties*

Under the act, the task force's duties include:

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1. reviewing and evaluating DMHAS facilities, including the operations, conditions, culture, and finances of CVH and Whiting;
2. evaluating the feasibility of creating an independent, stand-alone Office of Inspector General responsible for providing independent oversight of and receiving and investigating complaints about CVH and Whiting employees;
3. examining complaints and other reports of discriminatory employment practices at these hospitals, except information or documents that are not disclosable under the Freedom of Information Act (FOIA) or other state or federal confidentiality laws;
4. assessing the implications of allowing a Whiting patient to be present during a search of his or her possessions;
5. evaluating the membership of Whiting's advisory board;
6. examining the role of the Psychiatric Security Review Board;
7. evaluating the need to conduct a confidential survey on the employee work environment at CVH and Whiting, including worker morale; management; and incidences of bullying, intimidation, or retribution; and
8. reviewing statutory definitions of abuse and neglect in the context of behavioral health.

### *Membership*

Under the act, task force members include:

1. two appointed by the House speaker, (a) one of whom must be a behavioral health facility senior administrator and (b) one of whom must have experience in law enforcement, corrections, or working in a secured facility;
2. two appointed by the Senate president pro tempore, (a) one of whom must be a psychiatrist or psychologist with forensic experience and (b) one of whom must be a person who has lived with or experienced mental illness;
3. one appointed by the House majority leader, who must be a former or current administrator of a hospital with at least 200 beds;
4. one member appointed by the Senate majority leader, who must be a patient advocate;
5. one appointed by the House minority leader, who must have experience providing direct care services to people with behavioral health disorders; and
6. one appointed by the Senate minority leader, who must have experience providing hospital direct care services.

The appointing authorities must make all appointments no later than 30 days after the act's passage and fill any vacancies.

The act requires the chairperson to be selected from among the task force members, but it does not specify who makes the selection. The chairperson must schedule the first meeting to be held no later than 60 days after the act's passage. The Public Health Committee's administrative staff must serve as the task force's administrative staff.

The act also allows the task force, when completing its work, to hold a public

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forum that provides an opportunity for public comment.

### *Report*

The act requires the task force to submit to the Public Health Committee a (1) preliminary report on its findings and recommendations by January 1, 2019, and (2) final report by January 1, 2021. The task force terminates when it submits the final report or January 1, 2021, whichever is later.

### § 2 — MANDATORY REPORTING OF SUSPECTED PATIENT ABUSE

The act requires a person to report suspected abuse of a patient receiving services from a DMHAS-operated facility for mental health or substance abuse disorders (i.e., “behavioral health facility”) if the person is a mandatory reporter who, in the ordinary course of his or her employment, reasonably suspects a patient has:

1. been abused or is in a condition resulting from abuse or
2. had an injury that is at variance with the history given of the injury.

Under the act:

1. “abuse” means (a) the willful infliction of physical pain, injury, or mental anguish or (b) a caregiver’s willful deprivation of services necessary to maintain a patient’s physical and mental health and
2. “mandatory reporter” means a behavioral health facility (a) employee paid to provide direct patient care or (b) employee, contractor, or consultant who is a licensed health care provider.

The report must be made to the DMHAS commissioner, or her designee, within 72 hours after the suspicion or belief arose.

The act requires behavioral health facilities providing direct patient care to (1) provide mandatory training to mandated reporters on detecting potential patient abuse and (2) inform them of their obligations to report abuse.

Additionally, the act requires any other person having reasonable cause to suspect such patient abuse to report it to DMHAS in the same manner as the mandatory reporters. The DMHAS commissioner, or her designee, must then inform the patient or the patient’s legal representative of the services provided by Disability Rights Connecticut, Inc., the state’s protection and advocacy system.

### *Report Contents*

The act requires a patient abuse report to include (1) the facility’s name and address, (2) the patient’s name, (3) information on the nature and extent of the abuse, and (4) any other information the mandatory reporter believes may help the investigation of the case or the patient’s protection.

### *Report Confidentiality*

Under the act, a patient abuse report filed with DMHAS is not disclosable under FOIA. The DMHAS commissioner must disclose information derived from the report for which reasonable grounds are determined to exist after investigation, including the (1) facility’s identity, (2) number of complaints

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received, and (3) number and types of substantiated complaints. But the act prohibits her from disclosing the patient's name, unless the patient or his or her representative requests it or a judicial proceeding results from the report.

The act requires the commissioner, or her designee, to notify the patient's legal representative, if any, within 24 hours, or as soon as possible, after receiving a report of suspected abuse. The commissioner must obtain the legal representative's contact information from the facility.

Under the act, notification is not required if the legal representative is suspected of causing the abuse that is the subject of the report.

### *Immunity from Liability*

Under the act, a person who reports suspected patient abuse to DMHAS or who testifies in any related administrative or judicial proceeding is generally immune from civil or criminal liability. The act exempts from this protection perjury related to making the report, giving false testimony, or making fraudulent or malicious reports (see below).

### *Penalties*

A mandatory reporter who fails to report the abuse to DMHAS within the 72-hour deadline can be fined up to \$500. If the failure was intentional, the reporter can be charged with a class C misdemeanor for the first offense and a class A misdemeanor for any subsequent offense (see "Table on Penalties").

