REPORT OF THE
DEPARTMENT OF MENTAL HEALTH,
MENTAL RETARDATION AND
SUBSTANCE ABUSE SERVICES ON

The Management and Release of Individuals Found Not Guilty by Reason of Insanity

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 29

COMMONWEALTH OF VIRGINIA
RICHMOND
1991

STUDY COMMITTEE MEMBERS

Russell C. Petrella, Ph.D.
Director of Mental Health Services
Department of Mental Health, Mental Retardation and Substance Abuse Services

Susan C. Ward, J.D.
Assistant Director, Office of Forensic Services
Department of Mental Health, Mental Retardation and Substance Abuse Services

Tamson L. Six, M.Ed.
Special Projects Coordinator, Office of Forensic Services
Department of Mental Health, Mental Retardation and Substance Abuse Services

Richard L. Elliott, M.D.
Medical Director, Central State Hospital

Sue C. Lewis, R.N.
Forensic Unit Director, Central State Hospital

James C. Dimitris, M.D.
Forensic Unit Medical Director, Central State Hospital

Joan Freeman, M.S.W.
Social Worker, Forensic Unit, Central State Hospital

Kendra Pugh, Psy.D.
Psychologist, Forensic Unit, Central State Hospital

David Rawls, Ph.D.
Chief Psychologist, Forensic Program, Western State Hospital

Richard Mears, Ph.D.
Director, Psychology Services
Southwestern Virginia Mental Health Institute

Leo E. Kirven, Jr., M.D.
Director, Forensic and Court Services
Eastern State Hospital

The Honorable W. Edward Meeks, III
Commonwealth Attorney, Amherst County

Lundi S. Martin
Executive Director, Richmond Community Services Board

Dennis Cropper, Ph.D.
Coordinator of Outpatient Services
New River Valley Community Services Board

Judith R. O'Neil
Program Coordinator, Forensic Unit
Woodburn Center for Community Mental Health

James Stratoudakis, Ph.D
Director, Mental Health
Fairfax/Falls Church Community Services Board

The Honorable Richard J. Jamborsky
Judge, Fairfax Circuit Court

W. Lawrence Fitch, J.D.
Director, Forensic Evaluation, Training and Research Center
Institute of Law, Psychiatry and Public Policy
University of Virginia

Gail Y. Browne, Ph.D.
Member, Virginia Parole Board

TABLE OF CONTENTS

THE MANAGEMENT AND RELEASE OF INDIVIDUALS FOUND NOT GUILTY BY REASON OF INSANITY

EXECUTIVE SUMMARY

The 1990 General Assembly requested, pursuant to House Joint Resolution No. 68, that the Department of Mental Health, Mental Retardation and Substance Abuse Services study the management and release of persons found not guilty by reason of insanity (NGRI). The resolution requests the participation of representatives of the judiciary, defense bar, Commonwealth's attorneys, and the community services boards. The legislature directs that the Department complete its study in time to submit its findings and recommendations to the Governor and the 1991 Session of the General Assembly.

The Department, through its experience in the management of insanity acquittees in its facilities and information provided by the monitoring system, has identified the following issues, on which the study has focused:

- The clarity of the statutory guidance provided to the courts and mental health professionals for management of insanity acquittees.

- The current law's effectiveness in addressing and balancing clinical and public safety issues.

- The adequacy of current criteria for increasing the level of freedom available to insanity acquittees.

- The effectiveness of current treatment in preparing patients for gradual reintegration into the community.

- The adequacy of release provisions, especially the availability of conditional release options and the authority to rehospitalize upon violation of conditions.

- The appropriate locus for decision-making responsibility regarding management and disposition of insanity acquittees, including an examination of the feasibility of creation of an independent review board which manages and monitors evaluation, treatment, and release of insanity acquittees and advises the court on the disposition of these cases.

RECOMMENDATIONS

Temporary Custody and Evaluation

The post-acquittal pre-commitment evaluation should be conducted by two mental health professionals skilled in the diagnosis of mental illness and qualified by training and experience to perform forensic evaluations, one of whom shall be a psychiatrist and one a psychologist. Such psychologist shall be qualified as a licensed clinical psychologist or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services.

The Commissioner should appoint both evaluators, at least one of whom is not employed by the hospital in which the acquittee is confined for treatment.

The evaluators shall conduct their examination and report their findings separately.

The evaluators should complete their evaluations and submit their findings to the court within forty-five days of the Commissioner's assumption of custody. If either evaluator recommends conditional release of the acquittee, the court must extend the evaluation period to permit the hospital and appropriate community services board to prepare a discharge plan prior to the hearing.

