

Legislative History for Connecticut Act

HB 7288 P.A. 369 1993

Sen: 4336, 4350-4352 (4)

House: 4963, 6580-6581,
9073-9077 (8)

Judiciary - 2700-2702, 2706-2708,
2753-2758, 2801-2804, 2809-2811,
2820-2822, 2824-2828, 3018-3042 (52)
TOTAL 64

Transcripts from the Joint Standing Committee Public Hearing(s) and/or Senate
and House of Representatives Proceedings

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CONNECTICUT
GEN. ASSEMBLY
SENATE

PROCEEDINGS
1993

VOL. 36
PART 12
4089-4481

004336

MONDAY
June 7, 1993

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Calendar Item No. 600 is a Go, Calendar Item No. 601,
Substitute HB6416, I move to the Consent Calendar.

THE CHAIR:

Is there any objection in placing Senate Calendar
No. 601, Substitute HB6416 on the Consent Calendar? Is
there any objection? Hearing none, so ordered.

SENATOR DIBELLA:

Calendar Item No.603, Substitute HB7056, I would
move to the Consent Calendar.

THE CHAIR:

Is there any objection in placing Senate Calendar
603, Substitute HB7056 on the Consent Calendar? Any
objection? Hearing none, so ordered.

SENATOR DIBELLA:

Calendar Item No. 604, Substitute HB7288, I'd move
to the Consent Calendar.

THE CHAIR:

Is there any objection in placing Senate Calendar
604, Substitute HB7288 on the Consent Calendar? Is
there any objection? Hearing none, so ordered.

SENATOR DIBELLA:

On Page 8, Calendar Item No. 605 is a Go, Calendar
Item No. 606 is a Go, Calendar Item No. 607 is a Go,
Calendar Item No. 608, Substitute HB7135 I move to the
Consent Calendar.

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THE CHAIR:

Thank you very much, Mr. Clerk. The issue before the Chamber is Consent Calendar No. 1 for today, Monday, June 7, 1993. Mr. Clerk, would you please call the items that are on the Consent Calendar?

THE CLERK:

Madam President, First Consent Calendar begins on Calendar Page 3, Calendar No. 496, Substitute HB5199.

Calendar Page 5, Calendar No. 593, Substitute HB6664, Calendar No. 594, Substitute HB7200.

Calendar Page 6, Calendar No. 595, Substitute HB6036, Calendar No. 596, Substitute HB6627, Calendar No. 597, Substitute HB6860.

Calendar Page 7, Calendar No. 601, Substitute HB6416, Calendar No. 603, HB7056, Calendar No. 604, Substitute HB7288.

Calendar Page 8, Calendar No. 608, Substitute HB7135.

Calendar Page 9, Calendar No. 613, Substitute HB6822, Calendar 614, Substitute HB7163.

Calendar Page 10, Calendar No. 617, Substitute HB6072, Calendar 620, Substitute HB7207.

Calendar Page 12, Calendar No. 630, Substitute HB7119.

Calendar Page 13, Calendar No. 633, Substitute

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HB7272.

Calendar Page 15, Calendar No. 643, Substitute

HB6819.

Calendar Page 20, Calendar No. 178, SB836, Calendar
No. 201, Substitute SB1064.

Calendar Page 21, Calendar No. 280, Substitute

SB1053.

Calendar Page 23, Calendar No. 439, Substitute

SB838.

Madam President, that completes the First Consent
Calendar.

THE CHAIR:

Thank you very much, Mr. Clerk. You've heard the
items that have been placed on Consent Calendar No. 1
for today, Monday, June 7. The machine is on. You may
record your vote.

Senator Milner, Senator Fleming, Senator Upson,
Senator Crisco. Is Senator Crisco here? Have all
Senators voted and are your votes properly recorded?
Have all Senators voted and are your votes properly
recorded? The machine is closed.

The result of the vote:

36	Yea
0	Nay
0	Absent

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The Consent Calendar is adopted.

Mr. Clerk.

THE CLERK:

Calendar Page 2, Calendar No. 362, File No. 634,
Substitute HB5811, AN ACT PROHIBITING THE DEPARTMENT OF
PUBLIC UTILITY CONTROL FROM DENYING A PROJECT
CONCERNING OR CHANGING RATES AND CONDITIONS OF SERVICE
FOR THE SALE OF ELECTRICAL ENERGY OR CAPACITY BY A
SMALL RENEWABLE POWER PRODUCER TO A PUBLIC SERVICE
COMPANY, as amended by House Amendment Schedule "A".
Favorable Report of the Committee on Energy and Public
Utilities.

THE CHAIR:

Will the Senate please come to order and the Chair
will recognize Senator Peters.

SENATOR PETERS:

Thank you, Madam President. I move acceptance of
the joint committee's favorable report and passage of
the bill as amended in concurrence with the House.

THE CHAIR:

Thank you very much, Senator. Do you wish to
remark further?

SENATOR PETERS:

Yes, I do, Madam President. What this bill does is
require the DPUC to apply to any contracts filed after

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1993

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4778-5152

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House of Representatives

Thursday, May 13, 1993

CLERK:

Calendar 538, Substitute for House Bill 7288, AN
ACT CONCERNING PATIENTS' RIGHTS. Favorable Report of
the Committee on Judiciary.

SPEAKER RITTER:

Representative Luby.

REP. LUBY: (82nd)

I move that that matter be referred to the
Committee on Public Health.

SPEAKER RITTER:

So ordered.

CLERK:

Calendar 539, Substitute for House Bill 7238, AN
ACT CONCERNING SUSPENSION OF THE OPERATOR'S LICENSE OF
A PERSON RESPONSIBLE FOR A FATAL MOTOR VEHICLE
ACCIDENT. Favorable Report of the Committee on
Judiciary.

REP. LUBY: (82nd)

Mr. Speaker, I move that that matter be referred to
the Committee on Transportation.

SPEAKER RITTER:

Without objection, so ordered.

CLERK:

Calendar 541, Substitute for House Bill 7061, AN
ACT CONCERNING TRANSFER OF HAZARDOUS WASTE

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GEN. ASSEMBLY
HOUSE

PROCEEDINGS
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6521-6922

006580

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House of Representatives

Friday, May 21, 1993

Refer to the Appropriations Committee.

DEPUTY SPEAKER COLEMAN:

Motion is to refer to the Committee on Appropriations. Is there objection? If not, so ordered.

CLERK:

On Page 39, Calendar 536, Substitute for House Bill 7330, AN ACT CONCERNING THE AUTOMATION PROJECT WITHIN THE OFFICE OF THE SECRETARY OF THE STATE. Favorable Report of the Committee on Finance, Revenue and Bonding.

DEPUTY SPEAKER COLEMAN:

Representative Dillon.

REP. DILLON: (92nd)

Refer to the Appropriations Committee.

DEPUTY SPEAKER COLEMAN:

Motion is for referral to the Committee on Appropriations. Is there objection? Without objection, so ordered.

CLERK:

On Page 39, Calendar 538, Substitute for House Bill 7288, AN ACT CONCERNING PATIENTS' RIGHTS. Favorable Report of the Committee on Public Health.

DEPUTY SPEAKER COLEMAN:

Representative Dillon.

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House of Representatives

Friday, May 21, 1993

REP. DILLON: (92nd)

Refer to the Human Services Committee.

DEPUTY SPEAKER COLEMAN:

Motion is to refer to the Committee on Human Services. Is there objection? Seeing none, so ordered.

CLERK:

On Page 40, Calendar 547, Substitute for House Bill 6437, AN ACT CONCERNING SEXUAL ASSAULT. Favorable Report of the Committee on Public Health.

DEPUTY SPEAKER COLEMAN:

Representative Dillon.

REP. DILLON: (92nd)

Refer to the Committee on Government Administration and Elections.

DEPUTY SPEAKER COLEMAN:

Motion is to refer this item to the Committee on Government Administration and Elections. Is there objection? Seeing none, so ordered.

CLERK:

On Page 40, Calendar 550, Substitute for House Joint Resolution 12, RESOLUTION CONCERNING THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD. Favorable Report of the Committee on Government Administration and Elections.

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1993

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8782-9150

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House of Representatives

Monday, June 1, 1993

House Bill 5072, as amended by Senate "A"

Total number Voting 139

Necessary for Passage 70

Those voting Yea 139

Those voting Nay 0

Those absent and not Voting 12

SPEAKER RITTER:

Bill, as amended passes. Clerk, please continue with the call of the Calendar.

CLERK:

Calendar 538, on Page 30, substitute for House Bill 7288, AN ACT CONCERNING PATIENTS' RIGHTS. Favorable report of the Committee on Human Services.

SPEAKER RITTER:

The Honorable Representative Richard Tulisano.

REP. TULISANO: (29th)

Mr. Speaker, I move for acceptance of the Joint Committee's favorable report and passage of the bill.

SPEAKER RITTER:

The motion is on acceptance and passage. Please proceed, Sir.

REP. TULISANO: (29th)

Yes Mr. Speaker. Mr. Speaker, the bill before us,, is a bill that actually began a year ago, the last session of the General Assembly when both patients'

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House of Representatives

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advocates and members and representatives of the Department of Mental Health got together with regard to setting up some rules and the way medication, the other medical treatment decisions are made regarding both voluntary and involuntary patients.

Mr. Speaker, the Clerk has an amendment, LCO6968.

SPEAKER RITTER:

Clerk has amendment LCO6968 which I will designate as House "A". The Clerk can call it and Representative Tulisano has asked permission to summarize.

CLERK:

LCO6968, House "A" offered by Representative Tulisano.

SPEAKER RITTER:

Representative Tulisano.

REP. TULISANO: (29th)

Yes. Mr. Speaker, the amendment reflects language that in was addressed by the study group that came out with this bill. It was inadvertently left out of the language as it came out of committee.

It makes it clear that a patient advocate when getting information should not be employed by the facility and that the patient advocate has the right to discuss who that person would be, with the facility.

It changes language from cross examination so it is

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less of a formal hearing to questioning of witnesses.
it makes other technical changes in the language which
I move for adoption of the amendment.

SPEAKER RITTER:

The question is on adoption. Will you remark
further? If not, I will try your minds. All those in
favor, say Aye.

REPRESENTATIVES: (Aye)

SPEAKER RITTER:

Opposed, nay. House "A" is adopted and ruled
technical.

Representative Tulisano.

REP. TULISANO: (29th)

I think there is another amendment. LCO6948.

SPEAKER RITTER:

Clerk has amendment LCO6948 which will be
designated as House "B". He may call it and
Representative Tulisano would like to summarize.

CLERK:

LCO6948, House "B" offered by Representative Ward.

SPEAKER RITTER:

Representative Tulisano.

REP. TULISANO: (29th)

This just adds not to what the treatment or the
risk associated with receiving the proposed treatment

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that has to be explained. I move its adoption.

SPEAKER RITTER:

The question is on adoption. Will you remark further? If not, I will try your minds. All in favor say Aye.

REPRESENTATIVES:

Aye.

SPEAKER RITTER:

Opposed, Nay. House "B" is adopted and ruled technical. Anybody else care to comment on the bill as amended? If not, staff and guests come to the well of the House. The machine will be opened.

CLERK:

The House of Representatives is voting by roll.
Members to the Chamber, please. The House is voting by roll. Members, to the Chamber.

SPEAKER RITTER:

Have all the members voted? Please check the roll call machine and make sure your vote is properly cast. The machine will be locked and the Clerk will take the tally.

Clerk, please announce the tally.

