PSYCHIATRIC SECURITY REVIEW BOARD WORKING GROUP REPORT

SUBMITTED PURSUANT TO §6 OF PUBLIC ACT 22-45

AUGUST 2026

Mental Health and Addiction Services

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Executive Summary

Section 6 of Public Act (PA) 22-45 called for the Department of Mental Health and Addiction Services (DMHAS) to convene a working group to evaluate the Psychiatric Security Review Board (PSRB) and subsequently share a report of working group findings with the Judiciary and Public Health Committees of the Connecticut General Assembly. The working group was convened in November 2022 and met 34 times via videoconference over a two-year period to research, analyze, and discuss its several legislative charges. The agendas for the meetings have been posted online along with recordings of the meetings.

The working group reviewed and considered:

- recommendations made by the Connecticut Valley Hospital (CVH) and Whiting Forensic Hospital (WFH) Task Force in its December 16, 2021 report;
- amendments to PSRB statutes in PA 22-45;
- the requirement in section 1 of PA 22-45 that DMHAS consider construction of a new maximum-security facility to promote recovery and healing and meet modern standards;
- methods of optimizing processes by which persons are committed to the PSRB and released or discharged from that custody;
- processes in other jurisdictions for committing and releasing persons found not guilty by reason of mental disease or defect (acquittees[1]); and
- processes for victim notification when an acquittee is released or discharged from custody, as well as the range of available victim services and rights.

The working group examined the Connecticut system in detail, as well as reviewing available information on 17 other jurisdictions[2], including statutes, published literature and reports, and personal contacts with system leaders. The working group reviewed available literature on the management of acquittees and outcomes of that management. A Glossary is provided at the end of the report to define frequently used terms related to this topic.

Each of the subjects examined by the working group are detailed in a separate section of the report. Each section describes the charge to the working group, background information, information presented to or reviewed by the working group, and the group's recommendations. A summary of the working group's recommendations is provided near the end of the report. The working group made twelve recommendations unanimously; four recommendations were made with significant, but not unanimous, support; and four other recommendations were offered with majority support of the members of the working group.

The unanimous recommendations included:

- pursuit of a newly constructed forensic hospital;
- maintenance of the PSRB;
- maintaining the current frequency of mandatory review hearings by the PSRB;
- improvements to information available to victims about the PSRB process and services available to them;

[1] Pursuant to CGS §17a-580, "acquittee" means any person found not guilty by reason of mental disease or defect pursuant to CGS §53a-13.

[2] See Appendix A.

- modification of the VINE victim notification to permit continued notifications of victims of court hearings; and
- modifications to the definition of "victim" for PSRB purposes and to the description of persons who may be heard at PSRB hearings.

Recommendations with significant support among working group members included:

- amending statutes to provide for the balancing of the protection of society and the safety and well-being of the acquittee at various decision points in the legal system (rather than articulating primary and secondary concerns);
- establishing reasonable time limits to the periods of commitment to the PSRB ordered by the superior court;
- encouraging the use of conditional release in the management of acquittees; and
- revising statute to distinguish between hearings for application for discharge prior to the expiration of court-ordered commitment and hearings for recommitment at the expiration of the original commitment (to align statute with the 1994 Connecticut Supreme Court decision in *State v. Metz*).

Recommendations with majority support among working group members included:

- further definition of the term "well-being of the acquittee" (which was added to several statutes in PA 22-45) to include concepts of recovery, progress toward re-integration into the community, and treatment in the least restrictive setting consistent with public safety;
- encouragement of the use of conditional release to the extent possible that is consistent with public safety and the shifting of the burden of proof (at a hearing on an application for discharge from the Board) from the acquittee to the state after three successful years of treatment in the community on conditional release; and
- elimination of recommitment to the PSRB at the expiration of the original court-ordered period of commitment with use of the civil commitment process (once the original commitment has expired) for individuals who are thought to be a danger to self or others or gravely disabled.

The management system for individuals found not guilty by reason of mental disease or defect remains complex, dynamic, and evolving. Implementation of the proposed recommendations will provide a critical opportunity to gather empirical data on subsequent outcomes and systemic responses. Continuous data collection will enable future re-assessments, ensuring ongoing optimization of the system's capacity to balance acquittee well-being, public safety, and the interests of victims.

Introduction and Background

The Department of Mental Health and Addiction Services (DMHAS) was charged with implementing section 6 of PA 22-45, *An Act Concerning Connecticut Valley and Whiting Forensic Hospitals.*

The Act revised the statutes governing Connecticut Valley (CVH) and Whiting Forensic Hospitals (WFH). Specifically, section 6 of the act required DMHAS to convene a working group to evaluate the Psychiatric Security Review Board (PSRB) and subsequently share a report of working group findings with the Judiciary and Public Health committees of the Connecticut General Assembly. Working group members were to represent a wide range of stakeholders including, but not limited to:

- A person with expertise in public health;
- Two members of the judiciary;
- A defense attorney of the Judicial Department or the Public Defender Services Commission;
- A state's attorney;
- A licensed physician specializing in psychiatry;
- Two acquittees;
- Two victims of an acquittee or two representatives of an organization that advocates on behalf of victims of an acquittee;
- The Commissioner of DMHAS; and
- The Commissioner of Developmental Services (DDS).

In late 2022, working group members were named and included the following individuals:

- Oluwole Jegede MD, MPH (public health expert)
- Hon. David Gold (judiciary)
- Hon. Ernest Green (judiciary)
- Attorney Monte Radler (public defender services)
- Attorney William O'Connor (public defender services)
- Attorney Maureen Platt (state's attorney)
- Reena Kapoor MD (forensic psychiatrist)
- Peter Zeman MD (forensic psychiatrist)
- Lou Bovino (acquittee)
- Susan Silva (acquittee)
- Andrew Reynolds (victim)
- Jill Kidik (victim)
- Michael Norko MD (DMHAS forensic psychiatrist)
- Peter Tolisano PsyD, ABPP (DDS)
- Ellen LaChance (former Executive Director, PSRB)

Other individuals who attended the meetings and contributed to the process are:

- Vanessa Cardella (current Executive Director of the PSRB)
- Judy Dowd (Office of Policy and Management)
- Chris McClure (DMHAS Office of the Commissioner)
- Mary Kate Mason (DMHAS Office of the Commissioner)

Working Group Activity

After the working group members were appointed or designated, Dr. Michael Norko, Professor of Psychiatry at Yale University School of Medicine and then Director of Forensic Services for DMHAS, was named chair and Judge Gold was named co-chair. In November 2022, the working group held its first meeting. The meetings began monthly but increased in frequency from fall 2023 to spring 2024 and again in late summer 2024 to complete the statutory requirements. The working group met thirty-four times in two years. The meeting agendas and videos have been posted online.

Over these two years, the working group engaged in robust discussions and evaluations of items specifically named in statute, including:

- previous recommendations made by the CVH/WFH Task Force;
- improvements to the custody and commitment process after a finding of not guilty by reason of mental disease or defect as well as the process for release or discharge from such custody; and
- processes for notifying a victim of such person when such person is released or discharged from such custody.

During these meetings, the group examined Connecticut's PSRB, while comparing and contrasting the state's system with those of 17 other jurisdictions[3], reviewing statutes and available published literature and reports on systems in other jurisdictions (specific items are listed in meeting agendas), as well as direct communications with colleagues in those jurisdictions to clarify details. In addition, the group reviewed statistical analysis of the individuals committed to the PSRB, including average length of commitment, demography, and index crimes. The meetings also included multiple conversations about the concerns and rights of victims and families of victims, including a review of the services available through the Connecticut Office of Victim Services.

This extensive review of relevant information was undertaken carefully to ensure all perspectives were considered and that the recommendations submitted were fully contemplated.

Working Group Process

The working group engaged in a consensus process, inviting and encouraging comments from all members. Where there was no disagreement on a proposed discussion of a topic or on a proposed recommendation, these elements were accepted as the consensus of the group. Where there was disagreement on a point of discussion or a proposed recommendation, the report describes the nature of the disagreement and the arguments and evidence supporting the various positions taken by members of the working group. The working group generally did not put such items to a vote but tried to present the nature of the concerns as accurately as possible for the benefit of legislators considering these matters. (One exception was the set of proposals noted in Appendix I and Appendix J for which votes were taken.)

The defense of not guilty by reason of mental disease or defect is a complex area of criminal law. Events leading to its use most often involve violence and can be deeply traumatic for victims and their families. Individuals involved in these cases have experienced acute and severe mental illness, which, both in itself and within the context of the resulting criminal proceedings, can be distressing for the individuals involved and for society. In proceedings involving not guilty by reason of mental disease or defect determinations and PSRB processes, an adversarial legal framework is used to represent the interests of victims, society,

[3] See Appendix A.

and individuals with psychiatric disabilities. While this framework provides structure for decision-making, it does not eliminate all concerns or areas of disagreement.

The working group had the benefit of participation by members representing these various perspectives, and the opportunity over two years to investigate and discuss challenging and, sometimes, controversial ideas. The recommendations provided in this report are the result of consideration and respect for opposing viewpoints.

Relevant Legislative History

WFH includes the State of Connecticut's only maximum-security psychiatric facility. Located in Middletown on the CVH campus, the facility provides services to individuals involved in criminal justice and public mental health systems. WFH is under the administration of DMHAS. The maximum-security building was constructed in 1966 and opened as the Whiting Forensic Institute (WFI) in 1970. Dutcher Hall (the enhanced security building of the WFH) was constructed in 1950 and served other treatment purposes prior to the late 1990s.

In 1985, the PSRB was established in PA 85-506 to monitor all persons found not guilty by reason of mental disease or defect (i.e., acquittees) in the state. Prior to the establishment of the PSRB, acquittees were monitored only by the superior court having jurisdiction over their cases, and there was no statewide system for monitoring these individuals, their current treatment, or where they lived, worked, or received care.

WFI became part of CVH in 1995 as part of PA 95-257, and was then named the Whiting Forensic Division (WFD) of CVH. PA 95-257 also called for the closure of two state hospitals where acquittees were also treated - Norwich Hospital and Fairfield Hills Hospital. Patients from those two hospitals who could not be discharged to community services were relocated to CVH. In the late 1990s, after all acquittees were relocated to CVH, the superintendent re-organized the care system, and placed all acquittees receiving treatment at the state hospital level of care in Dutcher Hall, under the supervision of the WFD. WFD was thereafter responsible for all inpatient level of care of patients under the jurisdiction of the PSRB.

Public Act 18-86

In 2017, staff members of the WFD of CVH were documented on video engaging in abusive conduct toward an individual under state care who had been found not guilty by reason of mental disease or defect. The incident resulted in the termination of numerous staff, and several individuals were subsequently prosecuted and convicted on related charges. In response, significant changes were implemented to policies and procedures, including the establishment of continuous, 24/7 monitoring of video feeds in patient care areas by an independent private security contractor. Governor Malloy directed the separation of WFD from CVH in Executive Order # 63 on December 29, 2017. The Connecticut General Assembly subsequently affirmed and codified this separation in PA 18-86. The separation of the two facilities was completed on May 1, 2018, resulting in CVH and WFH becoming two standalone hospitals.

In addition to the separation of CVH and WFH, the act required mandatory reporting of patient abuse by all behavioral health employees and established specified procedures for the investigation of abuse allegations; required that WFH be inspected and licensed by the Department of Public Health; and mandated that the director of WFH report directly to the Commissioner of DMHAS. Of particular relevance to this report, section 1 of the act established a task force to "review and evaluate the operations, conditions, culture and finances of Connecticut Valley Hospital and Whiting Forensic Hospital," and to

"examine the role of the Psychiatric Security Review Board established pursuant to CGS §17a-581 of the general statutes," among other assigned responsibilities. The task force published its Final Report on December 16, 2021. In its section on the PSRB, the task force made the following recommendations on pages 13-14:

- Amend Connecticut General Statutes (CGS) §17a-584 "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 CGS §17a-541), including the right to placement in the least restrictive environment"
- End the possibility of recommitment to the PSRB in CGS §17a-593, and utilize the civil commitment process for patients at the end of their original commitment who are deemed to be gravely disabled or to represent a continued danger to self or others
- Amend CGS §17a-587 "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"
- Repeal CGS §17a-599 to "eliminat[e] 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)"
- Amend CGS §17a-585 to require that the PSRB review an acquittee's commitment every six months "unless the patient specifically waives the right to such review"

In its section on the Physical Plant of the existing hospital, the task force recommended 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" (p. 6). To be included in that planning were the following:

- 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.

Public Act 22-45

Following consideration of the report required under PA 18-86, and in response to several of its recommendations, the General Assembly passed PA 22-45, which was signed May 17, 2022, with sections taking effect either from passage or October 1, 2022. Amendments in the act directly related to the PSRB were as follows:

- Section 3 added "safety and well-being of the acquittee" to the criminal court's primary concern of "protection of society" in CGS §17a-582 in making its decision regarding commitment of an acquittee.
- Section 4 added the same language to the PSRB's considerations in making its findings regarding discharge, conditional release, or confinement of acquittees pursuant to CGS §17a-584.

- Section 5 added "safety and well-being of the acquittee" as the criminal court's "secondary concern" when making decisions regarding discharge from the PSRB pursuant to CGS §17a-593.
- Section 7 required the PSRB to notify victims when temporary leaves (TL) were granted and allowed acquittees to apply for TL in amendments to CGS §17a-587.
- Section 8 amended CGS §17a-599 to permit the WFH superintendent to transfer PSRB patients "to a lower security division of the hospital" after consultation with the hospital's risk management review committee if "the acquittee's psychiatric supervision and treatment would be safely advanced by permitting the acquittee to transfer to a lower security division of the hospital."

PA 22-45 also addressed the task force recommendation that the 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." Section 1 required DMHAS to "develop a plan for the construction of a new facility for Whiting Forensic Hospital," incorporating the concerns of the task force for advances in safety; enriched educational, vocational, living skills, and creative activities; and patient recovery and re-integration into the community. Of particular relevance to this report, section 6 required DMHAS to form the PSRB working group.

Tasks Undertaken by the PSRB Working Group

To facilitate the working group's attention to each of its charges stemming from PA 22-45 and the CVH/WFH Task Force Report, a grid[4] of tasks and potential discussion questions was formulated and circulated to the group. That grid referred to a separate Summary Table of Task Force Recommendations[5] and corresponding discussion questions.

This report addresses each of the assigned tasks at various stages of the work. The analysis of these issues, along with formal recommendations, is presented in the pages that follow.

[4] See Appendix B.

[5] See Appendix C.

Subjects Examined

The working group examined a range of subjects related to Connecticut's forensic mental health system, including the potential construction of a new facility for Whiting Forensic Hospital; the continued role of the Psychiatric Security Review Board (PSRB); the frequency of mandatory PSRB review hearings; use of the Connecticut On-Line Law Enforcement Communications Teleprocessing (COLLECT) system for acquittees; victim services; victim notification; victims' rights to be heard at PSRB hearings; processes utilized in other jurisdictions; vocational services for acquittees; and the processes governing commitment, temporary leave, conditional release, and discharge.

Each section that follows begins with the relevant statutory charge to the working group, provides background information and a summary of the information reviewed, and concludes with the working group's recommendations, where applicable.

Construction of a New Facility for Whiting Forensic Hospital

Charge

Section 6 of PA 22-45 charged the working group with examining the recommendations of the CVH/WFH Task Force established pursuant to section 1 of PA 18-86.

Section 1 of PA 22-45 required DMHAS to "develop a plan for the construction of a new facility for Whiting Forensic Hospital," incorporating the concerns of the task force for advances in safety; enriched educational, vocational, living skills, and creative activities; and patient recovery and re-integration into the community.

Background

Whiting Forensic Hospital (WFH) consists of two buildings: a maximum security building built in 1966 and opened in 1970 as the "security treatment center" (renamed the "Whiting Forensic Institute" in PA 73-245); and an "enhanced security" (step down from maximum security) building built in 1950, known as Dutcher Hall. Dutcher Hall became part of the Whiting Forensic Division of CVH in the late 1990s, mostly to provide the level of care to acquittees that had been provided in the three large state psychiatric hospitals prior to 1995 (consolidation of the state hospital system occurred as a result of PA 95-257). One unit in Dutcher Hall has also been used to provide the competency restoration service that had previously been provided at the state hospital level.

WFH is a 229-bed psychiatric hospital, with 91 beds in the Whiting building on 5 units, and 138 beds in the Dutcher building on 6 units.

After touring the Whiting and Dutcher buildings, the task force concluded that "the hospital buildings, work areas, and living quarters are in poor condition, particularly with respect to the Whiting building" (p. 5 of CVH/WFH Task Force Report).

Information Presented to Working Group

The Whiting and Dutcher buildings are older facilities, and their physical condition imposes constraints on the quality of the environment and the types of services that can be delivered. As noted in the section of this report on Processes in Other Jurisdictions, the lengths of hospital stay for Connecticut acquittees have ranged from 53 months to 42 years, with averages measured at different times of 17 years and 10.8 years.

Modern forensic facility design emphasizes safety and security while supporting environments that reduce institutional characteristics and promote therapeutic conditions, including open spaces, natural light, visibility, access to nature, and reduced blind spots[6]. These design principles have been in use for more than two decades and are reflected in hospital projects across multiple U.S. states and internationally (including Colorado, Florida, Georgia, Missouri, Texas, Virginia, and Washington D.C. and around the world).[7]

The working group is aware that a separate architectural analysis was undertaken by DMHAS and the Department of Administrative Services (DAS), beginning in August 2023, to outline various scenarios for construction of a new forensic treatment facility. That study was completed in late 2024.

[6] See Appendix D.

[7] Ulrich RS, Bogren L, Gardiner SK, Lundin S. Psychiatric ward design can reduce aggressive behavior. J Environmental Psychology. 2018; 57:53-66

Recommendation of the Working Group

The working group recognizes the important role that WFH plays in the lives of acquittees, as well as in supporting victims and promoting public safety. It is therefore important that this level of care be provided in an environment that best supports both clinical treatment and safety. Significant advances in the design, construction, materials, and technology of secure psychiatric facilities have been developed in recent decades, and these approaches are reflected in contemporary facilities in other jurisdictions.

The working group offers its strongest recommendation for the deliberate pursuit of a newly constructed forensic hospital in the state to replace both the Whiting and Dutcher buildings.

Maintain the Psychiatric Security Review Board

Charge
Section 6 of PA 22-45 charged the working group with examining the recommendations of the CVH/WFH Task Force established pursuant to section 1 of PA 18-86.

Background
PA 18-86 established the CVH/WFH Task Force, which published its final report December 16, 2021. The task force members had divided opinions about whether the PSRB should be maintained or abolished, and made no recommendation on this subject.

Information Presented to Working Group
Early in its series of meetings, the working group reached consensus that the PSRB should be maintained. As with the task force, concerns were raised regarding various aspects of PSRB processes, which were addressed through discussions of specific topics; the outcomes of those discussions are presented elsewhere in this report.

The working group identified several advantages of the PSRB process, including: a decision-making body composed of individuals with varied expertise relevant to the Board's responsibilities; formal, structured procedures guided by statute and regulation; a public and adversarial process that allows for the presentation and review of clinical updates and petitions; and opportunities for victims to provide statements.

The working group had the benefit of a detailed report prepared by Meryl Gersz, Deputy Assistant State's Attorney, Office of the Chief State's Attorney, regarding the dissolution of the Arizona Psychiatric Security Board (AZ PSRB) in July 2023. Among the concerns of the Arizona legislature was a history of ineffective protection of public safety, evidenced by tragic outcomes with some of the persons in Arizona who had been found Guilty Except Insane (GEI) and placed under the jurisdiction of their PSRB. An audit by the Arizona Auditor General in 2018 was critical of the AZ PSRB in several areas and recommended that it follow the example of the PSRBs in Connecticut and Oregon, which it set as models for efficient and effective operation.

The working group also reviewed selected articles in the forensic psychiatry literature on the operation of the Connecticut PSRB (see April 18, 2023 agenda). Zonana and colleagues[8] noted, prior to the establishment of the PSRB, no records were maintained identifying individuals found not guilty by reason of mental disease or defect (NGRI). Scott and colleagues[9] noted that the National Alliance on Mental Illness (NAMI) endorsed the PSRB model as preferable to the practices in many states. Scott et al. further reported the Connecticut Law Revision Commission's finding that, prior to the PSRB, criminal courts responsible for supervising acquittees "often lacked the time, resources, and expertise to make informed judgments about conditional release and discharge from custody of the state" (Scott, p. 981). Scott and colleagues also noted that, prior to the PSRB, hospital staff were frequently unaware of a patient's acquittal status.

[8] Zonana HV, Wells JA, Getz MA, Buchanan J. Part I: The NGRI Registry: Initial Analyses of Data Collected on Connecticut Insanity Acquittees. Bull Am Acad Psychiatry Law. 1990;18(2): 115-128

[9] Scott DC, Zonana HV, Getz MA. Monitoring Insanity Acquittees: Connecticut's Psychiatric Security Review Board. Hosp Comm Psychiatry. 1990;41(9):980-984

Norko and colleagues[10] reported on a study of Connecticut acquittees under PSRB jurisdiction, both on conditional release and following discharge from Board oversight. The study concluded that conditional release (CR) is an effective mechanism for monitoring patients that maintains public safety and is associated with some of the lowest rates of arrest recidivism reported in the literature. More than two-thirds of acquittees maintained conditional release without revocation, and more than 97% maintained CR without arrest. Placement on CR prior to discharge from Board oversight was also associated with a statistically significant reduction in post-discharge re-arrest, with more than 83% not being arrested and more than 90% not being arrested on felony charges.

This re-arrest rate of 16.3% (with an average community follow-up period of 12 years) compares favorably to Connecticut re-arrest rates for released offenders (56% over a 2-year follow-up), offenders with mental illness released from DOC custody in Connecticut (28.3% over a 6-month follow-up), offenders with mental illness released from DOC custody in Connecticut through a specialized re-entry program (14.1% over a 6-month follow-up), and offenders with and without mental illness released in other states (ranging from 18% to 73% recidivism over 2- to 7-year follow-ups).

The Treatment Advocacy Center, in its 2017 report[11] on all states, cited Connecticut and Oregon as having "exemplar state programs and practices" for their "statewide PSRB model[s] vested with oversight authority for the program, which is staffed with professionals with specialized expertise" (TAC Report, p. 103). The existence of the PSRB in Connecticut was a significant factor in receiving a grade of "B" (no state received an "A"), defined as "making a commendable effort and has many components of a model program" (TAC Report, p. 102).

Recommendation of the Working Group

The working group recommends that the Psychiatric Security Review Board be maintained.