The acquittee's attorney, the Commonwealth's attorney for the jurisdiction where the person was acquitted and the community services board serving the locality where the acquittee was acquitted should be apprised of the results of the evaluations.

Commitment

The commitment hearing should be scheduled on an expedited basis, given priority in scheduling over pending civil matters before the court. The matter may be continued on motion of either party for good cause shown.

If counsel has been appointed to represent the acquittee in trial for charges of which he was acquitted, such attorney should continue to represent the acquittee in post-acquittal commitment proceedings unless relieved of such representation by the court.

The court shall commit the acquittee if it finds that he is in need of inpatient hospitalization. The court's determination shall be based on its consideration of (i) the extent to which the acquittee suffers from mental illness or mental retardation and the nature of such disability, (ii) the likelihood that the acquittee will engage in conduct presenting substantial risk of bodily harm to other persons or to himself in the foreseeable future, (iii) the likelihood that the acquittee can be adequately controlled with

supervision and treatment on an outpatient basis, and (iv) such other factors as the court deems relevant to the issue of the need for inpatient hospitalization.

The terms "insane" and "dangerous" as used in the current statute should be eliminated.

If the court determines that an acquittee does not need inpatient hospitalization solely because of treatment or habilitation he is currently receiving, but the court is not persuaded that the acquittee will continue to receive such treatment or habilitation, it should be authorized to commit such acquittee for inpatient hospitalization.

Provision for appeal from a commitment order should be specifically included in the statute.

Confinement and Treatment

The Commissioner should be authorized to make interfacility transfers and treatment and management decisions regarding insanity acquittees in his custody without obtaining prior approval of or review by the committing court.

The Commissioner should notify in writing the Commonwealth's attorney for the committing jurisdiction of changes in any acquittee's courses of treatment which will involve authorization for the acquittee to leave the hospital grounds.

The committing court should conduct a formal judicial hearing at yearly intervals for five years and at biennial intervals thereafter to assess each confined acquittee's need for inpatient hospitalization.

Prior to the judicial review, the Commissioner should provide to the court a report of evaluation of the acquittee's condition and recommendations for treatment, to be prepared by a psychiatrist or psychologist who is currently treating the acquittee. Such psychologist shall be qualified as a licensed clinical psychologist or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services. Such psychiatrist and psychologist should be skilled in the diagnosis of mental illness. If such examiner recommends release or the acquittee requests further evaluation, the acquittee should be evaluated by a second person with such credentials who is not currently treating the acquittee, such evaluation to include an assessment of the acquittee's need for inpatient hospitalization.

If the court determines that release is appropriate, it should so order upon approval of a discharge plan jointly prepared by the hospital and the community services board.

The Commissioner should be authorized to delegate any of the duties and powers imposed on or granted to him with respect to the treatment and management of insanity acquittees in his custody. He may establish an administrative board composed of persons with demonstrated expertise in such matters, to which he may delegate such authority. The Department of Mental Health, Mental Retardation and Substance Abuse Services should assist any such board in its administrative and technical duties. Board members should serve without compensation and be provided with immunity from liability when performing their duties in the absence of intentional misconduct.

Escape of an acquittee from the custody of the Commissioner should be designated a crime to permit the application of criminal extradition procedures should the escapee leave the Commonwealth.

Section 37.1-134.5, which sets forth procedures for judicial authorization of treatment of persons incapable of consenting to treatment on their own behalf, should be amended to permit application of its provisions to authorize mental health treatment of forensic patients who object to treatment.

Release

While the Commissioner should retain the authority to petition for release of an acquittee at any time he believes he no longer needs hospitalization, the acquittee should be permitted to so petition only once each year in which no automatic annual judicial review takes place.

The evaluation process triggered by a petition for release should conform with that applied in precommitment evaluations.

Upon receipt of the reports of evaluation, the court should conduct a hearing on the petition, such hearing to be scheduled on an expedited basis, given priority over pending civil matters before the court.

The Commissioner should provide written notice of the release hearing to any victim submitting to him a written request for such notification at his last known address.

At the conclusion of the hearing, based upon the report and other evidence provided at the hearing, the court shall order the acquittee (i) released from confinement if he does not need inpatient hospitalization and does not meet the criteria for conditional release (see discussion below) and the court has approved a discharge plan jointly prepared by the hospital staff and the appropriate community services board, (ii) placed on conditional release if he meets the criteria for such release and the court has approved a discharge plan jointly prepared by the hospital staff and the appropriate community services board, or

(iii) retained in the custody of the Commissioner if he continues to require inpatient hospitalization.