CLERK:

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House of Representatives

Monday, June 1, 1993

House Bill 7288, as amended by House "A" and "B"

Total Number Voting	143
Necessary for Passage	72
Those Voting Yea	143
Those Voting Nay	0
Those absent and not Voting	8

SPEAKER RITTER:

Bill as amended passes. Clerk, please continue the call of the Calendar with 528.

CLERK:

Calendar 528 on page 30. Substitute for House Bill 7200, AN ACT CONCERNING THE ENHANCEMENT AND COST EFFECTIVENESS OF THE HEARING PROCESS FOR THE COMMISSION ON HUMAN RIGHTS AND OPPORTUNITIES. Favorable report of the Committee on Appropriations.

SPEAKER RITTER:

Representative Cam Staples from the 96th. You have the floor, Sir.

REP. STAPLES: (96th)

Thank you, Mr. Speaker. Mr. Speaker, I move acceptance of the Joint Committee's Favorable Report and passage of the bill.

SPEAKER RITTER:

The motion is on acceptance and passage. Please proceed, Sir.

JOINT
STANDING
COMMITTEE
HEARINGS

JUDICIARY
PART 8
2561-2962

1993

REP. TULISANO: There are no Brad Davis' here. I've known him for years; I don't see him. His name is here. It must be a surprise. I bet you got a ghost writer.

Go ahead. He is a ghost writer, what the heck to you think. Also violates the rules.

Madam.

ELINOR BUDRYK: Hi.

REP. TULISANO: Go ahead.

ELINOR BUDRYK: My name Elinor Budryk.

REP. TULISANO: Thank you.

ELINOR BUDRYK: Truly. I represent the office of Protection and Advocacy with persons with disabilities. We have a division; the protection and advocacy for individuals with mental illness. We are speaking in favor tonight on HB7288 AN ACT CONCERNING PATIENT RIGHTS.

We have been collaborating for about 5 years and the last with the .. at the request of Representative Tulisano on trying to clean this bill up and make it nice and tight; give protections to people who do not have them; involuntary patients.

REP. TULISANO: Right.

ELINOR BUDRYK: Mental institutions can, at this moment, be forced to take medication.

We are writing patient rights bill that will allow them to give informed consent before they are medicated with the exception, again at the request of Representative Tulisano, of those patients who are competent but dangerous but need protection.

REP. TULISANO: You wouldn't allow people who are competent and dangerous to do what ever they please anyway?

ELINOR BUDRYK: We allow people ...

REP. TULISANO: Just wondered.

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ELINOR BUDRYH: We would allow people who are competent but dangerous and need protection.

REP. TULISANO: You would allow people who are competent and dangerous to do what ever they please anyway?

ELINOR BUDRYH: We would allow people ...

REP. TULISANO: Just wondering.

ELINOR BUDRYH: We would allow people who are competent but dangerous to be medicated under certain conditions.

REP. TULISANO: Make it sound like it's just me.

ELINOR BUDRYH: In fact we are very concerned and we were very concerned all along about that issue and we are offering, attached to our testimony, an Amendment that is .. tries to protect those patients as much as possible.

SUSAN WERBOFF: Well, the reason why we generally support the proposed legislation is for a number of reasons. It provides an opportunity for involuntary patients to refuse medications. It encourages an internal appeal process as well as the patient has the right to appeal medication to probate court.

REP. TULISANO: Last year, we left one day. You worked with psychiatrist, Department of Mental Health, Protection of Advocacy, all the knottings yes?

SUSAN WERBOFF: Yes.

REP. TULISANO: Everybody is on board?

SUSAN WERBOFF: What?

REP. TULISANO: What don't you agree on.

ELINOR BUDRYK: There were three things that were changed in the drafting.

REP. TULISANO: Okay.

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ELINOR BUDRYK: There were others but there were three that we are concerned about and we put them in the testimony.

REP. TULISANO: Okay.

ELINOR BUDRYK: And than there is one major piece we call the competent but dangerous patients in the bill that you all have significant risk of harm and we changed that in an Amendment we would like you all to put on to direct threat.

REP. TULISANO: Everyone on board this Amendment?

ELINOR BUDRYK: Yes.

REP. TULISANO: Not just PA.

ELINOR BUDRYK: No. No. No. Psychiatrists, DMH are on board.

REP. TULISANO: Okay. Thank you.

SUSAN WERBOFF: That's it.

REP. TULISANO: I understand the bill from last year. We know where we are at. Okay. Thanks.

Faith Arkin. Faith Mandell please. Oh. Just for fun Faith.

FAITH ARKIN: You can call me whatever.

REP. TULISANO: I know.

FAITH ARKIN: Good evening. My name is Faith Arkin. I appear before you on behalf of Judicial Branch.

I 'd like to speak very briefly on two bills. I have submitted written testimony but would just like to highlight our position.

The first bill substitute SB1008 AN ACT CONCERNING HEALTH INSURANCE FRAUD.

I'd just like to limit my comments to section 4 of the bill which requires the court to notify the

REP. TULISANO: Representative Garcia.

REP. GARCIA: Thank you. Okay. I have a question. Doesn't the court appoint now in cases where there is to be determined whether the person is .. has a mental disability when they bring in expert witnesses; psychologists or people from DMR?

FAITH ARKIN: There are certain provisions within or certain proceedings with the Judicial Branch that the Judicial Branch is obligated to pay for certain professional "services".

In defense, for example, the attorney; a lot of times it's the public defenders office, and the criminal which is not part of the budgetary aspect of this Judicial Branch, with regard to doctors and some guardian proceedings we do assume the costs. So we are not saying we cannot, we are justing saying we would need funding.

REP. GARCIA: Okay. Thank you.

FAITH ARKIN: Thank you.

REP. TULISANO: Representative - Ken Marcus, DMH .. I skipped you and I'm sorry. I apologize.

KEN MARCUS: That's all right.

Hello. Senator Jepsen, Representative Tulisano and members of the Judiciary Committee, the Department of Mental Health supports HB7288, AN ACT CONCERNING PATIENTS' RIGHTS. Representative Tulisano, you've already indicated familiarity with the major issues involved with the bill. I don't think it's necessary to go over some of the details unless you have or anyone else has specific questions about them.

From the Department of Mental Health's point of view, we'd like to emphasize that the bill painstakingly balances patient's medical and liberty interests with the public's right to an appropriate degree of safety and security. Given the rigor of the procedural safeguards provided, we feel that any adjustment in the criteria or process established within the framework of this bill for administering medication to either a

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competent or incompetent patient who is dangerous and refusing medication would tilt this balance significantly in the direction of placing the public considerably at risk.

Attached to the testimony are several vignettes which illustrate this point. Really the controversial issue in all of this is the competent but dangerous.

REP. TULISANO: That's the first time we had that word this year.

KEN MARCUS: The first time what?

REP. TULISANO: We had vignettes this year.

KEN MARCUS: Vignette. We figured we could only, they would involve too much time going into here, but we thought that it would usefully illustrate the kinds of issues that are involved with a competent person who one still thinks might be dangerous.

REP. TULISANO: Did you review the amendment proposed amendment?

KEN MARCUS: Yes.

REP. TULISANO: That was prior was referred to?

KEN MARCUS: Yes, and we agreed with it.

REP. TULISANO: In prior testimony. You agree with it?

KEN MARCUS: Yes.

REP. TULISANO: ...on board?

KEN MARCUS: Yes.

REP. TULISANO: Is that one year study again? Last year over to this year year sat down with DNA, okay?

KEN MARCUS: Everybody's signed on.

REP. TULISANO: Is everybody equally unhappy? I guess that's the real clue.

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KEN MARCUS: Actually what was good about this was that everyone is actually equally happy.

REP. TULISANO: Happy?

KEN MARCUS: We really felt as though, with one exception.

REP. TULISANO: Okay, that's what I want to know.

KEN MARCUS: Okay, and you'll hear the exception, but everyone who stayed in the process is happy and it involved the balancing really of different values and different interests. I think protection and advocacy and us and the Connecticut Psychiatric Society really started out at different points, and we've worked our way together.

REP. TULISANO: Okay. Thank you. Any questions? Anybody? Okay, thank you.

KEN MARCUS: Thank you.

REP. TULISANO: It's one minute before eight so we have, so the public will lose two minutes. No, they won't lose two minutes, we'll just stay two minutes later. Representatives Mikutel and Simmons are here before the 8 o'clock deadline and next on the list. Please together, I understand.

: 7 o'clock.

REP. TULISANO: 7 o'clock, I mean. Yeah, listen. I'm on the wrong schedule again. The hour to which, the bewitching hour we have to shift.

REP. MIKUTEL: Greetings, Senator Jepsen and Representative Tulisano.

REP. TULISANO: He's not here again, don't worry about it.

REP. MIKUTEL: Members of the Judiciary Committee, I want to thank you first of all for raising the bill for a public hearing. For the record, I am Representative Mikutel from the 45th District. In 1989 a 7 year old boy was forced off his bicycle in the woods near his home in Tacoma, Washington. The

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ATTY. BRUCE STURMAN: The law says that by virtue of mental disease or defect, if you're incapable of conforming your conduct or appreciating the wrongfulness, that's not guilty defense by reason of mental disease or defect.

REP. RADCLIFFE: So under this definition if we place such a definition in our statutes, then someone could comply with the definition or conform to that definition, it might make it impossible for the state to prosecute them, wouldn't it?

ATTY. BRUCE STURMAN: If I had a case, I'd probably consider that defense I'm sure.

REP. RADCLIFFE: I'm sure you would. Thank you.

SEN. JEPSEN: The next witness is Edward Mattison. Let me observe at this time, at the end of Mr. Mattison's testimony, we will switch over to the one half hour presentations by the insurance industry and the trial lawyers' respectively, and let me further observe that our public hearing notice says we will terminate this at 10:30. That is only a slightly loose standard. What that means is that some people who have signed up will not be able to testify, and this always gets some people pretty unhappy. I will, if anyone has any questions as to where they are on the signup list and the likelihood that they will be called, they are welcome to direct their questions through the staff to us. Let me also say, that's enough. Thank you. Why don't you proceed?

EDWARD MATTISON: Thank you. Ladies and gentlemen, my name is Edward Mattison. I am the director of the Connecticut Legal Rights Project. We're the officially recognized legal aid agency for the patients and the state mental hospitals and other facilities. I'm here to talk to you about HB7288.

We very much support the idea of regularizing the procedure for involuntary medication. Right now we're in a sort of legal no man's land. It's clear that the state, the current state laws are unconstitutional and we have been unable to agree upon a replacement. The Committee that you have

heard about has worked very hard to come up with an alternative to the current chaos, and we certainly supported this idea.

With the suggested amendments tonight, we are down to one issue between the advocates at least some of the advocates for patients and some of the people who have to run hospitals. I would ask by the way, the next scheduled speaker is the representative of the Psychiatric Society, and it might make sense if you could to hear from him for a minute since he's going to be the opposite of my testimony.

The issue is who gets to decide on force medication. That is the only remaining issue between us. We have worked out everything else. The concern, I'm also speaking for the Civil Liberties Union also, an their concern and my concern is that especially when you're talking about potentially dangerous people, there seems an obvious and inherent conflict of interest to have the hospital staff decide whether somebody should be medicated.

Our fundamental goal is simply to have a neutral person make that factual decision. Now the obvious neutral person in Connecticut are the probate judges who are used to this type of decision and so we have given you a suggested alternative statute which for all intents and purposes is not significantly different from the one given to you by the Department of Mental Health except in that one area. It requires that if they want to medicate somebody and it's not an emergency, then they have to file a probate petition.

