Suggested Technical Revisions to CT Commitment Statutes

During my 27 years as a probate judge, mental health treatment has made amazing advances. One of the most significant evolutionary changes: duration of stay for civilly committed patients has decreased from stays measured in weeks, even months, to stays measured in days. This is largely due to dramatic improvements in psychotropic medications for treatment of bipolar illnesses and psychoses. Increasingly higher percentages of patients admitted on a fifteen day physician's emergency certification are discharged in under a week. When the hospital feels it must extend the fifteen day PEC by filing a civil commitment, in a significant number of cases the patient is discharged even before the matter is heard in court. (In state pay cases, the state must receive 10 days notice.)

The important nexus between admission and discharge is the institution of a medication regimen. By my observation, discharge generally takes place about a week after the institution of meds. If meds against will must be utilized, the delay may be a week or more. Since meds are almost universally a part of successful treatment that means significant hospital time is protective custody, not treatment. This is achieved at huge cost to the system and the patient, both in monetary terms and in the turmoil it imposes on the patient's life.

Finally, it should be noted that yo-yo hospitalizations in which a patient is admitted, medicated, discharged, discontinues meds and is subsequently re-hospitalized are an all too frequent part of the system. I have seen some of my respondents 10 or 20 times in my tenure in this court. Some nursing home residents are hospitalized once or twice a year for medication adjustments that easily could be accomplished in the nursing home. Community based patients often lose housing because of dramatic decompensation and are discharged to shelter type existences.

I propose the following adjustments to the process:

- Currently, a 16th birthday is the date of majority for treatment as an adult under our mental health statutes. This means a sophomore in high school can refuse treatment, prohibit their parent or guardian's involvement in mental health treatment planning, reject medications, or refuse involvement with school based counseling. The age for adult status under mental health laws should be 18.
- Require only one instead of two outside physicians to interview the patients and file a report. The reports are expensive ($400-$750 each) and are of relatively little value. Given the rapid improvement after the institution of meds, a report that is 5 or six days old is often too dated to have meaning. It is basically a précis of the record that almost always confirms hospital staff conclusions.

- Do not require the petitioner to pay for the costs of a civil commitment. The purpose of the process is to help a seriously ill patient—but also to protect the public from a potentially dangerous individual. We have learned in recent weeks the importance of having official review of mentally ill individuals. To require a hospital or individual to foot the cost of a commitment is to impose a burden that discourages applications.

- Modify patient privacy rights by allowing the hospital to talk to outpatient treaters and secure records from former inpatient providers. This is a safety issue since it could provide important guidance on what meds were tried unsuccessfully or induced serious side effects. It could dramatically shorten the time necessary to institute a proper and safe treatment regimen.

- Allow the hospital to talk to anyone with whom the patient has lived in the previous 12 months. This can be an important source of information and can assist in developing the discharge plan for the patient.

- Allow the hospital to talk to parents, siblings or children of the respondent to assist in developing an understanding of the patient's medical needs as well as determining if they are proper resources to help in the discharge plan. Given the abbreviated hospital stay, it is imperative that discharge planning commence upon admission. This cannot be done without access to community supports.

- Allow the court, as part of a commitment application, to order meds against will if the standard established in the current statute is met by clear and convincing evidence.

- Allow meds against will applications to be brought to the court for a patient in a general hospital, convalescent home or group home.

- Allow the court to authorize a conservator appointed to consent to meds to continue to do so for 120 days after discharge from a hospital.

All these measures are a good beginning; they are only a preamble however to what we desperately need: an outpatient commitment statute that will permit mandated treatment for seriously ill patients who are not in a hospital. Many states have adopted outpatient commitment laws and, in light of recent dramatic events involving mentally ill assailants, more states are likely to do so.

Most treatment protocols instituted in the hospital setting can, much more cost effectively, be provided in an outpatient setting. Of perhaps greater importance, by offering the services as a community based treatment option, there is much less intrusion in an individual's life and important life needs such as employment, housing, family relationships and interactions with the criminal justice system are often avoided.

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Judge