Acquittees committed pursuant to the procedures set forth herein should be released only in accordance with applicable procedures governing release and conditional release.

Conditional Release

At any time the court considers the acquittee's need for inpatient hospitalization, it should place the acquittee on conditional release if it finds that (i) based on consideration of the factors which the court must consider in its commitment decision, he does not need inpatient hospitalization but is in need of outpatient treatment and/or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization, (ii) appropriate outpatient supervision and treatment are reasonably available, (iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified, and (iv) conditional release will not present an undue risk to public safety.

The court should impose such conditions on the acquittee which meet each acquittee's need for treatment and supervision and best serve the interests of justice and society.

The community services board serving the locality in which the acquittee will reside upon his conditional release should implement the conditional release plan and submit written reports to the court on the acquittee's progress and adjustment in the community no less frequently than every six months.

If at any time the committing court finds reasonable ground to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, he may order an evaluation of the person by a psychiatrist, licensed clinical psychologist, or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services, such psychiatrist or psychologist qualified by training and experience to perform forensic evaluations. If the court, based on the evaluation and after hearing evidence on the issue, finds by a preponderance of the evidence that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, the court may revoke the acquittee's conditional release and order him returned to the custody of the Commissioner.

When exigent circumstances do not permit compliance with revocation procedures set forth above, procedures similar to those governing emergency custody and temporary detention pursuant to § 37.1-67.1 should be applied to permit confinement for evaluation pending the revocation hearing. Following the hearing, if the court determines, based on the evidence presented at the hearing, that the acquittee has violated the conditions of his release or is no longer a proper subject for conditional release and is in need of inpatient hospitalization, the court shall revoke the acquittee's conditional release and place him in the custody of the Commissioner. When any insanity acquittee on conditional release is taken into emergency custody, detained and/or hospitalized, such action shall be considered to have been taken pursuant to provisions governing insanity acquittees, notwithstanding the fact that his status as an insanity acquittee was not known at the time of custody, detention or hospitalization; detention or hospitalization of such acquittee pursuant to provisions of law other than those applicable to insanity acquittees shall not render such detention or hospitalization invalid. If a person's status as an insanity acquittee on conditional release is not recognized at the time of emergency custody or detention, at the time his status as such is verified, the provisions applicable to such persons shall be applied.

If an acquittee is returned to the custody of the Commissioner for inpatient treatment pursuant to revocation proceedings, and his condition improves to the degree that, within thirty days of resumption of custody following the hearing, the acquittee, in the opinion of hospital staff treating the acquittee, is an appropriate candidate for conditional release, he may be with the approval of the court conditionally released as if revocation had not taken place. If treatment is longer than thirty days in duration, the acquittee shall be returned to the custody of the Commissioner for a period of hospitalization and treatment which is governed by the provisions applicable to committed acquittees.

The committing court may modify conditions of release or remove conditions placed on release, ie, release the acquittee unconditionally, upon petition of the supervising community services board, the Commonwealth's attorney, or the acquittee or upon its own motion based on the reports of the supervising community services board.

The acquittee's opportunities to petition for modification or removal of conditions should be limited to permit annual petitions commencing six months after the conditional release order is issued.

As it deems appropriate based on the report provided by the supervising community services board and any other evidence presented to it, the court may issue a proposed order for modification or for removal of conditions. The court shall provide notice of the order, and of the right to object to it within ten days of its

issuance, to the acquittee, the supervising community services board, and the Commonwealth's attorneys for the committing jurisdiction and for the jurisdiction where the acquittee is residing on conditional release. The proposed order shall become final if no objections are filed within ten days of its issuance. If there is objection, the court shall conduct a hearing at which the acquittee, the Commonwealth's attorney, and the supervising community services board have an opportunity to present evidence challenging the proposed order. The court may require a representative of the supervising community services board to present oral testimony at the hearing. At the conclusion of the hearing, the court shall issue an order specifying conditions of release or removing existing conditions of release.

THE MANAGEMENT AND RELEASE OF INDIVIDUALS FOUND NOT GUILTY BY REASON OF INSANITY

INTRODUCTION

Authority for the Study

The 1990 General Assembly requested, pursuant to House Joint Resolution No. 68, that the Department of Mental Health, Mental Retardation and Substance Abuse Services study the management and release of persons found not guilty by reason of insanity (NGRI). The resolution requests the participation of representatives of the judiciary, defense bar, Commonwealth's attorneys, and the community services boards. The legislature directs that the Department complete its study in time to submit its findings and recommendations to the Governor and the 1991 Session of the General Assembly.