In the interim, if necessary they can go through an administrative procedure to medicate him pending a decision of the court. That's the opposite of the way the bill is presently written. It has an administrative procedure and then the person can appeal to court. We think that's a very critical difference and most states which have faced this issue have chosen the court route.

SEN. JEPSEN: Thank you. Are there any questions?
Representative Jarjura.

REP. JARJURA: Have you discussed this with the probate court administrators and the probate court judges, your proposal?

EDWARD MATTISON: We have talked to the probate court judges who deal with the cases, the major cases of the state hospitals, and the number which we suggest which was 15 days was one that was acceptable to them. We don't think the number of cases would be very large whichever proposal was adopted.

We have an interim policy that we worked out with the Department of Mental Health that calls for the appointment of a conservator in these cases, and we've had in the past two years, we've had six conservators appointed, so it's not, we're not talking about overloading the courts whichever proposal this body chooses to adopt.

REP. JARJURA: Thank you. Thank you, Mr. Chairman.

SEN. JEPSEN: Further questions. Thank you.

EDWARD MATTISON: I did ask. Yes. Could you hear from the Psychiatric Society for a moment?

SEN. JEPSEN: In the interest of democracy, small d, we'll ask you to come up and rebut briefly, and if anyone asks you a question, you have to respond in monosyllabic.

DR. HAROLD SCHWARTZ: I'll try. Thank you, Senator Jepsen. I appreciate your fitting me in. I'm Harold Schwartz. I'm the Chairman of the Legislative Committee of the Connecticut Psychiatric Society and Director of the Department of Psychiatry at Hartford Hospital and Associate Chairman of Psychiatry at the Medical School, University of Connecticut.

I just want to say that there actually are significant differences I believe in our position from that which Mr. Mattison just proposed and I want to emphasize that a number of parties sat down at a table following Representative Tulisano's direction over the course of the last year and that included the Psychiatric Society, the Department of Mental Health, the Protection and Advocacy Agency

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and Connecticut Legal Rights represented by Mr. Mattison, and came to an agreement that we thought balanced patients' rights versus needs for treatment which was not an easy feat to do, and three of those four parties are in support of the bill which the Department of Mental Health presented in the form that it currently exists with some modifications requested by the Protection and Advocacy Agency, which have been put before you.

It makes a big difference. One of the critical issues with involuntary treatment is whether each and every decision to involuntarily treat a patient must be made by a court of law or whether there are certain circumstances in which a clinical administrative decision can be made. Our bill struck a balance. It allowed for administration of medication after a rather rigorous but internal clinical administrative procedure of patients who are involuntary and incompetent for up to 15 days, excuse me for up to 30 days.

However, once that decision was made and the patient was medicated, the bill would allow patients to seek judicial review and that judicial could be within 15 days, so if patients can be medicated according to this bill for a maximum of 15 days without judicial review, we think that's a reasonable balance. I would add that in every state that requires judicial review of the decision up front every study that has ever been done indicates that the overwhelming majority of such patients are medicated by judicial order, but there's a lengthy period of time.

In some states in study performed in Massachusetts, the average period of time between the decision to medicate involuntarily and the court decision was five months, five months of extended hospitalization, of disruption of the hospitalization, of other patients before getting the court where the decision almost uniformly follows the original recommendation of the hospital medical staff.

This bill would also allow the treatment of a very, very small number of treatment refusing patients who are felt to be competent to refuse treatment. We feel that that very small number is defined by

strict standard of dangerousness and that that balances society's need to protect the individual and society, the patient's need for treatment with the obligation to protect the patient's autonomy.

SEN. JEPSEN: Could you move to summarize if you're not. Questions at this time.

REP. TULISANO: Can I ask you a question about another bill?

DR. HAROLD SCHWARTZ: Yeah.

REP. TULISANO: Committing civilly you have to be dangerous to yourself or others?

DR. HAROLD SCHWARTZ: Yes.

REP. TULISANO: Any other standard?

DR. HAROLD SCHWARTZ: You have to be mentally ill.

REP. TULISANO: Mentally ill? We have language mental abnormality or personality disorder. Does that fit any definition of mental illness that you know about in Connecticut or anywhere else?

DR. HAROLD SCHWARTZ: No. No, it does not, and it threatens to create a new standard for the definition of mental illness which would be based on a pattern of criminal acts. There's a taughtology there in that definition which would almost says that if an individual repeatedly commits this kind of criminal act by definition, that individual is mentally abnormal, and it is an attempt it seems to me to throw badness into the camp of madness and make criminal offenses matters for psychiatric care.

REP. TULISANO: Badness into madness? Say it again for us. Badness into madness? I like that, but. It sounds good.

DR. HAROLD SCHWARTZ: It seems to me it's an attempt to take behavior that is criminal and a moral issue and to medicalize it and to say that these acts are also bad, but they must be sick. They must be evidence of mental illness, and it doesn't meet any known criteria of mental illness. Now there

certainly is, which is not to say that some repeat sexual offenders are not mentally ill. Some certainly are, but some certainly are not.

REP. TULISANO: And if they are mentally ill and they are dangerous to others, can we commit them under current statute?

DR. HAROLD SCHWARTZ: You could do that, yes.

REP. TULISANO: Thank you.

SEN. JEPSEN: Further questions. Representative O'Neill.

REP. O'NEILL: Do we do that? Do you know of cases where we've actually committed people who committed sexual crimes and have been determined to be mentally ill?

DR. HAROLD SCHWARTZ: I don't myself know. I tend to think that we don't frequently do that if it gets done, but I really don't.

SEN. JEPSEN: I think we'll have to ask if you want to trade information why don't you do it outside, but apparently somebody does know of one or more cases of that. Further questions. Thanks. We're going to move into our panel portion. Before I suggest the ground rules of the panel, let me say for those who are worried about not being given the opportunity to testify because of the lateness or their position on the list, two things.

One, everyone is entitled to present written testimony even in the form of a letter. It will be considered. The second thing and this is what we did with our psychologist and psychiatrist last week. If it becomes clear and I think this is likely the case that one significant group of people that have signed up to testify will be excluded because of their collective position on the list, I will very late in the hearing at or around 10:30 allow a handful, one or two people from the group to testify.

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With the bill just proposed, there will be two types of insurance coverage making the insurance purchaser more confused. There is a provision that an agent or a seller of a policy will have no liability if the buyer discovers that the insurance policy sold to him does not meet his or her protection needs. I cannot imagine a more misguided policy. There will be no incentive to provide the best policy, but the most saleable policy for consumers.

Again, the taxpayer will pick up the medical and future needs of the program bill for the catastrophically injured. I have included in this report a chart at the back on the cost of traumatic injury. It is about seven years old. It will show you what it will cost the taxpayers if the people do not have the insurance that they need and I think that rise in number of accidents in the State is going to make this figure very, very large for the taxpayers.

REP. TULISANO: Thank you. Questions? Thank you very much. Yvette Sangster. Sorry if I mispronounce your name. And then, is Barry Kolar still here? That's a pass.

YVETTE SANGSTER: My name is Yvette Sangster. I am the Chairperson of the Advisory Council for the Protection and Advocacy for Persons with Mental Illness.

PAMI's Advisory Council is charged with the responsibility to advise the system on policies and procedures to be carried out and protecting and advocating for the rights of those individuals. The Advisory Council strongly supports the inherent right of a person with mental illness to be guaranteed the exact same rights as their brothers and sisters in our society.

Our clients are not sub-humans hidden away in institutions but are our friends and our relatives who while being treated in facilities, are entitled to the commonly accepted rights and dignity. In accordance with these principles we opposed the present draft of HB7288, AN ACT CONCERNING PATIENTS RIGHTS and the Commissioner's policy regarding the involuntary administration and medication to

patients in non-emergency circumstances. Both the proposed legislation and the policy deny rights to persons with mental illness that are accorded to every other member of society. In essence, of the proposed legislation is to force psychiatric medication upon a person with the competency to make a decision not to receive it.

It is important to recognize that people that are medicated are being held down and injected with this medication. The side affects of these medications are well documented and grave and permanent consequences result. Persons experience swelling of tongues, slurred speech, tightening of muscles, sexual dysfunction and permanent neurological damage.

In our society which is founded upon individual freedom and the freedom of choice regarding medical decisions, the decisions of a competent person to avoid these side affects must be given respect. While the proposed legislation policy is attractive to those members of the general public who cry out for protection against dangerous mental patients, the proposed legislation and policy does not address the issue and establishes a frightening precedent.

Under this present system in the institutions, patients who are presenting an emergency situation may be forced medicated in order to protect themselves and others. On the other hand, if the proposed legislation is passed, the General Assembly will establish the precedent that non-dangerous, competent people may be forced medicated because the law thinks that is the good thing to do.

If we wish to operate under this standard, then we must force cancer patients to take chemotherapy, diabetics to take their insulin, heart patients to accept bypass surgery.

In summary, we adamantly oppose the proposed legislation and policy in its present form. Our organization is created because Congress found that our clients were vulnerable to abuse and serious injury and are subject to neglect. The proposed legislation and policy would be opening the door to

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institutions returning to documented history of abusing patients and taking away their basic rights and dignity. Thank you.

REP. TULISANO: Representative Jarjura.

REP. JARJURA: As I understand the bill, it is limited to involuntarily committed patients?

YVETTE SANGSTER: No.

REP. JARJURA: No?

YVETTE SANGSTER: No it is not. It is all patients.

REP. JARJURA: It is all patients? If somebody is a patient out of control and you are suggesting that we not medicate?

YVETTE SANGSTER: Presently, your statute already protects the staff and others by the statute that is on the books that says a person who is in imminent physical danger, may be medicated against his will.

No, we are not suggesting that a person that is dangerous at the moment cannot be medicated.

REP. JARJURA: Well, then what is this bill doing?

YVETTE SANGSTER: A non-emergency situation where a person comes into a hospital and has a history of violence to self or others though not in an emergency situation at the moment, they can make the choice or we predict that this person is going to become dangerous, so we are going to medicate him now, rather than wait. That is taking the rights of an individual completely out of his hands.

REP. JARJURA: Would you support maybe putting him into a restraint at that point or no? You would have to wait for him or her to ...

YVETTE SANGSTER: You would have to have some kind of sign. The thing that is really upsetting about this bill is that there is no real way of having any kind of system to be able to appeal it. You have an internal appeal process. What is that?

That is the doctors telling you that you are going to agree with this. That's what that is. There's no outside opinion. There's no kind of judicial type of person that is outside saying okay, let's look at this in a realistic way. Giving both sides equal weight. Having a doctor and medical mind in thinking, telling another doctor, medical mind of thinking -- yeah, this guy looks he might do this. Let's put our crystal ball out and do it.

REP. JARJURA: Thank you.

REP. TULISANO: Nancy Sanotto? Sally Macha, Margery Cohen. Peter Schultheis. Lydia Tibbels.

LYDIA TIBBELS: Good evening. My name is Lydia Tibbels and I am here tonight because I am in favor of HB7284, the ACT CONCERNING SEXUALLY VIOLENT PREDATORS. I work with a girl whose name is Stacy McEwen. Her aunt was murdered by Michael Ross.

Stacy wrote a letter which she wanted me to read to you. She could not appear here tonight because the subject is never forgotten and too traumatic for her to speak about in public.

Now, if I can't read the letter, I have a statement to make myself.

REP. TULISANO: Inaudible.

LYDIA TIBBELS: No, I haven't. I didn't realize when I came down they couldn't so I wrote something myself.

