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Raised Bill 1238
***AN ACT CONCERNING THE CIVIL COMMITMENT OF PERSONS
FOUND NOT GUILTY BY REASON OF MENTAL DISEASE OR DEFECT***

**Judiciary Committee Public Hearing
February 26, 2007**

The Office of Chief Public Defender supports ***Raised Bill No. 1238, An Act Concerning the Civil Commitment of Persons Found Not Guilty by Reason of Mental Disease or Defect.***

Connecticut's Psychiatric Security Review Board (PSRB) has oversight of persons found not guilty by reason of mental disease or defect. Connecticut's PSRB was modeled on that of Oregon and Arizona. But, unlike the jurisdiction of Connecticut's Board which can be extended for life, the maximum period of jurisdiction of the boards of Oregon and Arizona are equal to the maximum sentence provided by statute for the underlying criminal act(s), after which time the state must refer the acquitted person for civil commitment. (See ORS § 161.327 (1) and A.R.S. § 13-3994. D.)

Under Connecticut state law and principles of equal protection, continued commitment under the jurisdiction of the PSRB after the point in time when an acquittee's commitment exceeds the maximum criminal sentence he/she would have served for a conviction of the underlying crime(s) subjects an acquittee to an automatic and protracted review process for increased privileges, change in legal status and release that results in that acquittee receiving more onerous treatment than the other similarly situated class identified by the Connecticut

Supreme Court in State v. Metz, 230 Conn. 400 (1994). An insanity acquittee bears the risk of a materially longer deprivation of liberty by virtue of the inherent differences in criminal (NGRI) and civil commitment proceedings.

It is 'arbitrary' within the meaning of equal protection law to distinguish between an alleged currently mentally ill and dangerous, or gravely disabled insanity acquittee as opposed to an alleged currently mentally ill and dangerous, or gravely disabled prisoner.

The insanity defense in Connecticut, '*not guilty by reason of mental disease or defect*', is an affirmative defense. It must be raised by the defense to go forward. Many insanity acquittals are not contested by the state, but are stipulated by agreement between the prosecution and the defense.

Every criminal defendant acquitted by reason of mental disease or defect undergoes an extensive 45-day in-patient evaluation at the Whiting Forensic Institute of the Connecticut Valley Hospital (CVH). At the end of the 45 day NGRI evaluation, the hospital submits a written report to the Trial Court. In that report, the hospital makes a recommendation for the acquittee's retention in the Whiting maximum secure facility, transfer to a less secure facility or conditional release at the end of the evaluation period. At that point, the Trial Court holds a dispositional hearing. If the Trial Court makes a determination after the hearing that the acquittee remains a danger to him/herself or others based on his/her current mental condition, the Court commits the acquittee to the jurisdiction of the Psychiatric Security Board. Current "mental condition" as applied to insanity acquittees includes any mental illness in a state of remission when the illness may, within reasonable medical probability, become active.

When the Court commits an acquittee to the jurisdiction of the Psychiatric Security Review Board, the Court also sets an initial term of commitment up to, but not exceeding, the maximum penal sentence carried by the crime or crimes of which the person is acquitted. The PSRB then holds its own hearing and makes a ruling on the level of care considering the following factors involving the acquittee: 1. Their illness is stabilized; 2. they are actively participating in treatment; 3. they are not currently violent; 4. they have an understanding of and insight into their illness, the need for ongoing treatment, and the requirements imposed on them by their legal status; and 5. the seriousness of their crimes. (WHITING FORENSIC DIVISION, OPERATIONAL PROCEDURAL MANUAL, Whiting Forensic Division Plan of Care, Discharge criteria and process).

The Psychiatric Security Review Board, created in 1985, is an administrative agency whose members are appointed by the governor. While the purpose of the commitment of insanity acquittees to the Board is for treatment and not punishment, the Board's statutory mandate is "that its primary concern is the protection of society." ("...The Board clearly has the mandate to use a standard that factors of dangerousness and safety to the community take

primary concern over issues of even treatment of what may be in the person's best interest. Joint Standing Committee Hearings, Howard Zonana, M.D., Judiciary, Part 5, 1985, pp. 1518-1520). The treatment paradigm for insanity acquittees includes a gradual, supervised re-entry into society, with a long period of conditional release after the initial period of hospitalization and prior to unconditional discharge.

