Legislative History for Connecticut Act

PA 19-99

SB967

House	9533-9535	3
Senate	3516-3518, 3547-3548	5
Public Health	4106-4115, 4193-4199, 4457-4466	27
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8848-9664

the Clerk please call Consent Calendar 710.

CLERK:

House Calendar 710, Substitute Senate Bill No. 967 AN ACT CONCERNING THE RECOMMENDATIONS OF THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES REGARDING EMERGENCY MEDICATION. Favorable Report of the Joint Standing Committee on Judiciary.

SPEAKER ARESIMOWICZ (30TH):

Representative Steinberg of the 136th.

REP. STEINBERG (136TH):

Mr. Speaker, I move for Acceptance of the Joint Committee's Favorable Report and Passage of the Bill in concurrence with the Senate.

SPEAKER ARESIMOWICZ (30TH):

Question before the Chamber is Acceptance of the Joint Committee's Favorable Report and Passage of the Bill in concurrence with the Senate. Will you remark?

REP. STEINBERG (136TH):

Mr. Speaker this is DEMAS Bill, ought to pass.

SPEAKER ARESIMOWICZ (30TH):

Thank you very much, sir. Representative Petit of the 22nd.

REP. PETIT (22ND):

Dittos, sir. Thank you.

SPEAKER ARESIMOWICZ (30TH):

Thank you very much. Will you remark further? If not Staff and guests to the Well of the House. Members take your seats, the machine will be open.

[Ringing]

CLERK:

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

SPEAKER ARESIMOWICZ (30TH):

Have all members voted? If all members voted please check the board to ensure your vote has been properly cast. If all members have voted, the machine will be locked and the Clerk will take a tally.

And the Clerk will announce the tally.

CLERK:

Senate Bill No. 967

Total Number Voting	150
Necessary for Passage	76
Those voting Yea	150
Those voting Nay	0
Absent not voting	1

SPEAKER ARESIMOWICZ (30TH):

Bill is passed in concurrence [Gavel]. Will the Clerk please call Consent Calendar 457.

CLERK:

House Calendar 457, Senate Bill No. 81 AN ACT MAKING CERTAIN INSTITUTIONS OF HIGHER EDUCATION AND PRIVATE OCCUPATIONAL SCHOOLS INELIGIBLE FOR PUBLIC FUNDS AND LICENSURE. Favorable Report of the Joint Standing Committee on Higher Education and Employment Advancement.

SPEAKER ARESIMOWICZ (30TH):

Representative Haddad.

REP. HADDAD (54TH):

Thank you, Mr. Speaker. Mr. Speaker, I move

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SENATOR MCCRORY (2ND):

Madam President, if there is no objection, I would ask that this bill be placed on the consent calendar.

THE CHAIR:

Seeing no objection, so ordered. Mr. Clerk.

CLERK:

Page 63, Calendar number 299, Substitute for Senate Bill No. 967, AN ACT CONCERNING RECOMMENDATIONS OF THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES REGARDING EMERGENCY MEDICATION. There is an amendment.

THE CHAIR:

Good evening, Senator Abrams.

SENATOR ABRAMS (13TH):

Good evening, Madam President. I move acceptance of the Joint Committee's Favorable Report and passage of the bill.

THE CHAIR:

The question is on passage. Will you remark?

SENATOR ABRAMS (13TH):

Thank you, Madam President. Currently, there is no clear reference in the Connecticut General Statutes

related to the issue of administration of emergency psychiatric medications to criminal defendants committed to the facility of the Department of Mental health and Addicted Services. This bill would address this oversight by codifying existing practice of the administration of emergency medications when a patient engages in behavior that places himself or herself or others in immediate risk of harm which would constitute the psychiatric emergency.

THE CHAIR:

Thank you, Senator Abrams. Will you remark further on the bill that is before the Chamber? Good evening, Senator Somers.

SENATOR SOMERS (18TH):

Good evening, Madam President. I rise in support of this bill. We heard directly from the Department of Public Health and DMHAS how important this bill is for both the people within our care and for the workers who are caring for the people that are in this particular position. Most of the time, these patients are being brought to a facility to have a psychiatric evaluation and at times, they become agitated and they a risk to themselves and to the people who are caring for them. If anything is necessary to be provided to the patient without consent, it is short-term, short-acting, less than four hours, but they go through a whole process of trying to deescalate the patient. They have specific techniques that they use. They try to get consent. Some of these patients, again, are in an evaluation stage for competency to stand trial so there's always an issue as to whether you can

actually really provide consent. This is used very rarely, but it is something that will add an added measure of safety for both the patient or the person in care and the person who is responsible for that care.

This is used only after all other efforts are exhausted. This is not something that is done commonplace and it has been something that has come to us. We've talked about this in the past, but it is something that would really help situations that can become quite frankly violent and have very unfortunate outcomes so I support this legislation fully. Thank you.

THE CHAIR:

Thank you, Senator Somers. Will you remark further on the legislation that is before us? Will you remark further? Senator Abrams.

SENATOR ABRAMS (13TH):

Madam President, if there is no objection, I would ask that the bill be placed on the consent calendar.

THE CHAIR:

Seeing no objection, so ordered. Mr. Clerk.