REP. TULISANO: (Inaudible - not using microphone)

LYDIA TIBBELS: Well, I am. I also supplied the letter for everyone to read.

REP. TULISANO: That's great.

LYDIA TIBBELS: If I cannot read this letter, I just want to state that I think it is next to impossible for anyone of us to ever imagine the pain and suffering of a family of a victim that the victim must endure daily for the rest of their lives for

almost like a tort system. And yet, I hear from Mr. Adelman and the Trial Lawyers Association that we are going to see a seven percent reduction if we repeal the non fault. Where do the savings come in if the current system is just like the no fault system - a tort system?

JIM GASTON: The savings comes in because we don't have the added pool on the no fault side, which people have to pay for. That comes out of somebody. For example, if you are not at fault in an accident, let's say you are at fault. Let's say you are driving down the road and you are intoxicated and you smash into a tree. I get no fault benefits. One would get no fault benefits. You would get up to \$5,000. You would get your medicals paid for, you lost wages paid for and yet, you are the individual at fault.

What the repeal of no fault will do, is take that out of the system so those people who are accountable will pay and those people who are not accountable will not pay for the drunk driver or for the people that....

REP. JARJURA: Thank you. Thank you, Mr. Chairman.

REP. TULISANO: Next person -- who did we say? Bob Nield. Then Thomas S, from N.E.A.T. Are you here?

BOB NIELD: Good evening. I would like to speak to HB7288, AN ACT CONCERNING PATIENTS RIGHTS. My name is Bob Nield. I am an independent living advocate at the Center for Independent Living in Southwestern Connecticut, in Stratford.

Our center serves as its resource and advocacy center for people with disabilities. As such, we assist people with disabilities in gaining and maintaining the resources that they need so they can live in a community they choose to live in.

Most of the people who work at the Center of Independent Living are people as myself, people with disabilities, as are the people who serve on our Board of Directors.

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I would like to acknowledge the position taken by the Advisory Council for the Protection and Advocacy of Individuals with Mental Illness, Ms. Sangster who spoke earlier. And I strongly encourage you to read their position statement and to respect and respond in kind to their recommendations.

The Center for Independent Living of Southwestern Connecticut recognizes that this committee as well as everyone on the committee are on the cutting edge of understanding the nature of mental and emotional health issues that face us at this time. As a result, they can provide sound direction as we all work towards sound and sane public policy.

I find it deeply disturbing that a proposal to administer psychotropic medicines in non emergency situations to (inaudible) of our state without their consent, is being seriously considered. People are guaranteed specific rights to adequate, appropriate treatment including treatment of mental and emotional dysfunction. People are protected by law from the denial of these rights even when they don't consent to medication.

Adequate, appropriate treatment in non-emergency situations should not include the forced administration of psychotropic or any other medications. We should focus our resources and energies on making alternatives to chemical restraints available to people who experience mental and emotional distress rather than retreating back to forced medication.

Commissioner of Mental Health, Albert Solnit put out a policy draft the title of which is Involuntary Administration of Medications to a Patient of Non-Emergency Circumstances. I have that for the record, just for reference. This can be seen -- I think it is important to make this reference because this draft can be seen as a policy which would follow from this legislation.

This draft provides guidelines directing the decision making processes by which medications may be administered to people against their choice. The process is directed at the protection of people who supposedly require protective intervention. In

the best case scenario, this protective process would take at least three working days, longer in the case of the weekend or a holiday. This is the crucial point though -- in the interim, what would happen to the individual in focus? Certainly, other less restrictive interventions would be employed.

These are the strategies that are available. These are the alternative strategies that can address this problem. They are more humane, they should be utilized and they should be utilized in place of chemical alternatives.

SEN. JEPSEN: Can I encourage you to summarize your three minutes.

BOB NIELD: To summarize, I would also point out that in reference to section two, number twelve of that same draft and this is also in the legislation, if a patient has the option of petitioning the probate court for an expedited hearing within fifteen days from the date of the request, the gravity of this issues demands that this be the rule and not the exception. Thank you for your consideration.

REP. TULISANO: Thank you. I thought we were in agreement. There goes a year's study down the tubes, huh?

BOB NIELD: I am sorry?

REP. TULISANO: There goes a year's study, huh? That's okay. We are used to it.

Thomas Schuch. May be misreading it again. Okay. Aleta Derooy then Bob Shanley.

ALETA DEROY: Good evening ladies and gentlemen. My name is Aleta Derooy and I support HB7284, AN ACT CONCERNING SEXUALLY VIOLENT PREDATORS. I don't have a degree in anything, but I do have some common sense.

The bill before us is not perfect, but then few things in life are. At least this offers us a means to protect ourselves from those who

WARREN RUPPAR: It certainly is complicated to know what we have, but that doesn't mean that people can't educate themselves and learn more about what they would like to do for their own insurance program. Insurance is a very complicated and very legal product. Just as auto insurance is, it is also very complicated coverage - commercial insurance, but all those clients seem to end up learning how to better insure themselves, too and I think the end result is that we make people more informed, more educated about what they are doing. I think it is a good result.

REP. WOLLENBERG: Does this apply to commercial as well?

WARREN RUPPAR: The hold harmless?

REP. WOLLENBERG: Yes.

WARREN RUPPAR: No. But if you would like to extend that to it, we would be happy to...

REP. WOLLENBERG: I think we have a long way to go before we do this one. So, we better just creep before we crawl.

REP. TULISANO: One thing. I am for it as long as you amend it to lawyers. What do you think of that? How far do you think that would go? Lead balloon, don't you think?

REP. WOLLENBERG: But I am pleased to see that it has become so difficult. This bill -- choice has become so difficult that you have to be protected.

Thank you.

REP. TULISANO: A lead balloon - that one would go over. Rick Lowe. Gone. Will Brady. Okay, Will. Then Natalie Travers. Natalie Travers here?

WILL BRADY: Chairman Tulisano, Senator Jepsen, members of the committee, thank you for letting me speak. My name is Will Brady. I advocate on behalf of the citizens with psychiatric disabilities. I have a history of such a disability and I am a member of

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Connecticut's Self Advocates for Mental Health, a statewide organizations of citizens who have had mental illnesses.

Last year, I spoke before this committee on a bill concerning informed consent. I understand this bill to be a stepchild of that one.

What Dr. Schwartz didn't mention was that there was no representation from direct receivers of services on that committee talking about ...

I wish to address matters of this bill concerning informed consent, the definition of terms such as "extremely critical nature", "direct threat" and how measures discussed in this bill may get translated into real life, everyday situations.

I also wish to bring up the matter of forced treatment and how easy it is to have one's status change from a voluntary commitment to an involuntary commitment once you have entered a psychiatric facility.

Certainly, I can well understand the social concerns about subduing an individual who maybe truly violent with the use of force including the use of physical and chemical restraints such as drugs and how they are used. But, in actual practice, how a person gets identified as a direct threat, can and frequently does vary with a particular day or a particular time of day.

In actual practice, what an extremely critical nature can be and often has been used by staff as a means to serve their own convenience and doesn't necessarily reflect the patient's actual condition at the time.

Furthermore, to allow the provisions such as those called for in Section (e) and (f) of this bill also potentially allow for serious violations of the rights of all citizens, but particularly citizens with psychiatric disabilities. Many of whom, have committed no crime, save that of exhibiting socially embarrassing behaviors in a public place and psychiatric institutions can also be construed as public spaces and places.

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The provisions set forth in these sections even deny a person the right of due process that suspected criminals are allowed. Moreover, the provisions set forth in this bill still do not address the questionable practice of granting medical personnel the privilege to subject a person to treatment against their will even if they are determined to be competent.

Finally, there are many individuals who end up in the psychiatric system who are victims and/or survivors of abuse, be it physical, emotional or sexual abuse. Forced treatment, whether it is by use of physical restraints, or medication dosages so potent as to put the patient in a confused stupor and drugs that can also cause permanent, irreversible disfiguring effects, can and often mimic the abuse the person received in the first place which led them to seek psychiatric treatment.

These methods of treatment are incorrectly referred to as "emergency psychiatric care". Until the issues of forced treatment and the attached assumptions that are too lengthy to go into here now, that society holds that psychiatric patients cannot be responsible to make decisions for themselves are addressed, then the provisions set forth in this bill might be just as well left aside and we go on with what currently exists.

I am not happy with the provisions in the present laws pertaining to patients' rights, informed consent or forced treatment, but there seems no good reason to replace them with more draconian measures which ultimately impact every citizen in society.

It has been said that the measure of a civilization is based on how equitably the civilization treats its least wanted. This bill would be an example of a poor measure of our society.

Thank you for your time and consideration.

(cass 4)

REP. TULISANO: Thank you. Natalie Travers. Next, Margaret Byram, then Bryan Sabin, still here. On automobile, close to that name?

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believe this bill would protect the victimizer from his own acts by removing him from situations which would induce him to commit offensive acts.

By passing this bill, perhaps the next time another person is victimized, you, the members of this committee, will know you have done your best to protect society from people who may not, themselves, be able to control their own actions.

Thank you for your attention.

REP. TULISANO: Thank you. Edna Jacobs. Edna Jacobs. Okay. Charles Szartan. That's good. Chrysler Szarlan. Sorry. It has not been a great evening. I have not been able to speak. Charles Pothier and Thomas Westbrook, I think I spoke to them. They are not here are they? Right, I spoke to them outside and I knew they passing. Okay, thank you. Go ahead.

ATTY. CHRYSLER SZARLAN: I am Chrysler Szarlan. I am an attorney with the Connecticut Legal Rights Project. I am here to testify about HB7288, AN ACT CONCERNING PATIENTS' RIGHTS.

As Edward Madison, the Director of our project has stated previously, we are opposed to the section of the bill that provides for an internal hospital hearing before forced medication of competent, mentally ill patients.

This internal review is like the fox guarding the chickens. There is no real due process because there's no impartial decision maker. Secondly, personally, as an attorney who represents clients who would be forced medicated under this statute, in my view, forced medication should only be used as a chemical restraint when persons are immediately and seriously dangerous to themselves or others. An alternative method of treatments should be pursued.

At this time, forced medication is considered treatment. It is my belief that forcing a person to take potentially life threatening drugs is not treatment, but a violation of rights that is aggriguous and often is not truly a treatment, but a method of control.

If this practice continues, many treating physicians will not be motivated to pursue and develop less intrusive treatments and to forge true therapeutic alliances with their patients without force or coercion.

Thank you.

REP. TULISANO: Bill Foreman. I thank you. Pass. David Kniffin. Pass. Catherine Costa. Pass. Lisa Mazzella. Pass. I gather, pass. Is there anybody else in the audience who has yet -- wishes to testify and present evidence to this body who has not signed up. Seeing none, you don't count. That was only in the first hour. You are a legislator, you are not a people. Person. You don't count.

This is the last one. Let the record also show for those who think otherwise, we stayed here and everybody was willing to stay with us. Mad'am. Which bill?

: Two of them.

REP. TULISANO: Two?

: I was only going to talk about one, but I am going to mention two.

REP. TULISANO: Okay.

DEBRA MANDRA: Good evening Representatives Tulisano and members of the Judiciary Committee. My name is Debra Mandra and I am a resident of New Haven and I came here tonight as a private citizen, mental health professional, advocate, and a person with a disability.

First, I would like to express my support of HB6437, AN ACT CONCERNING SEXUAL ASSAULT BY HEALTH CARE PROVIDERS, which I think Gail Burns-Smith addressed earlier this evening.