[10] Norko MA, Wasser T, Magro H. Assessing Insanity Acquittee Recidivism in Connecticut. Beh Sci Law. 2016; 34(2-3): 423-443

[11] Torrey EF, Dailey L, Lamb HR, et al. Treat or Repeat: A State Survey of Serious Mental Illness, Major Crimes and Community Treatment. Arlington VA: Treatment Advocacy Center; 2017

Frequency of Mandatory PSRB Review Hearings

Charge

Section 6 of PA 22-45 charged the working group to examine methods of optimizing the processes by which a person found not guilty by reason of mental disease or defect pursuant to CGS §53a-13 is released or discharged from custody, including, but not limited to, through a balancing of the protection of society, victims' rights, and the health and well-being of such person; and the processes for notifying a victim of such person when such person is released or discharged from such custody.

Section 6 of PA 22-45 also charged the working group to examine the recommendations of the CVH/WFH Task Force established pursuant to section 1 of PA 18-86. In its December 2021 report, the CVH/WFH Task Force expressed concern about the lengthy periods of commitment to the PSRB and for appropriate release to the community once an acquittee no longer poses a danger to self or others. The task force "agreed that a review of an acquittee's commitment once every two years is far too long a period of time" (p. 14). The task force recommended amending CGS §17a-585 to mandate reviews every six months.

Information Presented to Working Group

The working group reviewed procedures for managing the insanity defense and treating and monitoring acquittees in 17 states, in addition to Connecticut[12]. Information about the frequency of hearings was available for 16 other states. Eight of the 16 states specify the frequency of hearings. Oregon mandates PSRB hearings at least every two years, like Connecticut. Ohio has hearings every two years (in court). Virginia has yearly court hearings for five years, then biennial hearings. New York requires yearly hearings for persons not released from the hospital. Missouri requires yearly hearings for persons on conditional release. Tennessee requires yearly hearings for outpatients only. Massachusetts and North Carolina require yearly hearings after more frequent initial hearing frequencies. Eight states require hearings only to hear petitions for transfer or some form of release. The available data and research literature do not provide sufficient information to link hearing frequency to outcomes (such as length of hospitalization, length of commitment, or recidivism rates). This is also the conclusion reached by Linhorst in 1997,[13] who attempted to correlate system design to relevant outcomes.

The working group heard from both victims and acquittees that hearings can be distressing and that more frequent hearings would generally not be desirable. At the same time, the current statutory framework provides flexibility to convene hearings whenever circumstances warrant, including considering applications for temporary leave (CGS §17a-587) or conditional release (CGS §17a-588). In addition, section 17a-581-18 of the PSRB Regulations permits any party to apply to the Board for a hearing. As a result, the existing structure balances regularly scheduled review with the ability to respond to individual circumstances as they arise.

Recommendation of the Working Group

More frequent hearings, such as those held every six months, were not viewed as likely to contribute meaningfully to patient recovery beyond the review mechanisms already available. Even when a hearing is not convened to consider a proposed change in treatment or supervision, victims may feel obligated to attend and, in some cases, prepare a statement. Testimony received by the working group indicated that this process can be stressful and emotionally difficult for victims.

[12] For detailed information on the state data, see Appendix A.

[13] Linhorst DM. The impact of system design on the characteristics of Missouri's insanity acquittees. J Am Acad Psychiatry Law 25(4): 509-529, 1997

The working group concluded that increasing the frequency of mandatory review hearings would be unlikely to provide significant benefit while increasing the burden on patients, victims, treatment providers, Board members, and Board staff. Accordingly, the working group does not recommend any change to the frequency of mandatory review hearings under CGS §17a-585.

Use of COLLECT System for Acquittees

Charge

Section 6 of PA 22-45 charged the working group with examining methods of optimizing: "the processes by which a person is committed to DMHAS after NGRI finding" and "the processes by which a person is released or discharged from DMHAS custody, including through balancing of protection of society, victims' rights, and the health and well-being of such person."

Background

The Connecticut On-Line Law Enforcement Communications Teleprocessing system (COLLECT) is used by law enforcement to make information available to responding officers in the field, such as the Registry of Offenders Convicted of Offense Committed with a Deadly Weapon (CGS 54-280), the Sex Offender registry (CGS §§54-250 through 54-258), and the Protective Order Registry (CGS 51-5c).

A number of acquittees under the jurisdiction of the PSRB reside in the community while on conditional release (CR) or are participating in overnight temporary leaves (TL) from the hospital. When law enforcement officers encounter these individuals in the community, they may have no way of knowing that the person is under PSRB jurisdiction, the conditions governing that status, or whom to contact if concerns arise.

Although mental health providers responsible for an acquittee are required to notify the PSRB of significant issues once they become aware of them, law enforcement officers are sometimes the first to encounter an individual who is experiencing difficulties. In such circumstances, the absence of readily available information regarding the individual's status and appropriate points of contact may present challenges for effective response and coordination.

Information Presented to Working Group

At the February 20, 2024 meeting of the working group, there was a presentation by Ryan Rigon, Law Enforcement Analyst from the COLLECT Unit. COLLECT maintains a collection of databases as resources for law enforcement officers (LEOs). These databases can only be accessed by LEOs in the official discharge of their duties, and there are sanctions against any unauthorized use of the system. Various types of "registries" exist in COLLECT as specific "files." Some files are available nationally and others are for in-state use only. Some files have time limits or terminations imposed on them via their authorizing legislation. Data may be entered into the system by the Judicial Branch or by law enforcement agencies. The information available in a file varies by file type and is structured to conform to the intended purpose and authorizing legislation.

Recommendation of the Working Group

The COLLECT system should be amended to create a file for individuals under the jurisdiction of the PSRB. Records in this file should include the individual's name, date of birth, current address, the name of the person or agency responsible for the individual's care, contact information for that person or agency, and a notice directing law enforcement officers who encounter the individual in the course of their duties to communicate with the identified contact regarding any assistance the individual may require.

When a defendant found not guilty by reason of mental disease or defect pursuant to CGS §53a-13 is committed to the jurisdiction of the PSRB pursuant to CGS §17a-582(e)(1), the Superior Court should cause a record for that individual to be entered into the COLLECT system in the file created for this purpose. Implementation of this recommendation would require authorizing legislation.

When responsibility for an individual's care is transferred to a different person or agency, officers of the DMHAS Division of Safety Services should be responsible for updating the record by notifying the COLLECT Unit of the Department of Emergency Services and Public Protection of the revised information. Upon discharge from PSRB jurisdiction, the individual record in the COLLECT file should be deactivated. This function may be performed either by the Superior Court or by the DMHAS Division of Safety Services through notification to the COLLECT Unit, whichever approach is determined to be more practical.

Unlike other registries maintained within COLLECT, this file should not impose statutory penalties for failure to register, nor should it require individuals to appear in person at a local police department or State Police troop. The purpose of the file is solely to make information available to law enforcement officers who may encounter an individual in the course of their duties, thereby enabling appropriate persons or agencies to be notified and available to provide guidance regarding assistance to that individual.

Victim Services

Charge

Section 6 of PA 22-45 charged the working group to examine methods of optimizing the process by which a person found not guilty by reason of mental disease or defect pursuant to CGS §53a-13 of the Connecticut General Statutes is released or discharged from custody, including, but not limited to, through a balancing of the protection of society, victims' rights, and the health and well-being of such person; and the processes for notifying a victim of such person when such person is released or discharged from such custody.

Background

Individuals who qualify as "victims" are defined in CGS §54-201. The Office of Victim Services (OVS), within the Judicial Branch, is established pursuant to CGS §54-203, with additional provisions governing victim services contained in CGS §§54-201 through 54-235. OVS provides information regarding available services and benefits through a variety of publications, including the online pamphlet Compensation for Crime Victims, which describes eligibility criteria and available compensation benefits. One important resource available to victims and their family members is counseling. OVS contracts with 49 counseling providers statewide, including 45 funded through the federal Victims of Crime Act (VOCA) and four funded through Judicial Branch appropriations.

Information Presented to Working Group

At its September 19, 2023 meeting, the working group received presentations on victim services from Vanessa Cardella, LCSW, Executive Director of the Connecticut PSRB, and Mary Kozicki, Deputy Director of OVS, Superior Court Operations Division.

OVS offers a range of services to victims of crime, as described in its program materials. These services include court-based victim advocates who provide support during court proceedings and information regarding victims' rights, as well as financial assistance for medical expenses, counseling, lost wages, and other crime-related costs. Details regarding available financial assistance are provided in the OVS pamphlet Compensation for Crime Victims. OVS also provides notification of hearings to victims, a topic discussed in a separate section of this report.

OVS does not maintain data regarding utilization of counseling services by victims of individuals under PSRB jurisdiction and therefore cannot determine how many such victims have accessed those services. However, reports from victims who have utilized the services indicate that they found them beneficial.

Victim representatives serving on the working group reported that victim advocates were available during court proceedings but were not consistently available at other times, including instances in which telephone calls were not returned. OVS expressed interest in receiving additional feedback from the victim representatives participating in the working group. Victim representatives recommended that advocates with specialized knowledge of acquittee cases be available to assist victims involved in PSRB matters. OVS has recently assigned two advocates to work specifically with victims of individuals under PSRB jurisdiction. The working group viewed this as a positive development worthy of continued support.

The Council of State Governments Justice Center published a 2008 guide entitled Responding to People Who Have Been Victimized by Individuals with Mental Illness. The guide identifies the importance of informing victims "of crimes committed by people with mental illnesses about their rights when the person who committed the crime is transferred to the custody of the mental health system and

explain[ing] to these victims how the criminal justice and mental health systems interface during case proceedings" (p. 15).

In Connecticut, information regarding the process for cases involving findings of not guilty by reason of mental disease or defect is available through the OVS publication Crime Victims' Guide to the Adult Criminal Court. However, information relevant to acquittee cases is dispersed throughout the guide. Information regarding findings of not guilty by reason of mental disease or defect appears on page 38 and could be expanded to provide additional detail and specificity. Information regarding the PSRB appears on pages 50-51 but contains certain imprecisions, including references to a period of PSRB commitment as a "sentence," and does not include information regarding hearings held when an acquittee petitions for temporary leave or conditional release. Information regarding victim notification is provided on page 66, while information regarding victims' rights in connection with PSRB hearings and orders appears on page 72.

Victim representatives on the working group supported the need for more comprehensive information regarding the insanity defense and PSRB process to be made available to victims early in court proceedings and throughout subsequent PSRB involvement. OVS acknowledged that presenting information relevant to acquittee cases in multiple sections of the guide may make it more difficult to locate and understand. OVS indicated plans to revise the guide to improve accessibility and comprehensiveness of this information. The working group supports that effort. The PSRB and the DMHAS Division of Forensic Services would be available to assist in the revision process. A revised guide, together with the assignment of dedicated advocates, may improve the availability and accessibility of information for victims in acquittee cases.

In October 2023, the working group discussed the availability of Standing Criminal Protective Orders (SCPOs) under CGS §53a-40e. At that time, SCPOs were available only in cases involving criminal convictions. Victims harmed by individuals subsequently found not guilty by reason of mental disease or defect may have interests similar to those of victims in criminal cases with respect to avoiding unwanted contact from the person responsible for the harm.

During an acquittee's period of PSRB jurisdiction, a prohibition on contact with the victim is a standard condition of conditional release. The Board may also impose additional measures to reduce the likelihood of unwanted contact, including restrictions related to residence or employment. Upon discharge from PSRB jurisdiction, however, those conditions are no longer enforceable, while victims may continue to desire formal protections against contact.

The working group supported revising CGS §53a-40e to permit the issuance of SCPOs in cases involving findings of not guilty by reason of mental disease or defect. Section 8 of PA 24-137 subsequently implemented this change. Accordingly, no further action is required on this matter.

Recommendation of the Working Group

Improvements should be made to the information available to victims about the PSRB process and services that are available to them, especially in the Crime Victims' Guide to the Adult Criminal Court and via dedicated advocates in the OVS. No statutory amendments are needed for this recommendation, but the OVS should be supported in this work and receive assistance from the PSRB and DMHAS in these efforts.

Victim Notification

Charge

Another of the charges to the working group in section 6 of PA 22-45 was to examine the "processes for notifying a victim of [an acquittee] when such person is released or discharged from… custody."

Background

The Victim Information and Notification System (VINE) is "an automated and confidential victim information and notification service that provides crime victims and other interested parties with automatic notice of relevant offender information and status reports as a case proceeds through the criminal justice system." Information about the system is available online. Crime victims, relatives (and certain other identified individuals) can register for notifications about various hearings, releases from the Department of Correction, and other changes to a defendant's status. Once an individual is found not guilty by reason of mental disease or defect, however, the system is not currently equipped to provide further notifications to victims, even for future hearings in court related to discharge or recommitment.

In relation to PSRB processes, victims are defined separately in CGS §17a-601(a) under the heading of "Notice to victims of court and board hearings." Compared to the definition of "victim" in CGS §54-201, CGS §17a-601(a) includes a deceased victim's "immediate family" member, while CGS §54-201 is limited to a "person who is injured or killed." (CGS §54-201 has a broader definition of "relative" for other purposes related to the Office of Victim Services (OVS).)

Once an individual is identified as a victim of an acquittee by the superior court per CGS §17a-601, the PSRB provides notice to such a victim of upcoming hearings before the PSRB. It also provides notice to victims when an acquittee has absconded or escaped from custody. (Hospital superintendents or the Commissioner of Developmental Services are required to notify the PSRB of absconding or escapes, per PSRB Regulation Sec. 17a-581-57.)

Information Presented to Working Group

The Executive Director of the PSRB also communicates frequently with victims, providing notices of hearings, responding to queries, and presenting information about cases and processes. Not all victims wish to receive notice about every type of event in an acquittee's progress through the PSRB and treatment systems. Any person may request notice of PSRB hearings, as they are public hearings, so the definition of "victim" is not limiting for this purpose.

A formalized process for cataloging (and periodically updating) victim preferences does not currently exist, although the PSRB does try to remain aware of victims' preferences and provide information accordingly. The OVS has a mechanism for distinguishing different types of notice and would be available to provide guidance about such a system.

Recommendation of the Working Group

- The VINE victim notification should be modified to permit continuation of victim notifications after a defendant is found not guilty by reason of mental disease or defect to allow automated notifications of court hearings to continue. This would not require statutory amendments.
- Victims should be able to opt in to the specific types of notice they wish to receive from the PSRB. The PSRB already tries to keep track of these preferences but could develop a more systematized method of handling this information. This will require further exploration of available

technology/software and may require additional resources to enable an automated system. This change would not require statutory amendments.

- To make it easier for victims and others to find the definition of "victim" for purposes of PSRB procedures and processes, CGS §17a-601(a) should be moved to the definitions section for the PSRB statutes at CGS §17a-580. This would also require that current references to the definition in CGS §17a-601(a) (such as occurs in CGS §17a-587(b), CGS §17a-596(h), and CGS §17a-599(c)) be amended.

Victims' Right to be Heard at PSRB Hearings

Background

CGS §54-201(1) defines a "victim" as "a person who is injured or killed." CGS §54-201(4) defines "relative" (for purposes of services provided by the Office of Victim Services) as "a person's spouse, parent, grandparent, stepparent, aunt, uncle, niece, nephew, child, including a natural born child, stepchild and adopted child, grandchild, brother, sister, half brother or half sister or a parent of a person's spouse."

For purposes of describing notice to victims of PSRB hearings and the right to be heard at such hearings, CGS §17a-601(a) states " 'victim' means a person who is a victim of a crime, the legal representative of such person or a member of a deceased victim's immediate family."

CGS §17a-601(b) provides that "the victim may appear at any court or board hearing concerning the acquittee to make a statement." In some cases, individuals other than an immediate family member of a deceased victim (e.g., a significant other or close friend) may have a legitimate interest in PSRB proceedings and wish to provide a statement at a hearing. Although it has been the practice of the PSRB to permit such statements on a case-by-case basis, this authority is not expressly codified in statute or regulation and is therefore subject to interpretation.

Recommendations of the Working Group

The wording of CGS §17a-601(a) should be amended to be more consistent with the definition of "relative" in CGS §54-201(4). An example would be substituting "person immediately connected to a deceased victim" for "member of a deceased victim's immediate family." CGS §17a-601(a) would thus be amended as follows:

> **Sec. 17a-601. (Formerly Sec. 17-257v). Notice to victims of court and board hearings.** (a) For the purposes of this section, "victim" means a person who is a victim of a crime, the legal representative of such person or a [member of a deceased victim's immediate family] person immediately connected to a deceased victim.

A statement should be added to the end of the current CGS §17a-601(b) to permit, at the discretion of the chair, such other person or persons who are immediately connected to the victim and who have a legitimate interest in the proceedings to make a statement at Board hearings.

Processes in Other Jurisdictions

Charge

Section 6 of PA 22-45 charged the working group with examining "processes in place for committing and releasing a person who has been found not guilty by reason of a mental disease or defect in states that do not have a body that is similar to" the PSRB.

Background

The PSRB was established in Connecticut in 1985. Concerns over the acquittal of John Hinckley in 1983, and some in-state concerns about outcomes of insanity cases, prompted the Connecticut General Assembly to order the Connecticut Law Revision Commission to review provisions for the care and monitoring of acquittees. The Commission worked with "legislators, criminal justice experts, academicians, and mental health professionals"[14] in its review. The Commission "found that existing laws placed authority for disposition of acquittees with the criminal courts, which often lacked the time, resources, and expertise to make informed judgments about conditional release and discharge from custody of the state."[15] The creation of the PSRB was thought to be "a more equitable division of authority between the courts and the institutions that treat acquittees."[16]

The CT PSRB was modeled after the Oregon PSRB, which was created in 1979. The two state models have many similarities, and several noteworthy differences. The CT PSRB required courts to issue the final discharge from the PSRB, as opposed to the PSRB having that authority in Oregon. Connecticut required an inpatient evaluation to make recommendations about commitment to the Board; Oregon courts are advised by local mental health programs in the community on this matter. The CT PSRB statutes allowed for recommitment to the Board, which does not occur in Oregon. In Connecticut, no funds were appropriated separately for treatment of acquittees under the PSRB, as they were in Oregon.

PA 18-86 established a task force (CVH/WFH Task Force) to review and evaluate Connecticut Valley Hospital and Whiting Forensic Hospital and published its final report December 16, 2021. The task force members had divided opinions about whether the PSRB should be maintained or abolished, and a majority of the members agreed that abolition should be considered.[17] The working group sees the charge noted above as an outgrowth of that consideration.

Information Presented to Working Group

In 2019, the Oregon legislature commissioned a work group to "address concerns about the PSRB process."[18] According to the report of that work group, in 2019 there were 613 persons under the jurisdiction of the Oregon PSRB, of which 36% were receiving treatment in the hospital and 64% were on some form of conditional release in the community.[19] According to the Oregon PSRB's 2024 online "snapshot," as of January 1, 2024, there were 613 people under the jurisdiction of their PSRB, with 42% in the state hospital. Of those in the community, 18.7% live in locked residential treatment facilities.

[14] Scott DC, Zonana HV, Getz MA. Monitoring Insanity Acquittees: Connecticut's Psychiatric Security Review Board. Hosp Comm Psychiatry. 1990;41(9):980-984, p. 981

[15] Loc. cit.

[16] Loc. cit.

[17] Task Force to Review and Evaluate CVH and WFH, the Psychiatric Security Review Board, and Behavioral Health Care Definitions. Final Report. December 16, 2021. p. 12-13

[18] Oregon Psychiatric Security Review Board Work Group Report, December 2021, p. 4

[19] Oregon Psychiatric Security Review Board Work Group Report, December 2021, p. 11

Oregon has a population of 4.2 million. Their insanity defense is known as "Guilty Except for Insanity" (GEI).

By comparison, in March 2023, Connecticut had 145 acquittees under the jurisdiction of the PSRB, with 73% receiving treatment in the hospital and 25.5% receiving treatment in the community on conditional release.[20] The Connecticut population is approximately 3.6 million. From these data, the Oregon system has a higher percentage of defendants using the insanity defense, and a higher percentage of people receiving treatment in the community than in Connecticut.

Historically, misdemeanor defendants in Oregon who received an acquittal were placed under the jurisdiction of the PSRB. They could not be held in the hospital longer than the maximum criminal sentence (usually one year) and there was no possibility for recommitment. As of 2012, the Oregon PSRB no longer oversees misdemeanor cases. Individuals charged with misdemeanor only offenses who are acquitted by reason of mental disease or defect are either discharged immediately or committed to the state hospital (if dangerous), after which the hospital has sole jurisdiction over discharge.[21] The state hospital reports that, in the years 2013 through 2019 there were two to five misdemeanor insanity defense cases admitted per year, with an average of three per year.[22] The Oregon Judicial Department reported that in the years 2019 through 2023 there were one to seven cases of GEI findings in misdemeanor-only cases per year, with an average of 4.2 cases per year.[23] Not all misdemeanor-only GEI cases are admitted to the hospital (for example, in 2019 the Judicial Department reported 7 such cases, but only 3 were admitted to the hospital).

The Oregon report also noted that 28% of individuals discharged from their PSRB's jurisdiction over the prior three years were still living at the state hospital or in a secure (locked) residential facility at the time of discharge.[24] They considered the merits of the Connecticut model in which recommitment can be requested, but ultimately did not make a recommendation to move in that direction, expressing concerns about longer lengths of hospitalization and smaller proportion of individuals on conditional release (CR) in other states.