CLERK:

Page 31, Calendar number 440, Substitute for Senate Bill No. 939, AN ACT CONCERNING PSYCHIATRIC COMMITMENT EVALUATIONS.

THE CHAIR:

this legislation and then on the Consent Calendar. Mr. Clerk.

CLERK:

Senate Bill 869, Senate Amendment B, LCO No. 7731.

Total number voting	36
Necessary for adoption	19
Those voting Yea	11
Those voting Nay	25
Absent and not voting	0

THE CHAIR:

[Gavel] The amendment fails. Will you remark further on the legislation as amended? Senator Leone.

SENATOR LEONE (27TH):

Thank you, Madam President. As such, now that this is the bill, I would ask with no further objections it be placed on the Consent Calendar.

THE CHAIR:

Seeing no objection, so ordered. Senator Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. Madam President, if the Clerk can now call the items on our first Consent Calendar followed by a vote, please?

THE CHAIR:

Mr. Clerk.

CLERK:

Consent Calendar No. 1: Page 15, Calendar No. 268, Senate Bill 869, page 21, Calendar 357, Senate Bill 1082, page 45, Calendar 551, Senate Bill 1130, page 60, Calendar 151, Senate Bill 936, and page 63, Calendar 299, Senate Bill 967. Immediate roll call vote has been ordered in the Senate on Consent Calendar No. 1. Immediate roll call vote has been ordered in the Senate on Consent Calendar No. 1. Immediate roll call vote has been ordered in the Senate on Consent Calendar No. 1.

THE CHAIR:

Have all the Senators voted? Have all the Senators voted? The machine will be locked. Mr. Clerk, kindly announce the tally, please.

CLERK:

Consent Calendar No. 1.

Total number voting	36
Necessary for adoption	19
Those voting Yea	36
Those voting Nay	0
Absent and not voting	0

THE CHAIR:

[Gavel] The Consent Calendar is adopted. The Senate will stand at ease for a moment before we have points of personal privilege. Senator Duff.

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a year. And if it's into the cost long term, the children will not, it will reduce costs by vaccination, and also very expensive, requiring 24-hour-a-day nursing services to maintain a ventilator-dependent child. So, it will reduce costs exponentially.

REP. PETIT (22ND): Well, thank you, thank you very much for that education. Very much appreciate it.

MARIA ELENI KALOIDIS: Thank you.

SENATOR ABRAMS (13TH): Any other questions or comments from the committee? Thank you so much for being here today. You really helped us understand this bill and your advocacy is very much appreciated. Thank you. Next we have Commissioner Delphin-Rittmon. Good afternoon, Commissioner, welcome.

MIRIAM DELPHIN-RITTMON: Good afternoon, Senator Abrams and Representative Steinberg and distinguished members of the Public Health Committee.

I am Commissioner Miriam Delphin-Rittmon and I have with me, Dr. Tobias Wasser of, the Medical Director of Whiting Forensic Hospital. We thank you for the opportunity to provide testimony on raised Senate Bill 967, AN ACT CONCERNING THE RECOMMENDATIONS OF THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES REGARDING EMERGENCY MEDICATION.

CGS Section 17a-543,(b), describes procedures for making involuntary medication for patients admitted to psychiatric hospitals via civil statute. That statute allows for the emergency use of medication if obtaining the consent provided for in this

section would cause a medically harmful delay to an involuntary or voluntary patient whose condition is of extreme critical nature, as determined by personal observation by a physician or by a senior clinician on duty. Emergency treatment may be provided without consent, within that particular section.

The language in Senate Bill 967 adds similar language to 17a-543(a), essentially codifying existing practice for criminal defendants who are placed in the custody of DMHAS for restoration for criminal trial.

DMHAS would like to assure the committee, would like to assure the committee that significant measures are taken before involuntary emergency medication is administered. So, quite a bit of work and activity happens before involuntary medications are administered. These measures include efforts to first seek the patient's cooperation and consent, also de-escalation techniques and a number of other measures before involuntary medications are administered.

Involuntary emergency medication may not continue once the emergency has passed, so it really is a temporary measure. A Probate Court order, after a hearing, is required to continue the involuntary administration of such medication.

DMHAS would like to offer a small recommendation for substitute language for this particular bill. We respectfully requests the word, administer, be replaced with the word, order. This is in keeping with usual clinical practice. A practitioner, or a physician or an APRN, ordering the medication is unlikely to be the person actually administering the

drug. Typically, it will be a nurse or similarly-skilled clinician who would actually be administering the medication.

So, thank you for the opportunity to testify here before you today and we're happy to answer any questions that you may have.

SENATOR ABRAMS (13TH): Thank you. Are there any questions or comments from the members of the committee? Representative Betts.

REP. STEINBERG (136TH): Thank you, Representative Betts, I'll be brief. Commissioner thank you for testifying on this bill. I appreciate your, your focus on extreme emergency circumstances for needing to invoke this particular strong response to the problem. There is testimony before the committee that says, yes, this could potentially be a slippery slope. And once we allow more and more people in the system to have the discretion to forcibly order some sort of emergency procedure, that it can be problematic from a, a privacy and individual rights standpoint. What would be your response to that?