Issues Presented

When a court determines that a criminal defendant who has raised an insanity defense cannot be held responsible for his action because insanity or mental retardation have rendered him unable to appreciate the wrongfulness of his conduct or conform to the law, the court must acquit him of the criminal charges against him. Such individuals, who have acknowledged committing prohibited acts but who have been and may continue to be mentally disabled, present special management problems to the mental health and criminal justice systems. In order to successfully supervise these cases, these two systems must work together to assess, balance and integrate public safety interests and the acquittee's clinical needs and legal rights. This goal is relatively easily met in the hospital setting, where authorities have control of the patient and his treatment program and interactions. However, effective treatment should arguably include efforts to enhance the acquittee's reintegration into the community whenever possible. Much more difficult issues arise in designing a management system which addresses this goal while serving the interests of the public and the acquittee.

In Virginia, the court places insanity acquittees in the custody of the Department of Mental Health, Mental Retardation and Substance Abuse Services for evaluation and treatment of their mental health needs. However, the court retains jurisdiction over them, and the Department must seek court approval of management and release decisions affecting these patients. Administrative and judicial decision-making is guided to some extent by state statute. In addition, the Department has developed guidelines for evaluation, treatment and management of NGRI acquittees in an attempt to clarify policy for state psychiatric hospital administrators and staff. Ambiguities and omissions in these provisions have become apparent, however, particularly since the Department established

in 1988 the NGRI Patient Monitoring System. The system was developed to monitor the movement of NGRI patients through the mental health and criminal justice systems. The system contains demographic and anecdotal information submitted by the forensic coordinators at each facility from the time of admission to final discharge. All significant changes of patient status are reported and the system tracks all communications with the committing court. Data reported to the system demonstrate a lack of uniformity in procedures such as those governing issuance of grounds passes, submission of annual reports to the court, and transfer to civil status.

The Department, through its experience in the management of insanity acquittees in its facilities and information provided by the monitoring system, has identified the following issues, on which the study has focused:

- The clarity of the statutory guidance provided to the courts and mental health professionals for management of insanity acquittees.

- The current law's effectiveness in addressing and balancing clinical and public safety issues.

- The adequacy of current criteria for increasing the level of freedom available to insanity acquittees.

- The effectiveness of current treatment in preparing patients for gradual reintegration into the community.

- The adequacy of release provisions, especially the availability of conditional release options and the authority to rehospitalize upon violation of conditions.

- The appropriate locus for decision-making responsibility regarding management and disposition of insanity acquittees, including an examination of the feasibility of creation of an independent review board which manages and monitors evaluation, treatment, and release of insanity acquittees and advises the court on the disposition of these cases.

OVERVIEW OF VIRGINIA'S NGRI PATIENT POPULATION

The NGRI Patient Monitoring System, established in 1988, provides demographic information to the Department on insanity acquittees in state facilities. In June, 1990, there were 145 patients in state hospitals who had been acquitted of criminal charges by reason of insanity. Sixty-nine percent of that population was hospitalized at Central State Hospital, and about half of those

were confined in the Forensic Unit. Western State and Eastern State Hospitals were each treating about 11% of the acquittees in the system, and the remainder were at Southwestern and Southern Virginia Mental Health Institutes and Piedmont Geriatric Hospital. Eighty-six percent of the population was male. About 58% were black, 41% white, and one patient's race was designated as "other." Over 50% of the inpatient NGRI population were between 25 and 39 years of age; two-thirds of the total were between 20 and 44 years of age.

There were forty-four new NGRI admissions during 1989. Of the thirty-two males admitted, thirteen were black, eighteen white and one was "other." The twelve females admitted included eight who were black, three white, and one "other." Eighteen patients were discharged in 1989. For those discharged patients acquitted of misdemeanors, their lengths of stay were relatively short--four to seven months. For more serious offenses involving violent acts, length of stay varied from a few months to 89 months.

Of the 145 acquittees on inpatient status, the largest group--thirty-three or 23%--was those acquitted of murder. The next largest category, numbering 25, was those acquitted of some form of assault. About 80% of the inpatient NGRI population was diagnosed as psychotic.