The most recent Oregon PSRB snapshot notes a 2.9 % total conviction rate (felonies and misdemeanors) for all individuals while on CR during the years 2011 through 2023, with an annual recidivism rate of 0.3%. The total arrest rate in Connecticut for individuals on CR was 2.3%, with a conviction rate approximately one-half that rate; the four arrests reported were all for misdemeanors.[25]

The Oregon report re-arrest rates for individuals discharged from their PSRB, as reported in a ProPublica series.[26] The total re-arrest rate was 37.8% (21.9 % felonies, 16.0% misdemeanors). The report noted the importance of conditional release for community success following discharge[27], and that a number of

[20] Presentation by the CT PSRB, March 21, 2023

[21] Bloom JD. CRIPA, Olmstead, and the Transformation of the Oregon Psychiatric Security Review Board. J Am Acad Psychiatry Law. 2012 Sep; 40(3): 383-389

[22] Email communication 6/3/24 from Alison Bort JD, PhD, Executive Director of the Oregon PSRB

[23] Email communication 7/12/24 from Alison Bort JD, PhD, Executive Director of the Oregon PSRB

[24] Oregon Psychiatric Security Review Board Work Group Report, December 2021, p. 39

[25] Norko MA, Wasser T, Magro H, et al. Assessing Insanity Acquittee Recidivism in Connecticut. Beh Sci Law. 2016; 34(2-3): 423-443

[26] Oregon Psychiatric Security Review Board Work Group Report, December 2021, p. 38

[27] Oregon Psychiatric Security Review Board Work Group Report, December 2021, p. 53

individuals may have had little to no time on CR during their period of PSRB jurisdiction.[28] Comparative data for Connecticut have been reported: 16.3% total arrest rate following discharge from PSRB jurisdiction, 9% for felonies.[29] The same study noted a statistically significant difference in re-arrest rate for those on CR at the time of discharge from the PSRB compared to those who discharged while not on CR (11% vs. 27.9%).[30] A California study found that acquittees discharged from the hospital without CR were nearly nine times more likely to reoffend compared to those discharged while on CR. That report noted "abundant research" demonstrating the importance of CR programs in reducing hospitalizations and re-arrest, as well as managing symptoms of illness (p. 659). [31] A Fact Sheet from the California Department of State Hospitals noted that acquittees released in California without monitoring by their conditional release program (CONREP) were 4.5 to 7 times more likely to be arrested.[32]

The working group was able to locate data on percentages of acquittees in hospitals compared to community settings for a few other states. The percentage of acquittees in hospitals is 87.7% for Arizona, 100% for North Carolina (once released from the hospital, there is no monitoring of acquittees), and 60% for New York (half in forensic hospitals, half in civil hospitals).

Two peer-reviewed articles in the psychiatric literature also examined data on length of stay for acquittees in Missouri. Missouri does not have a PSRB but uses a Forensic Monitoring System to monitor acquittees in treatment in the community.[33] Linhorst[34] reported in 1997 that the inpatient/outpatient percentages for Missouri acquittees were 53.1/45.3. Linhorst also noted that half of the state's long-term psychiatric hospital beds were devoted to acquittees. In Connecticut, that figure is 18%. Reynolds[35] reported that in 2015 nearly all the Missouri state hospital beds were forensic (acquittees and persons being restored to competence to stand trial).

The Oregon work group also reported the average length of time under PSRB jurisdiction by offense type: Murder, 25.7 years; A felonies, 17.4 years; B felonies, 9.75 years; and C felonies, 5.6 years.[36] Linhorst reported on lengths of hospitalization for individuals who had been conditionally released, and for those who had never been conditionally released (at the time of the study in 1992, which is an incomplete accounting of length of stay for those individuals since they were still in the hospital). These data are presented in the following two tables.[37]

[28] Oregon Psychiatric Security Review Board Work Group Report, December 2021, p. 38

[29] Ibid.

[30] Ibid.

[31] McDermott BE, Ventura MI, Juranek ID, Scott CL. Role of mandated community treatment for justice-involved individuals with serious mental illness. Psychiatric Services. 2020;71 (7): 656-62

[32] California Department of State Hospitals Fact Sheet, January 2022. CONREP Effectiveness Research Study 2021

[33] Reynolds JB. A description of the forensic monitoring system of the Missouri Department of Mental Health. Beh Sci Law 34:378-395, 2016

[34] Linhorst DM. The impact of system design on the characteristics of Missouri's insanity acquittees. J Am Acad Psychiatry Law 25894): 509-529, 1997

[35] Reynolds, p. 389

[36] Oregon Psychiatric Security Review Board Work Group Report, December 2021, p. 11

[37] Linhorst, p. 522

Table 5
Mean and Median Months of Hospitalization of Conditionally Released Missouri Insanity Acquittees by Class of Crime, July 1, 1992 (*N* = 509)

Class of Crime	Mean Months*	Standard Deviation	Median Months	Percentage of Total
Class A Felonies	75.3	(61.8)	64	21.8
Class B Felonies	52.8	(57.8)	32	35.0
Class C Felonies	38.9	(45.7)	26	26.1
Class D Felonies	24.1	(26.3)	15	9.4
Misdemeanors	28.3	(31.6)	24	7.7
Totals	49.5	(54.3)	30	100.0

* $F = 13.90$, $df = 508$, $p = .0000$; missing data on two subjects.

Table 6
Mean and Median Months of Hospitalization of Never Conditionally Released Missouri Insanity Acquittees by Class of Crime, July 1, 1992 (*N* = 286)

Class of Crime	Mean Months*	Standard Deviation	Median Months	Percentage of Total
Class A Felonies	92.3	(89.0)	57	26.6
Class B Felonies	57.7	(58.2)	38	39.5
Class C Felonies	63.2	(57.9)	48	22.7
Class D Felonies	66.2	(70.2)	47	6.6
Misdemeanors	59.5	(59.3)	40	4.6
Totals	68.8	(69.5)	43	100.0

* $F = 3.15$, $df = 285$, $p = .015$.

Comparison data from the Connecticut Office of the Public Defender[38] (based on 109 acquittees represented out of a total of 148 in January 2023, or 73.6%) reported an average duration of 17 years from commitment to CR for individuals on CR as of January 2023. The range was 53 months to 502 months (42 years). The average time from initial commitment to temporary leave (TL) was 11 years for individuals on TL at that time.

At that time, 60 individuals in the hospital had no TL, 50 of whom had never received TL. For this group, the range of time under PSRB jurisdiction was 9 months to 491 months (41 years), with an average of 14 years.

Whiting Forensic Hospital provided updated data for the first six months of calendar year 2024. For individuals on CR as of July 1, 2024, the average duration from commitment to CR was 10.8 years, with a

[38] Presentation by the Office of the Public Defender, October 16, 2023

range of 6.5 to 14 years. For individuals on TL as of July 1, 2024, the average time from commitment to TL was 12.8 years.

As of July 1, 2024, there were 62 individuals in the hospital who were not on TL, 59 of whom had never received TL. For this group, the range of time under PSRB jurisdiction was 1.7 to 39.5 years, with an average of 14.5 years.

These data are generally consistent with the January 2023 figures, with a decrease in average time to CR (10.8 years compared to 17 years), likely related to the discharge of one or more long-term acquittees from PSRB jurisdiction, and a slightly longer average time to TL (12.8 years compared to 11 years). However, the lengths of hospitalization in Connecticut remain significantly longer than those reported in the Missouri comparison tables from 1992.

After reviewing available information about procedures for managing acquittees in 17 other jurisdictions, the working group was able to prepare a table of relevant features of these systems for those states.[39] Key points from the comparisons are listed below.

In most states, the evaluation to determine placement and treatment following an acquittal occurs at a state hospital or state forensic hospital. In several states, this evaluation occurs in the community (CA, OH, OR, and TN). In two states, evaluations can occur in inpatient or outpatient settings (HI and VA). (See "Location of Post-NGRI evaluation" column in Appendix A for further details.)

The criteria for commitment to hospital care in all states is some variation of mental illness creating danger to self or others. Georgia's criteria are the most explicit about what constitutes risk or danger; civil commitment criteria are used for this purpose: "(i) …presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or (ii) Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis…"[40] To be committed to the hospital the person must also be "in need of involuntary inpatient treatment."[41] (See "Commitment Criteria" column in Appendix A for further details.)

Many states use the maximum possible criminal sentence for the crime(s) charged as the maximum commitment period. In three states, the commitment is indeterminate and release hearings are held when clinically indicated (MD, MN, MO). In several other states, no commitment limit is specified, but recommitment hearings are required on a yearly (or earlier) basis (GA, MA, NC, NY, and VA). (See "Time Limit on Original Commitment" column in Appendix A for further details.)

Reports to the court (or the Board in OR, as in CT) are required every six months to two years. In two states, no reports are required (HI, MN). The frequency of reports is not specified in five of the states reviewed. (See "Frequency of Reports" column in Appendix A for further details.)

The frequency of hearings is not specified in some states, where hearings are held as needed to hear petitions. In other states, the frequency varies from every 12 months to every five years. (See "Frequency of Hearings" column in Appendix A for further details.)

[39] See Appendix A

[40] GA Code § 37-3-1(9.1)(A)

[41] GA Code § 37-3-1(9.1)(B)

Recommitment is not possible in Oregon (and AZ prior to the dissolution of its PSRB). Ohio and South Carolina only permit civil commitment. Other states allow periods of recommitment of one to two years (CA, MA, NY). For other states, the subject of recommitment is not applicable as they have indeterminate periods of commitment. (See "Re-Commitment Possible" column in Appendix A for further details.)

In several states, a court order is not necessary for the patient to have TL or furlough from the hospital (MA, MD, MN, OH, TN). In Missouri, the hospital must give notice to the court of intention to allow temporary leave; if no response is received from the court, the hospital may proceed with the leave. (See "Temporary Leave Process or Equivalent" column in Appendix A for further details.)

There is no process for CR in Massachusetts or North Carolina. In those states, once individuals are released from the hospital, there is no community monitoring of their condition or treatment. (See "Conditional Release Process" column in Appendix A for further details.)

Revocations of CR are ordered by the court in most states. In Oregon, the Board has this responsibility (as in CT). In Minnesota, the program director may order revocation of CR. In Missouri, the forensic director may do so. (See "Revocation Process" column in Appendix A for further details.)

Transfer decisions of acquittees from one facility to another are made by the court in two states (MA, NY). In other states, the hospital, the state mental health authority, or a clinical administrative review body makes that decision. (See "Who Makes Transfer Decision to Other Hospital" column in Appendix A for further details.)

Decisions to release individuals from the hospital are generally made by the court, except for Connecticut and Oregon (where the Board makes the decision) and Minnesota (where the Commissioner of Mental Health and a special review board make that decision). (See "Who Makes Release from Hospital Decisions" column in Appendix A for further details.)

The decision to release someone from all supervision is generally made by the court. In Oregon, that decision is made by the Board. In Massachusetts, the hospital medical director or hospital director may make that decision unless the court decides to hold a hearing on the matter. (See "Who Makes Decision for Discharge from Supervision" column in Appendix A for further details.)

The internal process of reviewing patients' progress and deciding on appropriate next steps is multi-layered in most states, consisting of clinicians, clinical leaders, hospital administrators, special review boards, and expert consultants. (See "Internal Review Process for Release/Discharge" column in Appendix A for further details.)

In most states, statutory language about the priorities to be considered in decision-making about changes in patients' status invoke some form of danger to society or others. Oregon adds "rights of the clients." Ohio adds the welfare of the person (patient) but gives preference to public safety. Connecticut added "well-being" of the patient in PA 22-45 as either a primary or secondary concern. Georgia uses their civil commitment criteria. The Georgia statutory scheme seemed to imply the potential for easier release of acquittees from involuntary hospitalization; a query was made to the former Director of Forensic Services for that state. The reality is that acquittees in Georgia experience the same long processes encountered in other states despite what appears to be a lower statutory bar. This fact underscores the working group's conclusion that the systems for managing acquittees are complicated, complex, and have many

stakeholders who can influence the outcome of any proposed statutory scheme. (See "Statutory Language Regarding Priority/Goals in Decision-Making" column in Appendix A for further details.)

One final highlight is that two states have statutory schemes for handling cases where the individual is ultimately determined to be an "inappropriate" person for acquittal (e.g., it is ultimately determined that the person has only conditions which are disqualified for the insanity defense). In Oregon, the Board is required to discharge such persons regardless of how dangerous they may be related to factors other than serious mental illness.[42] The Oregon Work Group considered additional legislative amendments to address the problem of releasing dangerous individuals without any further supervision or sanctions, but decided the matter needed significantly more research and discussion.[43] In Hawaii, on the other hand, there is an explicit statement that acquittees can be detained if dangerous even when no longer deemed mentally ill.[44] (See "Language Regarding Inappropriate NGRI Commitment" column in Appendix A for further details.)

Discussion

Several points are worth highlighting about the material the working group reviewed, organized in sub-sections below.

Recommitment

The system in Connecticut is more skewed toward hospital level of care for acquittees than in Oregon. The length of hospitalization is longer and there is a significantly smaller percentage of acquittees on conditional release while under the supervision of the PSRB. This difference seems to be due, in large measure, to the fact that recommitment is possible in Connecticut, but not in Oregon. Although the Oregon work group considered recommending the possibility of recommitment for some acquittees, they chose not to do so because of the anticipated effects on length of hospitalization and percentage of acquittees in the hospital versus the community.

There are arguments in favor of allowing recommitment, as noted by the Oregon group. However, eliminating recommitment in Connecticut with the intent of reducing lengths of stay in hospital and increasing the proportion of individuals under Board supervision living in the community may not directly or readily achieve those outcomes.

The insanity defense/PSRB system is a complex set of interrelated components and decision points. In complex systems, policy changes in one area may result in compensatory adjustments elsewhere in the system. For example, changes to recommitment authority could potentially be associated with changes in judicial decision-making at the point of initial commitment, prosecutorial willingness to enter into insanity defense dispositions, or victim response and participation in proceedings, which may also influence prosecutorial decision-making.

PSRB versus court-monitored processes

Most other states have systems that involve the court in the monitoring of the progress and settings for the care of acquittees. None of the states that the working group reviewed that use these processes seem to have significantly better outcomes – either in terms of public safety or the recovery trajectory and treatment needs of acquittees. However, there is no clear methodology for linking system design to these

[42] Oregon Psychiatric Security Review Board Work Group Report, December 2021, p. 15

[43] Ibid., 25-28

[44] https://law.justia.com/codes/hawaii/2016/title-37/chapter-704/section-704-412/

types of outcomes. As Linhorst observed in his attempts to do so, "In most cases, support did not exist to link characteristics with the state's system design."[45] It does seem clear, however, that having courts monitor the progress of acquittees (rather than a Board) does not lead to obviously better outcomes. In addition, as the Connecticut Law Revision Commission concluded in the work that led to the establishment of the PSRB, the criminal courts "often lacked the time, resources, and expertise to make informed judgments about conditional release and discharge from custody of the state."[46]

As envisioned by that Commission, the PSRB continues to provide for review by an independent body of people with relevant experience, permits adversarial scrutiny of proposed plans in a public setting, and provides opportunities for victims to be heard and to hear the arguments being made for proposed changes. In turn, that level of scrutiny encourages careful planning and preparation by clinical treatment teams in their work with acquittees.

Shorter hospitalization and increased percentage of acquittees receiving care in the community, as consistent with public safety

Shorter periods of hospitalization and an increased proportion of acquittees receiving treatment in the community, consistent with public safety, are goals identified by both the CVH/WFH Task Force and the legislation establishing this working group. The literature consistently associates community supervision with lower rates of recidivism and improved treatment engagement among acquittees. By contrast, the literature does not clearly demonstrate that longer periods of hospitalization are necessary to achieve these outcomes. The PSRB provides a structured system of review and oversight for individuals receiving treatment in the community, including the authority to revoke conditional release and order rehospitalization when clinically or legally indicated.

Changes that eliminate or substantially reduce the role of the PSRB could have broader implications for the operation of the insanity defense system. As discussed previously, such changes could affect victim participation and prosecutorial decision-making, which may influence the use of insanity defense dispositions.

Some states limit the duration of initial commitments and recommitments to shorter periods, while others use indefinite commitment, requiring periodic hearings to continue an individual's commitment. Indefinite commitment (i.e., not linked to the maximum possible sentence upon conviction) has been described as having the advantage of decoupling acquittal from punishment-based measures and potentially placing greater emphasis on clinical decision-making in the management of acquittees. Although either approach could be expected to encourage shorter periods of hospitalization or shorter overall periods of PSRB supervision, the working group found no evidence that these models consistently produce those outcomes. For example, in Georgia, where the criteria for recommitment are the same as the criteria for civil commitment, the working group learned that the system remains conservative in practice and that acquittees often experience a lengthy process before community reintegration.

The working group also recognized that substantial legislative changes to the structure or duration of commitment periods could have broader effects on the operation of the insanity defense system, including potential impacts on prosecutorial decision-making and victim participation, as discussed above.

[45] Linhorst DM. The impact of system design on the characteristics of Missouri's insanity acquittees. J Am Acad Psychiatry Law 25894): 509-529, 1997, p 527

[46] Scott DC, Zonana HV, Getz MA. Monitoring Insanity Acquittees: Connecticut's Psychiatric Security Review Board. Hosp Comm Psychiatry. 1990;41(9):980-984, p 981

Absent corresponding changes in broader system expectations regarding treatment and community reintegration, the working group did not identify evidence that changes to commitment periods alone would be likely to produce substantial changes in practical outcomes.

Under existing statutes and Board procedures, Whiting Forensic Hospital may petition for TL or conditional release CR whenever hospital staff determine that it is clinically appropriate. The Board grants a high percentage of these petitions (90% or more). This high approval rate likely reflects, in part, the hospital's careful approach to determining when a petition is appropriate. From 1985 until October 1, 2022, the hospital operated within a system whose primary concern was the protection of society. From 1985 until October 1, 2022, the statutory framework governing the PSRB emphasized the protection of society. During that period, state statute did not expressly articulate a corresponding expectation that the treatment system actively promote the recovery and community reintegration of acquittees to the fullest extent consistent with public safety. Although these principles were reflected in the professional responsibilities of individual clinicians and in the mission and values of DMHAS, they were not explicitly incorporated into statute. As noted by the CVH/WFH Task Force, exceptionally long commitment periods in some cases may also have reinforced an emphasis on continued hospitalization.

PA 22-45 sought to rebalance the statutory framework by adding the "well-being of the acquittee" as a consideration for the court and the Board. However, the Act did not define the term "well-being of the acquittee," which may have limited the practical effect of this statutory change.

Achieving the goals of shorter periods of hospitalization and increasing the proportion of acquittees receiving treatment under community supervision would require sufficient community-based treatment and residential resources. Conditional release often depends on the availability of supervised residential settings that provide appropriate clinical support and risk management. While Connecticut has effective programs of this type, they are not available in all regions of the state or in sufficient capacity to meet potential demand. Funding is one limiting factor. Even when funding is available, expanding capacity can be challenging because of factors including community provider capacity, availability of appropriate facilities, and workforce constraints.

Recommendation of the Working Group

The review of other jurisdictions did not identify a statutory framework, process, or procedure that the working group determined should be adopted in Connecticut. Nor did the review identify additional jurisdictions warranting further examination. Accordingly, the recommendations presented throughout this report are based on the working group's analysis and deliberations rather than the adoption of another state's model.

Vocational Services for Acquittees

Charge

Section 6 of PA 22-45 charged the working group to examine "methods of optimizing the process by which" a person found not guilty by reason of mental disease or defect pursuant to CGS §53a-13 "is released or discharged from…custody, including, but not limited to, through a balancing of the protection of society, victims' rights, and the health and well-being of such person."

Background

Persons who are found not guilty by reason of mental disease or defect pursuant to CGS §53a-13 (i.e. , "acquittees") usually spend a significant period of time admitted to the Whiting Forensic Hospital (WFH), typically starting with placement in the maximum security portion of the hospital and then advancing to the enhanced security portion of the hospital (i.e., the Dutcher building). Acquittees receive various modes of treatment and rehabilitation during their hospitalization. One important mode of rehabilitation and preparation for community reintegration is vocational services. Such services can contribute substantially to the well-being of acquittees.

Information Presented to Working Group

The working group heard from the acquittee members on the working group about how valuable their experiences with vocational services were to their recovery, and how they hear the same message from their peers. Vocational opportunities were available at the hospital and in the community during periods of conditional release (CR).

From 1995 (with the passage of PA 95-257) until 2018, Whiting was a division of Connecticut Valley Hospital (CVH), which allowed a sharing of various resources within CVH, including vocational services. When the hospitals were separated May 1, 2018 (by Executive Order 63, and confirmed in PA 18-86), many of the vocational opportunities for WFH patients were no longer available, as they were staffed by vocational counselors employed by CVH.

In recent years, there has also been significant turnover in vocational staff at WFH, with a number of positions vacant for an extended period. As of early May 2024, there were three vocational counselors (2 in Dutcher, 1 in Whiting), and one new counselor who was awaiting a pre-employment physical and background check (who was to be placed in Dutcher). Three positions were still to be filled (with interviews in process for two of these).

With the re-staffing of the vocational positions at WFH, it will be possible to supervise acquittees in some of the valuable vocational positions that were lost in 2018. There are also preliminary discussions underway to establish new patient employment opportunities with sites in the community. A variety of patient employment positions are currently active, including work at a local farm about which patients give very favorable reports. A total of 65 patients in WFH are currently able to take advantage of employment opportunities. More opportunities are in development within the hospital and campus.

Recommendation of the Working Group

The working group was pleased to learn of the re-staffing of vocational services personnel at the hospital and supports continued development of these services. The working group encourages hospital staff to incorporate appropriate vocational opportunities into temporary leave (TL) plans, particularly after acquittees begin overnight community leave, and encourages the Board to approve such plans when

appropriate. This recommendation has been shared with hospital leadership. No statutory change is necessary to support these practices.

Commitment, Temporary Leave, Conditional Release, and Discharge

Charge

Section 6 of PA 22-45 charged the working group to examine:

- methods of optimizing the processes by which a person found not guilty by reason of mental disease or defect pursuant to CGS §53a-13 is:
  - committed to DMHAS; and
  - released or discharged from custody, including, but not limited to, through a balancing of the protection of society, victims' rights, and the health and well-being of such person; and
- the processes for notifying a victim of such person when such person is released or discharged from such custody.

Section 6 of PA 22-45 also charged the working group to examine the recommendations of the CVH/WFH Task Force established pursuant to section 1 of PA 18-86. In its Final Report of December 16, 2021, the task force noted that "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." The task force made the following recommendations related to the examination of the role of the PSRB on pages 13-14:

CVH/WFH Task Force Recommendations Related to Role of PSRB	
Task Force Recommendation on PSRB Role 1	Amend CGS §17a-584 "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 CGS §17a-541), including the right to placement in the least restrictive environment"
Task Force Recommendation on PSRB Role 2	End the possibility of re-commitment to the PSRB in CGS §17a-593, and utilize the civil commitment process for patients at the end of their original commitment who are deemed to be gravely disabled or to represent a continued danger to self or others
Task Force Recommendation on PSRB Role 3	Amend CGS §17a-587 "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"
Task Force Recommendation on PSRB Role 4	Repeal CGS §17a-599 to "eliminat[e] 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)"
Task Force Recommendation on PSRB Role 5	Amend CGS §17a-585 to require that the PSRB review an acquittee's commitment every six months "unless the patient specifically waives the right to such review"

Background

Insanity Defense Process in Connecticut

Under Connecticut law, a defendant who is found not guilty by reason of mental disease or defect is not subject to a criminal sentence, such as incarceration, but rather, the acquittee[47] is committed to the

[47] Pursuant to CGS §17a-580, "acquittee" means any person found not guilty by reason of mental disease or defect pursuant to CGS §53a-13.

jurisdiction of the PSRB and confined to either DMHAS or the Department of Developmental Services (DDS) for treatment.

