

**Task Force to Review and Evaluate CVH and WFH,
the Psychiatric Security Review Board, and
Behavioral Health Care Definitions**

Final Report

Pursuant to Public Act No. 18-86

December 16, 2021

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INTRODUCTION

Over the past two years, we have met with numerous stakeholders who touch the lives of patients at Connecticut Valley Hospital (CVH) and Whiting Forensic Hospital (WFH) from admission to discharge and beyond. This has included representatives from the Offices of the State's Attorneys and the Public Defenders; the Psychiatric Security Review Board (PSRB); administrators and staff members from both hospitals, CVH and WFH; the Whiting Advisory Board; the Offices of the Victims' Advocates and Victim Services; the Department of Public Health; advocacy groups including Connecticut Legal Rights Project (CLRP) and Disability Rights Connecticut (DRCT); community service providers including Mental Health Connecticut, The Institute of Living, Community Health Resources, Connecticut Mental Health Affiliates, and Connecticut Coalition to End Homelessness; and the unions representing healthcare providers. We have heard testimony from current and former patients and staff members of both hospitals, as well as family members and other concerned citizens in the community¹.

Numerous documents were made available to us related to the instances of abuse and neglect that led to the creation of this Task Force and other seminal events in the hospitals' existence². Finally, we enlisted the expertise of the University of Connecticut Center for Population Health to conduct an independent survey of the staff of both hospitals, to obtain their input regarding a number of issues brought to our attention³. We have posited numerous recommendations for the legislature's consideration and have discussed their merits, implications, and practicalities. This report is the product of those meetings, reviews, and discussions. We hope that it contributes to your efforts in drafting legislation to address the issues exposed by the events of 2017.

There were three overarching themes that arose from our analysis and drove specific recommendations: the conditions, culture, and operations of the hospitals, particularly the physical plant of the Whiting facility; respect of patients; and accountability across the system. We have organized this Report by the responsibilities enumerated in PA 18-86.

¹ See Appendix A.

² See Appendix B.

³ See Appendix C.

State of Connecticut
GENERAL ASSEMBLY



Public Act No. 18-86

AN ACT CONCERNING WHITING FORENSIC HOSPITAL AND CONNECTICUT VALLEY HOSPITAL.

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

Section 1. (Effective from passage) (a) There is established a task force to (1) review and evaluate the operations, conditions, culture and finances of Connecticut Valley Hospital and Whiting Forensic Hospital, (2) evaluate the feasibility of creating an independent, stand-alone office of inspector general that shall be responsible for providing ongoing, independent oversight of Connecticut Valley Hospital and Whiting Forensic Hospital, including, but not limited to, receiving and investigating complaints concerning employees of Connecticut Valley Hospital and Whiting Forensic Hospital, (3) examine complaints and any other reports of discriminatory employment practices at said hospitals, except any information or documentation not subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes or any other federal or state confidentiality law, (4) assess the implications of a patient of Whiting Forensic Hospital being permitted to be present during a search of his or her possessions, (5) evaluate the membership of the advisory board for Whiting Forensic Hospital established pursuant to section 17a-565 of the general statutes, as amended by this act, (6) examine the role of the Psychiatric Security Review Board established pursuant to section 17a-581 of the general statutes, (7) evaluate the need to conduct a confidential survey regarding the employee work environment at Connecticut Valley Hospital and Whiting Forensic Hospital, including, but not limited to, worker morale, management and any incidences of bullying, intimidation or retribution, and (8) review the statutory definitions of abuse and neglect in the behavioral health context.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a senior administrator of a behavioral health facility, and one of whom shall have law enforcement or corrections experience or experience working in a secured facility;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a psychologist or psychiatrist with forensic experience, and one of whom shall be a person who has lived with or experienced mental illness;

(3) One appointed by the majority leader of the House of Representatives, who shall be a former or current administrator of a hospital with a bed capacity of at least two hundred;

(4) One appointed by the majority leader of the Senate, who shall be a patient advocate;

(5) One appointed by the minority leader of the House of Representatives, who shall have experience providing direct care services to persons with behavioral health disorders; and

(6) One appointed by the minority leader of the Senate, who shall have experience providing direct care services at a hospital.

(c) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The chairperson of the task force shall be selected from among its members. Such chairperson shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.

(f) In performing its review and evaluation under subsection (a) of this section, the task force may hold a public forum, which shall provide opportunity for public comment.

(g) Not later than January 1, 2019, the task force shall submit a preliminary report, in accordance with the provisions of section 11-4a of the general statutes, on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Not later than January 1, 2021, the task force shall submit a final report on its findings and recommendations to said joint standing committee. The task force shall terminate on the date that it submits such final report or January 1, 2021, whichever is later.

Task Force to Review and Evaluate CVH and WFH, the Psychiatric Security Review Board, and Behavioral Health Care Definitions

Membership List

Name	Area of Specialty	Appointing Authority
Paul Acker Chief of Staff, Advocacy Unlimited	Person who Has Lived with or Experienced Mental Illness	Senate President Pro Tempore of the Senate Martin Looney
Nancy Alisberg, J.D. Former Managing Attorney Office of Protection and Advocacy for Patients with Disabilities and Former Legal Director of Disabilities Rights Connecticut	Patient Advocate	Majority Leader of the Senate Robert Duff
Kimberly L. Beauregard, LCSW President & CEO Intercommunity Health Care	Senior Administrator of a Behavioral Health Facility	Speaker of the House of Representatives Joseph Aresimowicz
Lori Hauser, PhD, ABPP Board Certified Forensic Psychologist, Whiting Forensic Hospital	Psychologist or Psychiatrist with Forensic Experience	President Pro Tempore of the Senate Martin Looney
Michael P. Lawlor, J.D., Associate Professor of Criminal Justice, University of New Haven Former Undersecretary for Criminal Justice Policy and Planning, Office of Policy and Management; and Former State Legislator, CT State House of Representative	Individual with Law Enforcement or Corrections Experience or Experience Working in a Secured Facility	Speaker of the House of Representatives Joseph Aresimowicz
Shaun Mastroianni Manager of Assisted Living Facility, Stonington, CT	Individual with Experience Providing Direct Care Services to Persons with Behavioral Health Disorders	Minority Leader of the House of Representatives Themis Klarides <i>Resigned 10/13/2020</i>
John F. Rodis, MD, MBA, FACHE President, Saint Francis Hospital (2015-2020). And previously served as Saint Francis Executive VP, COO, and Chief Physician Executive.	Former or Current Administrator of a Hospital with a Bed Capacity of at least Two Hundred	Majority Leader of the House of Representatives Mathew Ritter
Linda Spoonster Schwartz, RN, DrPH, FAAN Associate Clinical Professor of Nursing, Yale University, Former CT Commissioner of Veteran Affairs (2003-2014) and Former Assistant US Secretary of Veteran Affairs for Policy and Planning.	Individual with Experience Providing Direct Care at a Hospital	Minority Leader of the Senate Leonard Fasano

Conditions, Culture, and Operations of the Hospitals

Review and evaluate the operations, conditions, culture and finances of Connecticut Valley Hospital and Whiting Forensic Hospital (PA 18-86, Sec. 1 (1))

One of our main charges from the legislature was to conduct a broad-strokes assessment of the inter-workings of the hospitals. Several recommendations flowed from that assessment.

Physical Plant

Findings:

The Task Force toured the maximum-security Whiting building and the adjacent enhanced-security Dutcher building of WFH. We also had the opportunity to speak with patients, staff, and advocates regarding the facility. The overarching consensus was that the hospital buildings, work areas, and living quarters are in poor condition, particularly with respect to the Whiting building.

There are numerous safety issues related to the outdated design of the Whiting building. We heard complaints of vermin, broken equipment, lice, and stark, primitive conditions. The ability of patients and staff to circumnavigate from one part of the building to another is limited to a single hallway. A number of stairwells do not have cameras. A number of program areas are located in windowless basement areas. Natural light is minimal in most patient rooms. Outside recreation is limited to a single diamond-shaped area. Collectively, the rundown and dreary surroundings seem to contribute to a palpable and pervasive atmosphere of hopelessness which is compounded by fear and constraints. There was unanimous agreement that these aspects of the maximum-security facility are, in part, a reason for hopelessness on the part of patients and low morale on the part of staff.

Whiting's maximum-security building has a capacity of 91 beds, with an additional unit that can accommodate 20+ beds that is currently off-line due to staffing shortages⁴. When the enhanced-security Dutcher building reaches its maximum census (138 beds), competency restoration patients that could be maintained there are housed in the maximum-security Whiting building, sometimes with acquittees and other long-term treatment patients. Patients in both buildings voiced complaints that comingling these populations is not tenable and often leads to confrontations and clashes among patients. In some cases, competency restoration patients who are unable to be recommended as restored to competency, become civil patients and then remain mired in the most restrictive confines and level of care in the Whiting building while they await a suitable discharge placement.

⁴ Of note, as of June 2021, a second long-term treatment unit is temporarily closed due to staffing shortages, making the current capacity 79 beds.

At the June 17, 2019, meeting of the Task Force, then Chief Executive Officer Hal Smith and Chief Medical Officer Dr. Tobias Wasser announced among their plans for improvements at WFH: a) the “development of a strategic plan using change management technology”; b) improving both patient and staff morale; c) increasing programming across all disciplines; d) seeking Joint Commission accreditation; and e) furthering a funded architectural study that reportedly was in progress. To the best of our information, this has not happened yet.

Recommendations:

The Task Force recommends that the Connecticut General Assembly authorize immediate consideration of a new maximum-security facility with an architectural design that would promote recovery and healing, meet modern standards for appropriate long-term care in a secure setting that is safe, healthy, and be conducive to creating diverse environments and security zones that better match patient needs. This process should include:

- the development of a comprehensive Facility Master Plan for the future delivery of competent, cost-effective care and treatment of Connecticut’s forensic patient population. This should be a dynamic process of review and revisions to assure patients have the state-of-the-art programs and services available to them. It should include input from all relevant stakeholders, including patients, throughout the process;
- a careful assessment of current and future service needs for beds in a new facility that takes into account the evolving standards of the care and treatment of patients and the impact of reforms and policies suggested in this report and adopted by DMHAS or legislated by the Connecticut General Assembly;
- a stated goal of both safety and recovery, and a pathway toward community reintegration. The facility should be designed to support a continuum/progression of steps and individualized care for each patient from admission to discharge with the ultimate goal of achieving their highest level of social, emotional, and physical health;
- a milieu that incorporates patient self-enrichment, creative activities, basic and advanced educational pursuits, vocational training, and mastery of independent living skills to foster a safe and confident transition to life in the community as an intrinsic part of the facility; and
- creation of a patient experience that is an incubator for growth, flowing from an individualized care plan that engages the patient as an active participant and includes adequate preparation to be safe and successful in returning to the community.