REP. TULISANO: What do you think about that problem about time? (inaudible - not using microphone)

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DEBRA MANDRA: Well, I personally don't think that -- I guess it is a special kind of relationship that I think because of the imbalance of power and sometimes -- I don't think there should ever be a time when a person ---

REP. TULISANO: (Inaudible - not using microphone) Age?

DEBRA MANDRA: No.

REP. TULISANO: No! (laughter)

DEBRA MANDRA: Second, I would like to express my strong opposition to HB7288, CONCERNING PATIENTS' RIGHTS, regarding forced medication.

In response to the question that you asked earlier, Mr. Tulisano -- is everyone on board?

REP. TULISANO: I got the answer already (laughter)

DEBRA MANDRA: Okay. I was going to say the answer is a resounding NO.

REP. TULISANO: I thought you were playing around there. (laughter)

DEBRA MANDRA: A resounding NO. I think the most significant passengers on this ship were never invited on board or perhaps were thrown overboard and asked to walk the gangplank. But, they weren't part of it. (Laughter)

REP. TULISANO: I make people walk the gangplank? Only once did I kick out...

DEBRA MANDRA: No. No, I am not saying that. People that were part of the planning process, they were the ones that did it.

REP. TULISANO: Okay.

DEBRA MANDRA: The important thing is that people were never included in the process that had direct significant effects and consequences on their lives. They had the patients and the ex-patients themselves. This was a gross miscarriage of

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justice. A comparison I can make is if a group of men got together and decided to run a women's center...

REP. TULISANO: Sexist. We would have more fun than you.

DEBRA MANDRA: Laughter. Or if a group of white people decided how to run the NAACP

REP. TULISANO: It probably would happen. (not completely using microphone -) (laughter)

DEBRA MANDRA: It probably did, but it shouldn't happen anymore. There is a gross gap in experience and understanding when that kind of thing happens.

I work in the mental health system and I have many friends who use mental health services and have received psychiatric labels. Of all the people I work with and people that I know personally, a large proportion of these people are survivors of psychological trauma. Physical abuse, sexual abuse, emotional abuse.

I can provide you with statistics. I don't have them with me tonight, but they co-operate with a significant proportion of people with psychiatric labels are victims rather than perpetrators of violence. This is in direct conflict with what the media and the Department of Mental Health would lead you to believe.

The breed upon people's worse fears of violent, deranged, mental patients attacking innocent victims and violating public safety and security. Instead of guiding us forward into more positive images of people with psychiatric labels, living successfully in the community. The Department of Mental Health with this proposed forced medication legislation is driving us backwards into the dark ages of myth, mistruth and misinformation.

The people with psychiatric labels who do become violent is very small. And to indite all psychiatric patients based on the actions of few is very disturbing to me. The danger that exists is not in the actions of these individuals, but in the violation of their rights and freedoms. The most

significant risk of harm is in the denial of the individual's choice and dignity of people who have already been abused. Until we start using crystal balls for scientific analysis and prediction, we will begin medicating all people who are in correctional facilities based on their patterns of thought or past behavior. Then we have to accord psychiatric patients the same rights and protections.

The significant risk of harm is by confusing people who had experienced abuse and have been diagnosed with psychiatric labels and require treatment and confusing those people with people who perpetrate violent crimes and go undiagnosed and untreated.

A therapist I know often compares the whole situation to the Holocaust in that if a group of psychiatrists were sent in to evaluate the situation, it would be like they would be saying, Oh, all the victims require treatment, but all the perpetrators are allowed to go free without any kind of consequences and that is what is happening now.

That is why I urge your opposition to HB7288. I am also going to be urging patients, ex-patients, consumers to be calling all of you.

REP. TULISANO: Oh, God, don't tell them that.
(LAUGHTER) Don't call my office.

REP. WOLLENBERG: Call Brad Davis.

REP. TULISANO: Call Brad. Call Brad. Call him at 12 in the morning. Call him up.

DEBRA MANDRA: I will give him your number. Thank you.
Good night.

The one on sexual assault of health care providers.
That is HB6437. I am in favor of that one.

REP. TULISANO: Thank you very much. No one else is here. I call this hearing to a close at whatever hour it is.

JOINT
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PART 9
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1993



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH

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THE FOLLOWING IS A STATEMENT BY KENNETH MARCUS, M.D., DEPUTY COMMISSIONER, IN SUPPORT OF H.B. 7288, AN ACT CONCERNING PATIENTS' RIGHTS

Senator Jepsen, Rep. Tulisano and members of the Judiciary Committee:

The Department of Mental Health supports H.B. 7288, An Act Concerning Patients' Rights

This bill has been developed in collaboration with the Office of Protection and Advocacy, the Connecticut Psychiatric Society, the Legal Assistance Research Center of Connecticut, and the Connecticut Legal Rights Project. Variations of this bill have been before the Judiciary Committee for the past several years. After a public hearing on a similar bill last year, the Committee chairs directed that all parties that testified on the bill should sit down and develop a consensus proposal that could be submitted to the legislature for consideration this year. H.B. 7288 is the result of that collaborative effort. Unfortunately, at this point in time, Connecticut Legal Rights has decided they can no longer support portions of this bill and they will be testifying later regarding their position.

This proposal accomplishes several things: it brings Connecticut law into compliance with U.S. Supreme Court rulings (Washington v. Harper & Riggins v. Nevada) on involuntary medication and it provides due process protections for patients while at the same time addressing the public safety concerns of Connecticut citizens.

Current law allows a person who has been voluntarily admitted to a mental health facility to refuse medication. However, it also provides that a person who has been involuntarily committed can be medicated against his/her will. The United States Supreme Court, over the last few years, has ruled that such statutes which unilaterally allow a state to medicate a person against his/her will are unconstitutional.

H.B. 7288 provides the following:

- 1) Subsection (a) provides that no person shall receive medication for the treatment of a mental illness without the person's informed consent except in accordance with the provision of this bill.
- 2) Subsection (b) provides that no medical or surgical procedures may be performed without the patient's written informed consent or, if the patient has been declared incapable of caring for himself/herself, the written consent of a conservator. Emergency treatment may be provided without consent.

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- 3) Subsection (d) allows a mental health facility to establish an internal procedure governing involuntary medication treatment decisions. This internal procedure provides rigorous due process protections for the patient and a time limit on the duration of involuntary medication.
- 4) Subsection (e) provides that if a person is incapable of giving informed consent, a facility may utilize the internal procedure described above or may apply for the appointment of a conservator to decide whether the patient should receive this medication.
- 5) Subsection (f) deals with patients who are competent, refuse medication and have a history of serious harm to themselves or others without medication. H.B. 7288 provides that in these cases, a facility may either utilize the internal procedure referenced above or apply to the Probate Court to authorize that the patient receive medication.
- 6) Finally, the definition of "informed Consent" (lines 161-165) has been strengthened.

H.B. 7288 painstakingly balances patients' medical and liberty interests with the public's right to an appropriate degree of safety and security. Given the rigor of the procedural safeguards provided, we feel that any adjustment in the criteria or process established within the framework of this bill for administering medication to either a competent or incompetent patient who is dangerous and refusing medication would tilt this balance significantly in the direction of placing the public considerably at risk. Attached to this testimony are several vignettes which illustrate this point.

This bill is a vast improvement over the current situation. We ask the committee's favorable action on this proposal and we are willing to meet with either committee members or staff on any refinements.

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EXAMPLES

CASE A

Mr. A., a 25 year old single man, homeless for the past year, presented to a local crisis team at the insistence of the shelter staff. They explained that Mr. A. resided at the shelter for the past three months, while working part-time at a local hardware store. Mr. A. was well known to the community due to his frequent encounters with police, usually for petty crimes. He has a history of multiple drug use since his teenage years and in the past few years favors cocaine. On a number of occasions, while intoxicated, Mr. A. had come to the shelter but had been refused domiciliary services due to his belligerent and erratic behavior (which the shelter staff thought was due to his cocaine problem.) On the day of the referral, Mr. A. had returned to the shelter displaying all of his usual signs of cocaine intoxication including hostile, loud, demanding behavior and threats to aggress against anyone who attempted to redirect him. Hours later in the emergency room the patient appeared calmer but explained to the psychiatrist in charge that he was reluctant to leave the emergency room because he was having thoughts of killing himself. Incidentally, the shelter staff had made it abundantly clear to Mr. A. and the emergency room staff that he would not be domiciled in the shelter ever again. Although the crisis team felt that Mr. A.'s suicidal ideation might be a manipulation to avoid sleeping on the street or finding alternative housing arrangements, he appeared impulsive enough to make his threats seem somewhat credible. Although the psychiatrist in the emergency room felt that the patient might eventually be more amenable to discharge once the effects of the cocaine had completely worn off, he nonetheless referred the patient to Fairfield Hills for admission since the patient had resided in the emergency room for close to 12 hours and was in danger of exceeding the DMH/CHA guideline in this regard.

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On admission to Fairfield Hills, the admission team obtained the following history. Mr. A. had been hospitalized in various acute inpatient psychiatric units in his community since the age of 18. These were usually short stays precipitated by conflicts with law enforcement authorities or actual arrests. On one occasion, Mr. A. was charged with disturbing the peace when he refused to leave the lobby of a downtown hotel, was evaluated by the DMH Court Clinic and referred to a state facility for competency restoration under 54-56d. At age 22 he was incarcerated for six months on a burglary charge during which time he received services from the prison psychiatrist and took antipsychotic medication.

Within two days of admission, Mr. A.'s behavior was superficially calm, pleasant and cooperative. However, after a meeting with his social worker, during which time the difficulties of finding aftercare housing were explained to the patient, Mr. A. challenged another patient's use of the water fountain. A brief fist fight ensued and Mr. A. was placed in 4-point restraints for six hours while receiving IM medication. Following his release from restraints he remained irritable and hostile toward staff and began to verbalize occasional ideas that the staff were "against him". Patient denied any auditory hallucinations and was not observed engaging in any bizarre or ritualistic behaviors. During the second week in the hospital, the patient was overheard discussing John Hinckley's attempted assassination of President Reagan with another patient. In his daily counselling session with the unit psychologist, the patient was questioned about his conversation. He stated "sometimes women are turned on by guys like that." He avoided further discussion of the issue. The next day he was overheard having a similar conversation with the same patient. Once again the topic came up of psychotherapy and the patient revealed fantasies about doing various things to impress women. These included kidnapping prominent public officials, detonating bombs and various other antisocial activities. He also revealed that he had kept a diary from time to time in which he had composed letters to a prominent local newscaster. He revealed that over the past year he had sent this person a variety of gifts including handmade notes, candy and a paperback book about the television news business. When asked if the newscaster had responded to these "gifts" he stated that she had but refused to elaborate. Psychological testing was performed over the next week and revealed a pattern of thought disorganization and ego deficits consistent with chronic schizophrenia. During this time the patient was maintained on a low dose of antipsychotic medication. During the third week of hospitalization, the patient revealed in a weekly meeting with his psychiatrist, how he knew the newscaster had received his gifts. Mr. A. reported that while walking on the sidewalk in front of the news building he had noticed a window on

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the fourth floor to be ajar. He immediately understood that this was her way of signaling her receipt and appreciation of his gifts. When asked why she didn't communicate more directly, he pointed out that he never expected her to respond since he was a "insignificant" person with whom she could ill afford to be associated. Thus, according to the patient, she had to resort to less direct ways of signaling her appreciation. He also was unable to put a return address on any of his gifts since he was either undomiciled or lived at a "bad address" at the time.