The PSRB, established in 1985, is a state agency and an administrative body appointed by the Governor, consisting of a psychiatrist and a psychologist experienced with the criminal justice system, a person experienced in the process of probation, a member of the general public, an attorney, and a member of the general public with experience in victim advocacy[48]. The responsibility of the PSRB is to order the level of confinement, supervision, and treatment for the acquittee through an administrative hearing process.

The vast majority of acquittees will begin their commitment at the maximum security setting of Whiting Forensic Hospital (WFH) and transition to the less restrictive setting of the Dutcher building at WFH. The hospital may transfer an acquittee to the Dutcher building without approval from the PSRB according to the requirements of CGS §17a-599(c), involving specialized consultants external to the hospital and a risk management review committee of licensed clinical professionals and hospital administrators. Any unsupervised access to the community is at the discretion of the PSRB.

What follows is an explanation of how most, albeit not all, acquittees advance from commitment to inpatient hospitalization toward the goal of community reintegration. Once transferred to the Dutcher building, acquittees advance through the hospital privilege level system beginning with hospital unit restriction, to staff supervised community trips and unsupervised passes on hospital grounds. The awarding of privileges is not subject to PSRB approval and is at the discretion of the hospital based on a clinical risk assessment process.

When an acquittee has achieved the highest level of privilege, they are considered for temporary leave (TL), allowing the acquittee access to the community while the hospital retains custodial and clinical authority. TL usually begins with brief visits to the community to participate in outpatient treatment and may progress to overnight stays in the community. Upon successful completion of TL, the acquittee may be considered for conditional release (CR), which, if approved by the PSRB, transfers all clinical oversight to community providers. The PSRB may revoke a CR if there has been a deterioration in mental condition of the acquittee or a violation of stipulations of the CR[49]. Throughout this process, the hospital and the Board carefully consider the level of treatment compliance evidenced by the acquittee. Compliance with recommended therapeutic programming, medication if applicable, and any other individualized service can play an important role in mitigating an acquittee's risk. It bears noting that for most acquittees this process can take many years and some acquittees may never achieve a level of clinical stability allowing for their unsupervised reintegration to the community.

Recent Legislative Efforts Related to CVH/WFH Task Force Recommendations on the Role of the PSRB
In PA 22-45, the Connecticut General Assembly enacted legislation in response to or in consideration of the above task force recommendations related to the role of the PSRB. Related to Recommendation 1, section 4 of PA 22-45 modified CGS §17a-584 to add that the "safety and well-being of the acquittee" are an additional "primary concern" of the PSRB in its consideration of conditional release and discharge applications. "Well-being of the acquittee" was not defined in that legislation or in existing statutes.

The General Assembly has not ended the possibility of re-commitment to the PSRB as per Recommendation 2, but section 5 of PA 22-45 modified CGS §17a-593 to add that the "safety and well-

[48]See CGS §17a-581

[49]See CGS §17a-594

being of the acquittee" are a "secondary concern" of the court in its consideration of conditional release and discharge applications.

In section 7 of PA 22-45, the General Assembly added subsection (b) to CGS §17a-587, permitting acquittees to file applications for their temporary leave (TL) with the PSRB. The modification did not adopt the proposal in Recommendation 3 to make this a clinical decision and instead maintained the PSRB's decision-making authority. Upon receipt of an application from the acquittee for TL, the Board must request a report from the hospital or commissioner of their opinion regarding granting TL. (Acquittees have previously been able to apply for their own conditional release (CR) under CGS §17a-588.)

Recommendation 4 was accomplished in section 8 of PA 22-45 (effective October 1, 2022), in which the General Assembly permitted the hospital to make transfers from its maximum security building to its enhanced security building without PSRB approval, after consultation with the hospital risk management review committee and a determination that "the acquittee's psychiatric supervision and treatment would be safely advanced" by such a transfer. The hospital must give at least 48 hours advance notice to the PSRB of such a transfer, and the board gives notice to identified victims.

Information Presented to Working Group

The information presented to the working group relating to this subject matter area (Commitment, Temporary Leave, Conditional Release, and Discharge), relates to the five CVH/WFH Task Force recommendations related to the role of the PSRB, as well as the charge under PA 22-45 to examine ways to optimize the commitment and discharge of acquittees. As this is overlapping and complex subject matter, the list below shows what information presented was relevant to which recommendation/charge[50].

Task Force Recommendation on PSRB Role 3	Amend CGS §17a-587 "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"

The statutory changes enacted in Section 7 of PA 22-45, codified in CGS § 17a-587(b), have had limited practical effect. Although the statute permits an acquittee to submit a temporary leave (TL) plan to the PSRB, approval of such a plan requires written agreement from the proposed community providers. In practice, community providers generally do not provide this agreement unless the hospital supports the proposed TL. If the hospital determines that TL is clinically appropriate, it typically prepares and submits its own TL plan. Absent hospital support, it is unlikely that a TL plan developed by an acquittee would receive a favorable recommendation from the hospital. In addition, TL plans are detailed and require extensive clinical and logistical information (see the TL application template provided to the working group).

Task Force Recommendation on PSRB Role 4	Repeal CGS §17a-599 to "eliminat[e] 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 January 2024, the Board was asked by the state to review the transfer of an acquittee from maximum to enhanced security (as per CGS §17a-599(c), as amended in section 8 of PA 22-45) after the transfer had

[50] Please note that information presented relating to discharge and commitment of acquittees was summarized in response to both CVH/WFH Task Force recommendations 1 and 2 relating to the role of the PSRB and the new charge outlined in PA 22-45.

been accomplished. The public defender filed a motion to dismiss the request for review, arguing that such review was not contemplated in the statutory amendment of PA 22-45. The Board Chair invited briefs from the parties, and the matter was decided by the Board on February 9, 2024 at which time the Board "acknowledged PA 22-45 removed the Board oversight of hospital transfers from maximum security division to lower security division pursuant to CGS §17a-599."[51]

Task Force Recommendation on PSRB Role 5	Amend CGS §17a-585 to require that the PSRB review an acquittee's commitment every six months "unless the patient specifically waives the right to such review"

As noted in the "Frequency of Mandatory PSRB Review Hearings" section of this report, "The working group heard from both victims and acquittees that they find hearings distressing and would not be in favor of having more frequent hearings. The current structure allows for hearings to be held whenever needed, such as reviewing an application for temporary leave (CGS §17a-587) or conditional release (CGS §17a-588). Further, PSRB Regulations Sec. 17a-581-18 permits any party to apply to the Board for a hearing."

Task Force Recommendation on PSRB Role 1	Amend CGS §17a-584 "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 CGS §17a-541), including the right to placement in the least restrictive environment"
Task Force Recommendation on PSRB Role 2	End the possibility of re-commitment to the PSRB in CGS §17a-593, and utilize the civil commitment process for patients at the end of their original commitment who are deemed to be gravely disabled or to represent a continued danger to self or others
Section 6(a)(2) of PA 22-45 Charge	Examine methods of optimizing the processes by which a person found not guilty by reason of mental disease or defect pursuant to CGS §53a-13 is: (1) committed to DMHAS; and (2) released or discharged from custody, including, but not limited to, through a balancing of the protection of society, victims' rights, and the health and well-being of such person

The CVH/WFH Task Force report (p. 12) noted their unanimous concern that excessive periods of commitment (like the example the task force noted of a young man committed for 120 years) create a "psychological constraint" that can demoralize a person in their efforts at recovery. In the working group's discussion, it was noted that this example of an acquittee committed for 120 years was biased in failing to also note that the statutes and procedures allow acquittees to be discharged earlier than their commitment period, and that such discharges regularly occur. Comments were also offered that such lengthy commitment periods are outliers.

In early November 2024, there were 133 individuals under the jurisdiction of the PSRB. An analysis of the offenses for which those individuals were committed to the PSRB produced the breakdown illustrated in the figure below. These counts are based on the most serious charge for each acquittee. The majority of commitment offenses are A felonies (including 44% of the total for murder).

[51] Psychiatric Security Review Board Hearing Minutes for February 9, 2024

Individuals Under Jurisdiction of PSRB: Analysis of Offenses

Charge	Current Acquittees	
MURDER	59	
ARSON	8	
KIDNAPPING	4	
SX ASLT 1-MINOR	3	
HOME INVASION	1	
A Felonies	**75**	**56%**
ASSAULT 1	23	
SEX ASSAULT 1	9	
BURGLARY 1	6	
MANSLAUGHTER 1	5	
ROBBERY 1	3	
LARCENY	1	
ARSON	1	
SEX ASSAULT 2	1	
WEAPON OFF	1	
B Felonies	**50**	**38%**
RISK OF INJURY	2	
ROBBERY 2	2	
MANSLAUGHTER 2	1	
ARSON	1	
ASSAULT 2	1	
FLR TO APPEAR 1	1	
C Felonies	**8**	**6%**
Total	**133**	

When the data are analyzed for all individuals ever committed to the PSRB (412 cases), the results are 43% A felonies (with 28% of the total for murder); 39% B felonies; 8% C felonies; 6% D felonies; and 4% misdemeanors and unclassified[52].

Individuals charged with murder can be (and often are) committed to the PSRB for 60 years, although they may be discharged prior to the maximum commitment period as noted previously. The group of people committed for this length are unlikely to ever face recommitment to the PSRB. Individuals who are committed for shorter lengths of time are more likely to face recommitment. The State's Attorney has the option of filing for recommitment prior to the expiration of the original commitment under CGS §17a-593(c). Under those circumstances, the acquittee may agree to a period of recommitment or may challenge the state's petition in court. Data from the PSRB in October 2024 show that of the 130 recommitments experienced by the current PSRB population, 65% of recommitments were agreed to. This is especially likely when acquittees are still hospitalized at the time the original commitment expires

[52] "Criminal offenses in Connecticut are classified as felonies, which are punishable by imprisonment for over one year, and misdemeanors, which are punishable by imprisonment for not more than 364 days (see CGS §53a-36a). In turn, felonies are classified according to severity as class A, B, C, D, or E. Misdemeanors are classified as class A, B, C, or D. There are unclassified felonies and misdemeanors which are punishable by imprisonment but not designated under one of the classes listed above." Connecticut Penal Code – Updated and Revised, Office of Legislative Research. February 3, 2026.

and there is doubt about their ability to prove in superior court that they meet the definition of "person who should be discharged" under CGS §17a-580(11). Such agreement is often based on advice from counsel to accept a specific length of recommitment to avoid the risk of a lengthier period of recommitment. There were also 19 short extensions (15%) agreed to, usually to cover a short period until the next scheduled hearing. Twenty-seven recommitments were contested in court (21%).

Data collected and reported by the Conditional Release Services Unit of the DMHAS Division of Forensic Services[53] show that 11 acquittees have been discharged earlier than their commitment date from January 2019 to August 31, 2024, while during that same period 18 acquittees were discharged at the end of their commitment period.

Data reported by the PSRB reveal there were 274 discharges from the Board from 1985 to October 15, 2024[54]. The reasons for discharge are summarized as follows:

Reason	Number	Percentage of Total
End of Commitment	145	53%
Discharge Application Approved	78	28%
Death	47	17%
Commitment Overturned	4	1%

"Discharge Application Approved" means discharge prior to the expiration of the current commitment period, occasioned by an application for discharge. This is sometimes referred to as "early discharge."

In the first 20 years, the most common reason for discharge was end of commitment. In the third decade of the PSRB, "discharge application approved" exceeded end of commitment (45% vs. 41%). In the most recent decade, end of commitment again exceeded "discharge application approved" (48% vs. 30%). (See charts of 10-year periods in Appendix G.)

It is not known how many of the "discharge application approved" cases were for discharge during an original commitment period or during a subsequent recommitment period. The data in the next two paragraphs probably apply to this sub-group of acquittees as well.

In data prepared by the PSRB on August 20, 2024, 112 of the 405 acquittees ever under the Board's jurisdiction (27.7%) have been recommitted; 17.8% of them have been recommitted three or more times.

Of the 130 persons currently under the jurisdiction of the PSRB, 24 of them (18.5%) have been recommitted at least once. Recommitment periods have ranged from 12 months to 60 months, with an average of all recommitments of 36.3 months. The average total recommitment length per person for these active PSRB cases ranges from 3 years to 22 years.[55]

Recommendation of the Working Group

In an effort to be responsive to the various elements of the charges to the working group in this subject matter section, a set of proposals was drafted by a sub-set of the working group for further review by

[53] See Appendix F.

[54] See Appendix G.

[55] See case-specific data in Appendix H.

members[56]. Because there was not unanimity of opinion about these proposals, a written poll was taken of the members. Detailed vote tallies and comments on member discussions of each proposal, including considered revisions, are included in Appendix J. Two members affirmatively abstained from the polling procedure and one member did not respond, leaving 12 voting members out of the 15 working group members. The following section summarizes final proposals that received (1) significant support or (2) support by smaller majorities. Categorization was determined by vote counts, as detailed in the summary.

Summary

The following proposals received significant support:

Proposal	Description	Vote
Proposal 2	Balancing the protection of society and the well-being of acquittees	Supported by 11 voting members and opposed by 1
Proposal 3	Establish some limits to commitment to the PSRB	Supported by 9 voting members and opposed by 3
Proposal 4b	Encourage supervision of acquittees on conditional release (*revised*)	Supported by 11 voting members and opposed by 1
Proposal 5	Distinguish early release hearings from re-commitment hearings in statute	Supported by 11 voting members and opposed by 1

The following proposals were supported by smaller majorities:

Proposal	Description	Vote
Proposal 1	Define well-being of the acquittee	Supported by 8 voting members and opposed by 4
Proposal 1b	Define well-being of the acquittee (*revised*)	Supported by 7 voting members and opposed by 5 (*4 of whom supported Proposal 1 without modification*)
Proposal 4	Encourage supervision of acquittees on conditional release	Supported by 8 voting members and opposed by 4
Proposal 6	Eliminate recommitment to the PSRB in favor of civil commitment when warranted	Supported by 8 voting members and opposed by 4

Detailed Overview

The following proposals received significant support:

Proposal 2	Balancing the protection of society and the well-being of acquittees	Supported by 11 voting members and opposed by 1

Rather than trying to articulate which concerns are primary and which are secondary for the court and for the PSRB at various stages of the process, and rather than having different articulations of the ranking of concerns in different parts of the relevant statutes, amendments should be made to CGS §17a-582, CGS §17a-584, and CGS §17a-593 to similarly task the court and the PSRB with *balancing* the protection of society and the safety and well-being of the acquittee in their decision-making. In addition, language

[56] See Appendix I.

should be added to "the protection of society" to include the interests of identified victims. It should be expected that the court and the PSRB will consider all available information in making their decisions and attempt to balance these various interests as the specific circumstances of each case and situation warrant.

Proposal 3	Establish some limits to commitment to the PSRB	Supported by 9 voting members and opposed by 3

The direction to the court in establishing a period of commitment to the PSRB in CGS §17a-582 should be less directly linked to the statutory punishment terms for conviction (since the individual has been found not criminally responsible because of their mental illness at the time of the offense), and that reasonable limits should be imposed. The CVH/WFH Task Force report (p. 12) noted their unanimous concern that excessive periods of commitment (like the example the task force noted of a young man committed for 120 years) create a "psychological constraint" that can demoralize a person in their efforts at recovery. The working group proposes an amendment to CGS §17a-582 that would impose a maximum total length of commitment of 60 years in cases of murder, and 35 years in non-murder cases as a first attempt at diminishing the potential for discouragement and at encouraging both patients and clinicians in their treatment efforts. Successful treatment and the opportunity for monitoring in the community under conditional release decrease the risk of future dangerous behavior – a benefit for society, identified victims, and the patients.

Proposal 4b	Encourage supervision of acquittees on conditional release (*revised*)	Supported by 11 voting members and opposed by 1

Because the literature demonstrates clearly that periods of success on conditional release and monitoring in the community are most important to reducing the risk of recidivism, and because conditional release under the PSRB is most consistent with the principle of providing treatment in the least restrictive setting that is appropriate and available, the treatment system should be encouraged to work toward conditional release to the extent possible that is consistent with public safety.

Proposal 5	Distinguish early release hearings from re-commitment hearings in statute	Supported by 11 voting members and opposed by 1

CGS §17a-593 should be amended to clearly distinguish between hearings on early discharge from the Board and hearings to recommit the person to the Board, and to distinguish their respective burdens and standards to be consistent with case law articulated in the *Metz* decision: an application for discharge prior to expiration of the original commitment (acquittee's burden by preponderance of the evidence), and the state's application for continued commitment at the expiration of the original commitment (state's burden by clear and convincing evidence).

The following proposals were supported by smaller majorities:

Proposal 1	Define well-being of the acquittee	Supported by 8 voting members and opposed by 4

The term "well-being of the acquittee," added in PA 22-45, needs further definition and expansion in CGS §17a-582, CGS §17a-584, and CGS §17a-593. Language should be added to note that acquittee well-being includes the acquittee's recovery and concomitant reduction in the acquittee's risk of future dangerous behavior, progress toward the acquittee's re-integration into the community, and treatment in the least restrictive setting consistent with public safety.

Proposal 1b	Define well-being of the acquittee (*revised*)	Supported by 7 voting members and opposed by 5 (*4 of whom supported Proposal 1 without modification*)

The term "well-being of the acquittee," added in PA 22-45, needs further definition and expansion in CGS §17a-582, CGS §17a-584, and CGS §17a-593. Language should be added to note that acquittee well-being includes the acquittee's recovery and concomitant reduction in the acquittee's risk of future dangerous behavior, and progress toward the acquittee's re-integration into the community.

Proposal 4	Encourage supervision of acquittees on conditional release	Supported by 8 voting members and opposed by 4

Because the literature demonstrates clearly that periods of success on conditional release and monitoring in the community are most important to reducing the risk of recidivism, and because conditional release under the PSRB is most consistent with the principle of providing treatment in the least restrictive setting that is appropriate and available, the treatment system should be encouraged to work toward conditional release to the extent possible that is consistent with public safety. The working group proposes that amendments be made to CGS §17a-593(f), such that in cases where the acquittee has demonstrated three or more years of uninterrupted tenure on conditional release, the burden of proof should shift from the acquittee to prove their non-dangerousness to the state to prove (by clear and convincing evidence) the acquittee's continued current dangerousness as a result of psychiatric disabilities.

Proposal 6	Eliminate recommitment to the PSRB in favor of civil commitment when warranted	Supported by 8 voting members and opposed by 4

Under the current statute, CGS §17a-593, at the end of an acquittees' commitment, the State's Attorney may petition the court to continue the commitment. State's Attorneys frequently file such petitions. There are no limits to the number of times such a petition can be pursued, nor any limit to the total number of years a commitment can extend beyond the original end date. This process can result in indefinite or lifetime commitments. Eliminating the process of continued re-commitment in Connecticut would end what the task force referred to as the "never-ending cycle of re-commitment."[57] Instead, once an acquittee's original term of commitment expires, the state can apply for civil commitment as provided in the Connecticut General Statutes if they believe the patient continues to be a danger to self or others or gravely disabled.

[57] Task Force to Review and Evaluate CVH and WFH, the Psychiatric Security Review Board, and Behavioral Health Care Definitions. Final Report. December 16, 2021. p. 13

Summary List of Working Group Recommendations

This first list of recommendations below are the items about which the working group achieved consensus (i.e., there were no objections to making these recommendations to the General Assembly):

The working group notes the crucial role that Whiting Forensic Hospital plays in the lives of acquittees, and in the lives of victims and the public. It is imperative for both the patients' recovery and for the greatest promotion of public safety that this vital level of care be offered in the best environment that can be provided. Major advances in design, construction, materials, and technology have been developed for use in secure psychiatric facilities, and such state-of-the-art settings should be made available in Connecticut. **The working group offers its strongest recommendation for the deliberate pursuit of a newly constructed forensic hospital in the state to replace both the Whiting and Dutcher buildings.**
The PSRB should be maintained.
The frequency of mandatory review hearings by the PSRB under CGS §17a-585 should not be amended.
The COLLECT (Connecticut On-Line Law Enforcement Communications Teleprocessing) system should be amended to create a file for persons under the jurisdiction of the PSRB.
Improvements should be made to the information available to victims about the PSRB process and services that are available to them, especially in the *Crime Victims' Guide to the Adult Criminal Court* and via dedicated advocates in the Office of Victim Services (OVS).
The VINE (Victim Information and Notification Everyday) system should be modified to permit continuation of victim notifications after a defendant is found not guilty by reason of mental disease or defect to allow automated notifications of court hearings to continue. This would not require statutory amendments.
Victims should be able to opt in to the specific types of notice they wish to receive from the PSRB. The PSRB could develop a more systematized method of handling this information. This will require further exploration of available technology/software and may require additional resources to enable an automated system. It would not require statutory amendments.
To make it easier for victims and others to find the definition of "victim" for purposes of PSRB procedures and processes, CGS §17a-601(a) should be moved to the definitions section for the PSRB statutes at CGS §17a-580. This will also require that current references to the definition in CGS §17a-601(a) (such as occurs in CGS §17a-587(b), CGS §17a-596(h), and CGS §17a-599(c) be amended).
The wording of CGS §17a-601(a) should be amended to be more consistent with the definition of "relative" in CGS §54-201(4), for example by substituting "person immediately connected to a deceased victim" for "member of a deceased victim's immediate family." (An illustration of how this could be accomplished is provided in the section on Victims' Right to be Heard at PSRB Hearings.)
A statement should be added to the end of CGS §17a-601(b) to permit, at the discretion of the chair, such other person or persons who are immediately connected to the victim and who have a legitimate interest in the proceedings to make a statement at Board hearings.
No other jurisdiction's model for the management of acquittees is clearly superior to the others, and thus no other model warrants wholesale adoption in Connecticut.
The Whiting Forensic Hospital should continue its re-staffing of vocational services personnel at the hospital. Hospital staff should be encouraged to consider vocational opportunities during patients' overnight temporary leave (TL) experiences, and the Board should be encouraged to grant TL applications that include such vocational opportunities. This would not require statutory amendments.

This next group of proposals achieved significant, but not unanimous, support:

Proposal 2	Balancing the protection of society and the well-being of acquittees	Supported by 11 voting members and opposed by 1

Rather than trying to articulate which concerns are primary and which are secondary for the court and for the PSRB at various stages of the process, and rather than having different articulations of the ranking of concerns in different parts of the relevant statutes, amendments should be made to CGS §17a-582, CGS §17a-584, and CGS §17a-593 to similarly task the court and the PSRB with *balancing* the protection of society and the safety and well-being of the acquittee in their decision-making. In addition, language should be added to "the protection of society" to include the interests of identified victims. It should be expected that the court and the PSRB will consider all available information in making their decisions and attempt to balance these various interests as the specific circumstances of each case and situation warrant.