The Task Force also discussed the need to strengthen community-based services and supports (see Community Services below) and highlighted the importance of creating a hospital environment that affords a more seamless transition to community living. Some members of the Task Force believe that this could involve the creation of modified units, or ‘apartment-style’ residence settings that afford more opportunity for teaching individuals independent living skills in a safe and secure environment. These additions to the therapeutic program would provide

‘hands on’ experiences in a supportive and educational atmosphere intended to contribute to a sense of confidence and success as patients re-enter the community⁵. Others on the Task Force opined that these services can and should be provided in the community itself and that a patient’s stay in the institution should not be prolonged when it is possible to provide such services in the community. Ultimately, the Task Force members were in unanimous agreement that when determining where monies are to be allocated, preference should be given to community services over institutional enhancements.

Competency Restoration⁶

Findings:

A recurrent theme of our discussions over the past two years was the practice of admitting certain groups of individuals to the maximum-security portion of WFH, and whether there are alternative options. We learned, for instance, that there are occasions in which individuals with low-level, nonviolent charges and little to no bond are sent to the maximum-security wards of the hospital for competency restoration. Relegating this category of patient to the most restrictive echelon of care seems counterproductive and punitive. Frequently, these individuals remain hospitalized for several months, only to have their criminal cases resolved through some type of treatment-related disposition in the community once they are deemed competent by the court. Some, who are unable to be restored, may remain in the hospital for considerably longer periods of time while awaiting placement in the community.

To provide some context on the national level, while the number of individuals getting arrested has trended down significantly in recent years, the number of individuals being referred for competency evaluations has trended up, resulting in a greater percentage of individuals in the criminal justice system being referred for competency evaluations and/or restoration. This has resulted in a nation-wide push to re-examine the competency process in an effort to find ways to better utilize sparse mental health resources.

Recommendations:

A key component of that reform is attempting to reduce the number of individuals who get entrenched in the competency process in the first place and, for those who do, to minimize the intrusions on their life and liberty. To that end, the Task Force recommends that steps be taken to: 1) expand opportunities for jail diversion at multiple points along the criminal justice process, reserving competency referrals for those cases where jail diversion is not appropriate; and 2) augment the existing structure for conducting competency restoration on an outpatient basis to avoid unnecessary referrals to the hospital. While these tools will not replace the need for inpatient competency restoration when that is the least restrictive environment as a mechanism of our justice system, they certainly can be better utilized to achieve the desired outcomes –

⁵ Citation for article re: Norway (Appendix D).

⁶ Connecticut General Statutes 54-56d (Appendix E).

providing mental health treatment to those who need it – in a more cost effective, relevant, and liberty-affirming manner.

In addition, we discussed the concept of a multi-disciplinary, multi-agency board of diverse stakeholders who work at the intersection of the criminal justice and mental health systems and meet quarterly to discuss issues, policies, and practicalities related to forensic mental health broadly, and competency evaluation / restoration. We believe such a group currently exists, specifically, the Behavioral Health Subcommittee of the Criminal Justice Policy Advocacy Commission (CJPAC), and that there have been some recent discussions related to reforms to competency in that venue. However, it is unclear whether this subcommittee historically has been utilized as optimally as it could. Consequently, we recommend that it be revitalized to meet more regularly, more formally, and in a more public and open format, drawing on outside resources to gather information about the latest trends and issues confronting forensic mental health. This group could share data, perspectives, and ideas across agencies to identify which policies and practices are having a meaningful, desired impact and which need to be amended or discarded. Cross-agency training and feedback would help all to develop a collective understanding of how decisions in one area of the system affect all others, with the goal of creating a cost-effective utilization of resources and improved services throughout the system.

As a specific example of an area in which cross-agency training and collaboration can be beneficial, we recommend that all relevant court actors who play a role in requesting, opposing or ordering competency evaluations of criminal defendants (e.g., judges, prosecutorial officials, defense attorneys, public defender social workers, bail commissioners) be provided with ongoing training regarding the non-judicial alternatives available to defendants who present as having an apparent behavioral health issue. Specifically, training should include information regarding the practical implications of competency evaluations ordered pursuant to Section 54-56d of the Connecticut General Statutes. This training should include the cost, time, and resources involved on the part of the mental health professionals who perform the evaluations, the standards used in making these determinations, and the possible outcomes of competency evaluations. Priority should be given to Geographical Area courts that statistics show to have demonstrated a high propensity to order such evaluations.

Patient Care and Programs

Findings:

A common theme that ran throughout patients' testimony that we heard was the lack of opportunities for recovery, healing, meaningful growth, learning, and vocational advancement in both hospitals. It appears as though there are more opportunities for inmates in the Department of Correction facilities than in our State psychiatric and forensic hospitals. Such skills are vital not only in providing a pathway to independent functioning in the community but also to instilling self-esteem, hope, and purpose within the hospital.

Another theme drawn from patients' testimonies regarding their overall treatment at the hospital was substantial evidence of barriers with trust, favoritism, and mixed messages between different parties: staff to patients; staff to staff; and staff and patients of the hospital to outsiders.

Recommendations:

We recommend that efforts be made to enhance opportunities and avenues for education (both secondary and advanced), vocational training, and meaningful employment throughout the hospital, and that patients be paid competitive wages for such work. Additionally, patients would be better served by having opportunities for social and community engagement activities (e.g., civic, educational, religious), including those that occur outside of the facility, that would help them to develop confidence, social skills, and connection with the communities to which they will return.

Staff Development/Training

Findings:

The Task Force is in agreement that professionals should not need training to avoid behaviors that are abusive, demeaning, or neglectful. However, we do believe that ongoing staff development, including specific training on how to treat people with dignity, sensitivity, and humanity, is key to maintaining competencies and mitigating the potential for these unacceptable behaviors. Most of the training at DMHAS facilities is accomplished using a web-based computer program. Staff members expressed dissatisfaction with such learning and noted the intrinsic opportunity for team building and actual case discussions when staff training/education is conducted in-person. Investing in preparing a staff that is competent, adequately prepared, and sufficiently supported in their roles is more likely to result in responses that are reasonable, effective and use sound clinical judgment in the most chaotic situations.

We also found that critical/sentinel events and/or actual patient crisis situations are debriefed with staff in a perfunctory and inconsistent manner, if at all. These unexpected and oftentimes dramatic situations provide learning opportunities that are relevant and set the tone for staff expectation in crisis situations. Discussing actual events afterward also demystifies and clarifies these complex situations and provides insight into best practices, 'dos and don'ts,' and realistic lessons learned.

Recommendations:

We recommend that modifications be made to the existing training protocols. Specifically, training should:

- be in person and not online so people can have meaningful discussions about the training topics using examples that occur in the setting in which they work;

- be ongoing (i.e., conducted both upon hiring and at regular intervals throughout employees' tenure per the existing contractual agreement);
- draw upon and utilize the talent available within DMHAS so that staff can take ownership of their work environment, be rewarded for their expertise, and be in a better position to apply that knowledge to the specific work environment; as well as
- bring in a variety of speakers from outside of DMHAS so that staff develop multiple lenses through which to view their work; and
- cover content applicable to the setting. This may include but is not limited to training in the areas of: diversity and inclusion; systemic biases; techniques for de-escalation; recovery principles; team cohesion and communication; forensic issues and a thorough understanding of serious mental illness and personality dynamics.

In addition, management should utilize in-house video data as 'teachable moments' following significant events. They should provide regular (quarterly) summaries of the data stemming from these video reviews, including the proportion of incidents that result in some type of supervision, counseling, or discipline.

We also strongly support changes to licensure guidelines to mandate that all licensed clinical professionals obtain annual continuing education credits in their field. Currently, some professions (e.g., psychiatry, psychology, social work, recovery support specialists) require this, or at least include it as part of their Code of Ethics. However, it is our belief that it should be required of all staff, including but not limited to nurses, rehabilitation therapists, occupational therapists, etc. Currently, nurses are not required to obtain any continuing education credits.

Finally, thought should be given to creating training/education opportunities that contribute to a staff member's potential for promotions and/or advancement within the system, in order to incentivize enrichment and enhancement of one's knowledge/skills.

Community Services

Findings:

The Task Force was in unanimous agreement that certain shortfalls and inequities in the provision of community services – e.g., housing, employment, health care, etc. – need to be addressed in order to facilitate discharge from the hospital for patients who are ready to make that transition. While this may be seen as an ambitious, multi-faceted and expensive goal, the Task Force strongly encourages that steps be taken toward developing robust community resources. Successful transition from hospital to home is a challenging time for any patient, more so when the individuals are re-entering the community after lengthy hospitalizations or facing new living situations. Connecticut has chronically underfunded community-based resources that can support people in a far more cost-effective, productive, and compassionate way than institutional care. With the oversight we propose by the creation of the Office of the Inspector

General (detailed later in this report), we expect that community services will include adequate housing with decent living conditions, increased funding for proven community services to address physical and mental health needs of clients, and competitive employment opportunities and peer support programs that promote recovery.

Recommendations:

As part of the Facility Master Plan for forensic and psychiatric services at CVH and WFH recommended earlier, discharge and return of patients to the community must be factored in. The challenge is to create a network of community services and providers with adequate funding, resources, and programming that accommodate the needs of patients discharged from State-operated institutions to the community. This includes housing that is affordable and accessible with sufficient services and support programs. Most importantly, funding must be made available so that individuals can be discharged when they are deemed ‘discharge-ready’ and that they not have to wait months or years for an available placement. When they are discharge-ready, the goal is that placement shall be made within 90 days.

