



# STATE OF CONNECTICUT

## DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

*A HEALTHCARE SERVICE AGENCY*

M. JODI RELL  
GOVERNOR

THOMAS A. KIRK, JR., Ph.D.  
COMMISSIONER

### Memorandum:

TO: The Judiciary Committee

FROM: Thomas A. Kirk, Jr., Ph.D.  
Commissioner of the Department of Mental Health and Addiction Services

DATE: February 26, 2007

SUBJECT: **Written Testimony on S.B. 1238, An Act Concerning the Civil Commitment of Persons Found Not Guilty by Reason of Mental Disease or Defect**

Senator McDonald, Representative Lawlor and distinguished members of the Judiciary Committee, thank you for the opportunity to submit written testimony on **S.B.1238, An Act Concerning the Civil Commitment of Persons Found Not Guilty by Reason of Mental Disease or Defect**. I regret that I am unable to attend today's hearing, but a scheduling conflict precludes my appearance.

DMHAS has concerns about this proposed legislation and the impact it could have on our current treatment system. When individuals are found not guilty by reason of insanity (NGRI), they are sent to DMHAS for treatment, but their specific case and activity are monitored by the Psychiatric Security Review Board (PSRB). This Board is composed of clinicians, a lawyer, a business person, a probation/parole professional, and a victims' advocate, who make decisions regarding the level of care of an individual's treatment within the Whiting Forensic Division, and when he or she may be moved from one level of care to the next.

The Board was created for the purpose of having an expert body that can deal with the complex psychiatric and forensic issues inherent in this population. In some respects, S.B. 1238 bypasses the reason for which the Board was created, because one cannot assume that at the close of an acquittee's initial commitment, he or she is no longer a danger to self or others.

The Board also plays a very active part in the person's re-entry into the community, which actually helps in many cases to provide a smoother transition. The Board is able to reassure prospective employers and landlords, family members and/or victims that the activities of the individual will continue to be monitored and, should the Board have any concerns about the individual's performance within the community, he or she can be brought back into Whiting for evaluation and additional treatment, if necessary.

The more pressing concern we have about this proposed legislation is one of resources. In Oregon (a state nearly identical in population to Connecticut) there is also a PSRB, but recommitments to their PSRB are not permitted. This makes the insanity defense more “attractive” to defense attorneys and, as a result, Oregon has three times the number of PSRB patients that Connecticut has in our system. For DMHAS that would require constructing a new facility, because we believe we would see an increased number of cases— both felonies and misdemeanors— putting forth a “not guilty by reason of insanity” defense, thus sending more people into our system. Over 80% of the PSRB patients in our system are in a hospital setting in the Whiting Forensic Division, and we are already exceeding the existing bed capacity of Whiting.

Some might argue that we would see a decrease in numbers of individuals at Whiting because the Board would no longer be able to recommit an individual. In the eleven-year period from 1985 to August of 2006, there have been 68 recommitments by the Board. The average length of such recommitment is 2 to 3 years. Our best guess is that the increase in admissions of new PSRB patients would be significantly larger than the number of patients “maxing out” of their commitments for at least several years.

As proposed in this legislation, acquittees would be brought before a probate judge at the close of their commitment and potentially returned to the community, leaving the DMHAS inpatient system. It should be noted here that the Board has a stricter standard for release than would a probate court. Thus, an individual could appear before a probate judge and be permitted to return to the community, without any ongoing supports from DMHAS. That may not be in the best interests of the either the individual or the community. Such a change raises several extremely important questions. What resources would be necessary to keep such individuals safe in the community, and who would provide such oversight? How would DMHAS then be able to locate housing and employment for them? Who would ensure that these individuals remain treatment-compliant after their discharge? Without the Board, and with larger numbers of individuals in this category, these would be difficult questions to answer.

We believe that we need some flexibility as the state agency charged with providing such services. The individuals in question need good clinical care, and the local communities into which they are discharged need to feel safe about the decisions that their elected leaders make. For all of the foregoing reasons, rushing to make this change at this time may not make the most sense.

We ask that the Committee consider having all interested parties meet on this matter over the summer and fall to develop recommendations on how to manage this issue. This could then be addressed in the 2008 legislative session for a resolution.

Thank you for your consideration of this request as you strive to seek a workable solution for all parties to the concerns raised in this bill. I would be happy to meet with you in future, or to provide you with additional information on this matter, as needed.