An acquittee's first access to the community is through the use of temporary leaves. Through temporary leave, acquittees begin the process of community-based treatment but primary clinical responsibility remains with the hospital. 'Community-based treatment' can range from day treatment at regional mental health facilities, day visits with family, and overnight stays in the community ranging from one night to seven nights per week with weekly check-ins with the hospital treatment team. Temporary leave plans for acquittees are typically phased in over periods of time which can range from weeks to years.

An acquittee's final access to the community while under the jurisdiction of the Board is through conditional release. When the Board grants an acquittee conditional release status, the hospital transfers the clinical supervision of an acquittee from itself to a state funded lead mental health authority (LMHA) which then co-ordinates an acquittee's treatment, treatment monitoring, and services.

Transfers in and out of maximum security, temporary leave plans, conditional release plans, and Board recommendations regarding discharge are subject to adversary hearings governed by the Uniform Administrative Procedures Act as adopted by Connecticut. Under the current law, the Board is statutorily required to file a written recommendation with the Superior Court in connection with any application for discharge made by an acquittee and any petition for recommitment made by the state at the end of an acquittee's term of commitment.

An acquittee's initial term of commitment to the jurisdiction of the Board can be extended by the Trial Court upon a petition by the state if the Court makes a finding that the person remains dangerous based on his/her then current mental condition. Board recommendations in the recommitment context are based on projected treatment goals and the protection of society. There are [actual number] acquittees who are currently under Board jurisdiction resulting from multiple recommitments for the same original insanity defense. The rate of recommitment is high if an acquittee remains hospitalized at Connecticut Valley Hospital as the end of his/her maximum term of commitment approaches [approximately 80% circa 1995]. The average length of commitment of acquittees was over 25 years as of 1995.

As a matter of federal constitutional law, an initial adjudication of NGRI through the criminal process is considered the functional equivalent of an **initial** involuntary civil commitment. Jones v. United States, 463 U.S. 354 (1983). A

'presumption of dangerousness' then follows an NGRI acquittee because he/she has already been found to have committed a criminal act. See State v. Metz, 230 Conn. 400 (1994). This 'presumption of dangerousness' justifies the state in placing the burden of proof on an acquittee in all subsequent procedures seeking release and/or movement to a less restrictive environment. In jurisprudential terms, the historical justification for this treatment has been stated as follows: "[An insanity acquittee] need not be overly protected against the possibility that the factfinder will commit [him or her] based on [isolated instances of] unusual conduct. The insanity acquittee already has been found to have committed a criminal act. Furthermore, if an insanity acquittee is committed because of an erroneous determination that he is mentally ill, then the odds are high that he may have been found not guilty on insanity grounds because of a similar erroneous determination that he is not sane. While the acquittee may therefore be erroneously deprived of his liberty in the commitment process, the liberty he loses is likely to be liberty which society mistakenly had permitted him to retain in the criminal process. Concomitantly, while society derives no benefit from erroneously confining ordinary persons who are not in fact mentally ill and dangerous, the erroneous confinement of an insanity acquittee who in fact was not mentally ill at the time of his crime indirectly benefits society by keeping the "sane" criminal off the streets. Stated another way, the freedom an acquittee might lose by virtue of the differences in criminal commitment procedure versus civil commitment procedure, is liberty which an acquittee might have obtained mistakenly by virtue of deficiencies in the original criminal process (e.g., an erroneous NGRI verdict by virtue an acquittee's successful malingering, error(s) in diagnosis, etc.). Society thereby insures that the traditional goals of the criminal justice system, i.e., punishment, deterrence, and rehabilitation are not subverted. Warren v. Harvey, 632 F.2d. 925 (2d. Cir. 1980); State v. Warren, 169 Conn. 207 (1975); Jones v. United States, 463 U.S. 354 (1983).