Relatedly, the Task Force believes that the community providers must be held accountable for their role in providing appropriate placement for patients exiting the hospital. These agencies should be expected to maintain and upload accurate and timely data to the state-wide utilization management database in order to facilitate patients’ placements in community settings once they are discharge-ready. Additionally, we recommend that these agencies be required to report data quarterly regarding: the number of individuals admitted to their setting/agency from the hospital; how long they remain in their care; where they go from there; the reasons for their discharge; and the number of referrals not accepted and the reasons why. Amassing data on this end of the system as well will help to identify pressure points and bottlenecks in the system and the factors that affect patients’ ability to discharge to the community when ready.

Respect of Patients

Two of the charges before this committee focused directly on issues related to respect of patients.

Assess the implications of a patient of Whiting Forensic Hospital being permitted to be present during a search of his or her possessions. (PA 18-86, Sec. 1, (4))

Findings:

The Patients’ Bill of Rights (Connecticut General Statutes Secs. 17a-540-17a-550) establishes specific rights for persons with mental health conditions receiving services from an inpatient or outpatient hospital, clinic, or other facility for the diagnosis, observation, or treatment of persons with mental health conditions. Sec. 17a-548(a), specifically, states that patients shall be permitted (among other things) “to be present during any search of his or her personal possessions, except a patient hospitalized in the maximum-security service of Whiting Forensic Hospital.

The Task Force discussed the implications of removing this exception, from a patients' rights and dignity perspective, as well as from a safety perspective. Allowing people to be present when their belongings are being searched enhances dignity and supports the respect for personal and civil rights, as opposed to creating additional conflict and mistrust. In addition, allowing people to be present during searches of their belongings may reduce patients' complaints about missing or damaged belongings, thereby avoiding the potential for conflict between staff and patients. The Patients' Bill of Rights stipulates that this right is to be restricted if it would be medically harmful to the patient. As such, it provides a mechanism to address extenuating circumstances of clinical concern without infringing unnecessarily the rights and dignity of all patients.

Recommendations:

The Task Force notes the passage of Public Act 21-75 which permits patients "to be present during any search of his or her personal possessions, except a patient hospitalized in the maximum-security service of Whiting Forensic Hospital when such search is conducted by police officers and probable cause exists that contraband or hazardous items are hidden in the patient's living area."

Role of the Psychiatric Security Review Board

Examine the role of the Psychiatric Security Review Board established pursuant to section 17a- of 49 581 of the general statutes

Findings:

The PSRB was established in 1985 in response to sweeping reforms in the insanity defense across the country in the wake of the attempted assassination of President Reagan by John Hinckley, Jr and the subsequent Insanity Defense Reform Act (IDRA). Connecticut is one of only three states that has such an entity. We had several lengthy discussions about the PSRB and its role in the lives of the patients at WFH. Some members on the Task Force expressed the view that the PSRB should be abolished and NGRI acquittees treated akin to civil patients. Others are of the opinion that there is merit in having a PSRB but that there are a number of places where its role can be re-shaped to better respect the rights of all involved.

Those who favored its abolition felt that it violates the rights of people who come before it and makes decisions on a non-clinical basis. Task Force members who were in favor of maintaining the PSRB noted that it provides an arm of oversight for both patients and the hospital. Additionally, the adversarial process ensures that all sides are represented and all perspectives can be heard and resolved.

There was unanimous concern among the members of the Task Force, however, about the lengthy periods of commitment placed upon acquittees found NGRI. A recent telling example of this was a young man who was committed to the PSRB for a period of 120 years. While we

recognize that this refers to one's commitment to the monitoring and supervision of the PSRB, and not to one's commitment to the hospital per se, it does impose a certain 'psychological constraint' that an individual will be incarcerated for a substantial period of time. Imposing such an arbitrary barrier can severely demoralize a person to the point that any treatment efforts are stymied, diminished, and an impediment to recovery.

The stated purpose of the PSRB is to protect public safety; these lengthy commitments do little to further that end. Rather, they seem to be more a mechanism to reassure the public that an individual will never get out of an institution. Per statute, once an individual has received appropriate treatment such that they no longer pose a danger to self or others, he or she must be released to the community. To do otherwise goes against all principles of recovery and criminal justice.

Recommendations:

The majority of the members of the Task Force agreed that abolishing the PSRB should be considered. If that is not to occur, however, there was near-agreement among the members of the Task Force about a number of ways that the PSRB could be modified to better respect the rights of acquittees, while balancing that with the need to protect the safety of society. Many of these were raised in Senate Bill 294, originally proposed during the 2018 legislative session, but we will summarize them here for convenience:

- Section 2: Consistent with Senate Bill 2018-294, we recommend that 17a-584 be amended to guide the PSRB to balance the protection of society with the rights to which all institutionalized patients are entitled under state and federal law (specifically pursuant to 17a-541), including the right to placement in the least restrictive environment.
- Section 3(c): Currently acquittees' periods of commitment can be extended indefinitely. We strongly disagree with this never-ending cycle of re-commitment and recommend that 17a-593 be amended to remove this cycle. Instead, once an acquittee's commitment has expired, the State should have to apply for Civil Commitment pursuant to part II of chapter 319i, if they believe the patient continues to be a danger to self or others or gravely disabled. Otherwise, the patient must be released.
- Section 4(c): Under the current statute, patients have no right to petition the PSRB regarding their release from the hospital; they are able only to petition the Superior Court for their release from the jurisdiction of the PSRB. Consequently, we recommend that 17a-587 be amended to permit patients the opportunity to petition the hospital for temporary leave and that this be a clinical decision, rather than decided by the PSRB.
- Section 7: Finally, we believe that the placement and movement of patients within the hospital setting should remain a clinical one, not a judicial one, that is orchestrated within the administrative ranks within the hospital. This is the case in the correctional system, where the Department makes all decisions on placement of inmates and the majority of decisions related to supervised release into a halfway house or directly into the community, without the involvement of judicial players. The Task Force recommends

that 17a-599 be repealed, eliminating the role of the PSRB in the internal movement of patients within the hospital (i.e., from the maximum-security Whiting building to the enhanced-security Dutcher building).

In addition to those points highlighted in Senate Bill 2018-294, the Task Force agreed that a review of an acquittee's commitment once every two years is far too long a period of time. We recommend that the PSRB statute be amended such that a review is conducted every six months unless the patient specifically waives the right to such review.

Dissenting opinion: Dr. Hauser agreed with most of the above recommendations. With respect to Sections 4(c) and 7, she noted that these cases are still inherently tied to the criminal justice system, and that the victims in these cases still retain certain rights that also must be respected. As such, while she agreed that patients should have the right to petition for advancement through the system (i.e., transfer out of maximum-security, granting of temporary leave, etc.), she argued that the decision should remain embedded within the adversarial process, with both sides (State and Defense) having opportunity to weigh in, and a neutral, objective trier of fact (the PSRB) to make the ultimate decision. As an alternative, Dr. Hauser recommended that 17a-599 be amended to allow parties (the State and the Defense) the choice to stipulate to a request for internal transfer within the hospital, and that the PSRB be notified, rather than hold a full hearing, in these cases. In addition, she suggested that an annual review of acquittees' cases (akin to that used for civil patients) be utilized instead of the biennial review under current statute, and that acquittees have the right to waive that review if they choose. The other members of the Task Force did not concur with Dr. Hauser's recommendations.

Accountability

Accountability needs to be enhanced throughout the system. The Task Force applauds the steps that were taken legislatively in the immediate aftermath of the abuse/neglect coming to light. Reporting of abuse was made mandatory and employees were made criminally liable for failure to do so. WFH was brought under the investigative purview of the Department of Public Health by virtue of its licensure, as directed by statute. Numerous independent entities, including this Task Force, were called upon to conduct investigations of various sorts to identify systemic issues and to make recommendations for their remedy.

Three of the charges before this committee were meant to address potential shortfalls in accountability and oversight.

Independent Office of Inspector General

Evaluate the feasibility of creating an independent, standalone office of inspector general that shall be responsible for providing ongoing, independent oversight of Connecticut Valley Hospital and Whiting Forensic Hospital,

including, but not limited to, receiving and investigating complaints concerning employees of Connecticut Valley Hospital and Whiting Forensic Hospital (PA 18-86, Sec. 1 (2))

Findings:

There is an obvious and critical need for oversight by an external authority that has the power to effect remedies to situations in a timely manner. Both facilities have a long history of violations in the standard of care (including overuse of restraint/seclusion, failure to provide for the safety and well-being of patients, incidents of abuse/neglect, etc.) that have drawn the attention of oversight agencies. This recurring theme suggests that systemic changes are required, rather than the temporary fixes, or a ‘Band-Aid’ approach, that has been utilized to date. There is a critical need to engage the full attention of all relevant stakeholders – including licensing agencies, professional communities, and the public – and the authority of the Governor and the Connecticut General Assembly to bring about change. An Office of the Inspector General with powers to investigate situations, to require the attention and response of the agency, and to make recommendations for corrective actions would be a positive force that could affect meaningful change and minimize harm. In our review of this issue, members of the Task Force came to the conclusion that the standards and quality of the vast array of DMHAS services and programs would benefit from the independent oversight of an Office of the Inspector General.

Recommendations:

We recommend that an Office of the Inspector General (OIG) be created with the authority to investigate complaints of patient abuse, safety violations, improprieties, and irregular situations that pertain to patient care and employee complaints. We recommend that this OIG have jurisdiction over all DMHAS-funded state psychiatric hospitals, and we strongly advise that its jurisdiction be extended to cover all DMHAS-funded agencies.

In terms of its scope and structure, this OIG should:

- be provided with the tools, resources, and staffing necessary to field and investigate complaints – from patients, staff, family members, advocates, etc. – and to make recommendations to the existing DMHAS hospital advisory boards regarding specific action plans to address those complaints;
- have the authority to receive and review any records of the hospitals (under the standard expectation to preserve the confidentiality of said records) necessary to complete its investigations;
- be required to report quarterly to the DMHAS hospital advisory boards regarding ongoing action, and to submit a report annually regarding complaints received, recommendations made, and resulting outcomes, to the DMHAS Commissioner for responses and remedial actions initiated;

- have the authority to require that the hospitals (or overarching agency, DMHAS) issue a formal response in writing addressing the recommended actions and engage in efforts at mediation, if necessary, to reach a resolution; and
- submit an annual report, along with the response(s) from the hospitals or DMHAS Commissioner, regarding their investigations and mitigation of complaints to the Connecticut General Assembly Committee of Jurisdiction, which will be made available for public information and scrutiny.

