Testimony of Judge Robert K. Killian, Jr.

Before the

Mental Health Services Working Group of the

Bi-PARTISAN TASK FORCE ON GUN VIOLENCE PREVENTION

AND CHILDREN'S SAFETY

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Several weeks ago, I was invited to participate in a panel discussion at the Institute of Living on "assessing Dangerousness." In preparation, I reflected on my involvement with the mental health community—doctors, therapists, social workers, clients and their families-- during the 29 years I have been privileged to serve as the judge of probate for the District of Hartford, Connecticut's largest probate district.

To my surprise, I learned that I have presided over just shy of seven thousand cases-- commitments, probable cause hearings, applications for medications against will or mandated ECT, conservatorships and placement hearings-- in which I have been called upon to assess dangerousness and determine if state intervention is appropriate.

Remember, the goal is to intercede only if a patient is dangerous to self in the sense of suicidality, dangerous to others in the sense of assaultiveness or homicidality, or gravely disabled in the sense that the respondent poses a serious threat to self by virtue of the inability to address basic human needs—food, clothing, shelter, medical treatment, safety.

Every hearing I hold is supported by medical testimony that one or more of these criteria exist. The caring professions take their obligation to force hospitalization or treatment only in extreme conditions. I know that I am there to protect individual rights and that I can legally only force hospitalization if I am satisfied by the highest civil standard, clear and convincing evidence, both that the patient harbors suicidal or assaultive intent or is gravely disabled and that treatment is not available in a less restrictive setting. Overwhelmingly, in perhaps 8 out of 10 cases, I concur with the judgment of the treating professionals who testify in support of continued hospitalization for those who are not among the significant population who they discharge even before the hearing is held.

Grave disability is the primary basis for hospitalization. Suicidality ranks second. Dangerousness to others is a distant third. The first two criteria are exercises of the state's parens patriae power: the power of the state to intervene for the best interest of its residents. The third criteria, while also imbued with the state's concern for the respondent, is also a civil exercise of the police power: the duty to protect society from those who would do harm to others.

May I make one more preliminary point: while those who are committed must meet one of these criteria, a very small subset of those with diagnosed mental illness are ever civilly committed. Most receive appropriate outpatient treatment or, if they require hospitalization, agree voluntarily to enter a hospital.

Unfortunately, the most concerning patients are among those I frequently commit, sometimes two or three times a year. These most troubled patients eschew outpatient help and often stop taking medicine shortly after their latest discharge from hospital. Their activities in society frighten family and neighbors and very often involve police who, mercifully, exercise their discretion to treat the matter as a mental health issue rather than one requiring incarceration.

Understand this: if the law requires me to determine the least restrictive environment for treatment, government's job is to insure that there are alternatives to hospitalization, which currently is the only venue in which non-cooperative, gravely disabled, dangerous mentally ill individuals can receive meaningfully beneficial treatment and that, my friends, means psychotropic medications.

When I started almost three decades ago, commitments lasted months. My first year, 1984, I had almost as many annual reviews—a review of hospitalizations that lasted a year or more—as I did new commitments. The average stay at the IOL, for example, was over 45 days. Now, I hear ten times the number of involuntary hospitalizations and last year had only one annual review. The average stay at the IOL, for example, is fewer than 7 days, well shy of the fifteen days which is the duration of a physician's emergency certificate and obviating in the majority of hospitalizations the need for a commitment hearing which takes at least ten days to schedule under the existing law.

So what's happened? In the overwhelming majority of the involuntary hospitalizations medications are instituted almost at once. Either the patient recognizes the need for meds or understands it's the shortcut to discharge. Those who refuse meds face an involuntary medication procedure either by an independent psychiatrist, who approve over 90% of the requests to medicate, or the much more cumbersome request to the court in which my colleagues report a slightly lower but statistically similar result. In short, in virtually every case for which involuntary hospitalization is sought, psychotropic medications are the sine qua non of treatment and the necessary precursor to a speedy discharge.