METHODOLOGY

To address the issues before it, the Department organized a committee which included representatives of mental health, legal and judicial interests currently managing insanity acquittees. Specifically, participants included representatives of the Department's Office of Forensic Services; administrators, physicians, psychologists, and social workers from the state mental health facilities treating insanity acquittees; administrators and clinical staff representing the Virginia Association of Community Services Boards; a member of the Virginia Parole Board; a representative of the Virginia Association of Commonwealth's Attorneys; a circuit court judge appointed by the Supreme Court of Virginia; and a representative from the Institute of Law, Psychiatry and Public Policy. Staff representing the Office of the Attorney General attended each meeting. The Department solicited the participation of the criminal defense bar through the Criminal Law Section of the Virginia State Bar, which cooperated with efforts to secure a representative from its membership. While these efforts were unsuccessful, the Department kept the staff of the Criminal Law Section apprised of its progress throughout the study.

The committee held four day-long meetings. The Department solicited the attendance and contributions of individuals and organizations around the state with expertise and interest in the

issues before it by providing notice of each meeting to key Department staff; the Departments of Rehabilitative Services, Social Services, Medical Assistance Services, and Rights of Virginians with Disabilities; the statewide bar associations; the American Civil Liberties Union of Virginia; the Virginia State Sheriffs Association; the Virginia Association of Chiefs of Police; mental health and mental retardation advocacy groups; key legislators; and clinical and other staff of state mental health facilities who have expertise and interest in forensic issues.

The committee confined its deliberations to issues arising after the court's NGRI finding but considered all post-adjudication matters, including issues related to post-acquittal evaluation, commitment, confinement and treatment, and conditional and unconditional release. The committee also considered assigning certain treatment and management decisions to authorities other than the court and considered whether procedures governing treatment and management of insanity acquittees should apply only to those who pose a threat to public safety.

The committee members drew on their extensive collective training and experience in examining the complex issues before it. The committee also reviewed current Virginia law and practice and other state's applicable laws and procedures. Of particular interest were model programs in other states, especially the independent review boards operating in Oregon and Connecticut. Model commitment and management schemes provided a basis for discussion, with the committee focusing particularly on the special commitment process developed by the American Bar Association in its Criminal Justice Mental Health Standards. The committee reviewed examinations of these issues undertaken in the Commonwealth in the past, especially the work of the Insanity Defense Plea Task Force, which reported to the Secretary of Human Resources in November, 1982. The committee reviewed current legal and clinical research on the issues, particularly findings regarding the prediction of dangerousness and the safety and effectiveness of community treatment for this population. The committee was able to apply data demonstrating characteristics of insanity acquittees in Virginia and practices in their management, available from the NGRI Patient Monitoring System, as it formulated its recommendations.

FINDINGS AND RECOMMENDATIONS

TEMPORARY CUSTODY AND EVALUATION

Current Law and Policy

Upon acquittal by reason of insanity or mental retardation, the defendant is placed in the temporary custody of the Commissioner of the Department of Mental Health, Mental Retardation and

Substance Abuse Services. The Department's policy is to place the defendant in a state facility which meets both clinical and security needs. Persons acquitted of felonies are usually placed in the Forensic Unit at Central State Hospital. The statute directs the court to appoint three physicians or two physicians and a clinical psychologist with skill in the diagnosis of mental disability to examine the defendant to determine whether he is currently "insane or mentally retarded and...whether his discharge would be dangerous to the public peace or safety or to himself," and to report such findings to the court. The statute defines "mentally retarded" in this context as describing a person who has been "adjudicated legally incompetent because of mental deficiency by a circuit court in which he is charged with a crime and who is also found to lack the mental condition to enable him to be discharged without danger to the public peace or safety or to himself." Departmental guidelines suggest that the examination and report should be completed within a reasonable time, not to exceed sixty days, unless otherwise specified by the court. The Department also recommends that examiners not be members of the defendant's treatment team.

Recommendations

The post-acquittal pre-commitment evaluation should be conducted by two mental health professionals skilled in the diagnosis of mental illness and qualified by training and experience to perform forensic evaluations, one of whom shall be a psychiatrist and one a licensed psychologist. Such psychologist shall be qualified as a licensed clinical psychologist or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services. Current law requires examination of insanity acquittees by only two evaluators prior to release from hospitalization but provides for examination by three evaluators prior to commitment. The committee believes that two evaluators will provide adequate precommitment evaluation and provide for consistency throughout the statute. However, the expertise of both a psychiatrist and psychologist should be represented in the evaluation.

The Commissioner should appoint both evaluators, at least one of whom is not employed by the hospital in which the acquittee is confined for treatment. The Commissioner is likely to be in a better position than the court to identify qualified evaluators employed either within and outside the state hospital system. In an effort to balance the importance of an independent assessment of the acquittee's condition against the issues of availability of evaluators in certain geographic areas, the committee agreed that no more than one of the evaluators be employed by the hospital in which the acquittee is primarily confined.