Whiting Forensic Hospital Advisory Board

Evaluate the membership of the advisory board for Whiting Forensic Hospital established pursuant to section 17a-565 of the general statutes, as amended by this act. (PA 18-86, Sec. 1 (5))

Findings:

After hearing from members of the Whiting Advisory Board (WAB), the Task Force concluded that this body is a shell of what it could and should be. The WAB members are appointed by the Governor for five-year terms. According to Connecticut General Statutes Title 17a-Chapter 319i, Sec17a-565: “Said board shall confer with the staff of the hospital and give general consultative and advisory services on problems and matters relating to its work. On any matter relating to the work of the hospital, the board may also confer with the warden or superintendent of the affected Connecticut correctional institution.” However, William Wynne, Chairman of the WAB, noted in a written statement to the Task Force:

In June 2017, I was asked to become chairman. It was shortly after this time that the revelations of abuse of the patient at Whiting became public. To the members of the Board, we were as shocked as persons of this Task Force and members of the general public. We were never advised by administration at Whiting that the incident had occurred, that there were numerous suspensions of staff or the fact that there was an investigation being conducted by the Federal Department of Health and Human Services. Upon learning there was a written report by the Department we requested a copy from the Department of Mental Health and Addiction Services. We were refused a copy and were told that we had to make an Independent Freedom of Information Request from the State Department of Health. (Wynne, September 8, 2020)

Recommendations:

We recommend that the nature and authority of the WAB (and its corollary boards at CVH and other State-operated inpatient hospitals) be modified to be more in accordance with an oversight commission or civilian review board. Specifically, we recommend that WAB be granted more authority to make recommendations, in large part based on the recommendations of the

aforementioned OIG, and that representatives from the hospitals and/or DMHAS be required to respond to such in writing.

In the course of preparing this report, we learned that legislation was passed to add two individuals with lived experience, including one who has been hospitalized, to the WAB. We support this legislation and additionally recommend that the membership of this oversight commission be expanded to include other important stakeholders (for instance, for the WAB someone with direct forensic experience; for all commissions, a member of the general public). We recommend that this commission be able to request, receive, and review data more readily to identify inequities in the treatment and care of vulnerable individuals.

A related but broader aspect of ensuring accountability across the system is mandating the regular reporting, assimilation, and analysis of data by external agents. This practice can raise awareness, expose deficiencies and inequities in practices, and lay the groundwork for making improvements and tracking their progress. As such, we recommend that all State-operated psychiatric inpatient facilities be required to report data quarterly to the OIG regarding the racial, ethnic, and language breakdown of individuals submitted to involuntary psychiatric treatment, including civil commitment, involuntary medication, involuntary electroconvulsive shock therapy (ECT), restraint, and seclusion.

Finally, to ensure fairness and equity in the hiring, training, and disciplinary practices of these facilities, we recommend that all State-operated inpatient hospitals be required to report data quarterly to the OIG regarding: 1) staffing vacancies and plans to rectify these conditions; 2) adherence to training needs (as outlined above); and 3) investigations of staff misconduct, including breakdown of disciplinary measures by race/ethnicity, gender, and job class, and the timeliness of their resolution (i.e., days from opening to closing an investigation).

Statutory Definition of Abuse and Neglect

Review the statutory definitions of abuse and neglect in the behavioral health context. (PA 18-86. Sec.1, (8))

Findings:

The Task Force reviewed and discussed the existing statutory definitions of “behavioral health facility” per CGS §17a-488, as well as definitions of “neglect” in various local, state, and national codes.

Recommendations:

We recommend that the statutory definition of “behavioral health facility” in CGS §17a-488 be changed to match the definition of “facility” in CGS §17a-540 (the Patients’ Bill of Rights): any inpatient or outpatient hospital, clinic or other facility for the diagnosis, observation or treatment

of persons with psychiatric disabilities. Currently, the law as amended applies only to DMHAS-operated facilities. There is no reason to think that abuse, neglect and exploitation only happen in facilities staffed by state employees. The statute should apply to all facilities covered by the Patients' Bill of Rights.

Further, we recommend that "neglect" within the behavioral health context be defined to include the failure by a caregiver, through action or inaction, to provide an individual with the services necessary to maintain his or her physical and mental health and safety, including but not limited to protection against incidents of inappropriate or unwanted individual-to-individual sexual contact, harassment, taunting, bullying, and discrimination. Consequently, mandated reporters should be required to report suspected neglect as well as suspected abuse.

Also related to statutory definitions in the Connecticut General Statutes, we recommend that the exemption of all State-operated inpatient hospitals from the purview of Connecticut Department of Public Health (DPH) oversight be removed, and that all DMHAS facilities should be required to be licensed by the State.

Staff Perspectives

Evaluate the need to conduct a confidential survey regarding the employee work environment at Connecticut Valley Hospital and Whiting Forensic Hospital, including, but not limited to, worker morale, management and any incidences of bullying, intimidation or retribution. PA 18-86, Sec. 1 (7).

Examine complaints and any other reports of discriminatory employment practices at said hospitals, except any information or documentation not subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes or any other federal or state confidentiality law PA 18-86, Sec. 1 (3).

The Task Force elected to request funding from the Connecticut General Assembly to create a Memorandum of Understanding with the University of Connecticut Health Center to conduct a confidential survey aimed at assessing the morale, work environment, and managerial climate, including any incidences of bullying, intimidation or retribution, at CVH and WFH. The survey used a non-experimental, descriptive design using both qualitative and quantitative methods to describe the environment of the hospitals and the perspectives of the staff. Data collection occurred between March 15, 2021, and March 31, 2021. A total of 417 employees responded out of 1,520 solicited, for a response rate of 27% (see Appendix B for complete details and analysis).

The Task Force learned the following from the survey results:

- A majority of the employees like the work they do. They get intrinsic satisfaction from it, know what is expected of them and how they fit into the organization, and generally get along with their colleagues.
- However, 66% of the respondents felt that their organization was not a good place to work, citing insufficient resources and supports, poor physical conditions, and low morale; the latter was particularly true for those in direct patient care. Almost 80% of respondents indicated staffing shortages were common on their unit.
- More concerning, survey responses revealed a substantial amount of incivility and/or bullying at the hospitals. Almost 90% of respondents, which equates to almost 24% of the total work force, reported experiencing at least one non-violent, uncivil behavior in the past six months, and a clear majority reported witnessing the bullying of co-workers by managers, supervisors, peers or supervisees.
- Employees expressed positive regard toward the teams with whom they worked, with a general view of team cohesion and support. More negative views were expressed regarding management: Less than 25% of employees indicated that they had confidence in management, and less than 20% believed that management valued constructive criticism. Overall, management was assessed more negatively by employees who worked overtime, especially if it was mandatory (which equates to those in direct patient care).
- A significant number of employees of color reported instances of discrimination, four times the proportion that their White colleagues experienced. Those experiences appear to be concentrated among those in direct patient care. Comparing the two hospitals, twice as many employees at WFH reported feeling discriminated because of gender, when compared to CVH.

In summary, we saw three dominant themes arising from the staff survey, themes that were echoed in other testimonials and documents we reviewed: staffing shortages; bullying and incivility; and a lack of confidence in, and reciprocity with, management. We will address each in turn.

Staffing Shortages

Findings:

Across all of these contexts, we heard numerous reports from staff of excessive ‘mandated overtime’ as frequent as two shifts per day for weeks at a time; denial of earned leave time; and widespread fear of retaliation from administration for questioning these practices. One staff member reported that he had so many shifts of mandatory overtime, he actually slept on the ward to save travel time and energy. Throughout the testimonies, there was a striking contrast of dedicated professionals attempting to provide quality care and their expressed frustrations, disappointments, and dejected descriptions of working conditions and patient care situations.

In June of this year, while preparing this report, the Task Force learned of yet another unit closure in the wake of chronic staffing shortages at WFH. It is clear to us that the mandatory overtime imposed on staff as a result of this shortage is a significant cause of the dissatisfaction many staff experience at WFH and CVH. Without question, these chronic staffing shortages have a serious negative impact on both patient care and staff morale⁷.

Recommendations:

The Task Force believes it is imperative that CVH and WFH be adequately staffed, without the need for cross-coverage of duties or mandatory overtime, to allow for proper care of patients and staff alike. Stretching existing staff to cover additional duties and/or to work extra shifts jeopardizes the safety and quality of care to patients as well as staff's capacity to function at their maximum competency. Toward that end, we believe that something drastic must be done at the highest levels of the State (for instance, the Department of Administrative Services) to re-examine the hiring practices and staffing requirements at the hospitals in order to facilitate smoother transition and replacement of staff due to attrition and retirement, and to ensure adequate numbers of staff to provide sufficient engagement with and treatment of patients. In addition, CVH and WFH should be exempted from all State hiring freezes.

Civil Work Environment

Findings:

Although both the testimonies and survey results from staff pointed to a general sense of cohesion and camaraderie with immediate colleagues, it is particularly alarming that such a high level of bullying, incivility, and hostility in the work environment also exists, including the experience of such from management. Much like staffing shortages, the toll this takes on staff cannot help but be palpable in the overall environment and transmitted to patient care in subtle or not-so-subtle ways.

Recommendations:

Bullying and hostility in the workplace should not be tolerated and must be addressed through ongoing supervision and training, rather than solely through progressive discipline measures once they reach that level. In addition, in an effort to create a more collaborative work environment in which employees feel heard, we encourage the management of both hospitals to hold regular, open dialogues, i.e. Town Hall Meetings with their all staff and all shifts regarding their experiences in the workplace and their suggestions for improvement, and that those ideas be given due consideration. Management needs to engage staff members at all levels, shifts, and service areas in meaningful exchanges about how to retool and recharge the culture and work environment to be positive and fulfilling experiences for both staff and patients.

⁷ Citation for recent news article (Appendix F).

Management

Findings:

The existing contract with Yale University is of concern. Management that is contracted out rather than the day to day engagement of State of Connecticut leadership is not an ideal situation. Even if implicit or unintended, there is too much potential for a conflict of interest in making decisions. Additionally, the oversight of the contract is questionable and there are too many ‘soft’ areas in the contract regarding goals, deliverables, and accountability.