MIRIAM DELPHIN-RITTMON: Yeah. So, what we're talking about here are really very limited situations, in which it's a clinical emergency for the individual. It's, it's really a very specific situation in which other measures have been tried, as I mentioned de-escalation. We're working with the person trying to get, trying to get them agree on their own. And so it's a very specific situation and once a certain medication is administered and the emergency has passed, then a court order is really required to be able to, to continue that, if needed.

So, it is a very specific situation that actually for individuals that are civil patients, there already is language and a bill or a law where that is allowable. So, this is just for individuals who are being sent to DMHAS for competency restoration and, you know, a medical emergency happens in which or a, a clinical emergency happens, which the medication is needed.

REP. STEINBERG (136TH): So, I take it you have a fairly detailed protocol for how this would be invoked and the circumstances and the reason why you might not want to wait for the head administrator is because there may be an urgency involved with that emergency and requiring that fairly quick administration?

MIRIAM DELPHIN-RITTMON: Absolutely, yes. So, there are clinical emergencies, and, in fact, I have Dr. Wasser here and I'll ask him to speak a little bit about some of the instances in which this might be used.

SB 967

TOBIAS WASSER: Thank you very much to the committee for the opportunity to speak today. As Dr. Delphin-Rittmon said, my name is Dr. Tobias Wasser, I'm the Medical Director of the Whiting Forensics Hospital. So, to further emphasize what she stated, we already have a separate statute for civilly hospitalized patients, both in Whiting and throughout the Connecticut hospital system, to allow us to emergently medicate individuals.

So, all that this bill is really asking for is to replicate that procedure for individuals who are sent to Whiting solely for competency restoration purposes. And we are the only hospital in

Connecticut that deals with that, so it primarily affects our hospital.

But as she stated before, we would emergently medicate somebody outside of an emergency situation, there's very clearly codified procedures we go through for involving the probate court or the superior court to get us a specific order allowing for involuntary medication on an ongoing basis.

These situations arise only when there's an emergency where someone's life or limb is in serious jeopardy and we need to be able to act in that moment for the safety of staff or patients. Despite that, we would still make every effort to work with the patient to try to de-escalate the situation with verbal interventions. We'd offer them oral medication, if they're agreeable to taking it. And we even give them choice into what medication they prefer to take. If there are other soothing techniques we could invoke to help calm them to reduce the risk of aggression. When all those measures have failed, it is only in that circumstance that we would utilize an emergency involuntary medicine to administer medicine in a different fashion.

This is typically, this would only be ordered by a physician, typically a psychiatrist, or a physician who's on the premises. So, the medicine would never be ordered absent a physician's order, which is also in keeping with the practice in all civil patients throughout the state.

So, I think you wouldn't be, we wouldn't see it as expanding the scope by any means. It would just be making sure that we can keep patients safe both,

regardless of the legal purpose for their being in the hospital.

REP. STEINBERG (136TH): Thank you, Dr. Wasser, that's exactly what I was looking for. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Representative Betts.

REP. BETTS (78TH): Thank you, Madam Chair. I'm trying to think of an example when this may apply. My assumption is it would be somebody who is having control, having trouble controlling the behavior, maybe a threat to him or herself or somebody else and is not responding to any requests to calm down or take any kind of treatment to help him or her calm down.

If you were, first of all, is that a fair example? And it's frankly the only one I can think of right now. And the second part is, if you give medication once, I don't know how long it lasts for, how fast it's supposed to act, should you need a follow up, do you need to get a court order or can you give the medication, let's say, two times within an hour because it's a, a clinical emergency, but from that point on you have to get an order before a third one is administered?

TOBIAS WASSER: So, your description of the kind of circumstances that would lead to this are accurate. So, it would only be in a situation where someone is really having a difficult time controlling their behavior and as a result of that, they're either actually attempting to harm somebody else or they're threatening to harm somebody else and all of our other interventions that I described before are not effective in helping to reduce the acuity of the

situation. It's only in that circumstance we would then utilize an emergency involuntary medication. You know, the duration of the medicine lasts, depends a little bit on the medicine, but you would expect it to last somewhere in the range of sort of, you know, one to four hours, ideally, potentially longer.

We only would administer the medicine in an emergency. So, the majority of cases, there's one administration of medicine and that's the sole administration. There are rare circumstances where somebody, despite being given a medicine, is unable to calm down in 30 minutes, 60 minutes, and is still really actively aggressive or threating to harm others in a way that it requires additional administration of medicines. But I would say that is more often the exception than the rule.

REP. BETTS (78TH): Okay. Thank you very much.

SENATOR ABRAMS (13TH): Representative Arnone.

REP. ARNONE (58TH): Answered, thank you.

SENATOR ABRAMS (13TH): Okay. Thanks very much.

SENATOR ANWAR (3RD): Thank you, Madam Chair, Dr. Wasser, Commissioner, thank you for your testimony. I wanted to clarify a couple of things. In acute care facilities, this is already happening?

TOBIAS WASSER: Correct.

SENATOR ANWAR (3RD): And what you're looking at is in non-acute situation, in a facility traditionally for behavioral and addiction services, that is where you're looking at an opportunity to adjust and manage a situation if there's an emergency

TOBIAS WASSER: Correct. So, again, this already happens --

SENATOR ANWAR (3RD): Right.

TOBIAS WASSER: -- and it's just replicating the same procedure that we have for civil patients, for our patients who are sent from the Department of Corrections for competency restoration.