In State v. Metz the Connecticut Supreme Court identified prisoners as a comparable class to acquittees who have reached their maximum term of commitment equivalent in length of time to the maximum criminal sentence carried by the crime(s) which he/she was/were acquitted of, at least for purposes of shifting the burden of proof in continued involuntary commitment proceedings on the basis of mental illness and dangerousness, or grave disability. State v. Metz, 230 Conn. 400 (1994). In the words of the Court, "[d]espite the substantial degree of legislative discretion recognized [in Connecticut and United States Supreme Court precedents], we are of the view that defendant has raised a serious constitutional concern [of equal protection] in this case. After the expiration of the maximum term of confinement, it is difficult to find a constitutional justification for a categorical distinction between an insanity acquittee and an incarcerated prisoner who was transferred to a mental hospital while he was serving his criminal sentence. In each instance the purpose of commitment "is to treat the individual's mental illness and protect him and society from his potential dangerousness. In each instance, furthermore, the qualitative character of the liberty deprivation is the same, irrespective of the fact that the

Superior Court rather than the Probate Court retains jurisdiction over the propriety of an acquittee's continued commitment."

At the point in time when an acquittee's term of commitment reaches the maximum sentence he/she could have served had he/she been convicted of the underlying crime(s), the historical justification for materially distinguishing insanity acquittees from civil committees for purposes of depriving them of their liberty is no longer applicable. Serving a maximum criminal sentence presumptively satisfies the traditional goals of the criminal justice system. After a criminal sentence has been served, the state is no longer justified in depriving an individual of his/her liberty based on the commission of the underlying crime(s), and cannot further deprive an individual of his/her liberty for reasons of mental illness and dangerousness without providing that person with the procedural and substantive protections of civil commitment law.

In civil commitment, procedural due process is theoretically designed to insure that the risk of error falls on the state as opposed to the individual; the liberty interest of the individual carries great weight in the balancing process than the state's *parens patriae* and police power interests. *Addington v. Texas*, 441 U.S. 418 (1979). For example, the burden of proof by clear and convincing evidence rests on the state and the statutory right of least restrictive placement is explicit. Under Connecticut state law, the risk of error remains on the state in all subsequent proceedings. *Fasulo v. Arafah*, 173 Conn. 473 (1977); C.G.S. §17a-495 *et seq.*, *Definitions. (Persons with Psychiatric Disabilities – Commitment. General Provisions)*. Unlike civil commitment law in most other jurisdictions, subsequent legal proceedings after the initial commitment are mandatory, periodic, and *de novo*. There is no difference between the statutory rights and remedies applicable to prisoners versus individuals outside the criminal justice system regardless of the extent or nature of a prisoner's criminal record.

Connecticut's current civil commitment statutory scheme clearly reflects an emphasis on the protection of an individual's liberty interests as well as a preference for placement in the community as the first option for treatment. The statutory goal of civil commitment is to prepare the patient for discharge with hospitalization as the last resort when all else fails. There is no formal outpatient commitment. The theory behind civil commitment is to expeditiously step the person down from an inpatient setting to an outpatient setting with an institutional preference to do whatever is necessary in the community. Each part of the step down process is not subject to adversary proceedings.

In order to be involuntarily committed to a hospital for psychiatric disabilities in Connecticut's civil system, 'any person' may file an application to the probate court in the district in which the individual resides. C.G.S. §17a-498, *Hearing on commitment application. Notice. Rights of respondent. Examination by physicians. Order of commitment. Election of voluntary status prior to adjudication. Review of confinement*, provides that the Probate Court assign a

time for a hearing not later than ten business days after the filing of the application. As part of the proceedings, the court requires signed certificates of at least two impartial physicians selected by the court, one of whom must be a practicing psychiatrist, and neither connected with the hospital for psychiatric disabilities to which the application is being made, or related by blood or marriage to the applicant, or to the respondent. The certificates must indicate that the physicians have personally examined such person within ten days of the hearing and shall include answers to such questions including, but not be limited to, questions relating to the specific psychiatric disabilities alleged, whether or not the respondent is dangerous to himself or herself or others, whether or not such illness has resulted or will result in serious disruption of the respondent's mental and behavioral functioning, whether or not hospital treatment is both necessary and available, whether or not less restrictive placement is recommended and available and whether or not respondent is incapable of understanding the need to accept the recommended treatment on a voluntary basis. The physicians must state the reasons for his or her opinions on the form. If the court finds at the commitment hearing by clear and convincing evidence that the person complained of has psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled, it shall make an order for his or her commitment, "CONSIDERING WHETHER OR NOT A LESS RESTRICTIVE PLACEMENT IS AVAILABLE, to a hospital for psychiatric disabilities..., there to be confined for the period of the duration of such psychiatric disabilities OR UNTIL HE OR SHE IS DISCHARGED OR CONVERTED TO VOLUNTARY STATUS . . . in due course of law . . .".