Recommendations:

The Task Force recommends that the relationship between DMHAS, WFH, and Yale University be re-examined. We strongly recommend that both WFH and CVH be under the direct management of State of Connecticut employee(s). The contract that exists with Yale, if the relationship is to continue, should be revised to have clear goals and deliverables with regular reports (at least quarterly) as to progress towards those stated and measurable goals to ensure accountability. Further, a managerial style that embraces a non-hierarchical, collaborative stance, that invites input, discussion, and alternate viewpoints, and that places a premium on its workforce would likely go a long way in creating a more satisfying, rewarding environment that would improve worker morale and retention.

Summary

Being mindful of the circumstances that created this Task Force, members were determined to remain faithful to the charges incorporated in the authorizing legislation. There were three overarching and reoccurring themes that arose from our work and drove specific recommendations: conditions, culture, and operations of the hospitals, particularly the physical plant of the Whiting facility; respect of patients; and accountability across the system. This summary highlights some of the major changes and recommendations to existing practices and policies.

Accountability Across the System

Members of the Task Force agreed that most of the things we learned were not new. Past reports, inspections, studies, and surveys identified many of the same problems noted in this document. What has been missing for years is follow-up and follow-through on corrective actions and changes in operations and processes (clinical, operational, and administrative). For this reason, the Task Force has recommended a system of checks and balances which will enhance the care of patients and the well-being and safety of staff. This includes:

- The exemption of all State-operated inpatient hospitals from the purview of Connecticut Department of Public Health (DPH) oversight needs to be removed; all DMHAS facilities should be required to be licensed by the State.
- An Office of the Inspector General (OIG) should be created with the authority to investigate complaints of patient abuse, safety violations, improprieties, and irregular situations that pertain to patient care and employee complaints. We recommend that this OIG have authority over all DMHAS-funded state psychiatric hospitals, that its jurisdiction be extended to cover all DMHAS-funded agencies, and that periodic reports from the OIG to the General Assembly Committee of jurisdiction be provided.
- The nature and authority of the existing Whiting Advisory Board (WAB) (and its corollary boards at CVH and other State-operated inpatient hospitals) needs to be modified to be in accordance with an oversight commission or civilian review board. Specifically, we recommend that the WAB be granted authority to make recommendations, in large part based on the recommendations of the aforementioned OIG, and that representatives from the hospitals and/or DMHAS be required to respond to those recommendations in writing.
- All State-operated psychiatric inpatient facilities should be required to report data quarterly to the OIG regarding the racial, ethnic, and language breakdown of individuals submitted to involuntary psychiatric treatment, including civil commitment, involuntary medication, involuntary electroconvulsive shock therapy (ECT), restraint, and seclusion, as another mechanism of providing accountability throughout the system.
- To ensure fairness and equity in the hiring, training, and disciplinary practices of these facilities, we recommend that all State-operated inpatient hospitals be required to report data quarterly to the OIG regarding: 1) staffing vacancies and plans to rectify these conditions; 2) adherence to training needs (as outlined above); and 3) investigations of staff misconduct, including breakdown of disciplinary measures by race / ethnicity, gender, and job class, and the timeliness of their resolution.

The Task Force believes these recommendations will provide potent tools to raise awareness, to expose deficiencies and inequities in practices, and to lay the groundwork for making the necessary improvements and, importantly, tracking their progress.

Physical Plant of the Whiting Facility

After touring and visiting both hospitals, we noted numerous safety deficiencies related to the outdated design of the Whiting building. We have described these deficiencies, as well as our vision of what such an environment should look like, more fully in the report. However, the overriding and ultimate goal of individuals entrusted to the care of these facilities should be achieving their highest level of social, emotional, and physical health.

Toward this end, the Task Force recommends that the Connecticut General Assembly authorize immediate consideration of:

- The development of a comprehensive Facility Master Plan for the future delivery of competent, cost-effective care and treatment of Connecticut’s forensic patient population.
- A new maximum-security facility with an architectural design that would promote recovery and healing, that would meet modern standards for appropriate long-term care in a secure setting, and that is safe, healthy, and conducive to creating diverse environments and security zones that better match patient needs.

Conditions, Culture and Operation of the Hospitals

The Task Force identified the need to strengthen community-based services while also creating a hospital environment that affords a more seamless transition to community living. While there was some divergence in the specifics of this approach, there was consensus on the goal of providing opportunities for teaching individuals independent living skills in a safe and secure environment.

Yale Contract

The existing contract with Yale University is of concern. The Task Force recommends that the relationship between DMHAS, WFH, and Yale University be re-examined. We strongly recommend that both WFH and CVH be under the direct management of State of Connecticut employee(s).

Staffing Shortages

In June of this year, while preparing this report, the Task Force learned of yet another unit closure in the wake of chronic staffing shortages at WFH. Without question, these chronic staffing shortages have a serious negative impact on patient safety, quality of care, and staff morale. It is imperative that the Department of Administrative Services make drastic changes to the hiring practices and staffing requirements at the hospitals, and that consideration be given to exempt CVH and WFH from State-mandated hiring freezes to assure safety for all.

The Psychiatric Security Review Board (PSRB)

The PSRB—one of only three in the United States-- was established in 1985, for the stated purpose of protecting public safety. By a 6 to 1 majority, the members of the Task Force agreed that abolishing the PSRB should be considered. If not, however, there was unanimous agreement on a number of ways in which it could be modified to better respect patients’ rights, including: amending the mission of the PSRB to balance protection of society with patients’ rights; ending the option for re-commitment to the PSRB in favor of a civil commitment process, if relevant; allowing patients the opportunity to petition for temporary leave status; and more frequent review of an acquittee’s case before the PSRB unless the patient waives that right. In addition, there was near-unanimous agreement that the placement and movement of patients within the hospital setting remain a clinical decision rather than a judicial one, eliminating the role of the

PSRB in the internal movement of patients within the hospital (i.e., from the maximum-security Whiting building to the enhanced-security Dutcher building).

There also was unanimous concern expressed by the members of the Task Force about the lengthy periods of commitment placed upon acquittees found NGRI.

Competency Restoration

A recurrent theme of our discussions over the past two years is the practice of admitting certain groups of individuals, with low-level, nonviolent charges and little to no bond, to the maximum-security wards of the hospital for competency restoration. Relegating this category of patient to the most restrictive echelon of care seems counterproductive and punitive. Further, there appear to be more individuals funneled into the competency restoration service of the hospital than is necessary, where treatment in the community would be the preferred judicial outcome.

In order to reduce the number of individuals who get entrenched in the competency restoration process in the first place, the Task Force recommends that steps be taken to: 1) expand opportunities for jail diversion at multiple points along the criminal justice process; and 2) augment the existing structure for conducting competency restoration on an outpatient basis to avoid unnecessary referrals to the hospital. In addition, cross-agency training, collaboration, and data sharing can be beneficial in illuminating the systemic factors driving these trends in the justice system. Therefore, we recommend that all relevant court actors who play a role in requesting, opposing or ordering competency evaluations of criminal defendants be provided with ongoing training regarding the non-judicial alternatives available to defendants who present as having an apparent behavioral health issue, and that such actors engage in regular dialogue about ways to modify the system as needed.

Staff Development/Training

The Task Force noted that ongoing staff development, including specific training on how to treat people with dignity, sensitivity, and humanity, is key to maintaining competencies and mitigating the potential for the unacceptable behaviors that led to our creation. Staff members expressed dissatisfaction that DMHAS facilities rely heavily on web-based computer programs for key trainings. We also found that critical/sentinel events and/or actual patient crisis situations are debriefed with staff in a perfunctory and inconsistent manner, if at all. Preparing a staff that is competent, adequately prepared, and sufficiently supported in their roles is more likely to result in responses that are reasonable, effective, and based in sound clinical judgment in the most chaotic situations. Hence, we recommended modifications be made to the existing protocols such that training: is in-person; is ongoing; utilizes the talent within the hospital as well as draws from those outside of the hospital; and covers a range of content that is applicable to the setting.

We also strongly support changes to licensure guidelines to mandate that all licensed clinical professionals obtain annual continuing education credits in their field. While some professions (e.g., psychiatry, psychology, social work, recovery support specialists) require this, others do

not. It is our belief that it should be required of all staff, including but not limited to nurses, rehabilitation therapists, occupational therapists, etc.

Additionally, thought should be given to creating training/education opportunities that contribute to a staff member's potential for promotions and/or advancement within the system, in order to incentivize enrichment and enhancement of one's knowledge/skills.

Review of the Statutory Definitions of Abuse and Neglect in the Behavioral Health Context

There was unanimous agreement that the statutory definition of "behavioral health facility" in CGS §17a-488 be changed to match the definition of "facility" in CGS §17a-540 (the Patients' Bill of Rights): any inpatient or outpatient hospital, clinic or other facility for the diagnosis, observation or treatment of persons with psychiatric disabilities. We expanded the scope of this recommendation to apply to all facilities covered by the Patients' Bill of Rights. Additionally, we recommend that "neglect" within the behavioral health context be defined to include the failure by a caregiver, through action or inaction, to provide an individual with the services necessary to maintain his or her physical and mental health and safety, including but not limited to protection against incidents of inappropriate or unwanted individual-to-individual sexual contact, harassment, taunting, bullying, and evidence of discriminatory practices. Consequently, mandated reporters should be required to report suspected neglect as well as suspected abuse.