Proposal 3	Establish some limits to commitment to the PSRB	Supported by 9 voting members and opposed by 3

The direction to the court in establishing a period of commitment to the PSRB in CGS §17a-582 should be less directly linked to the statutory punishment terms for conviction (since the individual has been found not criminally responsible because of their mental illness at the time of the offense), and that reasonable limits should be imposed. The CVH/WFH Task Force report (p. 12) noted their unanimous concern that excessive periods of commitment (like the example the task force noted of a young man committed for 120 years) create a "psychological constraint" that can demoralize a person in their efforts at recovery. The working group proposes an amendment to CGS §17a-582 that would impose a maximum total length of commitment of 60 years in cases of murder, and 35 years in non-murder cases as a first attempt at diminishing the potential for discouragement and at encouraging both patients and clinicians in their treatment efforts. Successful treatment and the opportunity for monitoring in the community under conditional release decrease the risk of future dangerous behavior – a benefit for society, identified victims, and the patients.

Proposal 4b	Encourage supervision of acquittees on conditional release (*revised*)	Supported by 11 voting members and opposed by 1

Because the literature demonstrates clearly that periods of success on conditional release and monitoring in the community are most important to reducing the risk of recidivism, and because conditional release under the PSRB is most consistent with the principle of providing treatment in the least restrictive setting that is appropriate and available, the treatment system should be encouraged to work toward conditional release to the extent possible that is consistent with public safety.

Proposal 5	Distinguish early release hearings from re-commitment hearings in statute	Supported by 11 voting members and opposed by 1

CGS §17a-593 should be amended to clearly distinguish between hearings on early discharge from the Board and hearings to recommit the person to the Board, and to distinguish their respective burdens and standards to be consistent with case law articulated in the *Metz* decision: an application for discharge prior to expiration of the original commitment (acquittee's burden by preponderance of the evidence), and the state's application for continued commitment at the expiration of the original commitment (state's burden by clear and convincing evidence).

This final group of proposals was supported by smaller majorities:

Proposal 1	Define well-being of the acquittee	Supported by 8 voting members and opposed by 4

The term "well-being of the acquittee," added in PA 22-45, needs further definition and expansion in CGS §17a-582, CGS §17a-584, and CGS §17a-593. Language should be added to note that acquittee well-being includes the acquittee's recovery and concomitant reduction in the acquittee's risk of future dangerous behavior, progress toward the acquittee's re-integration into the community, and treatment in the least restrictive setting consistent with public safety.

Proposal 1b	Define well-being of the acquittee (*revised*)	Supported by 7 voting members and opposed by 5 (*4 of whom supported Proposal 1 without modification*)

The term "well-being of the acquittee," added in PA 22-45, needs further definition and expansion in CGS §17a-582, CGS §17a-584, and CGS §17a-593. Language should be added to note that acquittee well-being includes the acquittee's recovery and concomitant reduction in the acquittee's risk of future dangerous behavior, and progress toward the acquittee's re-integration into the community.

Proposal 4	Encourage supervision of acquittees on conditional release	Supported by 8 voting members and opposed by 4

Because the literature demonstrates clearly that periods of success on conditional release and monitoring in the community are most important to reducing the risk of recidivism, and because conditional release under the PSRB is most consistent with the principle of providing treatment in the least restrictive setting that is appropriate and available, the treatment system should be encouraged to work toward conditional release to the extent possible that is consistent with public safety. The working group propose that amendments be made to CGS §17a-593(f), such that in cases where the acquittee has demonstrated three or more years of uninterrupted tenure on conditional release, the burden of proof should shift from the acquittee to prove their non-dangerousness to the state to prove (by clear and convincing evidence) the acquittee's continued current dangerousness as a result of psychiatric disabilities.

Proposal 6	Eliminate recommitment to the PSRB in favor of civil commitment when warranted	Supported by 8 voting members and opposed by 4

Under the current statute, CGS §17a-593, at the end of an acquittees' commitment the State's Attorney may petition the court to continue the commitment. State's Attorneys frequently file such petitions. There are no limits to the number of times such a petition can be pursued, nor any limit to the total number of years a commitment can extend beyond the original end date. This process can result in indefinite or lifetime commitments. Eliminating the process of continued re-commitment in Connecticut would end what the task force referred to as the "never-ending cycle of re-commitment."[58] Instead, once an acquittee's original term of commitment expires, the state can apply for civil commitment as provided in the Connecticut General Statutes if they believe the patient continues to be a danger to self or others or gravely disabled.

[58] Task Force to Review and Evaluate CVH and WFH, the Psychiatric Security Review Board, and Behavioral Health Care Definitions. Final Report. December 16, 2021. p. 13

Conclusion: Future Developments and Need for Reassessment

The system for managing individuals found not guilty by reason of mental disease or defect is complex and multifaceted, as reflected throughout this report. It is also a dynamic system that continues to evolve in response to developments in statute, case law, scientific knowledge, mental health treatment, available resources, and broader system design.

The analysis and recommendations presented in this report reflect current conditions, while recognizing relevant historical developments and trends. As the system continues to evolve, implementation of recommendations, statutory changes, and other reforms will provide opportunities to evaluate outcomes and assess their impact on acquittees, victims, public safety, and system operations. Such evaluation will help inform future policy discussions and identify additional opportunities for improvement.

The working group encourages continued collaboration among the agencies, organizations, and stakeholders involved in this system. Ongoing review, data collection, and consideration of emerging issues will be important to ensuring that the system remains responsive to the needs of acquittees, promotes public safety, and addresses the concerns of victims.

Glossary

Conditional Release (CR). Conditional release is defined in CGS §17a-580(3) and "person who should be conditionally released" is defined in CGS §17a-580(9). When individuals complete a period of temporary leave and are assessed to no longer need hospital level of care, the Whiting Forensic Hospital submits an application to the PSRB for conditional release (see CGS §17a-588). The application specifies where the individual will receive treatment, what services will be provided and by whom, where the individual will live, the details of any employment planned for the individual (volunteer or paid), and who will supervise the individual in the community (see CGS §17a-589 regarding supervision). If the PSRB approves the CR, the acquittee is discharged from the WFH, but remains under the jurisdiction of the PSRB. A CR supervisor files quarterly progress reports with the PSRB and with the Conditional Release Service Unit (CRSU) of the DMHAS Division of Forensic Services. The CRSU files reports with the PSRB every six months. When the Board approves an application for CR, it sets the conditions of release in a written document, known as a Memorandum of Decision. CR may be modified or revoked at any time by the Board if the acquittee is not adhering to the required conditions (see CGS §17a-594). Individuals on CR may also receive brief hospitalization in the community, when needed, without their CR being revoked.

Continued Commitment to the PSRB (also known as "Recommitment"). CGS §17a-593(c) allows the State's Attorney to petition the court for an order of continued commitment at least 135 days prior to the expiration of an acquittee's current commitment to the PSRB. Petitions for recommitment are forwarded to the PSRB, which conducts a hearing on the matter, after which it makes a recommendation to the superior court about whether to recommit the acquittee or allow the existing commitment to expire. The court conducts a hearing pursuant to CGS §17a-593(f) through (g), after which it makes a finding as to whether the acquittee is a person who should be discharged, as defined in CGS §17a-580(11).

Discharge from the PSRB. An acquittee may be discharged from the PSRB by order of the superior court, per CGS §17a-593, at any time during their initial commitment or following their initial period of commitment if the commitment was extended by the court (see Continued Commitment entry above). The Board's responsibility is to issue a recommendation to the court per CGS §17a-584 and CGS §17a-593. The court may grant the discharge if it finds that the acquittee is a "person who should be discharged" (see definition in CGS §17a-580(11)). Most discharges have occurred when the state's attorney decided not to petition the court to further extend the commitment upon expiration of the term (53%) or when an acquittee has directly petitioned the superior court for discharge (28%). While there are some exceptions, most acquittees who have been granted discharge have successfully completed a prolonged period of time on temporary leave and conditional release and established that the risk factors present at the time of their offense have been meaningfully mitigated. Persons discharged from the PSRB are no longer monitored by the PSRB and are free to remain in voluntary treatment. Most (at least 86% in the last five years) do so, continuing to receive services from the agency that served them during CR.

Dutcher Hall. Dutcher Hall was built as part of Connecticut Valley Hospital (CVH) in 1950. It became part of the Whiting Forensic Division of CVH in the late 1990s to house acquittees from the three state psychiatric hospitals who were not ready for discharge to services in the community. It has 138 beds on six units, one of which serves individuals referred for hospital level of care to restore competency to stand trial who do not require maximum security conditions. The other units serve mostly acquittees, with three of the units specifically designed for community re-integration. Civil patients are also treated in the Dutcher building.

Memorandum of Decision (MOD). A memorandum of decision is a legal document issued by the Board following any decisions it makes articulating the specific orders to be followed. In the case of temporary leave or conditional release orders, the MOD includes the explicit details of treatment activities to be offered by clinical providers, overnight residential arrangements in the community, and conditions to be followed by the acquittee (including prohibited travel areas and personal contacts).

Psychiatric Security Review Board (PSRB). The PSRB (or Board) was created in 1985 (PA 85-506) to supervise and monitor the care and treatment of persons found not guilty by reason of mental disease or defect (acquittees). It is composed of six members: a psychiatrist and psychologist experienced with the criminal justice system, a person experienced with probation, a member of the general public, an attorney, and a member of the public with experience in victim advocacy (see CGS §17a-581). Individuals who are found not guilty by reason of mental disease or defect are committed to the jurisdiction of the Board by the superior court (CGS §17a-582) for a period of time determined by the court. The Board meets at least twice a month on Fridays (the hearing schedule is available online) for adversarial hearings about the status and movement of acquittees. At hearings, the state is represented by State's Attorneys and acquittees are represented by public defenders (most often) or by private counsel. At hearings, the Board must approve applications for temporary leave, conditional release, and any modification requests to the MOD. The Board makes recommendations to the superior court regarding discharge of an acquittee from its jurisdiction.

Temporary Leave (TL). When acquittees are thought by the treatment system to be ready for the start of re-integration into the community, the hospital files an application for temporary leave with the PSRB (see CGS §17a-587). If approved by the PSRB, this process starts with short day trips to community providers and advances slowly to include more activities in the community and, later, overnight stays in a designated residence. The application specifies what services are provided when and by whom, who will accompany the acquittee during the leaves, and how the TL will progress. Individuals on TL may spend up to seven nights in the community, but return at least one day a week to meet with hospital staff. Individuals on TL status remain patients of the WFH, almost always in the Dutcher building. A TL supervisor provides a monthly update on the acquittee's status and progress to the WFH. WFH continues to provide six-month reports to the PSRB during the TL phase of their care.

Whiting Building. This is the maximum-security portion of the Whiting Forensic Hospital (WFH). It has 91 beds on five units. It was built in the late 1960s and opened in 1970 (and later named the Whiting Forensic Institute). Persons who are found not guilty by reason of mental disease or defect pursuant to CGS §53a-13 are admitted to the Whiting building for the initial evaluation required in CGS §17a-582. Persons ordered by the superior court into treatment to restore competency to stand trial (CGS §54-56d(h)) who require a maximum security hospital setting are treated in the Whiting building, as are civil patients who require maximum security because of aggressive behavior.

Whiting Forensic Hospital (WFH). WFH is a 229-bed psychiatric hospital in Middletown, CT on the grounds of Connecticut Valley Hospital. It is licensed by the Connecticut Department of Public Health and accredited by The Joint Commission, a non-profit organization that evaluates the quality and safety of care in healthcare organizations. It consists of two buildings: a maximum-security building (the Whiting building) and a step-down enhanced security building (Dutcher Hall). It provides court-ordered evaluations, and treatment for individuals who are found not competent to stand trial and for those who acquitted of crimes by reason of mental disease or defect. It also serves individuals in the Department of Correction who require hospital level of care, and civil patients in the public sector who present safety or

security risks that cannot be managed in other psychiatric hospitals (see CGS §17a-561). The WFH sends reports to the PSRB every six months for all hospitalized individuals under the jurisdiction of the PSRB.

APPENDIX A

Appendix A contains a landscape review of different states' forensic services system of care. Blanks denote that an answer was not provided, unknown, or potentially not applicable. The first three states are grouped together because they are similar in that they currently have, or had, a Psychiatric Security Review Board (PSRB). The rest of the states are listed in alphabetical order.

STATE	Does the state a PSRB?	Does the state have a separate forensic facility?	Location of Post-NGRI Evaluation	Who Determines Place of Initial Commitment
CT	Yes	Whiting Forensic Hospital	Forensic facility	Court
OR	Yes	No	Local mental health program consults with court as to whether supervision in community is available and appropriate	Court
AZ	Dissolved 7/1/23	No	State hospital for 30 days; report to court	Court
CA	No	Four state hospitals used for acquittees	Community	Court
GA	No	No	State hospital	State mental health authority
HI	No	No	Custody, community, or facility; by qualified examiner (3 if felony case)	Court
MA	No	Bridgewater hospital	State hospital or Bridgewater	Court
MD	No	Perkins hospital center	State hospital	Court after administrative law judge (ALJ) recommendation
ME	No	No	State hospital	Automatic
MN	No	Secure facility	State hospital or secure facility	Court, but hospitalization automatic
MO	No	Nixon forensic center	Secure facility	Court
NC	No	Secure forensic unit, called Forensic Treatment Program (FTP)	NGRI for crimes involving serious physical injury or death automatically referred to Forensic Treatment Program	*See column to the right*
NY	No	Two secure facilities	Secure facility or outpatient by 2 examiners (3rd if they disagree)	Court
OH	No	No	Community forensic psychiatric centers	Court
SC	No	No	State hospital ("secure facility")	Court
TN	No	Forensic services program	Outpatient	Court
VA	No	Separate forensic building, part of central state hospital (new forensic building under construction)	Can be outpatient or hospital; 45-day assessment	Court may authorize outpatient evaluation; if inpatient, commissioner determines hospital
WA				

State	Commitment Criteria	Time Limit on Original Commitment	Frequency of Reports
CT	Release would constitute danger to self/others	As ordered, not to exceed max prison sentence	6 months
OR	Substantial danger to others and cannot adequately be controlled if conditionally released on supervision	As ordered, not to exceed max prison sentence	Set of documents required prior to 2-year mandatory hearing or patient-requested hearing or upon order from board for evaluation for conditional release; monthly when on conditional release
AZ	Found Guilty Except Insane (GEI); mentally ill, dangerous, likely to reoffend	Committed for length of possible sentence	Monthly while on conditional release
CA	"sanity" has not been recovered fully	Max possible sentence (for inpatient commitment portion); conditional release program portion indeterminate	6 months
GA	Civil commitment criteria: "substantial risk of imminent harm" to self/others, "as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury" to the person/others; or "so unable to care for...own physical health and safety as to create an imminently life-endangering crisis; and "in need of involuntary inpatient treatment"	Court may order commitment for 6 months; chief medical officer may apply for order of continued hospitalization	Annual to court regarding whether acquittee continues to meet civil commitment criteria (outpatient civil commitment criteria for those on conditional release)
HI	Risk of danger to self/others, not proper subject for conditional release	No	None required
MA	Mentally ill; discharge would create likelihood of serious harm	6 months; then 1-year recommitments	Not specified
MD	Danger to self/other/property	Indeterminate	Not specified
ME	Likelihood that person will cause injury to self/others because of mental disease	No	Annual report to commissioner regarding readiness for release; if ready, commissioner reports to court
MN	Mentally ill and dangerous (MI&D) is a separate determination from NGRI, but all NGRI are presumed MI&D	Indeterminate	None required
MO	Mental disease rendering person dangerous to self/others	Indeterminate	Not specified
NC	Automatic as above	Indeterminate	Not specified
NY	Mental illness and dangerousness for secure hospital; mental illness for civil hospital	1 year for hospital commitment	NA
OH	Substantial risk of physical harm or serious physical impairment or injury to self by clear and convincing evidence	Max prison sentence; almost always committed for full time	6 months, then 2 years
SC	Need for continued hospitalization	Max possible sentence	None specified
TN	Substantially likely to injure self/others and in person's best interests	No	6 months, 6 months, then every year
VA	Mental illness; likelihood of conduct presenting substantial risk of bodily harm in foreseeable future; likelihood can be adequately controlled with supervision and treatment on outpatient basis; other factors court deems relevant	Indeterminate; first hearing regarding continued commitment at 1 year. For misdemeanors, 1 year limit.	Yearly for inpatient; every 6 months for outpatient
WA			

STATE	Frequency of Hearings	Re-Commitment Possible	Temporary Leave Process or Equivalent
CT	PSRB at least every 2 years; for temporary leave and conditional release applications, when requested, and when re-commitment requested	Yes	Hospital or patient petition PSRB
OR	PSRB at least every 2 years; for conditional release application, when requested by patient	No	Hospital may request PSRB overnight or out-of-town leave or pass; but hospital does not utilize this regulation (OAR 859-100-0030)
AZ	For release petitions, at request of treaters or party for modifications	No; may be referred for court-ordered evaluation for civil commitment	Court may implement conditional release in incremental steps; court must approve at each step finding by clear and convincing evidence that the community will be protected and the person will be safe
CA	For release decisions or termination of conditional release	Yes, called "extension"; for 2-year periods at request of prosecutor, if supported by hospital	No
GA	To hear petitions for release, which may be filed every 12 months	NA	Unaccompanied off-campus privileges up to 7 consecutive days; must be ordered by court
HI	Upon conditional release or discharge application; or revocation of conditional release hearings	NA	Not specified
MA	1st at 6 months, then every year to renew commitment order	Yes, for 1-year periods	Unsupervised community access with vendor staff, community providers, or family prior to hospital discharge
MD	For conditional release decisions, at end of conditional release order period (usually every 5 years)	Annual reviews held	Community visits can be approved by Forensic Review Board
ME	For "modified release", release, modification of release order, and discharge (hearings often uncontested and waived)	NA	Court may order "modified release treatment" off grounds up to 14 days at a time.
MN	No judicial hearings; only Special Review Board and Commissioner as noted in Temporary Leave Process or Equivalent, Conditional Release Process, and Revocation Process	NA	Passes for MI&D require medical director approval, and county case manager. Special Review Board (SRB) and Commissioner approval required for felony cases
MO	For conditional release; yearly review/renewal for those on conditional release; for unconditional release	NA	Per statute, hospital may give notice to court of "trial release" of up to 96 hours. If prosecutor objects, hearing held, court decides. For example, conditional release without discharge is generally not used for overnights.
NC	50 days, then 90, then 180, then one-year recommitment hearings; for release requested by hospital	NA	Not noted
NY	For transfer, furlough, release, extension of commitment (yearly, if not released)	Yes for 1 year, then 2 years repeatedly	Furlough orders for up to 14 days can be issued by court
OH	After each report above, for release, increase in some privilege levels	No; civil commitment only	Trial visits approved by forensic review team (FRT)
SC	For requests to release from hospital; for changes in release orders	No; only civil commitment	Not specified
TN	For inpatients, to hear transfer to outpatient petition; for outpatients, 6 months, 6 months, then yearly	NA	Furloughs from hospital reviewed by Chief Officer & risk management review committee (RMRC)
VA	Every year for 5 years, then biennial thereafter	Can be re-committed at annual or biennial hearing	Commissioner may grant for up to 48 hours
WA			

STATE	Conditional Release Process	Revocation Process
CT	Hospital or patient petition PSRB; results in hearing before PSRB, which must approve	PSRB may revoke
OR	Internal review process grants "conditional release readiness" privilege prior to requesting that the Board order evaluation for conditional release by community MH agency; ultimately a full hearing before PSRB	Any responsible agency or person may petition for revocation; PSRB holds hearing to decide to continue, modify, or terminate conditional release
AZ	Court and community treatment provider must agree on conditional release plan; court orders conditional release and conditions	Treatment provider notifies court and state hospital of changes in patient's condition; hospital Chief Medical Officer may order return to hospital; court sets hearing
CA	Hospital medical director recommends conditional release program (CONREP); court decides	"Temporary admission of an NGI"; admitted for 90 days observation; petition to court for return to inpatient commitment
GA	Team drafts conditional release plan; reviewed by hospital forensic director, External Forensic Review Committee (if serious violent felony), then Forensic Review Committee, then Clinical Director, then hospital administrator, then to court for hearing/review	Court may order revocation. Clinical team may bring patient back to hospital, then notify court.
HI	After 90 days, hospital director or patient may apply	Mental health professional reports to probation officer who may detain person; court holds hearing
MA	None	NA
MD	Hospital requests release hearing with administrative law judge, who makes recommendation to criminal court. Initial conditional release 5 years, can be extended.	Community providers notify central office, which petitions to state's attorney, who sends to committing judge. Administrative hearing with administrative law judge leads to recommendation to criminal court
ME	Psychiatrist must file report to Commissioner as soon as person may be released without likelihood of injury to self/others; Commissioner applies to court. In practice, treatment teams encourage pt to apply through their attorney to facilitate a court date	Commissioner may order return to hospital, then court hearing if held more than 7 days. Testimony from treating psychiatrist and State Forensic Service. Court may also order return to hospital for 14 days, followed by hearing.
MN	SRB and Commissioner make decision; called "provisional discharge"	Head of program may revoke; court may direct peace officer to transfer patient
MO	Treatment team to Forensic Review Committee of facility, to COO, to state forensic director, to court. Courts generally grant release when DMH supports it. Patient may also request.	State Forensic Director may revoke, then hearing by DMH hearing officer. Court can also "withdraw" its own release order. Release orders for 1 year for the first two years, then DMH can request 3 years.
NC	None; 1st release hearing at 50 days, then 90, then 180, then 1 year.	NA
NY	Commissioner applies to court; hearing held. conditional release order for 5 years, may be renewed for 5 years indefinitely.	Commissioner or DA may apply to court; if court orders, pt returned to secure facility. Try to avoid in favor of civil commitment for periods of decompensation
OH	Review by FRT, Forensic Center, and trial court	Court order
SC	Hospital director requests of court	Probation officer notifies court, which holds hearing
TN	Reviewed by COO & RMRC; court may hold hearing, where COO decision presumed correct but may be challenged	Court hearing
VA	Petition by Commissioner, with conditional release plan jointly prepared by hospital and community service board	Court may order evaluation by psychiatrist/psychologist; after hearing, may order revocation if finding by clear & convincing evidence has violated and needs hospital. If released from hospital within 60 days, court may return to conditional release. After that, new conditional release petition required. (Courts may also order emergency detention and evaluation of those on conditional release)
WA		