During the fourth hospital week the patient abruptly decided that he no longer wanted to take any medication since he felt it interfered with his "attractiveness" to women. He complained of grogginess, always having a dry mouth and tremor. One week after stopping the medication he became extremely impatient with a staff member and threatened to strike out. He was placed in 4-point restraints and received intramuscular medication. He continued taking all medication for another day and then began to refuse his medication again. A petition to the court of probate for involuntary commitment and appointment of conservator was made. The patient was interviewed by a psychiatric consultant for the purpose of determining competency. This psychiatrist determined that the patient was competent to make decisions regarding treatment insofar as his sensorium was clear and behavior was calm. When queried regarding his ideas about the newscaster, the patient replied that he thought "maybe" she was attracted to him but went on to say that he had no intention of sending her any other gifts or engaging in behaviors noted above. A second psychiatric opinion concurred with the finding that the patient was legally competent but noted serious concerns regarding the patient's potential for future dangerousness. In each instance, the psychiatrist confirmed the diagnosis of schizophrenia and recommended ongoing treatment with antipsychotic medication to diminish the intensity of the patient's delusional thinking as well as to improve his impulse control.

DB:lbk

File (GG2)

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Case B

Patient B is a man who was found not guilty by reason of insanity for the crime of murder and was sentenced to the jurisdiction of the Psychiatric Security Review Board for a period not to exceed 60 years. Mr. B has a long history of mental illness dating back to his adolescent years when he began to isolate himself and become increasingly paranoid. He carries a diagnosis of schizophrenia, paranoid type. His crime consisted of shooting to death an attorney who was working in his behalf on a pro bono basis to defend him against a minor misdemeanor charge.

Mr. B was sent to Whiting Forensic Institute in 1986 for care, custody, and treatment of his severe mental illness. He has been ambivalent about taking antipsychotic medication throughout the course of his hospitalization but until the summer of 1992, he did agree to take medication. During the past eight months, however, he has steadfastly, persistently, and adamantly refused to take any psychotropic medication. He has based his refusal on a complete denial of his mental illness and on his paranoid mistrust of the treatment staff. He is convinced that the staff have hidden television cameras in the walls to observe him at all times. He is fully aware of his legal rights and is able to clearly articulate his refusal of medications. He fully cooperates with his attorneys who are assisting him to assert his right to refuse medication. On the basis, his psychiatrist has found him to be legally competent to refuse medication.

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Since last summer, Mr. B's condition has deteriorated to the point where he has cut off virtually all contact with peers and treatment staff, and he has given indications of experiencing auditory hallucinations although he denies this under direct questioning. On a number of occasions he has made threatening physical gestures towards staff though he has not actually assaulted anyone in the hospital up to the present time. Because of the organized quality of his delusions and his ability to use quasi-logical cognitive skills in defense of those delusions, the treatment staff has been utterly unable to make any headway in convincing him to take medication despite strenuous efforts. They are extremely concerned that Mr. B's condition will continue to deteriorate to the point where he will act out in a violent manner. They are also of the opinion that without antipsychotic medication, Mr. B's chances for recovery and rehabilitation are nil.

Case C

Patient C is a man who found not guilty by reason of insanity of the crime of capital felony murder and was sentenced to the jurisdiction of the Psychiatric Security Review Board for a period not to exceed 60 years. Like Mr. B, first signs of mental illness appeared in adolescence when he began to have difficulty with classmates in school, and over the next several years he developed the symptoms of paranoid schizophrenia, including a fixed delusional belief that there was a politically motivated conspiracy against him which was perpetrated by his classmates in school and his neighbors' children. His crime consisted of strangling to death a young boy in his neighborhood whom he believed was part of this conspiracy. At the time of the homicide, he was under psychiatric treatment but was refusing to take antipsychotic medications.

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In 1984, Mr. C was sent to Whiting Forensic Institute for care, custody, and treatment of his psychiatric condition. He has been continually resistant to taking an adequate dose of antipsychotic medication throughout the period of his treatment. Approximately three months ago, he became even more adamant in his refusal to take an adequate dosage of psychotropic medication and, at present, he is only taking one quarter of the dosage which has been prescribed for him by his psychiatrist. Mr. C has a fixed delusional belief concerning antipsychotic medications, which he firmly believes to be poisonous and of no benefit to him. He is highly intelligent, logical, consistent, and coherent in advocating this belief and in working with his attorneys to assert his absolute right to refuse any unwanted medication. Because of this, his psychiatrist has found him to be legally competent to refuse medication.

Since his self-imposed decrease in the dosage of antipsychotic medication during the last three months, Mr. C has become more isolated from staff and peers and has shown some deterioration in his personal hygiene. He has made verbal threats to other patients and staff but has not as yet physically attacked anyone in the hospital. Of note is the fact that prior to committing his homicide he had committed two other serious assaults with a deadly weapon, both of which were motivated by delusional thinking. These assaults occurred while he was refusing to take antipsychotic medication prescribed by his outpatient therapists.

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Testimony Against Raised Bill 7288, April 8, 1993, Judiciary Committee
From Edna M. Jacobs, President, Connecticut Alliance for the Mentally Ill

I am Edna Jacobs, president of the Connecticut Alliance for the Mentally Ill, a statewide organization primarily of families of people with serious mental illness. Thank you for the opportunity to speak.

Families of the mentally ill have often wished, when someone they love is in a mental illness crisis, for a way to require that person to take the medication or treatment known to be helpful to him or her. But Raised Bill 7288 is light years away from proper legislation to accomplish this.

Rather than an act "Concerning Patients Rights," as this bill is titled, it should be called "Forced Medication, Through a Procedure Denying Patients' Rights." It seems to us the bill was written by someone who does not understand mental illness and it contains some of the most serious threats to patient and civil rights we have seen in any legislation.

Let's take just a few examples: The proposed bill says "The head of the hospital and two qualified physicians" can decide a patient "is incapable of giving informed consent to" mental illness medication or shock treatment. Why not specify "psychiatrists," not just any physicians? Would an obstetrician be qualified to make this judgment? How about an orthopedist or a proctologist? This provision is really inadequate.

A "facility" may have an "internal procedure" to force medication, the bill says. Does this mean you can have this done to you at any mental health clinic anywhere? Will the procedure have any uniformity or common standards from clinic to clinic? This sounds a little like the old Soviet Union, where the NKVD had only to pick you up, whip you off to the friendly neighborhood psychiatric clinic and you disappeared for a long time. This bill says the forced medication decision could remain in force for up to four months.

The bill says cross examination is permitted of people making the forced medication decision. Who will do the cross examination? The patient in crisis? Does anyone think that assures that the patient's rights are protected? This bill certainly does not protect them.

The patient's religious views must be considered in such a decision, this bill says. Will these be determined while the patient is in crisis? If so, they might be quite different from the views he or she may express when not in crisis.

If a forced medication decision is made under this legislation, the patient involved may petition a probate court to appeal against it. Will the probate court hear the matter before the forced medication or shock treatment is administered? Doesn't a decision by the physician, et al, under these forced medication provisions actually go into effect for up to four months, with the probate court hearing taking place after that? What protection for patients' rights is afforded by this? Shouldn't this properly be called an ex post facto hearing--locking the barn door after the horse is stolen?

Ladies and gentlemen, this issue has been around for years. Please do not approve this hastily conceived, deeply troubling legislation. We do want help for our loved ones, but not at the cost of basic rights and protections people with mental illness should have as citizens and human beings. It should be back to the drawing board with this bill. Thank you.

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TESTIMONY OF EDWARD MATTISON
ON BEHALF OF
THE CONNECTICUT LEGAL RIGHTS PROJECT AND
THE CONNECTICUT CIVIL LIBERTIES UNION
CONCERNING RAISED BILL NO. 7288
AN ACT CONCERNING PATIENT'S RIGHTS

For the past three years my colleagues and I, lawyers and paralegals at the Connecticut Legal Rights Project Inc. (CLRP) have been the officially recognized legal representatives for patients at Connecticut's public mental hospitals. We have been involved in virtually all instances when a patient has refused to take prescribed medication. For this reason, we were delighted to join with the Department of Mental Health and other interested parties to try to design a proposed statute which would protect patients' rights but provide for involuntary medication when essential.

The bill before you, which is the Committee's revision of a proposal from the deliberations of this group, attempts to balance the needs of patients, their constitutional rights and the hospitals' need for expeditious decisions, without unduly burdening the courts. Therefore, we and the Connecticut Civil Liberties Union, with whom we work closely, were looking forward to supporting it and urging its passage.

Unfortunately we find that the current bill has two critical deficiencies, which we fear will lead to wholesale violations of patients' rights. CLRP has prepared a revised proposal (attached) which we think is responsive to the legitimate concerns of hospitals and physicians, but limits the danger to civil liberties.

The first issue of concern is that the current draft essentially makes the hospital staff the decision makers if a patient refuses to accept proffered medication. Later the patient may appeal to probate court from the hospital decision. Under the Patients' Bill of Rights, treatment decisions are supposed to be jointly made by patients and their treaters. In fact, patients overwhelmingly tell us that even now they feel powerless. Granting hospital staff the authority to medicate forcibly will only make patients feel even less in control of their lives. In addition, we believe that hospitals have an inherent conflict of interest in making such decisions, because, in the short term at least, patients are much more easily managed when medicated.

Most state courts have ruled that the decision as to whether a person is competent to refuse medication is a legal decision properly made by a judge, not by a doctor. Our draft does permit the hospital to forcibly medicate a person, pending a court decision, if his or her condition is serious enough to justify it.

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We are also opposed to the inclusion of section (f) in its present form, which permits involuntary medication of a patient who is "capable of giving informed consent," but who "place(s) the patient or others at significant risk of harm," because of his or her refusal to accept medication. We believe that this section is an extraordinary extension of the right of the state to interfere with the medical decisions of competent persons and is unconstitutional, bad social policy and unnecessary.

It is now the law and will continue to be the law under the proposed statute that any psychiatric inpatient whose current conduct shows that he or she is imminently dangerous to him/herself or others may be medicated forthwith without any legal process. There is no question that some people in a psychotic state are so unable to control their behavior that emergency action must be taken to protect them or others.

However, section (f) of the proposed bill deals with patients who are presently competent and not dangerous, but who in the past have allegedly been harmful to themselves or others. It essentially provides for the hospital staff and then the court to declare someone to be chronically dangerous and therefore to take away his or her rights to make the same kinds of medical decisions that all other persons have.

We believe that section (f) runs afoul of the 5th amendment to the Connecticut Constitution, which forbids discrimination against any person "because of...mental disability." Our Supreme Court in many cases has found that a competent adult has an unlimited right to refuse medical treatment, regardless of his or her physician's recommendation. This principle was recently restated in the right to die cases, especially in *McConnell v. Beverly Enterprises*, 209 Conn. 692, which allows people the right to terminate life-sustaining medical treatment. The court stated that the right to refuse treatment is a right "rooted in this nation's fundamental legal tradition of self-determination."

DMH and other hospital officials feel strongly, that they need some right to forcibly medicate persons who have a history of harm to self or others before they become violent. In an attempt, however hesitant, to be responsive to this view, the CLRP draft proposes to allow involuntary medication of competent patients who are a "direct threat" to their own safety or that of others. We believe that our proposed definition is narrow enough that it will be limited to patients that the state may legitimately medicate under the police power.