Appendixes

- [Appendix A](#) CVH Whiting Task Force meeting history
- [Appendix B](#) Documents made available to the CVH Whiting Task Force
- [Appendix C](#) Connecticut Valley Hospital and Whiting Forensic Hospital Workplace Survey Report
- [Appendix D](#) Norway article
- [Appendix E](#) Connecticut General Statutes, 54-56d: Competency to stand trial
- [Appendix F](#) Connecticut Mirror: Investigation Finds ‘Grave Staffing Shortages’ at Whiting Forensic Hospital

Appendix A

CVH Whiting Task Force Meeting History

2019 Meetings

- 4/29 Organizational Meeting
- 5/20 Tom Hennick, Public Education Officer, Freedom of Information Commission
Ellen Lachance, MSW, Executive Director, Psychiatric Security Review Board
- 6/17 Kathy Flaherty, Executive Director, Connecticut Legal Rights Project, Inc.
Tobias Wasser, Medical Director & Hal Smith, CEO, Whiting Forensic Hospital
- 7/8 No invited speaker
- 8/5 Harold I. Schwartz, MD, Psychiatrist-in-Chief Emeritus, Institute of Living
Tobias Wasser, MD, Medical Director, Whiting Forensic Hospital
Kathy Flaherty, Executive Director, Connecticut Legal Rights Project, Inc.
- 9/16 Dr. Charles Dike and Dr. Vinneth Carvalho, Connecticut Valley Hospital
- 10/30 William Wynne, Chairman, Whiting Forensic Hospital Advisory Board
- 11/21 Rick Fisher, LCSW, Director of Workforce Development, DMHAS
Tobias Wasser, M.D., Medical Director, Whiting Forensic Hospital
Arlene Garcia, LCSW, EdD., DMHAS Director, Safety Education and Training Unit
Kevin Lawlor, Deputy Chief State's Attorney, Operations
Monte Radler, Attorney, Public Defender's Office
- 12/13 No invited speaker

2020 Meetings

- 1/9 Department of Public Health:
Barbara Cass, RN, Branch Chief, Healthcare Quality and Safety Branch
Donna Ortelle, RN, MSN, Section Chief, Facility Licensing and Investigation Section
- 1/27 Disability Rights Connecticut Disability:
Gretchen Knauff, Executive Director
Catherine Cushman
Jim Welsh
Anne Broadhurst
Richard Edmonds

- 2/28 Monte Radler, Assistant Public Defender
Kevin Lawlor, Deputy Chief State's Attorney
- 7/9 No invited speaker
- 7/29 Natasha Pierre, JD, MSW, State Victim Advocate, Office of the Victim Advocate
Valina Carpenter, Deputy Director, Office of Victim Services, Connecticut
Judicial Branch
- SEIU, District 1199:
Rebecca Simonsen, Vice President
Avery Pittman, Organizer
Kim Warner, Rehab Therapist 2, Dutcher Service
Darion Young, FTS, Whiting Max
Chris Fontaine, Registered Nurse, Dutcher Service
- 8/11 Luis Perez, Chief Executive Officer, Mental Health Connecticut
- 8/25 Richard Cho, PhD, Chief Executive Officer, Connecticut Coalition to End
Homelessness
Heather Gates, MBA, President & Chief Executive Officer, Community Health
Resources
Grace Cavallo, LCSW, Chief Program Officer, Community Mental Health
Affiliates
- 9/8 No invited speaker
- 9/22 No invited speaker
- 10/6 No invited speaker
- 10/13 No invited speaker
- 10/20 Virtual Informational Forum (8 speakers)
- 10/27 Virtual Informational Forum (21 speakers)
- 11/3 No invited speaker
- 12/1 No invited speaker
- 12/15 No invited speaker

2021 Meetings

- 1/5 No invited speaker

1/15	No invited speaker
1/29	No invited speaker
2/12	No invited speaker
2/26	Sara Wakai, PhD, Assistant Professor, Department of Medicine, UConn Health, CVH Whiting Forensic Hospital Workforce Survey
3/12	No invited speaker
4/9	No invited speaker
4/23	No invited speaker
5/21	Craig Awmiller, Former Lead Investigator, Disability Rights Connecticut
6/18	Sara Wakai, PhD, Assistant Professor, Department of Medicine, UConn Health, CVH Whiting Forensic Hospital Workforce Survey
7/9	No invited speaker
7/30	No invited speaker
8/20	No invited speaker
9/10	No invited speaker
10/1	No invited speaker

Appendix B

Documents Made Available to the CVH Whiting Task Force

For a complete list of documents made available to the Task Force, please click [\[here\]](#).

Appendix C

Connecticut Valley Hospital and Whiting Forensic Hospital Workplace Survey Report

Appendix D

Prisons in Norway: Inside a Norwegian Jail

Appendix E

Connecticut General Statutes, 54-56d: Competency to stand trial

Sec. 54-56d. (Formerly Sec. 54-40). Competency to stand trial. (a) **Competency requirement. Definition.** A defendant shall not be tried, convicted or sentenced while the defendant is not competent. For the purposes of this section, a defendant is not competent if the defendant is unable to understand the proceedings against him or her or to assist in his or her own defense.

(b) **Presumption of competency.** A defendant is presumed to be competent. The burden of proving that the defendant is not competent by a preponderance of the evidence and the burden of going forward with the evidence are on the party raising the issue. The burden of going forward with the evidence shall be on the state if the court raises the issue. The court may call its own witnesses and conduct its own inquiry.

(c) **Request for examination.** If, at any time during a criminal proceeding, it appears that the defendant is not competent, counsel for the defendant or for the state, or the court, on its own motion, may request an examination to determine the defendant's competency.

(d) **Examination of defendant. Report.** If the court finds that the request for an examination is justified and that, in accordance with procedures established by the judges of the Superior Court, there is probable cause to believe that the defendant has committed the crime for which the defendant is charged, the court shall order an examination of the defendant as to his or her competency. The court may (1) appoint one or more physicians specializing in psychiatry to examine the defendant, or (2) order the Commissioner of Mental Health and Addiction Services to conduct the examination either (A) by a clinical team consisting of a physician specializing in psychiatry, a clinical psychologist and one of the following: A clinical social worker licensed pursuant to chapter 383b or a psychiatric nurse clinical specialist holding a master's degree in nursing, or (B) by one or more physicians specializing in psychiatry, except that no employee of the Department of Mental Health and Addiction Services who has served as a member of a clinical team in the course of such employment for at least five years prior to October 1, 1995, shall be precluded from being appointed as a member of a clinical team. If the Commissioner of Mental Health and Addiction Services is ordered to conduct the examination, the commissioner shall select the members of the clinical team or the physician or physicians. When performing an examination under this section, the examiners shall have access to information on treatment dates and locations in the defendant's treatment history contained in the Department of Mental Health and Addiction Services' database of treatment episodes for the purpose of requesting a release of treatment information from the defendant. If the examiners determine that the defendant is not competent, the examiners shall then determine whether there is a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the maximum period of any placement order under this section. If the examiners determine that there is a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the maximum period of any placement order under this section, the examiners shall then determine whether the defendant appears to be eligible for civil commitment, with monitoring by the Court Support Services Division, pursuant to subdivision

(2) of subsection (h) of this section. If the examiners determine that there is not a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the maximum period of any placement order under this section, the examiners shall then determine whether the defendant appears to be eligible for civil commitment to a hospital for psychiatric disabilities pursuant to subsection (m) of this section and make a recommendation to the court regarding the appropriateness of such civil commitment. The court may authorize a physician specializing in psychiatry, a clinical psychologist, a clinical social worker licensed pursuant to chapter 383b or a psychiatric nurse clinical specialist holding a master's degree in nursing selected by the defendant to observe the examination. Counsel for the defendant may observe the examination. The examination shall be completed within fifteen business days from the date it was ordered and the examiners shall prepare and sign, without notarization, a written report and file such report with the court within twenty-one business days of the date of the order. On receipt of the written report, the clerk of the court shall cause copies to be delivered immediately to the state's attorney and to counsel for the defendant.

(e) **Hearing. Evidence.** The court shall hold a hearing as to the competency of the defendant not later than ten days after the court receives the written report. Any evidence regarding the defendant's competency, including the written report, may be introduced at the hearing by either the defendant or the state, except that no treatment information contained in the Department of Mental Health and Addiction Services' database of treatment episodes may be included in the written report or introduced at the hearing unless the defendant released the treatment information pursuant to subsection (d) of this section. If the written report is introduced, at least one of the examiners shall be present to testify as to the determinations in the report, unless the examiner's presence is waived by the defendant and the state. Any member of the clinical team shall be considered competent to testify as to the team's determinations. A defendant and the defendant's counsel may waive the court hearing only if the examiners, in the written report, determine without qualification that the defendant is competent. Nothing in this subsection shall limit any other release or use of information from said database permitted by law.

(f) **Court finding of competency or incompetency.** If the court, after the hearing, finds that the defendant is competent, the court shall continue with the criminal proceedings. If the court finds that the defendant is not competent, the court shall also find whether there is a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the maximum period of any placement order permitted under this section.

(g) **Court procedure if finding that defendant will not regain competency.** If, at the hearing, the court finds that there is not a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the period of any placement order under this section, the court shall follow the procedure set forth in subsection (m) of this section.

(h) **Court procedure if finding that defendant will regain competency. Placement of defendant for treatment or pending civil commitment proceedings. Progress report.** (1) If, at the hearing, the court finds that there is a substantial probability that the defendant, if provided with a course of treatment, will regain competency within the period of any placement order under this section, the court shall either (A) order placement of the defendant for treatment for the purpose of rendering the defendant competent, or (B) order placement of the defendant at a

treatment facility pending civil commitment proceedings pursuant to subdivision (2) of this subsection.

(2) (A) Except as provided in subparagraph (B) of this subdivision, if the court makes a finding pursuant to subdivision (1) of this subsection and does not order placement pursuant to subparagraph (A) of said subdivision, the court shall, on its own motion or on motion of the state or the defendant, order placement of the defendant in the custody of the Commissioner of Mental Health and Addiction Services at a treatment facility pending civil commitment proceedings. The treatment facility shall be determined by the Commissioner of Mental Health and Addiction Services. Such order shall: (i) Include an authorization for the Commissioner of Mental Health and Addiction Services to apply for civil commitment of such defendant pursuant to sections 17a-495 to 17a-528, inclusive; (ii) permit the defendant to agree to request voluntarily to be admitted under section 17a-506 and participate voluntarily in a treatment plan prepared by the Commissioner of Mental Health and Addiction Services, and require that the defendant comply with such treatment plan; and (iii) provide that if the application for civil commitment is denied or not pursued by the Commissioner of Mental Health and Addiction Services, or if the defendant is unwilling or unable to comply with a treatment plan despite reasonable efforts of the treatment facility to encourage the defendant's compliance, the person in charge of the treatment facility, or such person's designee, shall submit a written progress report to the court and the defendant shall be returned to the court for a hearing pursuant to subsection (k) of this section. Such written progress report shall include the status of any civil commitment proceedings concerning the defendant, the defendant's compliance with the treatment plan, an opinion regarding the defendant's current competency to stand trial, the clinical findings of the person submitting the report and the facts upon which the findings are based, and any other information concerning the defendant requested by the court, including, but not limited to, the method of treatment or the type, dosage and effect of any medication the defendant is receiving. The Court Support Services Division shall monitor the defendant's compliance with any applicable provisions of such order. The period of placement and monitoring under such order shall not exceed the period of the maximum sentence which the defendant could receive on conviction of the charges against such defendant, or eighteen months, whichever is less. If the defendant has complied with such treatment plan and any applicable provisions of such order, at the end of the period of placement and monitoring, the court shall approve the entry of a nolle prosequi to the charges against the defendant or shall dismiss such charges.