STATE	Average Length of Commitment	Average Length of Hospitalization	Who Makes Transfer Decision to Other Hospital?	Who Makes Release from Hospital Decisions?	Who Has Burden for Release Decisions?
CT	13.9 years for those not arrested after PSRB discharge; 7.75 years for those arrested after PSRB discharge	10.7 years for those *not* arrested after discharge from PSRB; 5.8 years for those arrested after discharge)	Hospital	PSRB	Petitioner
OR	Murder-25.7 years A felony-17.4 years B felony-9.75 years C felony-5.6 years	4.1 years	NA	PSRB	Applicant by preponderance
AZ			NA	Court	Petitioner by C&CE
CA		7.2 years	NA	Court	Applicant, by preponderance
GA			State mental health authority	Court	Petitioner
HI			NA	Court	Petitioner
MA			Court	Court	Seems like the state must prove need for re-commitment
MD	NA		Hospital	Court	Not specified
ME			NA	Court	Unspecified
MN			SRB & Commissioner	SRB & Commissioner	NA
MO	?	7+ years at min security; 1997 paper: 75.3 months mean for most serious felonies in those who achieved conditional release; 92.3 months for same crimes in those who did not achieve conditional release	DMH w/o hearing. Patients move from max to min secure to unlocked cottage w/in fenced perimeter	Court	Petitioner by C&CE
NC	?	8.1 years for those in hospital; 4.9 years for those released	Not noted	Court	Acquittee by preponderance
NY	?	6.33 years	Court	Court	Petitioner by preponderance
OH			NA	Trial court	State by C&CE
SC			NA	Court	Petitioner?
TN			Commissioner	RMRC +/- court	State by clear, unequivocal, and convincing evidence
VA	75% committed > 1 year; those released after 45-day hearing, mean hospital stay = 5.6 months; for others on conditional release, mean hospital stay = 77.2 months.	61.6 months	Commissioner may transfer to another hospital	Court	Not specified
WA					

STATE	Who Makes Decision for Discharge from Supervision?	Internal Review Process for Release/Discharge	Statutory Language Regarding Priority/Goals in Decision-Making
CT	Court	Consulting forensic psychiatrists & forensic review committee	Safety of public and wellbeing of patient
OR	PSRB (reviews all cases where person has been on conditional release 5 years)	Internal review process grants "conditional release readiness" privilege prior to requesting that the Board order evaluation for conditional release by community MH agency	From PSRB Work Group report: "protect the public and balance the public's concern for safety with the rights of the client" from ORS 161.351(3): "the board shall have as its primary concern the protection of society"
AZ	Court may permit jurisdiction to end or order civil commitment evaluation	State hospital, community provider, and court agree on plan for conditional release	Public safety and protection are primary
CA	Court; hearing each year to determine if sanity restored	Hospital medical director or community program director, as applicable	Danger to the health and safety of others
GA	Court	Team drafts conditional release plan; reviewed by hospital forensic director, external forensic review committee (if serious violent felony), then forensic review committee, then clinical director, then hospital administrator	Civil commitment criteria
HI	Court	Not specified	Danger to persons or property
MA	Medical director/ superintendent unless court holds hearing	Medical director or superintendent, after independent forensic risk assessment	Likelihood of serious harm
MD	Court, if contested	Forensic review board for inpatients; "central admissions office" for those on conditional release	Danger to self/others/property
ME	Court	Treatment team/psychiatrist to commissioner; review by state forensic service	Likelihood of injury to self/others
MN	Srb & commissioner	Srb & commissioner	Reasonable degree of safety for the public; will enable person to adjust successfully to community
MO	Pt or head of facility files applications; court decides	Treatment team to forensic review committee of facility, to coo, to state forensic director	Not now or likely in reasonable future to commit another violent crime because of mental illness; has capacity to conform behavior to requirements of law in future
NC	Court	Periodic discharge panel meetings	No longer dangerous or no longer mentally ill
NY	Court	Treating clinicians and Office of Mental Health (OMH) staff; court rarely disagrees with OMH recommendation	Presence of dangerous mental disorder
OH	Court if prior to max term of commitment	Forensic review team and forensic centers review	Least restrictive alternative consistent with public safety and welfare of person; preference to public safety
SC	Court; prior to max only in exceptional circumstances	Not specified	Likelihood of serious harm; lacks insight/capacity to make responsible decisions regarding treatment
TN	Trial court	Risk Management Review Committee, Chief Officer	Likelihood of harm unless under court-ordered treatment, other factors
VA	Court	If one examiner (psychologist or psychiatrist) recommends release, 2nd examiner appointed; if 2nd agrees, report to court recommending release and detailing conditional release plan created with community	For conditional release, acquittee does not need inpatient, needs outpatient monitoring to prevent deterioration to need for inpatient, appropriate outpatient available and significant reason to believe acquittee would comply with conditions, and conditional release will not present "undue risk to public safety"
WA			

STATE	% Acquittees In Hospital	Re-Arrest Rate Under Supervision	Re-Hospitalization Rate	Re-Arrest Rate After Discharge from Monitoring	Language Regarding Inappropriate NGRI Commitment
CT	73%	2.3% (half dismissed; half for misdemeanor; none for violence)	31%	16.3% over average of 12.5 years community exposure (11% for those on conditional release at time of discharge; 27.9% for those not on conditional release at discharge)	
OR	36%	3.6% (felonies & misdemeanors) over 7 years. Annual recidivism rate=0.87%	(25% of court-ordered conditional release fail w/in 6 months) In 2020, 0.63% were revoked and returned to hospital	Over 7-year period, 37.8% total (21.9% for felonies; 16% for misdemeanors) [n.b. 29% of discharges still in hospital at time of discharge; i.e., no conditional release time]	"If a person is inappropriately placed under PSRB jurisdiction, the PSRB is required to discharge that person at a subsequent hearing, even if they are very dangerous, due to a lack of jurisdiction"
AZ	87.7%				
CA	?	3% w/in one year	?	?	Can ask for "decertification" of patient
GA					
HI					Even if feigned mental illness, NGRI process can be used to detain person who remains dangerous but not mentally ill
MA		NA	NA		
MD	?	0.53% for violent crimes; 2.5%/year for all arrests over 5 years community exposure	31% / year		
ME					
MN					
MO	38.4% (1997)	?	2016: 7% per year (most voluntarily); 2023: 1% (3% highest in recent years)	?	
NC	100%; once released, no monitoring	NA	28%	15% re-conviction (4.9% for violent offenses)	
NY	60% (half in forensic hospitals, half in civil hospitals)	21% over avg 14-year community exposure (11% for violent offense); nearly half during 1st 2 years, 2/3 by year 5	?	?	
OH					
SC					
TN					
VA			24.4% had conditional release revoked over 3-year period		
WA					

STATE	Victim Notification
CT	PSRB notifies victim of transfers to Dutcher building from Whiting building and of any PSRB hearings. Victim has right to make statement at any PSRB hearing. Court notifies victim of court hearings
OR	Board notifies victims of hearings and orders, conditional release, discharge, or escape; victim has right to be heard orally or in writing at any hearing
AZ	Victim notified by MH treatment agency by mail at least 10 days prior to release or discharge of patient; notified immediately of escape or subsequent readmission; notified of hearings
CA	
GA	
HI	
MA	
MD	
ME	
MN	
MO	Victims are notified of all changes of location. Can make statement at any hearing.
NC	
NY	
OH	
SC	
TN	Statutes are silent on victim notification in acquittal cases
VA	Commissioner to give notice to victim of offense for which 5-year sentence possible for any unescorted release from hospital. Commissioner to give notice of conditional release hearing to victim or next of kin.
WA	Statutes require notice to prosecutor for unescorted community outings of acquittees and, when requested in writing, to victims/next of kin for community outings, conditional release to the community, unconditional release, and escape or disappearance of an acquittee

APPENDIX B

PSRB Working Group Charge from Section 6 of PA 22-45

Tasks	Discussion Questions
1. Examine the recommendations of the CVH/WFH Task Force	*See separate Summary Table of Task Force (TF) Recommendations*
2.a. Examine methods of optimizing the processes by which a person is committed to DMHAS after NGRI finding	Any recommendations for this part of the process? Could include: changes to commitment length and re-hearing processes; affirmative statement re expectations of treatment system to foster recovery and community re-integration; statement about least restrictive alternative in addition to definitions of who should be confined, released, and discharged; defining "well-being" to include recovery, treatment in least restrictive setting, promoting re-integration into community; others.
2.b. Examine methods of optimizing the processes by which a person is released or discharged from DMHAS custody, including through balancing of protection of society, victims' rights, and the health and well-being of such person	Can psychological barriers of lengthy commitments that have no logical connection to clinical progress/stability/safety be considered? Would shorter commitment periods and more frequent re-commitment hearings help mitigate that barrier? Consider re-commitment to hospital every 2 years and to PSRB every 5 years, for example? Or should the current commitment scheme be maintained, but make re-commitment at expiration a civil commitment process? Should the task force recommendation for TL as clinical decision be considered (see # 3 of Summary Table)? What comments/recommendations should the work group make regarding efforts to shorten hospital stay, but maintain significant period on conditional releases? Others?
3. Examine processes for committing and releasing persons found NGRI in states that do not have a body similar to the PSRB	Should the workgroup consider the models in GA, MA, NC, NY, and VA which require yearly (or earlier) recommitment, or models in MD, MN, MO, where the commitment is indeterminate and release hearings are held when clinically indicated?
4. Examine processes for notifying a victim of such person when such person is released or discharged from such custody.	What recommendations should be considered regarding Victim Notification, Victim Services, and Victims' Right to be Heard at PSRB Hearings?

APPENDIX C

CVH/WFH Task Force Final Report of December 16, 2021
regarding Role of the Psychiatric Security Review Board
Summary Table of Task Force Recommendations (with comments and questions for discussion; revised 1/23/24)

#	Recommendation	Statutes involved	Comments	Questions for Discussion
TF1	Amend CGS §17a-584 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 CGS §17a-541)".	CGS §17a-584 CGS §17a-541	§4 of PA 22-45 amended CGS §17a-584 such that the PSRB's "primary concerns are the protection of society *and the safety and well-being of the acquittee*"	Does "safety and well-being of the acquittee" adequately accomplish balance of patients' rights? Should concepts of least restrictive alternative, recovery, re-integration into the community be recommended as additional guides? (FYI: CGS §17a-580 defines who should be confined, released, or discharged from PSRB) Should there be an affirmative statement in statute that charges the hospital with promoting acquittees' recovery and community re-integration? Other questions related to this recommendation? ***See draft proposal #1 & draft proposal #2***
TF2	Amend CGS §17a-593 to remove ability to recommit person to PSRB [CGS §17a-593(c)], and utilize civil commitment process [CGS §§17a-497 – 498] instead.	CGS §17a-593 CGS §17a-497 CGS §17a-498	§5 of PA 22-45 amended CGS §17a-593 such that the court's "secondary concern is the safety and well-being of the acquittee"	Does "secondary concern" convey an appropriate balance? Why should it be secondary concern at re-commitment, when it is a primary concern at initial commitment in CGS §17a-582 (e)? Why should an acquittal commitment term be tied to a conviction penalty? Can we consider the models in GA, MA, NC, NY, VA which require yearly (or earlier) recommitment, or models in MD, MN, MO, where the commitment is indeterminate and release hearings held when clinically indicated? If any such changes are made, will they need to be prospective only, given that victims expect existing commitments to stand? For prospective changes, what education tasks need to be recommended so that all participants understand the process? ***See draft proposal # 3*** If we maintain current provisions re commitment length, should re-commitment at expiration be a civil process, as the CVH/Whiting Task Force recommended? ***See draft proposal # 4*** Other considerations? ***See draft proposal # 6***

#	Recommendation	Statutes involved	Comments	Questions for Discussion
TF3	Amend CGS §17a-587 to permit patients to petition the hospital for temporary leave as a clinical decision, rather than a PSRB decision.	CGS §17a-587 CGS §17a-588	§5 of PA 22-47 now allows patients to apply to the PSRB for temporary leave. Task Force report is inaccurate when it says "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." CGS §17a-588 has allowed patients to apply to PSRB for conditional release. Dissenting opinion was to keep this decision within adversarial process of PSRB, but allow patients to request temporary leave.	Is there anything further to recommend? Should we note that the statutory amendment in PA 22-45 has no pragmatic effect because community providers are very unlikely to agree to assume a TL care role without the hospital's recommendation that patient is ready for TL? Can TL be considered a clinical decision (as in MA, MD, MN, OH, TN, and VA), or perhaps with notice (as in MO)?
TF4	Repeal CGS §17a-599 to eliminate role of PSRB in determining movement from Whiting max to Dutcher enhanced-security.	CGS §17a-599	§8 of PA 22-45 amended CGS §17a-599(c) to allow Whiting to make these transfers without PSRB approval, only 48-hour advance notice. Dissenting opinion was to keep this decision within adversarial process of PSRB, but allow parties 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."	Is this matter resolved or are there further comments or recommendations to be made? ***NOTE:*** *A motion was made before the PSRB regarding this amendment and whether it does or does not allow for hearings after the transfer is accomplished. Briefs from the two legal parties were due 1/26/24 and the Board discussed on 2/9/24. The Board decided that PA 22-45 removed its oversight of intra-hospital transfers.*

#	Recommendation	Statutes involved	Comments	Questions for Discussion
TF5	Amend CGS §17a-585 to require PSRB review of acquittee's status every 6 months, rather than every 2 years.	CGS §17a-585	Dissenting opinion was to change to an annual review instead of every two years, giving acquittee the right to waive that review. Current statute: "The board shall conduct a hearing and review the status of the acquittee not less than once every two years."	We heard early on that victims and acquittees find hearings distressing and would not be in favor of having more frequent hearings. Any change in that stance? This recommendation seems to have been premised on encouraging patient movement within the hospital system. Are there other ways to accomplish that goal, when safe and appropriate? Was the task force correct in positing the barrier created by the psychological effect of very long-term commitment periods? Should we consider alternate commitment durations (e.g., 2-5 years) after which re-commitment would be considered by the PSRB and the court? Would that help stimulate movement, while still permitting appropriate balance of public safety and patient recovery? Other questions or recommendations to consider for this item? ***See draft proposal # 5***

APPENDIX D

Goals and Values of Contemporary Forensic Facility Design

Michael Norko MD

9/18/23

The overarching goal of a secure forensic psychiatric hospital is to provide a shared sense of safety for patients, staff, visitors, and the community, while simultaneously creating for patients a sense of dignity, autonomy, hope, and privacy that enables and supports their recovery. Several facilities have been constructed in the 21st century to achieve these goals and values.

It is most important to consider these goals in the early decisions of designing new construction because the results will remain for decades – both the successes and the missed opportunities. The following considerations are described in the literature as vital to quality of care and quality of life within the facility:

- Reducing the institutional and correctional feel of the facility
- Creating a more homelike environment
- Maximizing the amount of natural sunlight and views of nature
- Easy access to outdoor settings
- Open spaces and wide hallways/corridors
- Maximizing well-designed therapeutic spaces that support activities that parallel natural rhythms of the day in the world outside the hospital (sleep in one's room, go to "work" [e.g., therapy, rehabilitation, skill-building activities, vocational programming, recreation] elsewhere during the day, relax in a comfortable living space with others in the evening/weekends)
- Avoiding unsupervised or unobservable spots (no blind spots)
- Creating calming places and spaces to allow patients and staff to de-escalate or avoid conflict
- Maximizing casual observation (sight lines) to maintain safety while preserving privacy/dignity
- Reduction in noise

Other opportunities that arise with new construction include: the installation of technology that enhance videoconferencing capabilities (e.g. telecourt and telehealth activities); the inclusion of a space for legal hearings obviating the need for transport outside of the facility; comfortable secure space for professional and family/friends visiting; design permitting maintenance access to systems outside of the secure perimeter; private secure entrances for patient admissions; deliveries outside of the secure perimeter; and the potential creation of publicly accessible spaces that increase community interaction, decrease stigma, and offer a sense of the quality and character of the care provided in the facility.

Sources:

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Seppänen A, Törmänen I, Shaw C, Kennedy H: Modern forensic psychiatric hospital design: clinical, legal and structural aspects. Int J Ment Health Syst 12:58, 2018. https://doi.org/10.1186/s13033-018-0238-7

Shaw MA: The secure residential psychiatric facility: process, design, and results for behavioral healthcare, in Forensic and Ethical Issues in Military Behavioral Health. Edited by Ritchie EC. Fort Sam Houston, Texas: Office of the Surgeon General, Borden Institute, 2014

Wasser TD, Dike CC, Norko MA: The Forensic Unit, in Trivedi HK, Sharfstein SS (eds.): Textbook of Hospital Psychiatry, Second Edition. Washington DC: American Psychiatric Association Publishing, 202

APPENDIX E

Date of Application:

Vanessa Cardella, LCSW, Executive Director
Psychiatric Security Review Board
505 Hudson Street, First Floor
Hartford, CT 06106-7107

In Re:	Date of Birth:
Court District:	Commitment Term:
Date of Commitment:	Commitment Ends:
Criminal Offense(s):	
Last PSRB Hearing:	

Dear Ms. Cardella,

In accordance with Connecticut General Statutes (CGS) Section 17a-587, this Application for Temporary Leave is submitted on behalf of Jose Crego, LCSW, LADC, Chief Executive Officer of Whiting Forensic Hospital (WFH).

DNA Registration
The acquittee has cooperated with providing a DNA sample in accordance with Connecticut General Statues Section 54-102g. ☐ Yes ☐ No

If yes, the DNA sample was obtained on and has been submitted to the State of Connecticut Department of Emergency Services and Public Protection (DESPP).

If no, the reason is:

Sex Offender Registration
The acquittee is required to register as a sex offender pursuant to Connecticut General Statues Section 54-250 through 54-261. ☐ Yes ☐ No

Application for Temporary Leave for:

☐ **Community Treatment**
☐ **Residence**
☐ **Community Treatment and Residence**

Overview of the Purpose of the Temporary Leave
The purpose of this temporary leave is to initially allow the acquittee to participate in day treatment, staff-led rehabilitation, and recreational activities at . Mr. X is expected to utilize this temporary leave for a minimum of three months prior to consideration of further community reintegration. Any forward movement will factor in, at a minimum, his adherence to his MOD, his clinical stability, his overall progress, and the management of his individual risk factors.

When determined to be clinically appropriate, a second phase of the leave will allow the acquittee to gradually, and as clinically indicated, receive all of his treatment in the community and begin staying overnight in his future residence, , gradually increasing to living in his residence seven days and nights per week.

Rationale for Current Proposal:

Frequency and Duration of Temporary Leave

Phase I. The **frequency** (hours per day and days per week) and **duration** (the estimated *minimum* period of time) that Phase I (Day treatment of this Temporary Leave is expected to be used:

- Up to hours per day and up times per week
- For a minimum duration of months

Phase II. The **frequency** (hours per day and days per week) and **duration** (the estimated *minimum* period of time) that Phase II (overnight stays in his/her residence) of this Temporary Leave is expected to be used:

- Up to 24 hours per day, up to days per week
- For a minimum duration

Community Service Providers

Local Mental Health Authority (LMHA)

Agency:	
Executive Director:	
Address:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	

Other Community Service Providers

Agency:	
Executive Director:	
Address:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	

Agency:	
Executive Director:	
Address:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	

Agency:	
Executive Director:	
Address:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	

Community Service Provider PSRB Training

The proposed Temporary Leave Supervisor, other community service providers who will have regular contact with the acquittee, and relevant supervisors/managerial staff have completed formal PSRB training. For any staff who have not completed formal PSRB training, the person's name and the expected date that the training will be completed is: ☐ N/A

Communuity Service Provider:	**Temporary Leave Supervisor**
Name:	
Agency:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Communuity Service Provider:	**Clubhouse Supervisor**
Name:	
Agency:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Communuity Service Provider:	**Residential Supervisor**
Name:	
Agency:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Communuity Service Provider:	**Psychiatrist/APRN**
Name:	
Agency:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Communuity Service Provider:	**Therapist**
Name:	
Agency:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Communuity Service Provider:	**Residential Supervisor**
Name:	
Agency:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Communuity Service Provider:	**Visiting Nurse**
Name:	
Agency:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Communuity Service Provider:	**Judicial Branch, Court Support Services Division, Adult Probation Services (JB-CSSD)**
Name:	
Address:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Communuity Service Provider:	**Other:**
Name:	
Agency:	
Executive Director:	
Address:	
Telephone Number:	
Fax Number:	
Email Address:	
Emergency Contact No:	
Completed PSRB Training:	☐Yes ☐No; If No, date scheduled to attend:

Hospital and Community Service Provider Assessments and Monitoring

Hospital Clinical Assessment
The acquitee will be assessed by a psychiatrist within 48 hours prior to using each Temporary Leave and by a registered nurse immediately before and upon return from each Leave.

Acquitee Call-In
The acquittee will be required to call his/her WFH treatment unit to check in with staff at least once per day during each Temporary Leave at a predetermined time set by the treatment team.

Monitoring of Medications
In addition to WFH staff administering the acquittee's medication, when on ***overnight*** Temporary Leaves in the community, the acquittee's taking of his/her prescribed medication will be monitored/supervised by the following community service provider(s).

Agency:	
Contact Person:	
Telephone Number:	
Cellphone Number:	
Email Address:	
Type of Monitoring:	
Frequency:	

Summary of medication administration:

Drug/Alcohol Screenings

Agency	Type of Screen	Frequency
WFH	☐Urine toxicology screen	☐ Upon return from each TL ☐ Weekly, randomly ☐ Weekly ☐ Monthly, randomly ☐ Twice monthly, randomly ☐ Before and after each TL ☐As clinically indicated ☐Other:
	☐Urine toxicology screen	☐ Upon return from each TL ☐ Weekly, randomly ☐ Weekly ☐ Monthly, randomly ☐ Twice monthly, randomly ☐ Before and after each TL ☐As clinically indicated ☐Other:
	☐Urine toxicology screen	☐ Upon return from each TL ☐ Weekly, randomly ☐ Weekly ☐ Monthly, randomly ☐ Twice monthly, randomly ☐ Before and after each TL ☐As clinically indicated ☐Other:
	☐Urine toxicology screen	☐ Upon return from each TL ☐ Weekly, randomly ☐ Weekly ☐ Monthly, randomly ☐ Twice monthly, randomly ☐ Before and after each TL ☐As clinically indicated ☐Other:

The acquittee has collaboratively developed a Relapse Prevention Plan with the hospital's Certified Alcohol and Drug Counselor (CADC). ☐ Yes ☐ No ☐ N/A

Supervision of the Acquittee

1. **Supervision by Judicial Branch- Court Support Services Division (JB-CSSD)**

   A representative of JB-CSSD participated in the planning of this Temporary Leave Application.
   ☐ Yes ☐ No

   JB-CSSD will supervise the acquittee pursuant to JB-CSSD policy and procedures that are not contrary to the conditions imposed by the PSRB.