SENATOR ANWAR (3RD): One of the, and I understand this is lifesaving medicine in many situations, at least in the acute care facility, I, I recognize and respect that. But in the acute care facilities, we also have monitoring devices and a little bit different level of training for those emergencies. Would you need to have more monitoring devices, if some of those emergency medicines are going to be used? I presume it's IV Haldol and Ativan intravenous or something?

TOBIAS WASSER: They're typically administered through intramuscular injections as opposed to IV because in a psychiatric setting --

SENATOR ANWAR (3RD): Okay.

TOBIAS WASSER: -- we hopefully don't have IVs, but yes, it's a similar group of medicines. And typically for individuals after they receive the medicine, their vital signs are checked. And then we check them at regular periodic intervals afterwards.

So, I don't think we would need additional equipment because, again, we already, in our sister facility that house civil patients, we're doing this all the time and we're not finding any significant troubles in that regard.

SENATOR ANWAR (3RD): Okay. So, what you're saying is they won't be none, there will not be a need for monitoring and special training if this was provided?

TOBIAS WASSER: No, I don't believe so because it's a practice we typically employ throughout the state in other DHMAS and acute care facilities as you've mentioned.

SENATOR ANWAR (3RD): Okay. Thank you so much. Thank you, Madam.

SENATOR ABRAMS (13TH): Representative Tercyak.

REP. TERCYAK (26TH): Thank you very much, Madam Chair. Thank you very much and thank you for your participation in this. You may know, I've retired from actively psych nursing and it's great not to have to wake up that early in the morning anymore. However, this addresses a concern I've long had.

I personally think it's this side of criminal, when we're able to help somebody and don't. It is if soon they won't be taking their medication. Soon they won't be interested in getting better and the rest of their life they get to regret what they've just done because we thought medication was so horrible, that it was so special that we shouldn't help those people regain their self-control.

So, thank you very much for this. No questions. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Thank you, Representative. Representative Petit.

REP. PETIT (22ND): Thank you, Madam Chair. Doctor, if you could in the, I think in the statute it talks

about two physicians making a determination. Is there ever a time at Whiting, in these situations, is it always a psychiatrically trained M.D., or is there sometimes psychiatric APRNs that are involved as well or a combination of the two?

TOBIAS WASSER: So, currently right now it's always a psychiatric physician. We don't currently employ psychiatric, we do employ APRNs for medical purposes, but not for psychiatric purposes. So, at this point it would always be a physician making the order.

REP. PETIT (22ND): Thank you. Thank you, Madam Chair.

SENATOR ABRAMS (13TH): Are there any other questions or comments from the committee? Thank you very much for your testimony. Appreciate it.

MIRIAM DELPHIN-RITTMON: Thank you.

SENATOR ABRAMS (13TH): Commissioner Jordan Scheff. Welcome Commissioner.

JORDAN SCHEFF: Thank you for having me. Senator Abrams, Representative Steinberg and members of the committee. My name's Jordan Scheff, Commissioner of the Department of Developmental Services, and I'm here to testify in support of Senate Bill No. 920, AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS FOR VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

Our support is very specific to Section 25 of the Bill. DDS has currently learned that the current language in Section 17a-227a of the Connecticut General Statutes restricted the department's ability to provide a criminal history records check to all

JUDAH PRERO: I think so also.

SENATOR ANWAR (3RD): And I think the key thing is gonna come down to is, if we need more data on the safe fire retardants and that's gonna be flame retardants, and I think that may be, that may help us be in a better place, but in the absence of that having some protection for the people in the interim may not be bad, at least that's where I'm at in my mind. But thank you for your testimony.

JUDAH PRERO: Thank you.

REP. YOUNG (120TH): Any other questions? If not, thank you for your testimony.

JUDAH PRERO: Thank you very much.

REP. YOUNG (120TH): Next up with be Representative Camillo. If not, then we'll go to Kirk Lowry.

KIRK LOWRY: Good afternoon. Good afternoon, I'm Kirk Lowry, I'm the Legal Director of the Connecticut Legal Rights Project. I'm here to testify in opposition to Senate Bill 967, which deals with the amendment to add an emergency exception to the involuntary medication of pretrial detainees who are being held for competency restoration purposes.

So, this, this bill deals with and attempts to balance the constitutional rights of a pretrial criminal detainee, who's subject to competency restoration, so somebody's who not been convicted yet and who's mental health and competency to stand trial has been questioned but not determined yet. Those people all get sent to Whiting Forensic Hospital, as Dr. Wasser testified to. And the

Connecticut Legal Rights Project represents those people in Whiting Forensic Hospital.

So, the balance is between their long-held and long-established constitutional right to informed consent, like everyone else has, including the constitutional right to refuse psychiatric medications versus the state's interest in making them competent and bringing them to trial.

So, this section is in the Connecticut Patient's Bill of Rights. There is a general and civil side, as Dr. Wasser testified, to all of these provisions and those were established after certain constitutional cases from the Supreme Court in 1990 that involuntary medication statute was changed in '93. This part of the statute was added after another case, Sell vs. United States, and they added that in 2004.

So, that's when the U.S. Supreme Court held that it was constitutional to involuntarily medicate in rare circumstances a pretrial detainee, even though they haven't been convicted yet and have not had their competency determined yet.