At any time prior to adjudication of the application, the subject of an involuntary commitment application must be given the opportunity to elect voluntary status. The status of being a voluntary patient has legal significance. If a voluntary patient wishes to be discharged from a hospital for psychiatric disabilities, and gives written notice to the facility that he or she wishes to be discharged, the facility has a three day window of time to commence involuntary civil commitment proceedings in probate court in order to retain legal custody of the individual.

The probate court in Middletown has jurisdiction over the involuntarily committed patients at Connecticut Valley Hospital. Each civil patient at Connecticut Valley Hospital is required to be notified annually by the hospital that he or she has a right to a de novo involuntary commitment hearing. If the patient requests a hearing it is expeditiously scheduled in accordance with the statutory guidelines. The hospital is required to furnish the probate court on a monthly basis with a list of patients who have been confined for over a year without a new hearing. At each statutorily required annual review, the probate court appoints an impartial physician to examine the patient and report back to the court. Based on the physician's report, the probate court may schedule a new hearing immediately. The statute requires that a patient receive a de novo hearing at least every two years.

There are three major categories of civil patients that enter Connecticut Valley Hospital from the Department of Corrections (hereafter referred to as DOC). These include prisoner transferees who are admitted during the course of their incarceration, prison transferees who have reached the end of their sentence who DOC seeks to commit, and pre-trial prisoners who have been found not competent and not restorable within the statutorily required period of time who the Superior Court refers to the Commissioner of the Department of Mental Health and Addiction Services for civil commitment proceedings pursuant to subsection (m) (*Release or placement of defendant who will not attain competency*) of C.G.S. §54-56d(m), *Competency to stand trial*. Prison transferees ready for discharge who have not reached the end of their sentence are transferred back to the custody of DOC. Prisoners who have reached the end of their sentences and individuals who are referred for civil commitment proceedings pursuant to C.G.S. §54-56d(m) are treated as persons otherwise subject to civil commitment.

The procedure which is typically followed with DOC transferees is that DOC transfers the prisoner to Connecticut Valley Hospital pursuant to a physician's emergency certificate. This procedure allows the hospital to retain legal custody of the prisoner for up to fifteen days. A physician's emergency certificate (P.E.C.) is a document where any licensed physician in the State of Connecticut can examine an individual and commit that individual to a hospital for treatment of mental illness, on the basis of that physician's opinion that the individual has a mental illness and as a result of that illness is either dangerous to self or others or gravely disabled AND IS IN NEED OF IMMEDIATE CARE AND TREATMENT IN A HOSPITAL. Connecticut Valley Hospital must commence formal involuntary commitment proceedings in probate court prior to the expiration of fifteen days in order to retain legal custody of the transferee.

In the event DOC seeks to transfer a prisoner in its custody to Whiting/Connecticut Valley Hospital pursuant to a P.E.C., that prisoner has all of the procedural rights and remedies guaranteed under the civil commitment statutes. Currently, about 15% or more of DOC's prisoner population is being treated at any one time for some form of mental illness exclusive of substance related disorders. A significant percentage of these individuals require anti-psychotic medication to manage the symptoms of their illness. DOC has currently identified about 10% of its prisoner population (approx. 1,500) as having serious mental health needs. Diagnoses fitting the category of major mental illness include, but are not limited to, schizophrenia, bipolar, and schizoaffective disorder, for example.