The evaluators shall conduct their examination and report their findings separately. Currently, evaluators often submit one report signed by all three evaluators. Separate reports of examinations

will ensure that the court receives the best representation of professional opinion on the acquittee's condition.

The evaluators should complete their evaluations and submit their findings to the court within forty-five days of the Commissioner's assumption of custody. If either evaluator recommends conditional release of the acquittee, the court shall extend the evaluation period to permit the hospital and appropriate community services board to prepare a discharge plan prior to the hearing. The statute currently does not specify the time within which the evaluation must be completed; Departmental guidelines suggest that reports should be submitted to the court within sixty days. The committee agreed that a time limit is appropriate and that forty-five days provided a reasonable period within which to conduct a thorough examination if the court provides additional time to address release issues in appropriate cases.

The acquittee's attorney, the Commonwealth's attorney for the jurisdiction where the person was acquitted and the community services board serving the locality where the acquittee was acquitted should be apprised of the results of the evaluations.

COMMITMENT

Current Law and Policy

Upon receipt of the report of the evaluation conducted after acquittal, the statute directs the court to conduct a hearing on the issues addressed in the report. If, based on the report and the testimony of the examiners, the court is satisfied that "the defendant is insane or mentally retarded or that his discharge would be dangerous to public peace and safety or to himself, the court shall order him to be committed to the custody of the Commissioner." The defendant can be so committed if he meets either of these criteria alone. Otherwise, the defendant is released from custody. If committed, the patient is placed in an appropriate state facility. As with placements during temporary custody, Department policy suggests that placement decisions be based on clinical needs and security requirements, with most patients acquitted of felonies being placed in the Forensic Unit at Central State Hospital.

Recommendations

The commitment hearing should be scheduled on an expedited basis, given priority in scheduling over pending civil matters before the court. The matter may be continued on motion of either party for good cause shown. Reports submitted to the NGRI Patient Monitoring System indicate that frequently, when the evaluation report is submitted to the court, the hearing is not scheduled in a timely fashion. Rather than designate a period within which a hearing must

be held, the committee determined that the matter should be given priority in scheduling, with opportunity provided for continuance if either party needs additional time for preparation. Such a provision will expedite the hearing without raising the question of consequences should the hearing not be held within the designated period.

If counsel has been appointed to represent the acquittee in trial for charges of which he was acquitted, such attorney should continue to represent the acquittee in post-acquittal commitment proceedings unless relieved of such representation by the court. Representation in the commitment process will be most effective if provided by counsel who is familiar with the acquittee's case. An acquittee with privately retained counsel can ensure consistent representation if desired; acquittees with court appointed counsel should have the same option. If the acquittee or his court-appointed counsel objects to such representation, the court should be authorized to permit other arrangements.

The court shall commit the acquittee if it finds that he is in need of inpatient hospitalization. The court's determination shall be based on its consideration of (i) the extent to which the acquittee suffers from mental illness or mental retardation and the nature of such disability, (ii) the likelihood that the acquittee will engage in conduct presenting substantial risk of bodily harm to other persons or to himself in the foreseeable future, (iii) the likelihood that the acquittee can be adequately controlled with supervision and treatment on an outpatient basis, and (iv) such other matters as the court deems relevant to the issue of the need for inpatient hospitalization. Concerns have been raised about the current commitment standard, which permits commitment on the basis either of mental disability or dangerousness. The hospitalization of persons solely because they have been determined to be dangerous arguably subverts the primary treatment focus of the psychiatric hospital. However, the Fourth Circuit in the Virginia case of Harris v. Ballone, 681 F 2d 225 (4th Cir. 1982) upheld Virginia's commitment scheme, finding that because the acquittee has committed "at least one dangerous act," due process is not denied by confinement of acquittees who are no longer insane but are dangerous. Other state and federal courts have decided this issue differently, consistently requiring a showing of mental impairment in addition to dangerousness to justify commitment of insanity acquittees. In 1988 the Fifth Circuit held unconstitutional a Louisiana statute permitting commitment of insanity acquittees on the basis of dangerousness alone. Francois v. Henderson, 850 F. 2d 231 (5th Cir. 1988). Concerns about the hospitalization of persons who are not mentally ill must also be balanced, however, against public safety issues raised by the lack of other resources for confinement and management of dangerous insanity acquittees. The committee notes that current commitment standards also permit the hospitalization of mentally retarded acquittees for whom treatment may not be effective and who then may be subject to post-acquittal

commitment indefinitely. In attempting to balance these concerns, the committee agreed that the standard for commitment should be a finding that the acquittee needs inpatient hospitalization. The court should weigh the factors relevant to this need to determine whether commitment is appropriate.