So, that's been determined. So, Connecticut attempted to and did pass that statute. But in the involuntary medication for competency restoration patients, there was no emergency exception in there. Nevertheless, since 2003, they have been doing emergency medication at Whiting on these patients.

So, for some reason, somebody thinks that it needs to be either balanced with the other section or brought in just to make it correct on this, this new part of the statute.

Dr. Wasser testified that they think that one part of the statute allows for it on the civil side. That has not been determined by the Court of Appeals or the Supreme Court. And there is a Superior Court case that says that that is incorrect. I cite that in my testimony, that's Doe vs. Hunter.

So, we're opposed to this. We don't think that it's necessary and we also think that as it's written it's overbroad. So, we think that it should be rejected.

REP. YOUNG (120TH): Would this have to do also with detainees that are addicted to certain --

KIRK LOWRY: No.

REP. YOUNG (120TH): -- drugs and things like that?

KIRK LOWRY: No. This provision, involuntary medication is pretty complicated and there's a lot of different populations that go into the civil part of the hospital and the forensics side. And this statute only applies to those pretrial detainees who are subject to competency restoration. So, Sell said that the U.S. Supreme Court said that the preference is to do it the way Connecticut's doing it, and have it done in Probate Court. That's the standard way.

This emergency provision is, there's no pretrial deprivation due process hearing at all. This is just the doctor on the unit determining that there's an emergency because of direct threat of harm. So, it's an exception to all that.

And interestingly with all the other discussion, there is a religious exception for both the civils

and the forensics. So, if they raise a religious exception, it's supposed to be respected.

REP. YOUNG (120TH): Are there any other questions? Dr. Petit.

REP. PETIT (22ND): Thank you, Mr. Chair. So, maybe I'm misunderstanding where you're going. So, in the clinical situation of someone potentially causing harm to themselves or others, if this is not allowed, what's the option? Maybe I'm missing what the option is.

KIRK LOWRY: Well, right now there's a commissioner's policy that most of go to and that commissioner's policy allows for emergency involuntary medication at the very start of the commissioner's policy 6.15. The statute has not been that big of a factor. As I said, since 2003 and, you know, forever, they've been doing involuntary medications, emergency medications on patients in the forensics side, subject to competency restoration.

So, it's unclear to me the necessity of this. If it is gonna be addressed, I think it should be addressed in a more comprehensive manner to make sure that both the civil side and the forensics statute, 17a543 and then 543a get matched up because they all have been done at different times and they've all kind of gotten incongruent.

REP. PETIT (22ND): So, you're saying that, excuse me, under current statutes, psychiatric physicians have the ability to administer emergency medication to avoid harm to the person and/or other people on the unit under current statute and they don't need this statute to be able to do so?

KIRK LOWRY: No, I'm not saying that.

REP. PETIT (22ND): Okay. Tell me again.

KIRK LOWRY: I'm saying that the practice is, is that we use the commissioner's policy and it hasn't been challenged. And, you know, the emergency exception is hundreds of years old, it's part of the informed consent process that doctors are familiar with. So, there's, there's a general understanding that there is authority by a physician to exercise their right to involuntarily medicate somebody in an emergency.

Now, the statute as it's written, I don't think says that. The commissioner's testimony was that they, they're reading it as it does, and I just disagree. There's no Court of Appeals case, there's no Supreme Court case. There's one Superior Court case from Hartford from 1995 and that case says that they, that they do not have that authority. In a different context, but generally, they read it as the section that they're relying on does not give the authority to involuntarily medicate somebody in an emergency.

REP. PETIT (22ND): Leaving the civil issues aside for the moment, is there a way that this could be amended to make it satisfactory or you think not?

KIRK LOWRY: I think that it could be amended to make it satisfactory. My, there's several different ways, we could just try to work on that section to clean it up because even the section that's been proposed is much broader and much less detailed than the commissioner's policy already, 6.15, has a lot more protections for my client. So, that's a little bit concerning.

So, we could work on that section or we could look at both sections and all of the involuntary medication provisions that are applicable to the hospitals and try to make them congruent and consistent.

REP. PETIT (22ND): Thank you. I appreciate the information.

REP. YOUNG (120TH): Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Chair. Thank you, Mr. Lowry for your testimony. I'm just gonna follow on the same line of conversation. Look in the inpatient setting, when there is an emergency of this capacity, the individual actually truly becomes a threat to themselves or someone else. And then we have to make sure we protect them, but also protect the workforce. And then in the, the other setting that we are looking at outside of the inpatient, there is the same risk that is there.

So, it is, it is almost not right to not have a protection in that emergent situation when an individual who is going through addiction management as well as mental health emergent situation, do not have that capacity to provide them emergency management at that time.

So, this legislation is focused towards giving them that protection. I, that's the intention for this.

KIRK LOWRY: This, this proposed bill attempts to provide protection for patients subject to competency restoration, not addictions.

SENATOR ANWAR (3RD): Well --

KIRK LOWRY: Correct?

SENATOR ANWAR (3RD): -- both. You're talking about 967?

KIRK LOWRY: Yes. So, people with addictions go to a different part of the hospital or other facilities, they don't go to Whiting.

SENATOR ANWAR (3RD): But they would still be in the emergency situation if there is, if they are in an emergent situation, they will need intervention?