For prisoners that DOC has identified as being seriously mentally ill, referral is made to the Department of Mental Health and Addiction Services (DHMAS) three to six months prior to release. A DHMAS staff member visits that person in the institution and creates a discharge plan. Such a plan would

typically include elements to insure that these individuals have entitlements in place, housing, case management services, psychiatric appointments, and follow-up appointments with a therapist or other treatment providers if needed. Although such a discharge plan is created for most of the DOC prisoners identified as having serious mental health needs, there is no formal mechanism in the DOC programs of care comparable to the standard program of care for PSRB patients. DOC looks to create a discharge plan and/or reentry plan in the first instance, rather than seeking civil commitment.

DOC will typically alert DHMAS only if a prisoner is looking significantly impaired close to his or her release date; DHMAS would then in turn try to find an appropriate bed in the community to meet the needs of that person. If on the day (or very close to the day) that person was to be discharged, such a prisoner's behavior is such that he or she appeared to be grossly impaired, DOC would have one of their psychiatrists evaluate him or her for purpose of preparing a PEC and transferring the person immediately from DOC to a hospital. If an identified mentally ill individual has been reasonably compliant in DOC, i.e., basically following the rules, though not actively participating in any specific treatment, DOC does not generally seek to involuntarily commit that individual.

Upon admission to Connecticut Valley Hospital as an inpatient, DOC transferees are assessed as to whether they need a hospital level of care or less than a hospital level of care. With the exception of prisoner transferees who have not completed their sentence, the first preference is to look at whether treatment can occur in the community and if so, whether resources are available to do so. From a clinical standpoint, achievement of clinical stability for the patient is the initial goal. While the state of 'clinical stability' in the context of civil commitment is difficult to quantify in the sense that manifestations of mental illness in any one individual can be relative, the hospital would generally expect to see a significant reduction of active symptoms, the absence of assaultive conduct for a period of time (typically six months or less in the civil commitment context), and an ability on the part of the patient to discuss the issue of discharge planning, or in the case of the patient categorized as 'gravely disabled', an assessment as to whether the individual can be managed in existing community programs.

Patients assessed as requiring a course of hospitalization for six months or more are typically placed at Whiting or in the general psychiatry unit at Battell Hall, a less restrictive facility than Whiting. For the "typical" patient assessed at needing six months of care or longer, there is a model time line of less than two years from admission to community placement, at which point involuntary commitment legally ends. Obviously there is a category of civil patient, members of which more often than not fall into the category of "gravely disabled", whose length of hospital stay is measured in terms comparable to the average length of stay of PSRB acquittees. Patients assessed as needing less than six months of hospitalization are placed in one of four shorter stay in-patient facilities, Capital

Region Mental Health Center (Hartford), Greater Bridgeport Mental Health (Bridgeport), Connecticut Mental Health Center (New Haven), or Cedarcrest (Newington). In these facilities, inpatient stays range from one to two months or less, or up to one year in unusual cases, or cases in which there is a lack of appropriate or available housing for the patient in the community. The only obstacle to a timely placement may be long waiting lists in particular programs. Those patients who are assessed as not needing a hospital level of care may be placed directly with local community mental health authorities (LMHA) in respite beds, group homes, or otherwise with wrap around services similar if not identical to the wrap around services arranged for prisoners in the DOC re-entry program.

Most of the long term insanity acquittees would fall under the legal category of 'danger to others'. The label 'insanity acquittee', however, is a legal term and does not have any clinical significance in and of itself in terms of assessing a person's clinical level of dangerousness after the lengthy period of commitment experienced by the average insanity acquittee. The typical acquittee under the jurisdiction of the PSRB who has reached the level where he/she has earned unsupervised grounds passes on hospital grounds, let alone temporary leave and conditional release status, would not meet civil commitment criteria as currently understood and applied. Effectively, Connecticut Valley Hospital employs parallel commitment systems which do not operate according to the same clinical criteria; a case can be made that the system applied to insanity acquittees is not even consistent with the Practice Guidelines for Recovery-Oriented Behavioral Health Care as promulgated by the Connecticut Department of Mental Health and Addiction Services. Both systems are currently operating at near or above capacity and are not serving the needs of either population in the most cost efficient manner and a manner which reflects best psychiatric practice.

For the reasons cited, the Office of Chief Public Defender urges this Committee to support this proposal. Thank you.