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I should note that several of the consumer groups who will testify today believe that our proposal also has insufficient safeguards. The CCLU has asked me to inform you that as a matter of principle, it opposes any legislation which would take away the right to refuse medication, except after a judicial finding that the person is incapable of exercising that right. Therefore, it has concerns about the clause in the CLRP draft that would permit interim involuntary medication, pending a court decision. Moreover, both the CCLU and some consumer groups continue to fear that our narrow definition of competent patients who may be forcibly medicated- those who are a direct threat-will lead to significant abuses. Our view is that because it is desirable to do away with the current legal chaos about involuntary medication, the compromises in the CLRP draft would be worth it, if they help bring about a resolution.

I am also attaching a list of other changes from the Committee bill. Many are typos or return the language to current law to avoid claims that the Legislature intended a substantive change by using new language. The only significant difference is the addition back of a 15 day time limit on court action. It would lead to chaos in the mental health system, if medication decisions are not made promptly.

The Bill as written creates a new class of people, those who may someday become dangerous and therefore may have their civil rights taken away from them now. CLRP offers a compromise proposal that we believe will be fair to both patients and hospitals. The Connecticut Civil Liberties Union and the Connecticut Legal Rights Project have relied on this body's fundamental fairness. Please exercise that fairness again.

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Substitute Bill # 7288

AN ACT CONCERNING INFORMED CONSENT FOR THE TREATMENT OF MENTAL ILLNESS

1 Be it enacted by the House of Representatives and Senate in
2 General Assembly convened:

3 Section 1. Section 17a-543 of the general statutes is
4 repealed and the following substituted in lieu thereof:

1 (a) [Voluntary patients may receive medication or treatment,
2 but shall not be forced to accept unwanted medication or treat-
3 ment.] NO PATIENT SHALL RECEIVE MEDICATION FOR THE TREATMENT OF
4 THE MENTAL ILLNESS OF SUCH PATIENT WITHOUT THE INFORMED CONSENT
5 OF SUCH PATIENT, except in accordance with procedures set forth
6 in [subsection (c)] SUBSECTIONS (b), (d), (e) AND (g) of this
7 section OR IN ACCORDANCE WITH SECTIONS 17a-566 OR 54-56d. [No
8 medical or surgical procedures may be performed without the
9 patient's written informed consent, except in accordance with
10 subsection (c) of this section.

11 (b) Involuntary patients may receive medication and treat-
12 ment without their consent, but no] NO medical or surgical
13 procedures may be performed without the patient's written in-
14 formed consent, OR [unless] IF the patient has been declared
15 incapable of caring for himself or herself pursuant to sections
16 45a-644 TO 45a-662, inclusive, AND A CONSERVATOR OF THE PERSON
17 HAS BEEN APPOINTED PURSUANT TO SECTION 45a-650, THE WRITTEN
18 CONSENT OF SUCH CONSERVATOR. If the head of the hospital, in
19 consultation with a physician, determines the condition of an

20 involuntary patient not declared incapable of caring for himself
21 or herself pursuant to said sections is of an extremely critical
22 nature and such patient is incapable of informed consent, medical
23 or surgical procedures may be performed with the written informed
24 consent of: (1) The patient's guardian, if he or she has one; (2)
25 such persons's SPOUSE OR next of kin; or (3) a qualified physi-
26 cian appointed by a judge of the probate court, [which signed the
27 order of hospitalization, except that] NOTWITHSTANDING THE
28 PROVISIONS OF THIS SECTION, if obtaining the consent provided for
29 in this section would cause a medically harmful delay to [the] A
30 VOLUNTARY OR INVOLUNTARY patient, WHOSE CONDITION IS OF AN
31 EXTREMELY CRITICAL NATURE, AS DETERMINED AFTER PERSONAL OBSERVA-
32 TION BY A PHYSICIAN OR THE SENIOR CLINICIAN ON DUTY, EMERGENCY
33 TREATMENT MAY BE PROVIDED WITHOUT CONSENT, [medical or surgical
34 procedures may be performed in accordance with subsection (c) of
35 this section.]

36 [(c) If the head of the hospital, in consultation with a
37 physician, determines that the condition of a patient, either
38 voluntary or involuntary, is of an extremely critical nature,
39 then emergency measures may be taken without the consent other-
40 wise provided for in this section.

41 (d)] (c) No psychosurgery or shock therapy shall be
42 administered to any patient without such patient's written
43 informed consent, except as provided in this subsection. Such
44 consent shall be for a maximum period of thirty days and may be

45 revoked at any time. If it is determined by the head of the
46 hospital and two qualified physicians that the patient has become
47 incapable of giving informed consent, shock therapy may be
48 administered upon order of the court of probate, if, after
49 hearing, such court finds that the patient is incapable of
50 informed consent and there is no other reasonable alternative
51 procedure.

52 (d) IF IT IS DETERMINED BY THE HEAD OF THE HOSPITAL AND TWO
53 QUALIFIED PHYSICIANS THAT A PATIENT IS INCAPABLE OF GIVING OR
54 WITHHOLDING INFORMED CONSENT TO MEDICATION FOR THE TREATMENT OF
55 SUCH PATIENT'S MENTAL ILLNESS AND SUCH MEDICATION IS DEEMED TO BE
56 NECESSARY FOR SUCH PATIENT'S TREATMENT, A FACILITY SHALL APPLY TO
57 THE COURT OF PROBATE FOR APPOINTMENT OF A CONSERVATOR OF THE
58 PERSON UNDER SECTION 45a-650. SUCH APPLICATION SHALL BE APPROVED
59 OR DENIED WITHIN 15 DAYS. ONCE SUCH A CONSERVATOR HAS BEEN
60 APPOINTED, HE OR SHE SHALL MEET WITH THE PATIENT AND THE PHYSI-
61 CIAN, REVIEW THE PATIENT'S WRITTEN RECORD AND CONSIDER THE RISKS
62 AND BENEFITS FROM THE MEDICATION, THE LIKELIHOOD AND SERIOUSNESS
63 OF ADVERSE SIDE EFFECTS, THE PREFERENCES OF THE PATIENT, THE
64 PATIENT'S RELIGIOUS VIEWS, AND THE PROGNOSIS WITH AND WITHOUT
65 MEDICATION. AFTER CONSIDERATION OF SUCH INFORMATION, THE CONSER-
66 VATOR SHALL EITHER CONSENT TO THE PATIENT RECEIVING MEDICATION
67 FOR THE TREATMENT OF THE PATIENT'S MENTAL ILLNESS OR REFUSE TO
68 CONSENT TO SUCH MEDICATION.

69 (e) IF IT IS DETERMINED BY THE HEAD OF THE HOSPITAL AND TWO
70 QUALIFIED PHYSICIANS THAT (1) A PATIENT IS CAPABLE OF GIVING OR
71 WITHHOLDING INFORMED CONSENT BUT REFUSES MEDICATION FOR THE
72 TREATMENT OF SUCH PATIENT'S MENTAL ILLNESS, (2) THERE IS NO LESS
73 INTRUSIVE BENEFICIAL TREATMENT, (3) WITHOUT MEDICATION, THE
74 MENTAL ILLNESS WITH WHICH THE PATIENT HAS BEEN DIAGNOSED WILL
75 CONTINUE UNABATED AND (4) THE PATIENT POSES A DIRECT THREAT TO
76 THE SAFETY OF SUCH PATIENT OR OTHERS, AS DEFINED IN THIS ACT, THE
77 FACILITY MAY FILE AN APPLICATION WITH THE COURT OF PROBATE TO
78 AUTHORIZE THE PATIENT TO RECEIVE MEDICATION FOR THE TREATMENT OF
79 THE PATIENT'S MENTAL ILLNESS, DESPITE THE REFUSAL OF THE PATIENT
80 TO CONSENT TO SUCH MEDICATION.

81 (f) NO ORDER FOR MEDICATION UNDER SUBSECTIONS (d) OR (e) OF
82 THIS SECTION SHALL BE EFFECTIVE FOR MORE THAN ONE HUNDRED TWENTY
83 DAYS. ANY HEARING UNDER SUBSECTIONS (d) OR (e) OF THIS SECTION
84 SHALL BE CONDUCTED IN ACCORDANCE WITH THE PROCEDURES SET FORTH IN
85 SECTION 45a-649 AND 45a-650, TO THE EXTENT SUCH PROVISIONS ARE
86 NOT INCONSISTENT WITH THE STANDARDS OF THIS SECTION.

87 (g) A FACILITY MAY ESTABLISH AN INTERNAL PROCEDURE GOVERNING
88 INTERIM INVOLUNTARY MEDICATION DECISIONS, PENDING A HEARING ON
89 THE FACILITY'S APPLICATION UNDER SUBSECTIONS (d) OR (e). THIS
90 PROCEDURE SHALL PROVIDE (1) THAT ANY INVOLUNTARY MEDICATION
91 TREATMENT DECISION SHALL BE MADE BY A PERSON NOT INVOLVED IN THE
92 PATIENT'S TREATMENT, (2) WRITTEN AND ORAL NOTIFICATION OF AVAIL-
93 ABLE ADVOCACY SERVICES, (3) THE RIGHT TO REPRESENTATION BY AN

94 ADVOCATE OF THE PATIENT'S CHOICE DURING ANY PROCEEDING FOR THE
95 DETERMINATION OF THE NECESSITY FOR INVOLUNTARY MEDICATION, (4)
96 CROSS-EXAMINATION OF WITNESSES AT ANY SUCH PROCEEDING AND (5) A
97 WRITTEN DECISION. IF A DECISION IS MADE IN ACCORDANCE WITH THE
98 STANDARDS SET FORTH IN THIS SECTION THAT A PATIENT SHOULD RECEIVE
99 INTERIM INVOLUNTARY MEDICATION, AND THE DECISION MAKER FINDS THAT
100 WITHOUT SUCH MEDICATION, EITHER THAT THERE IS A SUBSTANTIAL
101 PROBABILITY THAT THE PATIENT WILL RAPIDLY DETERIORATE PRIOR TO A
102 HEARING ON SUCH APPLICATION UNDER SUBSECTION (d), OR THERE IS A
103 SUBSTANTIAL PROBABILITY OF SERIOUS PHYSICAL HARM TO SELF OR
104 OTHERS PRIOR TO A HEARING ON SUCH APPLICATION UNDER SUBSECTION
105 (e), THEN SUCH INVOLUNTARY MEDICATION MAY BE PROVIDED FOR A
106 PERIOD NOT TO EXCEED 15 DAYS OR UNTIL A DECISION IS MADE BY THE
107 PROBATE COURT, WHICHEVER IS SOONER. THE RECORD OF ANY SUCH
108 PROCEEDING SHALL NOT BE ADMISSIBLE IN A HEARING UNDER SECTIONS
109 (d) OR (e).

110 (h) NO PUBLIC OR PRIVATE FACILITY SHALL REQUEST OR REQUIRE
111 BLANKET CONSENT TO ALL PROCEDURES AS A CONDITION OF ADMISSION OR
112 TREATMENT.