A Probation Officer has been assigned to the acquittee: ☐ Yes ☐ No

Name:	
Address:	
Telephone Number:	
Cellphone Number:	
Fax Number:	
Email Address:	
Recommendations regarding the nature and frequency of their supervision:	

Temporary Leave Supervision

- The Temporary Leave Supervisor will monitor and supervise the acquittee's compliance with the conditions of this Temporary Leave including – but not limited to – providing the following services at the indicated frequency.

Supervision Services	***Minimum Frequency Provided***
☐Supervision meetings with the acquittee	
☐Supervision telephone calls with the acquittee	
☐Reviewing with the acquittee the conditions of the TL as stated in the Board's Order (contained in the MOD)	
☐Contacting and obtaining feedback on the acquittee's progress from *all* treatment and service providers	
☐Verifying atendance at community substance abuse peer support meetings	
☐Verifying/coordinating drug/alcohol screenings	
☐Reviewing/approving the acquittee's travel	
☐Contacting and obtaining feedback on behavior and job performance from the acquittee's employer	
☐Visiting the aquittee's residence	

☐Reviewing the residential program sign-in/sign-out log	
☐Meeting with the WFH treatment team	
☐Reporting to the WFH treatment team by telephone	
☐Other Service (see below)	

Supervision at Treatment, Rehabilitation, Psychosocial, and Vocational Sites

Phase I
During Phase I, the acquittee will participate in day treatment, rehabilitation, and psychosocial activities at .
Phase II

Supervision at the Residence/Residential Program

Location and availability of residential program/support staff for the acquittee throughout the day during: (1) the regular work week, and (2) weekends and holidays:

The schedule for the acquittee's curfew and how compliance with the curfew will be confirmed:

Other forms of residential monitoring (e.g., acquittee calls, use of a sign-in/sign-out log, staff calls, or in-person room/apartment checks):

Supervision of the Acquittee During Personal Free Time
During free time, the acquittee will be in his own custody as outlined below. Any exceptions will require prior approval from the acquittee's TL Supervisor/designee, the WFH treatment team in conjunction with the CFP, and the acquittee's community treatment team.

Travel and Transportation
The following community service providers may provide transportation for the acquittee during this Temporary Leave:

Geographic limitations or **special conditions** as to where the acquittee may travel within the state of Connecticut when *with community agency staff:*

The acquittee may travel within the State of Connecticut ***without*** *community agency staff:*
☐ Yes ☐ No ***If yes,*** the acquittee may travel *in his/her own custody* (by him-/herself) under the following proposed TL conditions:

Where the acquittee may travel by himself/herself:

The **purpose** for travel by himself/herself:

The **amount of time** each day or per *occasion* each *day* that the acquittee may travel by himself/herself:

Modes of transportation the acquittee may use to travel by himself/herself:
☐ Walking or bicycle
☐ Public transportation (bus, taxi, or medical taxi) once oriented by agency staff
☐ May be transported in a private vehicle by a friend, family member, or other person(s) as approved by the TL Supervisor and hospital treatment team in consultation with the CFP
☐ May drive his/her own vehicle (copies of the acquittee's driver license, vehicle registration, and proof of insurance are enclosed)

Review and approval (or **other conditions**) regarding the acquittee's travel:

Phase I
During Phase I, the acquittee
Phase II

Victim and Potential Victim Contact

The acquittee *may* have contact with the victim(s) of is/her crime(s). ☐ N/A ☐ Yes ☐ No
If yes, the conditions for contact with the victim(s) are:

There will be a *general* limitation on contact with children under 18 years of age. ☐ Yes ☐ No
If yes, the rationale is:

There are *other persons* with whom the acquittee should have no/limited contact. ☐ Yes ☐ No
If yes, the **person(s),** the **reason,** and recommended **limitations** regarding contact are:

Acquitee Use of Telephones, Computers, and Social Media

There are **contraindications** or **risk management** concerns regarding the acquittee having access to, using, and/or possessing the following:

Cell/cellular telephones	☐ Yes ☐ No
Computers/computer tablets	☐ Yes ☐ No
Email	☐ Yes ☐ No
The Internet	☐ Yes ☐ No
Social media	☐ Yes ☐ No

Concerns or **contraindications** for access to and use of *each* item checked "yes":

Recommended **conditions** and/or **interventions** that will be used to supervise and/or monitor the acquittee's access and use of *each* item checked "yes":

Acquittee Residence and Residential Services

The acquittee will reside at:

Residence:	
Address:	
Acquittee's Home Telephone #:	
Acquittee's Cellphone #:	

The residence is a:
☐ A residential program operated by DMHAS/DDS or a DMHAS-/DDS-funded agency.
☐ Another health/human service facility (e.g., nursing home, boarding home).
☐ The acquittee's own independent residence (☐ with / ☐ without residential support).
☐ The residence of a friend/family member (☐ with / ☐ without residential support).

The name of the Friend/Family Member(s)	Relation to the Acquittee

Description of the Residence:

Emergency Contact Number and Procedure for the Residence:

Services that the residential program will provide:
☐ Visiting the acquittee's room, apartment, or home at a minimum frequency of
☐ Monitoring medications (as described above in this application)
☐ Drug/alcohol screenings (as described above in this application)
☐ Providing and monitoring a sign-in/sign-out log
☐ Congregate meals
☐ Daily living skills training/assistance
☐ Health/medical assistance
☐ Budgeting Assistance
☐ Peer/residents support group
☐ Leisure/recreational activities
☐ Substance use/abuse counseling
☐ Group counseling
☐ Vocational assistance/rehabilitation

The schedule for the acquittee to stay overnight in his/her future community residence is:

If the acquittee is *not* in a residential facility/program or receiving residential support services, there is a community service provider **emergency contact** for the acquittee:

☐ N/A ☐ Yes ☐ No ***If yes,*** please provide the information below:

Agency:	
Type of Agency	
Contact Person:	
Contact's Telephone Number:	
Contact's Fax Number:	
Work Week Daytime Emergency Contact:	Contact: Number:
Night, Weekend, & Holiday Emergency Contact:	Contact: Number:

Treatment Activities

Current treatment activity schedules for listed agencies reviewed. ☐ Yes ☐ No

Phase I			
Agency	***Type***	***Activity***	***Frequency***
	☐ Staff-led ☐ Peer-led	Clinical Groups	
	☐ Staff-led ☐ Peer-led	Substance Use Treatment	
	☐ Staff-led ☐ Peer-led	Therapeutic Recreation Groups and Activities	
	N/A	Individual Therapy	

Phase II			
Agency	***Type***	***Activity***	***Frequency***
	☐ Staff-led ☐ Peer-led	Clinical Groups	
	☐ Staff-led ☐ Peer-led	Substance Use Treatment	
	☐ Staff-led ☐ Peer-led	Therapeutic Recreation Groups and Activities	
	N/A	Individual Therapy	
	N/A	Psychiatric Engagement	During Phase II, once the acquittee is on overnight TLs 7 nights per week, he will begin to participate in monthly psychiatric engagement meetings.

Vocational, Volunteer, and Educational Activities

Agency	***Contact Person***	***Activity***	***Frequency***

Based on clinical considerations, the recommended *maximum* number of hours per week that the acquittee may work at a paid or volunteer job is: ☐ N/A ☐ Phase II: up to hours/week.

The acquittee's employer is: ☐ N/A

Employer:	
Address:	
Contact Person:	
Telephone #:	
Email Address:	

WFH staff [☐ has oriented/ ☐ will orient] the acquittee's immediate work supervisor(s) and relevant managers of the acquittee's status under the PSRB and the requirements of this status.

Visitation with Friends and Family

Full Name*	**Relation to Acquittee**

**Using the State of Connecticut Judicial Branch criminal case look up feature and the Sex Offender Registry Offender Search, (date), the above contacts were not on the sex offender registry, did not have any prior criminal convictions, and did not have any pending criminal cases.*

The treatment team has met with the above *significant contacts* and determined that the person(s) is an appropriate contact for the acquittee. ☐ Yes ☐ No

If no, the reason for not having evaluated the person is:

Hospital Visitation:

The acquittee may have contact with his/her *own children* under 18 years of age.
☐ N/A ☐ Yes ☐ No

If yes, the recommended **frequency** and **conditions** for this contact are:

The acquittee may have contact with the children under 18 years of age of the friends of family members *listed above.* ☐ N/A ☐ Yes ☐ No

If yes, the parent(s) or legal guardian of the children has given his/her permission for this contact to occur. ☐ Yes ☐ No

If yes, the recommendations regarding this contact are:

If no, the explanation for this is:

Recommendations for conditions when the acquittee is with the above significant contacts

The **frequency** and **amount of time** (per occasion) the acquittee may spend with the friends or family members listed above:

The **location(s**) within the state where the acquittee may travel and spend time with friends or family:

The **review and approval** of **(**or **other conditions** regarding) the acquittee's contact or activities with the friends or family members listed above:

There are individuals other than the above-listed significant contacts with whom the acquittee should have ***no*** or ***only limited*** contact during this temporary leave. ☐ Yes ☐ No

If yes, the **person(s), reason** for the prohibition, and **recommendations** are:

Finances: The costs for the acquittee's proposed services and living expenses will be paid for by/from the following sources.

a. Federal Assistance or Insurance	
SOURCE	**AMOUNT/DESCRIPTION**
☐ Medicare Part A (hospital insurance)	
☐ Medicare Part B (outpatient insurance)	
☐ Medicare Part D (prescription insurance)	
☐ Social Security Disability Insurance (SSDI)	
☐ Supplemental Security Income (SSI)	
b. State Assistance or Insurance	
☐ Medicaid (Title 19)	
☐ Food Stamps	
☐ Cash/rental assistance	
c. Other Income or Insurance	
☐ Personal Savings	
☐ Personal Insurance	
☐ Employment	
☐ Family	

The costs to be paid *by the acquittee* for his/her living expenses (housing, food, clothing, etc.) and **treatment** or **other services** (e.g., medications, co-pays, deductibles, insurance premiums):

Expense:	Anticipated Cost:

It is anticipated that the acquittee's entitlements will allow him to cover all projected expenses, though the precise amounts of his entitlements can not be determined at this time.

The acquittee requires financial/budgeting assistance. ☐ Yes ☐ No
If yes, this service will be provided by the following:

The acquittee requires a third-party payee. ☐ Yes ☐ No
If yes, the payee will be:

Person or Agency:	
Contact Person:	
Address:	
Telephone Number/Fax Number:	
Email Address:	

The acquittee has a Conservator of Estate. ☐ Yes ☐ No

If yes, the conservator is:

Probate Court:	
Name of Conservator:	
Contact Person:	
Address:	
Telephone Number/Fax Number:	
Email Address:	

This Application for Temporary Leave was prepared by:

_____ _____

Unit Clinical Social Worker Unit Attending Psychiatrist

Application reviewed by:

In my opinion, under the conditions described in this Application for Temporary Leave, would not present a substantial risk of harm to himself/herself or others.

_____

Consulting Forensic Psychiatrist
Division of Forensic Services, DMHAS

Application reviewed and approved by:

_____

WFH CEO or Designee

Transitional Support Plan

This plan is not meant to be a substitute for a contemporaneous clinical and risk assessment.

The following signs and symptoms may be indicative of psychiatric or behavioral decompensation, though are not exhaustive (things to notice or look for that may signify psychiatric decompensation):

Symptom Management Strategies (interventions that may support psychiatric stability and safety):
Internal or Independent Coping Strategies:

Interpersonal and Environmental Supports:

Hospital Contact Info- Please try to contact the unit directly first:

Dutcher Unit	(860) 262-
Nurses Station	(860) 262-
Dutcher Nursing Supervisor Office	(860) 262-6245
General Switchboard	(860) 262-5000

If there is a significant medial emergency such as evidence of a heart attack, stroke or another life-threatening condition, please call **911** as one would usually do and then also follow up with an immediate call to the unit **860) 262-** when the 911 call has ended.

What to say- how I communicate what I am observing to the acquittee's treatment team

- Identify the concern, i.e., What are you observing (symptom listed above, concerning verbalizations, or concerning behavior)?
- How long has this been going on?
- What have you tried to help (if anything) and what was the response?

Next Steps

The staff will help to make a determination if it is safe to continue the TL or to discontinue the TL for that day. If there is significant concern about the acquittee's mental status, the unit will send one or more staff members to pick the acquittee up.

APPENDIX F

DMHAS Conditional Release Service Unit (CRSU): PSRB Data
2019 to 8/31/2024

Year	New NGRI	Discharge Early Release	Discharge End of Commitment	Death	New CR Application	Total Discharges for the Year
2019	6	1	1	4	1	2
2020	2	0	3	3	3	3
2021	2	1	2	1	3	3
2022	5	2	2	0	4	4
2023	0	4	6	0	4	10
Up to 8/31/2024	4	3	4	0	4	7
Totals	19	11	18	8	19	29[59]

Total discharges: 29[60]

Out of 29, 25 clients have remained in treatment with the LMHA of origin. 86% remained in treatment

Out of the remaining 4 clients who did not remain in treatment with LMHA, 2 may have moved out of state, or unknown. Of note 2 were not prescribed any psychotropic medications at the time of discharge.

Average length of commitment 21.5 yrs[61]

Clients discharged from 60 West have remained there or passed away

There were Zero arrests from 2019 to 8/31/24 as checked in CT Judicial website.

[59] This does not include the 8 deaths.

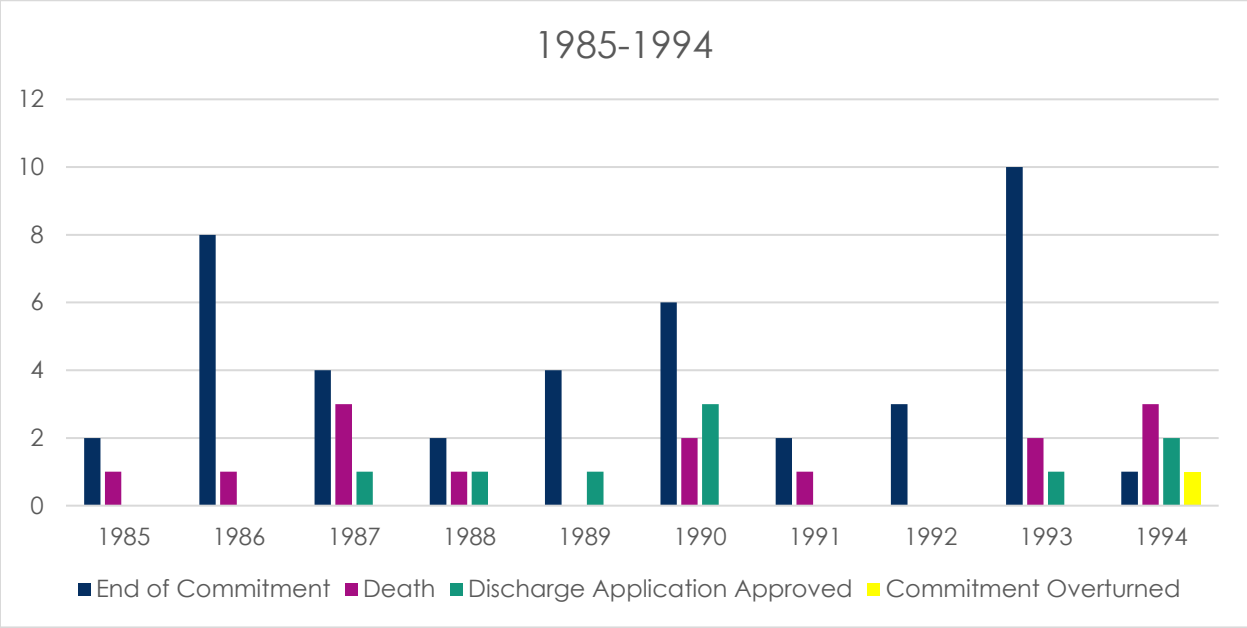
[60] On 8/31/24, there were 18 fewer individuals under the PSRB than at the end of 2018. (19 new persons minus 11 early discharges minus 18 discharges at end of commitment minus 8 deaths).

[61] This is the value for all clients discharged from the Board since 2019, including deaths.

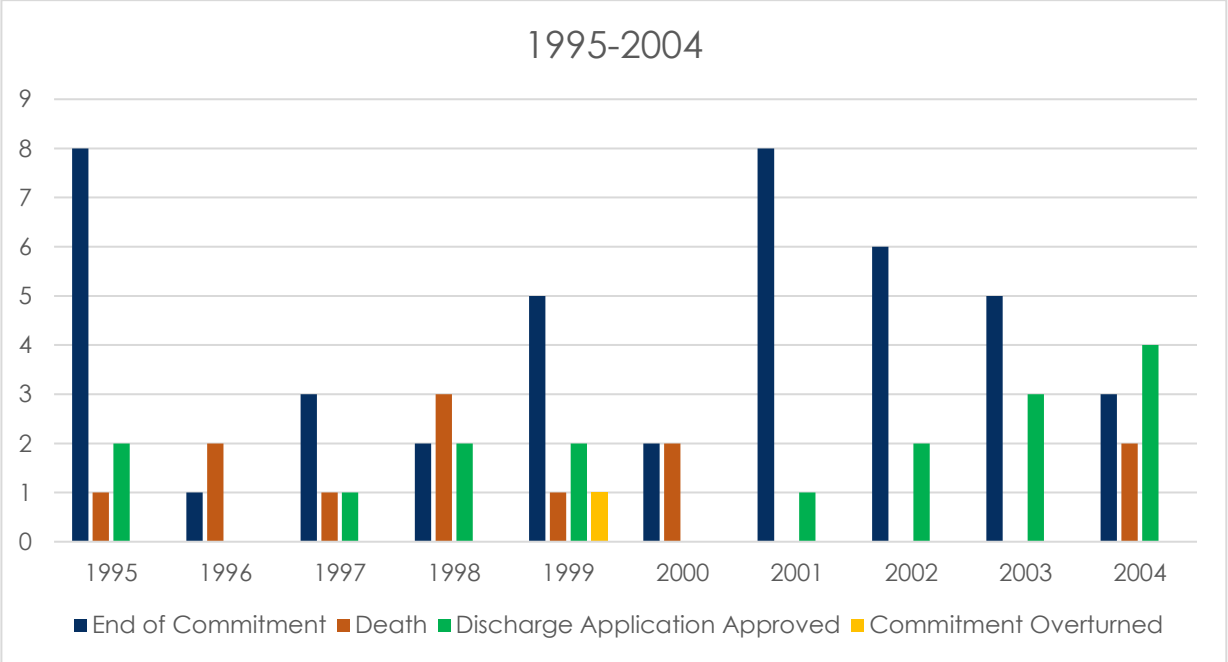
APPENDIX G

PSRB Discharges 1985 to 2024

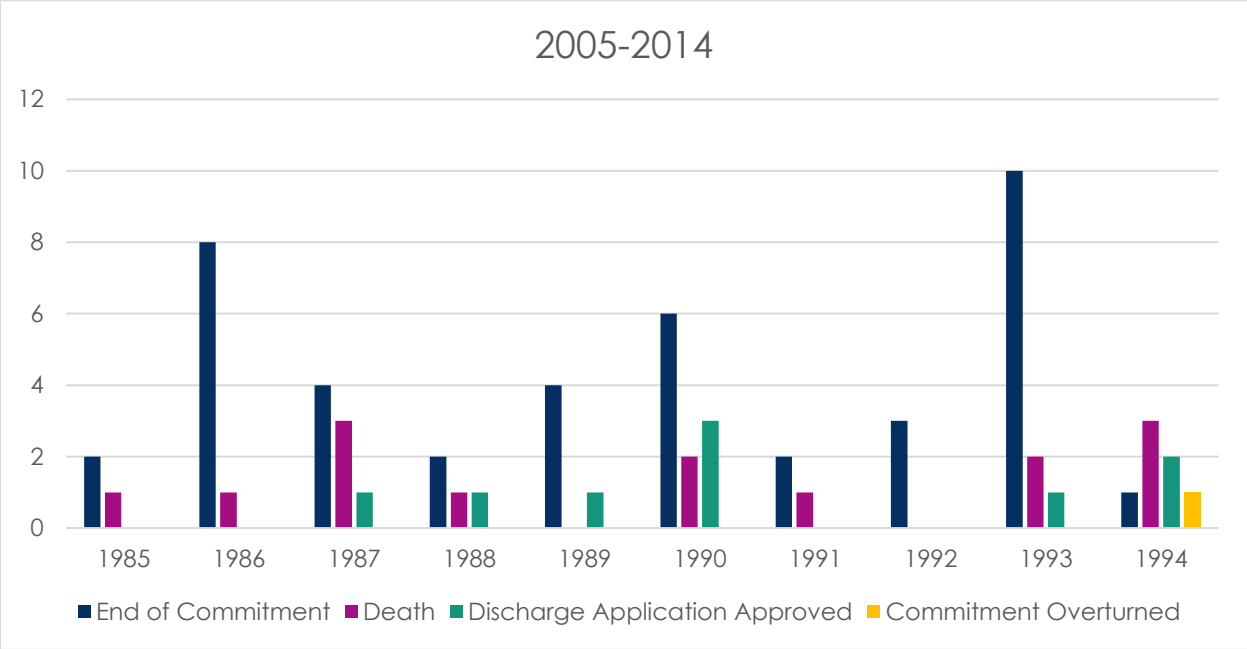
Year	End of Commitment	Death	Discharge Application Approved	Commitment Overturned	TOTALS
1985	2	1	0	0	**3**
1986	8	1	0	0	**9**
1987	4	3	1	0	**8**
1988	2	1	1	0	**4**
1989	4	0	1	0	**5**
1990	6	2	3	0	**11**
1991	2	1	0	0	**3**
1992	3	0	0	0	**3**
1993	10	2	1	0	**13**
1994	1	3	2	1	**7**
1995	8	1	2	0	**11**
1996	1	2	0	0	**3**
1997	3	1	1	0	**5**
1998	2	3	2	0	**7**
1999	5	1	2	1	**9**
2000	2	2	0	0	**4**
2001	8	0	1	0	**9**
2002	6	0	2	0	**8**
2003	5	0	3	0	**8**
2004	3	2	4	0	**9**
2005	3	1	3	0	**7**
2006	5	1	3	0	**9**
2007	4	0	7	0	**11**
2008	3	1	0	1	**5**
2009	7	2	2	0	**11**
2010	2	2	3	0	**7**
2011	1	1	2	0	**4**
2012	3	1	5	0	**9**
2013	1	0	6	0	**7**
2014	2	0	3	0	**5**
2015	2	3	3	0	**8**
2016	2	0	2	0	**4**
2017	3	1	2	0	**6**
2018	2	3	1	1	**7**
2019	3	2	0	0	**5**
2020	1	2	1	0	**4**
2021	1	1	1	0	**3**
2022	4	0	3	0	**7**
2023	6	0	5	0	**11**
2024	5	0	0	0	**5**
TOTAL	**145**	**47**	**78**	**4**	**274**
	53%	*17%*	*28%*	*1%*	