KIRK LOWRY: And that would be a different statute, I think.

SENATOR ANWAR (3RD): So, what we are trying to do is to have a protection of the workforce and that patient in that emergent situation; that is the rationale?

KIRK LOWRY: That would be a valid subject of policy debate in the bill.

SENATOR ANWAR (3RD): Okay. Thank you.

REP. YOUNG (120TH): Anybody else? Thank you.

REP. DAUPHINAIS (44TH): I'm Representative Anne Dauphinais. Welcome. Good afternoon, esteemed members of the Public Health Committee. My name is Anne Dauphinais. I'm representing the 44th District and I'm here today in opposition of 7199. And I have here with me Dr. Sin Hang Lee, is a resident of Connecticut, a pathologist who spent more than 50 years first in reading Pap smears and then in HPV diagnosis for cervical cancer prevention.

I will yield my time to him. Thank you.

SIN HANG LEE: Thank you. I finished my residency in the early '60s. I'm a Board Certified

Legislative Testimony
765 Asylum Avenue, First Floor
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Written Testimony Opposing Senate Bill 967, An Act Concerning the Recommendations of the Department of Mental Health and Addiction Services Regarding Emergency Medication

Senator Abrams, Representative Steinberg, and distinguished members of the Public Health Committee:

My name is David McGuire, and I am executive director of the American Civil Liberties Union of Connecticut (ACLU-CT). I am submitting this testimony in opposition to Senate Bill 967, An Act Concerning the Recommendations of the Department of Mental Health and Addiction Services Regarding Emergency Medication. The ACLU-CT opposes this proposal because it would severely curtail the privacy rights and liberty interests of people with serious mental health conditions.

Our Constitution protects the liberty and privacy rights of all people, including people with serious mental health conditions. In addition, people have a civil liberty right to make their own health care decisions. Senate Bill 967, however, infringes on patients' liberty and privacy rights by expanding who can medicate a patient without his or her consent. Under our state's current law, the decision to forcibly medicate someone is made by the "head of the hospital," with consultation from other medical experts. Limiting the process by which an individual may be forcibly medicated provides protections for people with psychiatric disabilities.

This bill, however, would allow a physician or a senior clinician to make the decision to forcibly medicate someone. As a result, this proposal would take Connecticut down a slippery slope of creating more pockets of impunity with regard to patients' privacy, liberty, and bodily autonomy.

Health experts have found that involuntary treatment can prevent mental health recovery, not promote it, and evidence from other states has shown that involuntary mental health treatment is disproportionately used against minorities. In New York, for instance, Black patients were five times more likely to receive forcible mental health treatment orders than their white peers.

Connecticut has more pressing needs surrounding mental health care, and Connecticut residents deserve greater protections for their privacy and liberty rights. We urge this committee to oppose Senate Bill 967.

CONNECTICUT
LEGAL
RIGHTS
PROJECT, INC.

TESTIMONY OF KIRK W. LOWRY, ESQ.
LEGAL DIRECTOR, CT LEGAL RIGHTS PROJECT, INC.
PUBLIC HEALTH COMMITTEE PUBLIC HEARING
MARCH 13, 2019

In opposition to: SB 967, AN ACT CONCERNING THE RECOMMENDATIONS OF THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES REGARDING EMERGENCY MEDICATION

Senator Abrams, Representative Steinberg, and distinguished members of the Public Health Committee:

My name is Kirk W. Lowry. I am the legal director of the Connecticut Legal Rights Project (CLRP). We represent patients in all the state psychiatric hospitals, including those who are respondents in probate court defending against Whiting Forensic Hospital's (WFH) petitions for a special limited conservator (SLC). CLRP opposes DMHAS's proposed amendments to the SLC section of the Connecticut Patient's Bill of Rights. 1

Patients, including those who are pre-trial detainees, have a constitutional right to refuse psychiatric medication. "It is well established that [a]n individual has a constitutionally protected liberty interest in avoiding involuntary administration of antipsychotic drugs—an interest that only an essential or overriding state interest might overcome. *Riggins v. Nevada,* 504 U.S. 127, 134, 135, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992). This is because the forcible injection of medication into a non-consenting person's body represents a substantial interference with that person's liberty. *Washington v. Harper,* 494 U.S. 210, 229, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990). Indeed, it has been observed that when the purpose or effect of forced drugging is to alter the will and the mind of the subject, it constitutes a

deprivation of liberty in the most literal and fundamental sense. Id., at 237–38, 110 S.Ct. 1028 (Stevens, J., dissenting).

At the same time, the government has a significant interest in bringing a person accused of a serious crime to trial. See *Sell v. United States,* 539 U.S. 166, 180 (2003). The power to bring an accused to trial is fundamental to a scheme of ordered liberty and prerequisite to social justice and peace. *Illinois v. Allen,* 397 U.S. 337, 347 (1970) (Brennan, J., concurring). When an individual commits a crime, he forfeits his liberty interests to the extent necessary for the government to bring him to trial. Recognizing this important governmental interest, the United States Supreme Court has held that in some circumstances, forced medication to render a defendant competent to stand trial for a crime that that person is charged with committing may be constitutionally permissible, even though the circumstances in which it is appropriate may be rare. See *Sell v. United States,* supra, at 180.