Additionally, a person is guilty of (1) making a fraudulent or malicious patient abuse report or (2) providing false testimony related to such a report if he or she:

1. willfully makes a fraudulent or malicious report,
2. conspires with another person to make a fraudulent or malicious report or cause such a report to be made, or
3. willfully provides false testimony in any administrative or judicial proceeding related to the patient abuse report.

Violators are guilty of a class A misdemeanor.

### *Whistleblower Protection*

Under the act, a person who is discharged or who is discriminated or retaliated against for making a patient abuse report in good faith is entitled to all remedies available by law.

## § 3 — PATIENT ABUSE INVESTIGATIONS

The act requires the DMHAS commissioner to investigate reports of suspected abuse of behavioral health facility patients she receives to determine the patient's condition and if any actions or services are required. The investigation must include:

1. an in-person visit with the patient,
2. consultation with individuals having knowledge of the facts surrounding the report, and
3. a patient interview, unless the patient refuses to participate.

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After completing the investigation, the act requires the commissioner to prepare written findings and recommended actions.

### *Investigation Results*

The act requires the commissioner, within 45 days after completing an investigation, to disclose its results in general terms to the person who reported the suspected abuse if the:

1. person who made the report is a mandated reporter (see § 3),
2. information is not otherwise privileged or confidential under state or federal law,
3. names of the witnesses or other people interviewed are kept confidential, and
4. names of the people suspected to be responsible for the abuse are not disclosed unless they were arrested as a result of the investigation.

### *Disclosure of Records*

Under the act, DMHAS must maintain a statewide registry of the number of patient abuse reports it receives, the allegations in the reports, and the outcomes of the resulting investigations.

The patient's file, including the original abuse report and investigation report, is not disclosable under FOIA. The act permits the DMHAS commissioner to disclose part or all of it to a person, agency, corporation, or organization if the patient or patient's legal representative consents to its disclosure in writing or the disclosure is authorized under the act. But it prohibits the commissioner from disclosing the name of the person who reported the suspected abuse, unless he or she provides written permission or a court order requires the name to be disclosed to a law enforcement officer.

### *Access to Records*

The act generally permits the patient, or the patient's legal representative or attorney, to access DMHAS records that pertain to or contain information or material concerning the patient. Such records include those on investigations; reports; or the patient's medical, psychological, or psychiatric examinations, except:

1. if it includes protected health information from someone other than a health care provider under the promise of confidentiality and the requested access would, with reasonable likelihood, reveal the information's source;
2. information identifying the person who reported the abuse, neglect, or exploitation cannot be released unless the patient or the patient's representative or attorney applies to the Superior Court, serves the application to the DMHAS commissioner, and a judge determines after a private records review and a hearing that there is reasonable cause to believe the person knowingly made a false report or that other interests of justice require the release;
3. if a licensed health care provider determines that the access is reasonably

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- likely to endanger the life or physical safety of the patient or another person;
4. if the protected health information references another person, other than a health care provider, and the requested access would reveal the other person's protected health information; or
  5. the access is requested by the patient's legal representative and a licensed health care provider determines, in his or her professional judgement, that the requested access is reasonably likely to harm the patient or another person.

### § 4 — WHITING FORENSIC HOSPITAL INSPECTION

The act requires DPH, by January 1, 2019, to conduct an on-site inspection of Whiting and a review of its records, including (1) the hospital's operating protocols and procedures, (2) documentation of employee training, (3) complaints against the hospital or its employees, and (4) allegations of patient abuse or neglect.

The act requires the DPH commissioner to report the outcome of the inspection and review to (1) the Public Health Committee and (2) the DMHAS facility task force (see § 1). The commissioner must do this within 30 days after completing the inspection and review.

By law, Whiting, under maximum security conditions, generally cares for patients with psychiatric issues, some of whom have been convicted of serious offenses or were found incompetent to stand trial.

### §§ 5-53 — WHITING FORENSIC HOSPITAL

In December 2017, the governor issued Executive Order 63, which designated Whiting as an independent division within DMHAS, instead of a division of CVH. The act effectuates the executive order by making various minor, technical, and conforming changes to reflect the hospital's separation from CVH.

As under prior law, Whiting remains under DMHAS administrative control and supervision. But the act subjects it to DPH regulation by adding Whiting to the statutory definition of health care "institution." In doing so, the act subjects Whiting to DPH hospital licensure, inspection, and complaint investigation requirements. Under prior law, state psychiatric hospitals were not licensed and were exempt from DPH regulation.

#### *DMHAS Control (§ 17)*

The act requires the director of Whiting to report to the DMHAS commissioner, instead of CVH's director of forensic services.

#### *Searches of Patients' Personal Belongings (§ 32)*

Prior law prohibited Whiting patients from being present when their personal belongings were searched. The act specifies that this prohibition applies only to patients in the hospital's maximum security service, and not those in other units.

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### § 54 — REPEALERS

The act repeals obsolete provisions:

1. requiring DMHAS to complete a consolidation program at CVH to consolidate inpatient mental and substance abuse services (CGS § 17a-451b);
2. substituting “Whiting Forensic Institute” for “Whiting Forensic Division” in various statutes (CGS § 17a-560a);
3. establishing an effective date for statutes on evaluating and treating certain individuals with psychiatric disabilities who commit crimes (CGS § 17a-576); and
4. establishing a behavior analyst licensing fee expense account within the General Fund to contain behavior analyst license fees to cover DPH staff and equipment costs for collecting the fees (DPH now funds the licensure program through its General Fund appropriation and no longer needs a dedicated account) (CGS § 20-185n).