The terms "insane" and "dangerous" as used in the current statute should be eliminated. The term "insane" is a legal term which focuses on the acquittee's ability to distinguish right from wrong; the term "mentally ill," defined in § 37.1-1, focusing on such clinical issues as disability and treatment, is more appropriate with respect to commitment considerations. The term "dangerous" is ambiguous and exacerbates difficulties in predicting future violence. The term should be replaced with a standard requiring a finding on the likelihood that the acquittee will engage in conduct presenting substantial risk of bodily harm to other persons or to himself in the foreseeable future.

If the court determines that an acquittee does not need inpatient hospitalization solely because of treatment or habilitation he is currently receiving but the court is not persuaded that the acquittee will continue to receive such treatment or habilitation, it may commit such acquittee for inpatient hospitalization. Because of the risk to public safety presented by an acquittee who discontinues treatment, which often includes antipsychotic medication, necessary to maintain his adjustment outside the hospital, the court should be authorized to commit an acquittee who it is not persuaded will continue such treatment or habilitation. The court may also place such acquittees on conditional release (see discussion below), revoking release if the condition of receipt of treatment is breached.

Provision for appeal from a commitment order should be specifically included in the statute. The Commonwealth should have the same right to appeal as does the acquittee. The current statute specifically confers jurisdiction on the Court of Appeals to hear appeals only from release decisions. Because commitment and release proceedings are deemed civil, the Commonwealth should be permitted to appeal errors in the same manner as the acquittee.

CONFINEMENT AND TREATMENT

Current Law and Policy

The Department provides its full range of services to insanity acquittees once they are committed. Management of such patients is governed by Department policy set forth in The NGRI Manual - Guidelines for the Management of Patients Found Not Guilty by Reason of Insanity. The Department defines its patient management responsibilities as including evaluation and treatment; compliance with court reporting requirements; and ensuring security of

patients, hospital staff and the public. To effectively meet these responsibilities, the Department, through its Office of Forensic Services, has appointed Forensic Coordinators in each of its facilities confining forensic patients and has created the NGRI Patient Monitoring System. The Forensic Coordinators ensure compliance with court reporting requirements and coordinate adherence to applicable statutes, Department policies and court orders. The NGRI Patient Monitoring System is a management information system which monitors movement of committed acquittees through the mental health and criminal justice systems. The Forensic Coordinators submit to the system demographic and anecdotal information on each patient from admission to final discharge. All significant changes in patient status are reported and the system tracks all communications with the committing court.

The current statute requires the facility director to submit to the court annually, beginning six months after the date of confinement, a report of the acquittee's condition. The placement of this provision in the statute raises some question as to whether it applies to all committed acquittees or only to those for whom the court has authorized treatment as a civil patient. The Department has interpreted the provision to apply to all acquittees.

Recommendations

The Commissioner should be authorized to make interfacility transfers and treatment and management decisions regarding insanity acquittees in his custody without obtaining prior approval of or review by the committing court. The Attorney General has held in an opinion to the Commissioner (June 17, 1988) that the Commissioner has authority to make treatment and management decisions, including interfacility transfers, without prior approval or review by the committing court. However, the Department has by policy required court approval, by written request, of all changes in placement or level of security. However, data collected through the NGRI Patient Monitoring System indicate that facility staff do not consistently identify the treatment and management decisions which require court approval nor follow the procedures for obtaining such approval. The committee agreed that the Commissioner or his designee should exercise control over such decisions, which are clinical in nature, in order to eliminate inconsistencies in practice and avoid delays resulting from court involvement.

The Commissioner should notify in writing the Commonwealth's attorney for the committing jurisdiction of changes in any acquittee's course of treatment which will involve authorization for the acquittee to leave the hospital grounds. Such notification provides some protection for the public by notifying an official with knowledge of the acquittee's history and offense of treatment plans which may bring the acquittee into the community.

The committing court should conduct a formal judicial hearing at yearly intervals for five years and at biennial intervals thereafter to assess each confined acquittee's need for inpatient hospitalization. The annual report currently required by statute provides periodic information to the court on the acquittee's clinical condition and therefore an opportunity for the court to review the appropriateness of hospitalization of an acquittee. The committee was concerned, however, that this review is inadequate to protect acquittees who are unaware of their right to petition for release and therefore may be deprived indefinitely of a full hearing on the question of the need for hospitalization when such hearing may be appropriate. The committee, therefore, agreed that each acquittee should receive an automatic formal judicial hearing each year for five years. At that time, hospitalization may be reasonably considered long-term and such hearings should be necessary only on a biennial basis. With the provision of an automatic hearing, the acquittee should be permitted to petition for release only in those years when a biennial judicial review is not held.