(B) This subdivision shall not apply: (i) To any person charged with a class A felony, a class B felony, except a violation of section 53a-122 that does not involve the use, attempted use or threatened use of physical force against another person, or a violation of section 14-227a or 14-227m, subdivision (1) or (2) of subsection (a) of section 14-227n, subdivision (2) of subsection (a) of section 53-21 or section 53a-56b, 53a-60d, 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a or 53a-72b; (ii) to any person charged with a crime or motor vehicle violation who, as a result of the commission of such crime or motor vehicle violation, causes the death of another person; or (iii) unless good cause is shown, to any person charged with a class C felony.

(i) **Placement for treatment. Conditions.** The placement of the defendant for treatment for the purpose of rendering the defendant competent shall comply with the following conditions: (1) The period of placement under the order or combination of orders shall not exceed the period of

the maximum sentence which the defendant could receive on conviction of the charges against the defendant or eighteen months, whichever is less; (2) the placement shall be either (A) in the custody of the Commissioner of Mental Health and Addiction Services, the Commissioner of Children and Families or the Commissioner of Developmental Services, except that any defendant placed for treatment with the Commissioner of Mental Health and Addiction Services may remain in the custody of the Department of Correction pursuant to subsection (p) of this section; or, (B) if the defendant or the appropriate commissioner agrees to provide payment, in the custody of any appropriate mental health facility or treatment program which agrees to provide treatment to the defendant and to adhere to the requirements of this section; and (3) the court shall order the placement, on either an inpatient or an outpatient basis, which the court finds is the least restrictive placement appropriate and available to restore competency. If outpatient treatment is the least restrictive placement for a defendant who has not yet been released from a correctional facility, the court shall consider whether the availability of such treatment is a sufficient basis on which to release the defendant on a promise to appear, conditions of release, cash bail or bond. If the court determines that the defendant may not be so released, the court shall order treatment of the defendant on an inpatient basis at a mental health facility or facility for persons with intellectual disability. Not later than twenty-four hours after the court orders placement of the defendant for treatment for the purpose of rendering the defendant competent, the examiners shall transmit information obtained about the defendant during the course of an examination pursuant to subsection (d) of this section to the health care provider named in the court's order.

(j) **Progress reports re treatment.** The person in charge of the treatment facility, or such person's designee, or the Commissioner of Mental Health and Addiction Services with respect to any defendant who is in the custody of the Commissioner of Correction pursuant to subsection (p) of this section, shall submit a written progress report to the court (1) at least seven days prior to the date of any hearing on the issue of the defendant's competency; (2) whenever he or she believes that the defendant has attained competency; (3) whenever he or she believes that there is not a substantial probability that the defendant will attain competency within the period covered by the placement order; (4) whenever, within the first one hundred twenty days of the period covered by the placement order, he or she believes that the defendant would be eligible for civil commitment pursuant to subdivision (2) of subsection (h) of this section; or (5) whenever he or she believes that the defendant is still not competent but has improved sufficiently such that continued inpatient commitment is no longer the least restrictive placement appropriate and available to restore competency. The progress report shall contain: (A) The clinical findings of the person submitting the report and the facts on which the findings are based; (B) the opinion of the person submitting the report as to whether the defendant has attained competency or as to whether the defendant is making progress, under treatment, toward attaining competency within the period covered by the placement order; (C) the opinion of the person submitting the report as to whether the defendant appears to be eligible for civil commitment to a hospital for psychiatric disabilities pursuant to subsection (m) of this section and the appropriateness of such civil commitment, if there is not a substantial probability that the defendant will attain competency within the period covered by the placement order; and (D) any other information concerning the defendant requested by the court, including, but not limited to, the method of treatment or the type, dosage and effect of any medication the defendant is receiving. Not later than five business days after the court finds either that the defendant will not attain competency within the period of

any placement order under this section or that the defendant has regained competency, the person in charge of the treatment facility, or such person's designee, or the Commissioner of Mental Health and Addiction Services with respect to any defendant who is in the custody of the Commissioner of Correction pursuant to subsection (p) of this section, shall provide a copy of the written progress report to the examiners who examined the defendant pursuant to subsection (d) of this section.

(k) Reconsideration of competency. Hearing. Involuntary medication. Appointment and duties of health care guardian. (1) Whenever any placement order for treatment is rendered or continued, the court shall set a date for a hearing, to be held within ninety days, for reconsideration of the issue of the defendant's competency. Whenever the court (A) receives a report pursuant to subsection (j) of this section which indicates that (i) the defendant has attained competency, (ii) the defendant will not attain competency within the remainder of the period covered by the placement order, (iii) the defendant will not attain competency within the remainder of the period covered by the placement order absent administration of psychiatric medication for which the defendant is unwilling or unable to provide consent, (iv) the defendant would be eligible for civil commitment pursuant to subdivision (2) of subsection (h) of this section, or (v) the defendant is still not competent but has improved sufficiently such that continued inpatient commitment is no longer the least restrictive placement appropriate and available to restore competency, or (B) receives a report pursuant to subparagraph (A)(iii) of subdivision (2) of subsection (h) of this section which indicates that (i) the application for civil commitment of the defendant has been denied or has not been pursued by the Commissioner of Mental Health and Addiction Services, or (ii) the defendant is unwilling or unable to comply with a treatment plan despite reasonable efforts of the treatment facility to encourage the defendant's compliance, the court shall set the matter for a hearing not later than ten days after the report is received. The hearing may be waived by the defendant only if the report indicates that the defendant is competent. With respect to a defendant who is in the custody of the Commissioner of Correction pursuant to subsection (p) of this section, the Commissioner of Mental Health and Addiction Services shall retain responsibility for providing testimony at any hearing under this subsection. The court shall determine whether the defendant is competent or is making progress toward attaining competency within the period covered by the placement order. If the court finds that the defendant is competent, the defendant shall be returned to the custody of the Commissioner of Correction or released, if the defendant has met the conditions for release, and the court shall continue with the criminal proceedings. If the court finds that the defendant is still not competent but that the defendant is making progress toward attaining competency, the court may continue or modify the placement order. If the court finds that the defendant is still not competent but that the defendant is making progress toward attaining competency and inpatient placement is no longer the least restrictive placement appropriate and available to restore competency, the court shall consider whether the availability of such less restrictive placement is a sufficient basis on which to release the defendant on a promise to appear, conditions of release, cash bail or bond and may order continued treatment to restore competency on an outpatient basis. If the court finds that the defendant is still not competent and will not attain competency within the remainder of the period covered by the placement order absent administration of psychiatric medication for which the defendant is unwilling or unable to provide consent, the court shall proceed as provided in subdivisions (2), (3) and (4) of this subsection. If the court finds that the defendant is eligible for civil commitment, the court may

order placement of the defendant at a treatment facility pending civil commitment proceedings pursuant to subdivision (2) of subsection (h) of this section.

(2) If the court finds that the defendant will not attain competency within the remainder of the period covered by the placement order absent administration of psychiatric medication for which the defendant is unwilling or unable to provide consent, and after any hearing held pursuant to subdivision (3) of this subsection, the court may order the involuntary medication of the defendant if the court finds by clear and convincing evidence that: (A) To a reasonable degree of medical certainty, involuntary medication of the defendant will render the defendant competent to stand trial, (B) an adjudication of guilt or innocence cannot be had using less intrusive means, (C) the proposed treatment plan is narrowly tailored to minimize intrusion on the defendant's liberty and privacy interests, (D) the proposed drug regimen will not cause an unnecessary risk to the defendant's health, and (E) the seriousness of the alleged crime is such that the criminal law enforcement interest of the state in fairly and accurately determining the defendant's guilt or innocence overrides the defendant's interest in self-determination.

(3) (A) If the court finds that the defendant is unwilling or unable to provide consent for the administration of psychiatric medication, and prior to deciding whether to order the involuntary medication of the defendant under subdivision (2) of this subsection, the court shall appoint a health care guardian who shall be a licensed health care provider with specialized training in the treatment of persons with psychiatric disabilities to represent the health care interests of the defendant before the court. Notwithstanding the provisions of section 52-146e, such health care guardian shall have access to the psychiatric records of the defendant. Such health care guardian shall file a report with the court not later than thirty days after his or her appointment. The report shall set forth such health care guardian's findings and recommendations concerning the administration of psychiatric medication to the defendant, including the risks and benefits of such medication, the likelihood and seriousness of any adverse side effects and the prognosis with and without such medication. The court shall hold a hearing on the matter not later than ten days after receipt of such health care guardian's report and shall, in deciding whether to order the involuntary medication of the defendant, take into account such health care guardian's opinion concerning the health care interests of the defendant.

(B) The court, in anticipation of considering continued involuntary medication of the defendant under subdivision (4) of this subsection, shall order the health care guardian to file a supplemental report updating the findings and recommendations contained in the health care guardian's report filed under subparagraph (A) of this subdivision.

(4) If, after the defendant has been found to have attained competency by means of involuntary medication ordered under subdivision (2) of this subsection, the court determines by clear and convincing evidence that the defendant will not remain competent absent the continued administration of psychiatric medication for which the defendant is unable to provide consent, and after any hearing held pursuant to subdivision (3) of this subsection and consideration of the supplemental report of the health care guardian, the court may order continued involuntary medication of the defendant if the court finds by clear and convincing evidence that: (A) To a reasonable degree of medical certainty, continued involuntary medication of the defendant will maintain the defendant's competency to stand trial, (B) an adjudication of guilt or innocence

cannot be had using less intrusive means, (C) the proposed treatment plan is narrowly tailored to minimize intrusion on the defendant's liberty and privacy interests, (D) the proposed drug regimen will not cause an unnecessary risk to the defendant's health, and (E) the seriousness of the alleged crime is such that the criminal law enforcement interest of the state in fairly and accurately determining the defendant's guilt or innocence overrides the defendant's interest in self-determination. Continued involuntary medication ordered under this subdivision may be administered to the defendant while the criminal charges against the defendant are pending and the defendant is in the custody of the Commissioner of Correction or the Commissioner of Mental Health and Addiction Services. An order for continued involuntary medication of the defendant under this subdivision shall be reviewed by the court every one hundred eighty days while such order remains in effect. The court shall order the health care guardian to file a supplemental report for each such review. After any hearing held pursuant to subdivision (3) of this subsection and consideration of the supplemental report of the health care guardian, the court may continue such order if the court finds, by clear and convincing evidence, that the criteria enumerated in subparagraphs (A) to (E), inclusive, of this subdivision are met.