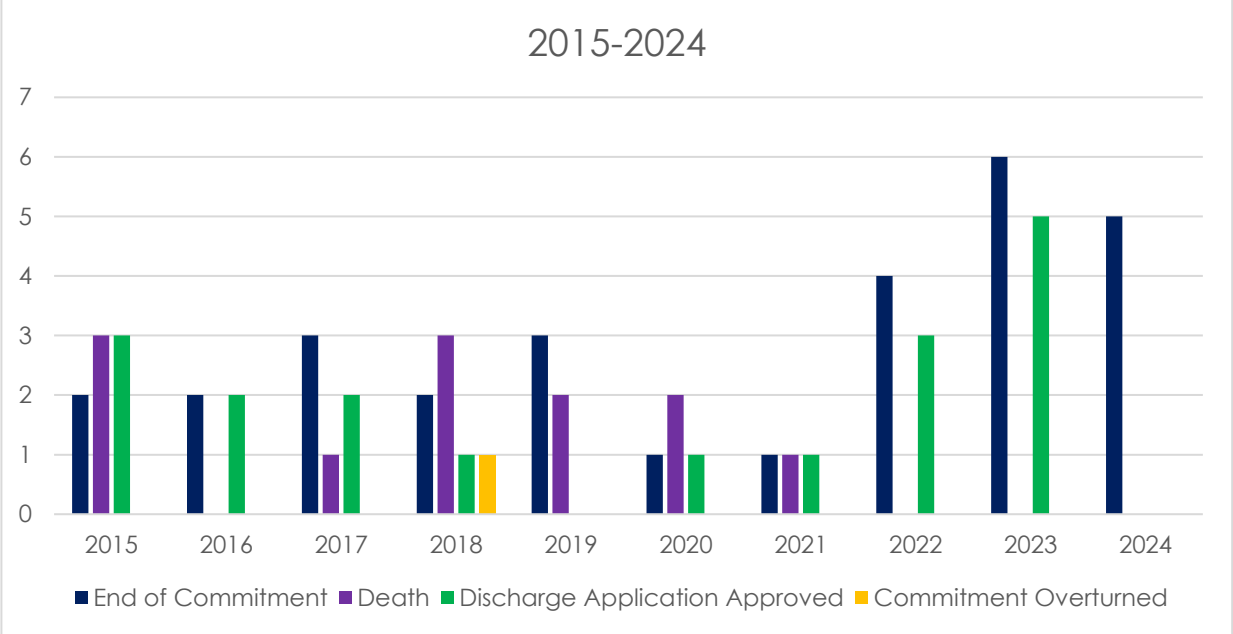
End of commitment = 64%
Discharge application approved = 14%
Death = 21%
Overturned = 1.5%



End of commitment = 59%
Discharge application approved = 23%
Death = 16%
Overturned = 1%



End of commitment = 41%
Discharge application approved = 45%
Death = 12%
Overturned = 1%



End of commitment = 48%
Discharge application approved = 30%
Death = 20%
Overturned = 2

APPENDIX H

Case-Specific Data for Continued Commitments ("Recommitments")

# recommitments	# persons	Periods in months of each recommitment	Avg length of recommitments in months	Avg total recommitment length in months per person (yrs)
1	5	30 24 60 36	37.5	37.5 (3.1)
2	2	30;24; 24;60	34.5	69 (5.8)
3	4	60;18;24; 30;12;12; 36;24;24; 60;84;48	36	108 (9)
4	3	48;60;36;36 36;36;36;36 36;60;48;60	44	132 (11)
5	4	48;36;48;36;24 36;60;60;60;60 18;12;12;24;16 60;60;60;60;60	42.5	212.5 (17.7)
6	1	36;24;48;36;36;24	34	204 (17)
7	1	18;18;18;13;24;15;18	17.7	124 (10.3)
8	1	18;24;24;12;24;12;60;60	29.25	234 (19.5)
9	1	30;18;24;36;36;36;24;24;24	28	252 (21)
11	1	24;24;12;12;12;24;24;24;24;24;60	24	264 (22)

Each row represents the number of acquittees who have been recommitted the number of times listed in the first column.

Each line within a row represents a given acquittee, the numbers of months in each recommitment separated by semi-colons

APPENDIX I

Proposals Related to Working Group Charges

1. Define well-being of the acquittee.

The term "well-being of the acquittee," added in PA 22-45, needs further definition and expansion in CGS §17a-582, CGS §17a-584, and CGS §17a-593. Language should be added to note that acquittee well-being includes the acquittee's recovery and concomitant reduction in the acquittee's risk of future dangerous behavior, progress toward the acquittee's re-integration into the community, and treatment in the least restrictive setting consistent with public safety. Connecticut General Statutes already require consideration of the availability of a "less restrictive placement" in civil commitment procedures (CGS §17a-498(c)). Similarly, our criminal statutes require consideration of the "least restrictive placement" in the courts' ordering treatment to restore competency to stand trial (CGS §54-56d(i, j, k)). The least restrictive alternative concept was initiated in 1966 by Judge Bazelon in a D.C. Circuit case.[62] The U.S. Supreme Court supported the concept in 1999 in the *Olmstead* case,[63] in which it quoted the aspirations of the Developmentally Disabled Assistance and Bill of Rights Act of 1975 that "treatment, services, and habilitation for a person with developmental disabilities . . . should be provided in the setting that is least restrictive of the person's personal liberty."[64]

2. Balancing the protection of society and the well-being of acquittees.

Rather than trying to articulate which concerns are primary and which are secondary for the court and for the PSRB at various stages of the process, and rather than having different articulations of the ranking of concerns in different parts of the relevant statutes, amendments should be made to CGS §17a-582, CGS §17a-584, and CGS §17a-593 to similarly task the court and the PSRB with *balancing* the protection of society and the safety and well-being of the acquittee in their decision-making. In addition, language should be added to "the protection of society" to include the interests of identified victims. It should be expected that the court and the PSRB will consider all available information in making their decisions, and attempt to balance these various interests as the specific circumstances of each case and situation warrant.

3. Establish some limits to commitment to the PSRB.

The direction to the court in establishing a period of commitment to the PSRB in CGS §17a-582 should be less directly linked to the statutory punishment terms for conviction (since the individual has been found not criminally responsible because of their mental illness at the time of the offense), and that reasonable limits should be imposed. The Task Force report (p. 12) noted their unanimous concern that excessive periods of commitment (like the example the Task Force noted of a young man committed for 120 years) create a "psychological constraint" that can demoralize a person in their efforts at recovery. The working group proposes an amendment to CGS §17a-582 that would impose a maximum total length of commitment of 60 years in cases of murder, and 35 years in non-murder cases as a first attempt at diminishing the potential for discouragement and at encouraging both patients and clinicians in their treatment efforts. Successful treatment and the opportunity for monitoring in the community under conditional release decrease the risk of future dangerous behavior – a benefit for society, identified victims, and the patients.

[62] *Lake v. Cameron* , 364 F.2d 657 (D.C. Cir. 1966)

[63] *Olmstead v. L. C* ., 527 U.S. 581 (1999)

[64] Ibid, 599

4. Encourage supervision of acquittees on conditional release.

Because the literature demonstrates clearly that periods of success on conditional release and monitoring in the community are most important to reducing the risk of recidivism, and because conditional release under the PSRB is most consistent with the principle of providing treatment in the least restrictive setting that is appropriate and available, the treatment system should be encouraged to work toward conditional release to the extent possible that is consistent with public safety. The working group can learn from the civil commitment process, where the state must prove by clear and convincing evidence (every year if requested by the patient, and at least every two years per CGS §17a-498(g)) that the person is dangerous and has psychiatric disabilities in order to deprive the person of their liberty. The working group proposes that amendments be made to CGS §17a-593(f), such that in cases where the acquittee has demonstrated three or more years of uninterrupted tenure on conditional release, the burden of proof should shift from the acquittee to prove their non-dangerousness to the state to prove (by clear and convincing evidence) the acquittee's continued current dangerousness as a result of psychiatric disabilities.

5. Distinguish early release hearings from re-commitment hearings in statute.

In *State v. Metz*, 230 Conn. 400, the Connecticut Supreme Court ruled in 1994 that once an acquittee reaches the end of the original court-imposed term of commitment, the burden of proof must shift from the acquittee to the state "to show by clear and convincing evidence that the acquittee is currently mentally ill and dangerous to himself or herself or others or gravely disabled" (p. 425). It is now 30 years since that decision was released, but the relevant statute in CGS §17a-593(f) has never been modified to distinguish the acquittee's burden in a petition for release prior to the termination of the commitment order from the state's burden at the expiration of that commitment order. CGS §17a-593 should be amended to clearly distinguish the two types of hearings and their respective burdens and standards to be consistent with case law articulated in the *Metz* decision: an application for discharge prior to expiration of the original commitment (acquittee's burden by preponderance of the evidence), and the state's application for continued commitment at the expiration of the original commitment (state's burden by clear and convincing evidence).

Possible language to effectuate this amendment is as follows:

> **Sec. 17a-593. (Formerly Sec. 17-257n). Court order to discharge acquittee from custody.**
> (f) After receipt of the board's report and any separate examination reports, the court shall promptly commence a hearing on the recommendation or application for discharge or petition for continued commitment. At [the] a hearing on the recommendation or application for discharge, the acquittee shall have the burden of proving by a preponderance of the evidence that the acquittee is a person who should be discharged. At a hearing on the state's attorney's petition for continued commitment, the state shall have the burden of proving by clear and convincing evidence that the acquittee has psychiatric disabilities and is currently a danger to self or others as a result of those psychiatric disabilities.
>
> [x] = proposed deleted material; underline = proposed new material

6. Eliminate continued commitment ("recommitment") to the PSRB in favor of civil commitment when warranted.

The Task Force recommended the elimination of the practice of re-commitment at the end of the commitment term set by the court (and suggested replacing re-commitment with the existing civil commitment process). Under the current statute (CGS §17a-593) at the end of an acquittees' commitment the State's Attorney may petition the Court to continue the commitment. State's Attorneys frequently file such petitions. There are no limits to the number of times such a petition can be pursued, nor any limit to the total number of years a commitment can extend beyond the original end date. This process can result in indefinite or lifetime commitments.

At a March 21, 2023 presentation to the working group, it was reported that 36 of the 145 acquittees then under the PSRB had their commitment continued by the superior court. Of those 36, 26 acquittees had their commitment extended three or more times.

As a result of this process, individuals often remain in confinement longer than the maximum prison sentence which they could have received if convicted. These individuals, who were found not criminally responsible for their crime because of their psychiatric disability, therefore receive a longer confinement than persons without a disability who have been convicted of similar crimes. There have been repeated challenges to the constitutionality of Connecticut's continued commitment procedure and that litigation remains ongoing.

In Oregon, the only other state with a PSRB and the model for Connecticut's PSRB, there is no similar procedure to petition for continued commitment. Oregon has a much higher percentage of acquittees being monitored and receiving care in the community than does Connecticut (58% vs. 25.5%). Oregon considered establishing a re-commitment process but decided not to do so because of the likely effects on length of hospitalization and percentages of acquittees in institutional settings. Eliminating the process of continued re-commitment in Connecticut would end what the Task Force referred to as the "never-ending cycle of re-commitment."[65] Instead, once an acquittee's original term of commitment expires, the state can apply for civil commitment as provided in the Connecticut General Statutes if they believe the patient continues to be a danger to self or others or gravely disabled.

[65] Task Force to Review and Evaluate CVH and WFH, the Psychiatric Security Review Board, and Behavioral Health Care Definitions. Final Report. December 16, 2021. p 13

APPENDIX J

In an effort to be responsive to the various elements of the charges to the working group in this subject matter section, a set of proposals was drafted by a sub-set of the working group for further review by members . Because there was not unanimity of opinion about these proposals, a written poll was taken of the members. Detailed vote tallies and comments on member discussions of each proposal, including considered revisions, are included below.

Proposal #1. Define well-being of the acquittee. Proposal 1 suggests defining the term "well-being of the acquittee," as added in PA 22-45 to CGS §17a-582, CGS §17a-584, and CGS §17a-593 to include "the acquittee's recovery and concomitant reduction in the acquittee's risk of future dangerous behavior, progress toward the acquittee's re-integration into the community, and treatment in the least restrictive setting consistent with public safety."

The working group noted that Connecticut General Statutes require consideration of the availability of a "less restrictive placement" in civil commitment procedures in probate court, which is a separate system from the criminal court system and has different structures and processes (described in CGS §17a-498(c); see the further discussion of this difference under Proposal #6). In Connecticut's criminal court system, existing statutes require consideration of the "least restrictive placement" in the courts' ordering treatment to restore competency to stand trial (CGS §54-56d(i) through (k)). The least restrictive alternative concept was initiated in 1966 by Judge Bazelon in a D.C. Circuit case.[66] The U.S. Supreme Court supported the concept in 1999 in the *Olmstead* case,[67] in which it quoted the aspirations of the Developmentally Disabled Assistance and Bill of Rights Act of 1975 that "treatment, services, and habilitation for a person with developmental disabilities . . . should be provided in the setting that is least restrictive of the person's personal liberty."[68] The CVH/WFH Task Force Report specifically recommended, in Task Force Recommendation 1 relating to the role of the PSRB, that "the right to placement in the least restrictive environment" was one of the "rights to which all institutionalized patients are entitled under state and federal law" that should be balanced with protection of society.

The working group did not have consensus on this proposal, with 8 voting members supporting it, and 4 opposing it. Supporters noted that the proposal is consistent with state and federal law and with principles of mental healthcare, and that it is contextualized by concern for public safety. The opposing viewpoint sees "least restrictive setting" language as applicable to civil commitment statutes and to the probate court system where serious crimes are not the impetus for legally-mandated treatment.

Proposal #1b. Define well-being of the acquittee (revised). Proposal 1b offers a similar recommendation but does not include the language related to "least restrictive alternative consistent with public safety." This proposal is that "well-being of the acquittee," as used in CGS §17a-582, CGS §17a-584, and CGS §17a-593, should be defined to include the acquittee's recovery and concomitant reduction in the acquittee's risk of future dangerous behavior, and progress toward the acquittee's re-integration into the community.

The working group did not have consensus on this proposal, with 7 voting members supporting it, and 5 opposing it (4 of whom supported instead the unamended version of Proposal #1 described above).

Proposal # 2. Balancing the protection of society and the well-being of acquittees. Proposal 2 specifically addresses the balancing of the protection of society and the safety and well-being of acquittees, as

[66] *Lake v. Cameron* , 364 F.2d 657 (D.C. Cir. 1966)

[67] *Olmstead v. L. C* ., 527 U.S. 581 (1999)

[68] Ibid, 599

discussed above. It recommends changing the language of primary and secondary concerns found in CGS §17a-582, CGS §17a-584, and CGS §17a-593 to a language of balancing of concerns. Proposal 2 also adds that the protection of society should be amended to include the interests of identified victims. It also provides that "It should be expected that the court and the PSRB will consider all available information in making their decisions and attempt to balance these various interests as the specific circumstances of each case and situation warrant."

There was significant, but not unanimous, support for this proposal, with 11 voting members supporting it, and 1 voting member opposing it. Supporters of the proposal think the concept of balancing of various interests based on consideration of all available information at each decision point makes sense. The opposing viewpoint expressed concern that public safety should remain the primary consideration.

Proposal #3. Establish some limits to commitment to the PSRB. Proposal 3 suggests that a period of commitment to the PSRB in CGS §17a-582 should be less directly linked to the statutory punishment terms for conviction (since the individual has been found not criminally responsible because of their mental illness at the time of the offense), and that reasonable limits should be imposed. The proposal suggests a maximum total length of commitment of 60 years in cases of murder, and 35 years in non-murder cases as a first attempt at diminishing the potential for discouragement and at encouraging both patients and clinicians in their treatment efforts. The available data about commitment length, recommitments, and discharges from the PSRB were presented in the background discussion of Task Force Recommendations 1 and 2.

There was significant, but not unanimous, support for this proposal, with 9 voting members supporting it, and 3 voting members opposing it. In discussions after the voting, questions arose as to whether members understood that the time limits of this proposal would prevent courts from ordering commitment lengths that took consecutive sentencing into account (e.g., a defendant charged with two or more offenses, the punishment for which – if imposed consecutively – would amount to more than the limits proposed). Each of the members who supported the original proposal was queried about their understanding and their support; each of them understood this result of the proposal and continued to support it.

Supporters of the proposal noted the psychological benefits of reasonable time limits that are sufficient to effectively manage risk and protect public safety without being punitive.

Those who opposed the proposal noted that commitment lengths are not mandatory and that acquittees and care teams may apply for community release and discharge from the PSRB prior to the expiration of any period of commitment, based on the acquittee's progress in treatment.

Proposal #4. Encourage supervision of acquittees on conditional release. Proposal 4 was an effort to encourage the use of conditional release as an evidence-based strategy to reduce recidivism and support patient's re-integration into the community. It suggests amendments to CGS §17a-593(f), such that in cases where the acquittee has demonstrated three or more years of uninterrupted tenure on conditional release, the burden of proof should shift from the acquittee to prove their non-dangerousness to the state to prove (by clear and convincing evidence) the acquittee's continued current dangerousness as a result of psychiatric disabilities.

While there was support for the idea that "the treatment system should be encouraged to work toward conditional release to the extent possible that is consistent with public safety" (see Proposal #4b below),

the specific suggestion of shifting the burden after three or more years of uninterrupted tenured had mixed reviews, with 8 voting members supporting it and 4 voting members opposing it.

Supporters of the proposal noted that acquittees with lengthy commitments will not benefit from the shift of the burden of proof to the state at the end of their commitment (see Proposal #5 below) and that conditional release should be encouraged as a means of reducing risk.

Those who opposed the proposal noted the arbitrary nature of the time parameters of this proposal; that time spent on conditional release, by itself, does not denote mitigation of risk; and that other variables must be considered.

Proposal #4b. Encourage supervision of acquittees on conditional release (revised). This proposal only puts forward the recommendation that "the treatment system should be encouraged to work toward conditional release to the extent possible that is consistent with public safety."

There was significant, but not unanimous, support for this proposal, with 11 voting members supporting it, and 1 voting member opposing it. The opposing viewpoint was not further elaborated in the voting process.

Proposal #5. Distinguish early release hearings from re-commitment hearings in statute. Proposal 5 suggests statutory amendments to codify the 1994 decision of the Connecticut Supreme Court in *State v. Metz*, 230 Conn. 400. The Supreme Court ruled that once an acquittee reaches the end of the original court-imposed term of commitment, the burden of proof must shift from the acquittee to the state "to show by clear and convincing evidence that the acquittee is currently mentally ill and dangerous to himself or herself or others or gravely disabled" (p. 425).

This proposal recommends that CGS §17a-593 should be amended to clearly distinguish the two types of hearings and their respective burdens and standards to be consistent with case law articulated in the *Metz* decision: an application for discharge prior to expiration of the original commitment (acquittee's burden by preponderance of the evidence), and the state's application for continued commitment at the expiration of the original commitment (state's burden by clear and convincing evidence).

Possible language to effectuate this amendment is as follows:

> **Sec. 17a-593. (Formerly Sec. 17-257n). Court order to discharge acquittee from custody.**
> (f) After receipt of the board's report and any separate examination reports, the court shall promptly commence a hearing on the recommendation or application for discharge or petition for continued commitment. At [the] a hearing on the recommendation or application for discharge, the acquittee shall have the burden of proving by a preponderance of the evidence that the acquittee is a person who should be discharged. At a hearing on the state's attorney's petition for continued commitment, the state shall have the burden of proving by clear and convincing evidence that the acquittee has psychiatric disabilities and is currently a danger to self or others as a result of those psychiatric disabilities.
> [x] = proposed deleted material; underline = proposed new material

There was significant, but not unanimous, support for this proposal, with 11 voting members supporting it, and 1 voting member opposing it. The opposing viewpoint was not further elaborated in the voting process.

Proposal #6. Eliminate recommitment to the PSRB in favor of civil commitment when warranted. Proposal 6 is related to ending the possibility of recommitment to the PSRB in favor of the use of civil commitment. This proposal was also the recommendation of the CVH/WFH Task Force which stated, "We strongly disagree with this never-ending cycle of re-commitment and recommend that CGS §17a-593 be amended to remove this cycle" (p. 13). As noted above (under Proposal #1), the civil commitment system is not the same as the system for commitment to the PSRB. Civil commitment hearings are heard in probate court, which does not hold public hearings, and would not permit media access or involvement of victims in the hearings. There is also no process for conditional release in the civil commitment structure and no monitoring of an individual once discharged to the community. This is the process that is followed for involuntary commitments to the hospital under CGS §17a-497 through CGS §17a-501.

In Oregon, the only other state with a PSRB and the model for Connecticut's PSRB, there is no similar procedure to petition for continued commitment. As noted in the section above on Processes in Other Jurisdictions, Oregon has a much higher percentage of acquittees being monitored and receiving care in the community than does Connecticut (58% vs. 25.5%). Oregon considered establishing a re-commitment process, but decided not to do so because of the likely effects on length of hospitalization and percentages of acquittees in institutional settings. The available data about recommitments and discharges from the PSRB were presented above in the background discussion of Task Force Recommendations 1 and 2.

The working group did not have consensus on this proposal, with 8 voting members supporting it, and 4 opposing it. Supporters of the proposal noted that the Oregon model produces a system where more acquittees receive care in the community rather than in the hospital, and have shorter lengths of stay in the hospital.

Those who opposed the proposal noted the absence of conditional release for civil patients and the value that monitored conditional release and support services have for mitigating risk for outpatients. They also noted the significant differences between the civil/probate system and the PSRB system, including the inability of victims, state's attorneys, and the public and media to participate in probate court hearings or be made aware of probate court decisions.