113 Sections 2 and 3 of Raised Bill No. 7288 shall be unchanged
114 except for the following:

115 Section 17a-540(h) is repealed and the following is
116 substituted in lieu thereof:

117 'Informed consent' means permission given COMPETENTLY AND
118 VOLUNTARILY AFTER A PATIENT HAS BEEN INFORMED OF THE REASON FOR

119 TREATMENT, THE NATURE OF THE PROPOSED TREATMENT, ITS ADVANTAGES
120 AND DISADVANTAGES, MEDICALLY ACCEPTABLE ALTERNATIVE TREATMENT AND
121 THE RISK OF NO TREATMENT; [on the basis of knowledge of the
122 implications, consequences or possible complications or effects
123 of such permission;]

124 Section 17a-540 (1) is added to provide as follows:

125 (1) "DIRECT THREAT" MEANS THAT THE PATIENT'S CLINICAL
126 HISTORY DEMONSTRATES A PATTERN OF LIFE THREATENING INJURY TO SELF
127 OR SERIOUS PHYSICAL INJURY TO OTHERS, CAUSED BY THE MENTAL
128 ILLNESS WITH WHICH THE PATIENT HAS BEEN DIAGNOSED, WHICH IS
129 DOCUMENTED BY OBJECTIVE MEDICAL AND OTHER FACTUAL EVIDENCE, IS
130 RECENT AND NOT SPECULATIVE OR REMOTE. IN ADDITION, THERE MUST BE
131 A HIGH PRESENT PROBABILITY OF SUBSTANTIAL PHYSICAL HARM TO SELF
132 OR OTHERS.

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SUGGESTED CHANGES TO BILL NO. 7288
AN ACT CONCERNING PATIENTS' RIGHTS

In order to assist in understanding the differences between the Committee bill and the CLRP suggested alternative, we have prepared a comparison of the two. The line numbers are those in the CLRP draft. We haven't copied every single word, but we have noted, we hope, all changes.

6 - Subsection citations vary by draft, but are substantively the same.

24 - Committee bill omits SPOUSE.

30 - Committee bill omits WHOSE CONDITION IS OF AN EXTREMELY CRITICAL NATURE. This reverses current law

52 - Committee bill has this subsection as (e)

53 - CLRP adds OR WITHHOLDING.

56 - Committee bill provides A FACILITY MAY (1) UTILIZE THE PROCEDURES ESTABLISHED IN SUBSECTION (d) OR (2)... CLRP requires a facility to file a probate petition.

58 - Committee bill has no time limit for probate petitions.

59 - Committee bill says THE CONSERVATOR...

69 This is the Committee bill section (f).

70 Committee bill omits OR WITHHOLDING.

75 Committee bill has AND PLACES THE PATIENT OR OTHERS AT SIGNIFICANT RISK OF HARM AS DEFINED IN SUBSECTION (h) OF THIS ACT.

76 Committee bill provides THE FACILITY MAY (1)UTILIZE THE PROCEDURES ESTABLISHED IN SUBSECTION (d) OF THIS SECTION OR (2)...

87 Committee bill provides in section(h) for an expedited appeal of an internal administrative decision, but has no time limit.

87 Committee bill has this subsection as (d).

88 Committee bill omits PENDING A HEARING ON THE FACILITY'S APPLICATION UNDER SUBSECTIONS (d) OR (e).

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92 Committee bill has DIRECTLY before INVOLVED. CLRP doesn't think the physician's supervisor is a neutral party.

94 Committee bill omits BY AN ADVOCATE OF THE PATIENT'S CHOICE.

100 Committee bill omits AND THE DECISION MAKER FINDS THAT WITHOUT SUCH MEDICATION

101 Committee bill has THE CONDITION OF THE PATIENT WILL RAPIDLY DETERIORATE and omits THERE IS A SUBSTANTIAL PROBABILITY OF SERIOUS PHYSICAL HARM TO SELF OR OTHERS PRIOR TO A HEARING ON SUCH APPLICATION UNDER SUBSECTION (e).

110 Committee bill omits (h) NO PUBLIC OR PRIVATE FACILITY SHALL REQUEST OR REQUIRE BLANKET CONSENT TO ALL PROCEDURES AS A CONDITION OF ADMISSION OR TREATMENT. This is in current law.

117 Committee bill has COMPLETELY instead of COMPETENTLY

120 Committee bill omits AND DISADVANTAGES.

125 Committee bill has a definition of "SIGNIFICANT RISK OF HARM" instead of "DIRECT THREAT."

129 Committee bill omits IS RECENT AND NOT SPECULATIVE OR REMOTE. IN ADDITION, THERE MUST BE A HIGH PRESENT PROBABILITY OF SUBSTANTIAL PHYSICAL HARM TO SELF OR OTHERS. CLRP believes that a person who is not a current threat should be involuntarily medicated because in the past he or she was dangerous.

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STATE OF CONNECTICUT

OFFICE OF PROTECTION AND ADVOCACY FOR
PERSONS WITH DISABILITIES
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TESTIMONY
OF THE
OFFICE OF PROTECTION AND ADVOCACY FOR
PERSONS WITH DISABILITIES
BEFORE THE JUDICIARY COMMITTEE
ON
HB 7288 AAC PATIENT RIGHTS

Presented by: Susan Werboff
April 8, 1993

My name is Susan Werboff. I represent the State Office of Protection and Advocacy for Persons with Disabilities (P&A). P&A is funded by the State and Federal governments with a mandate to advocate for and, when necessary, protect the rights of persons with disabilities. A division within P&A is PAIMI - Protection and Advocacy for Mentally Ill Individuals whose specific jurisdiction is persons with mental illness.

We have, indeed, collaborated with the groups referred to by the Deputy Commissioner of the Department of Mental Health (DMH), support the bill and believe that it is past time for the protections in HB 7288 to be available to involuntary patients in both Connecticut's public and private institutions for persons with mental illness.

All of the collaborators on this bill agree that the bill is in the best interests of and substantially beneficial to patients.

Currently, involuntary patients in both public and private psychiatric hospitals can be forced medicated. This is allowable under current Connecticut statute. There are not enough advocates to protect all these individuals from being forced medicated and we continuously hear abuse stories after the fact. These individuals now have no right to appeal.

This bill is a substantial improvement on current law. It provides for the right to refuse medication to both voluntary and involuntary patients. It encourages the development of an internal medication review process and it allows the patient to have the forced medication decision reviewed by probate court.

This bill does allow for a very narrow group of patients to be forced medicated under very specific circumstances. Many of the people we represent oppose this as they don't believe any

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"competent" person should be force medicated. We share their concerns, but feel with our proposed amendments, this bill provides sufficient safeguards for this group of people.

Because we have such a deep concern, we are offering the attached amendment that will offer further protection to patients who are competent but dangerous. The recommended change uses the phrase "DIRECT THREAT" in the place of SIGNIFICANT RISK OF HARM in lines 110 and 111 and, in line 182 changes the phrase and revises the definition to specify that the patient's pattern of dangerous behavior is manifested in his current behavior.

We have three other concerns:

- 1) On line 130, we believe it to be absolutely imperative that patients have the right to an expedited hearing held within the time frame of 15 days. This protects their right to refuse medication and limits the potential number of days for being involuntarily medicated to 15 days. This bill already provides for a maximum of 30 days of involuntary medication through the use of an internal procedure (Line 84). The appeal of the 30 days of involuntary medication must take place prior to the 30 days, otherwise it is an irrelevant appeal.
- 2) The definition of informed consent as it appears in the bill contains a typographical error and is incomplete. In Line 161 we believe "COMPLETELY" SHOULD BE "COMPETENTLY"; in Line 162, the word problem is more appropriate in this context than "REASON", and in Line 163, please add AND DISADVANTAGES after the word ADVANTAGES.
- 3) In Line 46 after the word patient, the words "WHOSE CONDITION IS OF AN EXTREMELY CRITICAL NATURE" should be inserted. The phrase, that also appears on line 37 is necessary because Line 46 appears after the words "NOTWITHSTANDING THE PROVISIONS OF THIS SECTION."

P&A strongly supports HB 7288, AAC Patient Rights. The bill substantially improves the rights of patients in public and private institutions and is long past due. We urge the committee to finally give this bill a joint favorable report and usher its passage through the House and Senate.

Thank you.

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SUGGESTED AMENDMENT TO HB 7288

In Line 110 and 111 CHANGE "AT SIGNIFICANT RISK OF HARM" TO "UNDER DIRECT THREAT"

LINE 182-186 should read "DIRECT THREAT MEANS THAT THE PATIENT'S CLINICAL HISTORY DEMONSTRATES A PATTERN OF LIFE-THREATENING INJURY TO SELF OR SERIOUS PHYSICAL INJURY TO OTHERS, CAUSED BY THE MENTAL ILLNESS WITH WHICH THE PATIENT HAS BEEN DIAGNOSED AND IS DOCUMENTED BY OBJECTIVE MEDICAL AND OTHER FACTUAL EVIDENCE. SUCH EVIDENCE OF THE PAST PATTERN OF DANGEROUS BEHAVIOR MUST BE MANIFESTED IN THE PATIENT'S RECENT BEHAVIOR. A HIGH PROBABILITY OF SUBSTANTIAL HARM MUST BE PRESENT AND MUST BE CAUSED BY THE MENTAL ILLNESS WITH WHICH THE PATIENT HAS BEEN DIAGNOSED."

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**Connecticut
Psychiatric
Society**

*District Branch
American Psychiatric
Association, Inc.*

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I am Dr. Harold I. Schwartz, M.D. I serve as Chairman of the Legislative Committee of the Connecticut Psychiatric Society, as Director of the Department of Psychiatry at Hartford Hospital and as Associate Chairman of the Department of Psychiatry at the University of Connecticut Medical School. I am here to testify in favor of House Bill 7288, An Act Concerning Patients' Rights. This bill addresses the vital issue of informed consent for psychiatric patients and frames the conditions and circumstances under which severely mentally ill psychiatric patients can be treated involuntarily. This bill raises many important issues which have been the subject of debate in legislatures and courts throughout the country. It requires a balancing of very important conflicting interests: on the one hand the rights of patients to give informed consent for treatment and the right to be free of involuntary treatment. On the other, the need of patients for treatment when they may be too impaired to consent and the right and obligation of society to protect its citizens from severely mentally ill patients who may be dangerous to themselves or others.

Everyone agrees that a balance must be struck between these interests and we believe that an appropriate balance has been struck within this bill. One central question is whether all involuntary treatment must be judicially approved or whether there are circumstances in which clinical/administrative decision making may be sufficient. This bill allows for the administration of involuntary treatment following a rigorous internal clinical/administrative review procedure for a period not to exceed 30 days. Patients who seek judicial review may have expedited judicial review within 15 days. In any event, a probate court order would always be required for involuntary treatment beyond 30 days. Thus, patients can be expeditiously treated but judicial review is always rapidly available. This is consistent with the recent Supreme Court decision in *Washington v. Harper* that such clinical/administrative review adequately protected the patient's rights. I should further note that numerous reviews of the scientific literature indicate that even in those jurisdictions in which all involuntary treatment decisions must be made by the courts, in the vast majority of cases judges follow the recommendations of treating hospital staff and order medication.

A second central questions is whether involuntary treatment may ever be administered to a patient who appears to be competent to accept or refuse medication. This bill would limit the administration of involuntary medication to incompetent patients and a small group of patients who appear to be at very great risk of harming themselves or others.

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Harold I. Schwartz, M.D.

Increasingly, society seems to look towards psychiatrists and psychiatric hospitals to be the guarantor of the public safety. Psychiatric hospitals are often in the position of having to hospitalize individuals who are suicidal or threatening to others in order to protect the patient and society. If such patients cannot then be further treated, hospitals become warehouses or detainment centers. Hospitalizations are unnecessarily prolonged and the treatment of other patients is disrupted by the psychotic behavior of patients who should be treated but who refuse. There is evidence that prolonged periods of psychosis predispose to further chronic deterioration and that rapid and effective intervention in the psychotic process with medication may have a beneficial effect on the overall course of mental illness. Many patients who have been treated involuntarily acknowledge, in retrospect, that such treatment was appropriate and necessary.

We are very concerned that patients' autonomy and need for treatment be carefully balanced. We believe that this bill achieves this purpose.