(5) The state shall hold harmless and indemnify any health care guardian appointed by the court pursuant to subdivision (3) of this subsection from financial loss and expense arising out of any claim, demand, suit or judgment by reason of such health care guardian's alleged negligence or alleged deprivation of any person's civil rights or other act or omission resulting in damage or injury, provided the health care guardian is found to have been acting in the discharge of his or her duties pursuant to said subdivision and such act or omission is found not to have been wanton, reckless or malicious. The provisions of subsections (b), (c) and (d) of section 5-141d shall apply to such health care guardian. The provisions of chapter 53 shall not apply to a claim against such health care guardian.

(l) Failure of defendant to return to treatment facility in accordance with terms and conditions of release. If a defendant who has been ordered placed for treatment on an inpatient basis at a mental health facility or a facility for persons with intellectual disability is released from such facility on a furlough or for work, therapy or any other reason and fails to return to the facility in accordance with the terms and conditions of the defendant's release, the person in charge of the facility, or such person's designee, shall, within twenty-four hours of the defendant's failure to return, report such failure to the prosecuting authority for the court location which ordered the placement of the defendant. Upon receipt of such a report, the prosecuting authority shall, within available resources, make reasonable efforts to notify any victim or victims of the crime for which the defendant is charged of such defendant's failure to return to the facility. No civil liability shall be incurred by the state or the prosecuting authority for failure to notify any victim or victims in accordance with this subsection. The failure of a defendant to return to the facility in which the defendant has been placed may constitute sufficient cause for the defendant's rearrest upon order by the court.

(m) Release or placement of defendant who will not attain competency. Report to court prior to release from placement. (1) If at any time the court determines that there is not a substantial probability that the defendant will attain competency within the period of treatment allowed by this section, or if at the end of such period the court finds that the defendant is still not competent, the court shall consider any recommendation made by the examiners pursuant to

subsection (d) of this section and any opinion submitted by the treatment facility pursuant to subparagraph (C) of subsection (j) of this section regarding eligibility for, and the appropriateness of, civil commitment to a hospital for psychiatric disabilities and shall either release the defendant from custody or order the defendant placed in the custody of the Commissioner of Mental Health and Addiction Services, the Commissioner of Children and Families or the Commissioner of Developmental Services. If the court orders the defendant placed in the custody of the Commissioner of Children and Families or the Commissioner of Developmental Services, the commissioner given custody, or the commissioner's designee, shall then apply for civil commitment in accordance with sections 17a-75 to 17a-83, inclusive, or 17a-270 to 17a-282, inclusive. If the court orders the defendant placed in the custody of the Commissioner of Mental Health and Addiction Services, the court may order the commissioner, or the commissioner's designee, to apply for civil commitment in accordance with sections 17a-495 to 17a-528, inclusive, or order the commissioner, or the commissioner's designee, to provide services to the defendant in a less restrictive setting, provided the examiners have determined in the written report filed pursuant to subsection (d) of this section or have testified pursuant to subsection (e) of this section that such services are available and appropriate. If the court orders the defendant placed in the custody of the Commissioner of Mental Health and Addiction Services and orders the commissioner to apply for civil commitment pursuant to this subsection, the court may order the commissioner to give the court notice when the defendant is released from the commissioner's custody if such release is prior to the expiration of the time within which the defendant may be prosecuted for the crime with which the defendant is charged, provided such order indicates when such time expires. If the court orders the defendant placed in the custody of the Commissioner of Developmental Services for purposes of commitment under any provision of sections 17a-270 to 17a-282, inclusive, the court may order the Commissioner of Developmental Services to give the court notice when the defendant's commitment is terminated if such termination is prior to the expiration of the time within which the defendant may be prosecuted for the crime with which the defendant is charged, provided such order indicates when such time expires.

(2) The court shall hear arguments as to whether the defendant should be released or should be placed in the custody of the Commissioner of Mental Health and Addiction Services, the Commissioner of Children and Families or the Commissioner of Developmental Services.

(3) If the court orders the release of a defendant charged with the commission of a crime that resulted in the death or serious physical injury, as defined in section 53a-3, of another person, or with a violation of subdivision (2) of subsection (a) of section 53-21, subdivision (2) of subsection (a) of section 53a-60 or section 53a-60a, 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a or 53a-72b, or orders the placement of such defendant in the custody of the Commissioner of Mental Health and Addiction Services or the Commissioner of Developmental Services, the court may, on its own motion or on motion of the prosecuting authority, order, as a condition of such release or placement, periodic examinations of the defendant as to the defendant's competency at intervals of not less than six months. If, at any time after the initial periodic examination, the court finds again, based upon an examiner's recommendation, that there is a substantial probability that the defendant, if provided with a course of treatment, will never regain competency, then any subsequent periodic examination of the defendant as to the defendant's competency shall be at intervals of not less than eighteen months. Such an

examination shall be conducted in accordance with subsection (d) of this section. Periodic examinations ordered by the court under this subsection shall continue until the court finds that the defendant has attained competency or until the time within which the defendant may be prosecuted for the crime with which the defendant is charged, as provided in section 54-193 or 54-193a, has expired, whichever occurs first.

(4) Upon receipt of the written report as provided in subsection (d) of this section, the court shall, upon the request of either party filed not later than thirty days after the court receives such report, conduct a hearing as provided in subsection (e) of this section. Such hearing shall be held not later than ninety days after the court receives such report. If the court finds that the defendant has attained competency, the defendant shall be returned to the custody of the Commissioner of Correction or released, if the defendant has met the conditions for release, and the court shall continue with the criminal proceedings.

(5) The court shall dismiss, with or without prejudice, any charges for which a nolle prosequi is not entered when the time within which the defendant may be prosecuted for the crime with which the defendant is charged, as provided in section 54-193 or 54-193a, has expired. Notwithstanding the record erasure provisions of section 54-142a, police and court records and records of any state's attorney pertaining to a charge which is nolle or dismissed without prejudice while the defendant is not competent shall not be erased until the time for the prosecution of the defendant expires under section 54-193 or 54-193a. A defendant who is not civilly committed as a result of an application made by the Commissioner of Mental Health and Addiction Services, the Commissioner of Children and Families or the Commissioner of Developmental Services pursuant to this section shall be released. A defendant who is civilly committed pursuant to such an application shall be treated in the same manner as any other civilly committed person.

(n) **Payment of costs.** The cost of the examination effected by the Commissioner of Mental Health and Addiction Services and of testimony of persons conducting the examination effected by the commissioner shall be paid by the Department of Mental Health and Addiction Services. The cost of the examination and testimony by physicians appointed by the court shall be paid by the Judicial Department. If the defendant is indigent, the fee of the person selected by the defendant to observe the examination and to testify on the defendant's behalf shall be paid by the Public Defender Services Commission. The expense of treating a defendant placed in the custody of the Commissioner of Mental Health and Addiction Services, the Commissioner of Children and Families or the Commissioner of Developmental Services pursuant to subdivision (2) of subsection (h) of this section or subsection (i) of this section shall be computed and paid for in the same manner as is provided for persons committed by a probate court under the provisions of sections 17b-122, 17b-124 to 17b-132, inclusive, 17b-136 to 17b-138, inclusive, 17b-194 to 17b-197, inclusive, 17b-222 to 17b-250, inclusive, 17b-256, 17b-263, 17b-340 to 17b-350, inclusive, 17b-689b and 17b-743 to 17b-747, inclusive.

(o) **Custody of defendant prior to hearing.** Until the hearing is held, the defendant, if not released on a promise to appear, conditions of release, cash bail or bond, shall remain in the custody of the Commissioner of Correction unless hospitalized as provided in sections 17a-512 to 17a-517, inclusive.

(p) Placement of defendant who presents significant security, safety or medical risk. Defendant remaining in custody of Commissioner of Correction. (1) This section shall not be construed to require the Commissioner of Mental Health and Addiction Services to place any defendant who presents a significant security, safety or medical risk in a hospital for psychiatric disabilities which does not have the trained staff, facilities or security to accommodate such a person, as determined by the Commissioner of Mental Health and Addiction Services in consultation with the Commissioner of Correction.

(2) If a defendant is placed for treatment with the Commissioner of Mental Health and Addiction Services pursuant to subsection (i) of this section and such defendant is not placed in a hospital for psychiatric disabilities pursuant to a determination made by the Commissioner of Mental Health and Addiction Services under subdivision (1) of this subsection, the defendant shall remain in the custody of the Commissioner of Correction. The Commissioner of Correction shall be responsible for the medical and psychiatric care of the defendant, and the Commissioner of Mental Health and Addiction Services shall remain responsible to provide other appropriate services to restore competency.

(3) If a defendant remains in the custody of the Commissioner of Correction pursuant to subdivision (2) of this subsection and the court finds that the defendant is still not competent and will not attain competency within the remainder of the period covered by the placement order absent administration of psychiatric medication for which the defendant is unwilling or unable to provide consent, the court shall proceed as provided in subdivisions (2), (3) and (4) of subsection (k) of this section. Nothing in this subdivision shall prevent the court from making any other finding or order set forth in subsection (k) of this section.

(q) Defense of defendant prior to trial. This section shall not prevent counsel for the defendant from raising, prior to trial and while the defendant is not competent, any issue susceptible of fair determination.

(r) Credit for time in confinement on inpatient basis. Actual time spent in confinement on an inpatient basis pursuant to this section shall be credited against any sentence imposed on the defendant in the pending criminal case or in any other case arising out of the same conduct in the same manner as time is credited for time spent in a correctional facility awaiting trial.

Appendix F

Connecticut Mirror:

Investigation Finds 'Grave Staffing Shortages' at Whiting Forensic Hospital