The constitutional right to involuntarily medicate a pre-trial detainee, convicted of nothing, whose competency to stand trial has been questioned, but not determined, is a qualified right balanced against the state's interest to bring him or her to trial. The United States Supreme Court, in *Sell v. United States*, 539 U.S. 166, 181-83 (2003) recommended that hospitals move for civil petitions for involuntary medication for treatment purposes, since the standards are less rigorous, more objective and whose alleged purpose is treatment, not competency restoration. Connecticut took the Court's suggestion and passed substitute language for Senate Bill 291 in 2004. The bill was Public Act No. 04-160 and amended the Connecticut Patients' Bill of Rights to add involuntary medication procedures for pretrial detainees subjected to competency restoration treatment. The Act added the definition of a special limited conservator at General Statutes § 17a-540(13). Section 3 of the Act added a totally new section which would become General Statutes § 17a-543a. The Act did **not** substantially amend General Statutes § 17a-543, the civil provisions for involuntary psychiatric medication in psychiatric facilities. The Act left in place the involuntary medication procedures for pretrial detainees in competency restoration commitments pursuant to General Statutes § 54-56d(k).

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General Statutes § 17a-543(a) establishes the general rule for all involuntary psychiatric medication and memorializes the constitutional right to self-determination and treatment only with informed consent: "No patient shall receive medication for the treatment of psychiatric disabilities of such patient without the informed consent of such patient, except in accordance with procedures set forth in subsections (b), (d), (e), and (f) of this section or in accordance with section 17a-543a, 17a-566 or 54-56d." The general rule of informed consent modifies the common law of informed consent in this context and also applies to the involuntary medication of pretrial detainees undergoing competency restoration and subject to involuntary medication procedures in General Statutes § 17a-543a.

None of these sections, 17a-543(d), (e), or (f), or 17a-543a, 17a-566 or 54-56d, provide for emergency administration of involuntary psychiatric medication. Only General Statutes § 17a-543(b), which applies only to "medical and surgical procedures," not administration of involuntary psychiatric medication, provides for an emergency exception. There is a common law exception to informed consent that provides for an exception for emergencies, but General Statutes § 17a-543(a) eliminates that exception except for "medical and surgical procedures" governed by General Statutes § 17a-543(b).

In *Doe v. Hunter*, 44 Conn. Supp. 53 (J.D. Hartford, 1995), in a case brought by now Justice Maria Araujo Kahn when she was an attorney for the Connecticut Office of Protection and Advocacy, the Superior Court held that Connecticut General Statutes § 17a-543(b) did not apply to involuntary psychiatric medication and therefore the consent of a conservator without a court order was insufficient authority to involuntarily medicate a patient in a psychiatric facility. The Court stated that, "The phrase used in both sections (a) and (b) of § 17a-543 prior to its amendment by Public Acts 1993, No. 93-369 was 'medication and treatment,' which is a much broader term than 'medical or surgical procedures,' but the former phrase was not retained in Public Acts 1993, No. 93-369. This would indicate a legislative intent not to include the medication for the treatment of mental illness within the term 'medical or surgical procedures.'" Therefore, the emergency exception to the general rule of informed consent does not apply to involuntary psychiatric medication.

DMHAS, nonetheless, by Commissioner's Policy 6.15 provides authority for psychiatrists or senior clinicians to order the administration of emergency involuntary psychiatric medication, often after manual restraint, in the form of intramuscular medications such as Geodon, Ativan and Benadryl. Legal authority for the Commissioner's Policy has not been provided or challenged, to the best of my knowledge. The authority may be asserted based on the well-established common law exception to informed consent, but a plain reading of an unambiguous C.G.S. § 17a-543(a) forestalls that option. The authority may be asserted by an over-broad reading of General Statutes § 17a-543(b), but that reading has been rejected by a well-reasoned, published Superior Court opinion that clearly lays out the legislative history of that provision.

DMHAS's proposed emergency exception to the statutory rule requiring informed consent is even broader than that contained in their current Commissioner's Policy 6.15. The text of the new subsection (c) in SB 967 has no time limits; it also eliminates the requirement in the Commissioner's Policy that the patient's condition also present an immediate risk to the patient's well being and/or to the physical safety of others. The Commissioner's Policy also defines medically harmful delay and has four other restrictions on emergency medication that are not included in SB 967(c).

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The efficacy and necessity of psychiatric medication is very complicated. Every single person reacts differently to psychiatric medication. Psychiatric medication is not the magic pill that the general public seems to assume it is. Generally, about one third of people experience benefits with few negative side effects; one third of people experience limited benefit and some adverse effects; and one third experience little benefit and many adverse effects. These lines are not absolute and may cross over one another. The point is that the assertions that "people should just take their meds" is not based on science or the scientific evidence. The best practice is for a clinician to develop a therapeutic alliance with a patient, take the time and put in the work necessary to accomplish full informed consent, except in the rarest of cases. It is the law, it is humane and dignified treatment, it is recovery oriented treatment, it is the safest treatment and it is evidence-based treatment.

CLRP is opposed to adding an overbroad emergency exception to the involuntary psychiatric medication provisions for pretrial detainees subject to involuntary competency restoration in a state psychiatric hospital.