Virtually all beneficial meds have potential side effects. Even over-the-counter drugs carry warnings. Here are the warnings for ADVIL:

- chest pain, weakness, shortness of breath, slurred speech, problems with vision or balance;
- black, bloody, or tarry stools, coughing up blood or vomit that looks like coffee grounds;
- swelling or rapid weight gain;
- urinating less than usual or not at all;
- nausea, upper stomach pain, itching, loss of appetite, dark urine, clay-colored stools, jaundice (yellowing of the skin or eyes);
- fever, sore throat, and headache with a severe blistering, peeling, and red skin rash;
- bruising, severe tingling, numbness, pain, muscle weakness; or
- severe headache, neck stiffness, chills, increased sensitivity to light, and/or seizure (convulsions).

This is not intended to minimize the significant side effects often attendant to psychotropic meds. It is to illustrate that a risk/benefit analysis must be undertaken whenever we take meds.

Here's my hypothesis:

- Psychotropic medications are almost universally required for committed patients to be discharge.
- A significant subset of the most severely mentally ill—those who by history have multiple hospitalizations—are routinely non-compliant with meds in the community.
- Those who have serious, recurrent hospitalizations, all of which require a finding of dangerousness to self or others, are now routinely released after a matter of days or at most weeks while we engage in the legal fiction that they are no longer a danger to self or others even though all too many will stop meds, decompensate and shortly become dangerous again.
- These regular re-hospitalizations extract a terrible price on people who face loss of jobs, housing, family supports, community ties and continuity of treatment services.
- The current outpatient modalities don't reach these patients who end up living in shelters, being discharged from outpatient treatment programs, finding help only through civil commitments (which seem to spike in the frigid months) or the criminal justice system. (Some say the largest mental health treatment system is found in the Department of Correction and its facilities.)

This committee is engaged in a herculean task of defining a program that protects society, protects the civil rights of patients, and offers appropriate treatment options tailored to the needs of a population which currently runs from the well-served to ignored. There is no simple or single answer to any of the challenges facing these individuals or those who would serve them. Forty-five American jurisdictions have determined that one piece of the puzzle that can help this very troubled subset of our community, is what has come to be called "out- patient commitment" or "Mandated community medication."

Outpatient commitment is not an idea, it is a treatment system. It is as different as assisted living is from skilled nursing care and will only work if we support the concept with community treatment providers who are up to the challenge of dealing with very challenged individuals who heretofore have reached bottom only when they become hospitalized or jailed. It presupposes that the current strictures which allow forced medication only for inpatients, would also apply to a specially designated category of out- patients. Under my proposal, the following preconditions would pertain:

- Only an individual who within six months was found by a court to be dangerous and hospitalized or jailed as a result of activities determined to be related to severe mental illness.
- Only after a Court hearing in which a special limited conservator with special training about psychotropic meds and their impact on individuals by attending at least 6 hours of training approved by DMHAS and offered periodically, without charge, by the Office of the Probate Court Administrator.
- Only if a DMHAS approved service provider, of the skill level currently required to be able to order a patient's transport to an emergency department for a psychiatric review, sees the patient at least once a week.
- With a Court review mandated every six months for the program to continue for an additional six months with the continuation ordered only if the patient has refused medication at least three times for oral meds or once for deconoates during the previous six months.
- The substitution of an injectable medication only if there is a standby order from the medication provider.
- A mandatory transport to a hospital emergency department only if the special conservator or the service provider signs a transport order which states the existence of a current outpatient commitment order and observable clinical evidence of de-compensation such that the patient has deteriorated to less than a base level and that the patient has refused and is in need of meds and at least three doses of oral meds or one dose of injectable meds.
- The ED doctor or APRN may order the patient be admitted to a hospital for the reinstitution of meds without finding that the patient is currently a danger to self or others but must find that the patient is subject to an outpatient order and appears in need of medications.

These are significant services, but they mirror to a large extent the services currently offered to many recently released hospital admittees. They assist hundreds of patients to avoid re-hospitalizations and are, in many instances, the bridge to a good therapeutic relationship which can extend for months or even years. They reassure families and friends, landlords and neighbors that a mentally ill patient can be safely welcomed back into the community. They are costly, of course, but they are a fraction of the cost of hospitalizations. They are not a response to the horrors of Newtown, but rather they represent an opportunity to provide a needed service to an underserved small segment of our population.

Robert Frost, our New England sage, defined freedom as "moving easy in the harness." As a judge, I am frustrated that we have nothing to offer a severely mentally ill patient who has demonstrated dangerousness to self or others between forced hospitalization and a discharge to a community currently without any viable treatment program for the most troubled of them.