Connecticut Legal Rights Project, Inc. P.O. Box 351, Silver Street, Middletown, CT 06457 (860) 262-5030

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

NED LAMONT
GOVERNOR

MIRIAM DELPHIN-RITTMON, PH.D.
COMMISSIONER

Testimony by Miriam Delphin-Rittmon Commissioner Department of Mental Health and Addiction Services Before the Public Health Committee

Good Morning Senator Abrams and Representative Steinberg and members of the Public Health Committee. I am Commissioner Miriam Delphin-Rittmon of the Department of Mental Health and Addiction Services (DMHAS). Thank you for the opportunity to provide testimony on raised Senate Bill 967 AN ACT CONCERNING THE RECOMMENDATIONS OF THE DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES REGARDING EMERGENCY MEDICATION

CGS Sec. 17a-543 (b) describes procedures for seeking involuntary medication for patients admitted to psychiatric hospitals under civil statutes. That statute allows for emergency use of medication *if obtaining the consent provided for in this section would cause a medically harmful delay to a voluntary or involuntary patient whose condition is of an extremely critical nature, as determined by personal observation by a physician or the senior clinician on duty, emergency treatment may be provided without consent.* The language in SB 967 adds similar language to 17a-543a, codifying existing practice for criminal defendants who are placed in the custody of DMHAS for restoration of competence to stand trial.

DMHAS would like to assure the committee that significant measures are taken before involuntary emergency medication is administered. These measures include efforts to first seek the patient's cooperation with the medication offered, and de-escalation efforts that are guided by actions that the patients have expressed as their preferences for how we can help them in such situations. Involuntary emergency medication may not continue once the emergency has passed. A Probate Court order, after an adversarial hearing, is required to continue the involuntary administration of such medication.

DMHAS would like to offer one small recommendation for substitute language. DMHAS respectfully requests the word "administer" in SB 967 be replaced with the word "order". This is in keeping with usual clinical practice. The practitioner, a physician or APRN, ordering the medication is unlikely to be the person actually administering the drug. Typically, it will be a nurse or similarly-skilled clinician who will administer the medication.

Thank you for the opportunity to testify on this bill. I would be happy to answer any questions you may have regarding this testimony.

NAMI Connecticut
National Alliance on Mental Illness
Find Help. Find Hope.

Testimony of NAMI Connecticut (National Alliance on Mental Illness)

Before the Public Health Committee

March 6, 2019

In Opposition to:

SB 967, An Act Concerning the Recommendations of the Department of Mental Health and Addiction Services Regarding Emergency Medication

Senator Abrams, Representative Steinberg, and members of the Public Health Committee, thank you for the opportunity to testify before your committee. My name is Susan Kelley, and I am the Director of Advocacy and Policy for NAMI Connecticut. NAMI Connecticut is the state chapter of national NAMI, the largest grassroots mental health organization dedicated to building better lives for all those affected by mental health conditions. NAMI Connecticut provides mental health support, education, and advocacy for all Connecticut children, youth, and adults impacted by mental health conditions.

I am testifying today in opposition to SB 967, An Act Concerning the Recommendations of the Department of Mental Health and Addiction Services (DMHAS) Regarding Emergency Medication. This bill would allow a hospital to administer emergency medication to a patient who is a defendant placed in the custody of the Commissioner of Mental Health and Addiction Services without consent if obtaining consent would cause a medically harmful delay.

We oppose SB 967 because Connecticut law does not permit involuntary and emergency psychiatric medication as proposed. Patients, including those who are being detained in psychiatric facilities prior to trial, have the right to refuse psychiatric medication. In Connecticut, this right is articulated in provisions of the general statutes which provide that "no patient shall receive medication for the treatment of psychiatric disabilities of such patient without the informed consent of such patient…." CGS Section 17a-543(a).

While DMHAS has a policy, Commissioner's Policy 6.15, which provides for administration of emergency psychiatric medication in the form of "intramuscular medications," this narrow circumstance and usage does not and should not extend to the broad authority being sought in SB 967. New subsection (c) does not provide for time limits for providing involuntary medication when it "would cause a medically harmful delay to a patient whose condition is of an extremely critical nature." It is also a broad standard which is not tethered to any objective criteria such as the patient presents an immediate risk to him/her self and/or the physical safety of others.

DMHAS should not be given broad authority to administer involuntary medication, as described in SB 967, when there are effective best practices and recovery-oriented means which are

appropriate for obtaining voluntary treatment. For example, developing a therapeutic relationship with the patient, providing peer supports or other recovery oriented method, or taking the time to obtain informed consent should be utilized in order to avoid contrary-to-the-rights-of-the-individual methods of treatment.

The involuntary medication contemplated by SB 967 improperly assumes that medication is the answer to psychiatric problems. Unfortunately, taking medication is not a panacea for psychiatric conditions. In other words, there's a common misperception that if people took their psychiatric medications, "everything would be fine." Psychiatric medication is complex and not scientifically proven to work: some people experience benefits with limited side effects; some experience little benefit with some adverse effects, and others still experience very little benefit with many side effects. This is further reason why SB 967's solution is inappropriate.

For all of the above reasons, NAMI Connecticut opposes SB 967.

Thank you for your attention to my testimony. I would be happy to answer any questions you may have.

Respectfully submitted,

Susan R. Kelley
Director of Advocacy and Policy
NAMI Connecticut