Prior to the judicial review, the Commissioner should provide to the court a report of evaluation of the acquittee's condition and recommendations for treatment, to be prepared by a psychiatrist or licensed psychologist who is currently treating the acquittee. Such psychologist shall be qualified as a licensed clinical psychologist or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services. Such psychiatrist and psychologist should be skilled in the diagnosis of mental illness and qualified by training and experience to perform forensic evaluations. If such examiner recommends release or the acquittee requests release, the acquittee should be evaluated by a second person with such credentials who is not currently treating the acquittee, such evaluation to include an assessment of the acquittee's need for inpatient hospitalization. A meaningful review requires provision to the court of thorough current information on the acquittee's clinical condition. If release of the acquittee is not contemplated, the committee agreed that one evaluation by a qualified mental health professional was adequate. However, if release is to be considered at the review hearing, the committee believed that a second evaluation would provide a sound basis for the court's decision. Such a procedure would conform release procedures at the time of the review hearing to those recommended upon petition for release, discussed below.

If the court determines following the review hearing that release is appropriate, it should so order upon approval of a discharge plan jointly prepared by the hospital and the community services board. This practice, now suggested as policy, should be set forth by statute.

The Commissioner should be authorized to delegate any of the duties and powers imposed or granted to him with respect to the treatment

and management of insanity acquittees in his custody. He may establish an administrative board composed of persons with demonstrated expertise in such matters, to which he may delegate such authority. The Department of Mental Health, Mental Retardation and Substance Abuse Services should assist any such board in its administrative and technical duties. Board members should serve without compensation and be provided with immunity from liability when performing their duties in the absence of intentional misconduct. The committee examined and discussed a variety of models for decision-making with respect to management of insanity acquittees. In some states, the courts make all decisions affecting the acquittee from the time of acquittal to unconditional release. Oregon, in contrast, has established a Psychiatric Security Review Board, an administrative multidisciplinary group which assumes jurisdiction of insanity acquittees from the court at the time of acquittal. The board is responsible for the periodic review of all committed acquittees and is authorized to issue orders for discharge and conditional release and to modify commitment orders. Connecticut has created a similar board which monitors acquittees on conditional release and is authorized to modify conditions or discharge the acquittee from outpatient commitment. In Maryland, a combination of approaches has been developed. Outpatient acquittees are supervised by a statewide aftercare program, but the court retains ultimate decision-making authority. The committee discussed benefits and disadvantages of a range of models. Placing responsibility with the court for all decisions insulates treatment providers from liability for ultimate release decisions. The court, however, has limited time and expertise for examining the appropriateness of management decisions. A board can contribute a range of expertise and experience to the decision-making process. However, use of an independent board, while eliminating institutional biases, can require the expense of creation of a separate public agency. Liability issues must also be considered as private citizens are asked to make important decisions potentially affecting public safety. For these reasons, the committee recommends that changes in decision-making responsibility be made gradually. By permitting the Commissioner to delegate his authority over insanity acquittees in state hospitals to a "volunteer" board which has immunity from liability, a range of expertise can be applied to treatment and management decisions at minimum expense. The existing system of community services boards can assume monitoring responsibility for outpatients with the court assuming responsibility for community placement decisions. Such a scheme serves the economic and safety interest of the public and ensures that the acquittce receives effective treatment and supervision. Board responsibility can be expanded in the future after its initial effectiveness has been assessed.

Escape of an acquittee from the custody of the Commissioner should be designated a crime to permit the application of criminal extradition procedures should the escapee leave the Commonwealth. Forensic patients charged with or convicted of a crime designated

at least a Class 6 felony who escape from state mental health facilities and flee the Commonwealth can be returned through criminal extradition procedures. These provisions are inapplicable to insanity acquittees, however, unless they are subject to additional charges or convictions. Existing methods of apprehension and return of insanity acquittees who leave the Commonwealth are not uniformly effective. These include the Interstate Compact on Mental Health and the Uniform Act on the Extradition of Persons of Unsound Minds (§ 37.1-172 et seq). While "criminalizing" escape should be avoided and other methods of returning escaped insanity acquittees used when possible, a penal provision should be available to ensure that authority exists to apprehend and return such escaped patients when other methods fail.

Section 37.1-134.5, which sets forth procedures for judicial authorization of treatment of persons incapable of consenting to treatment on their own behalf, should be amended to permit application of its provisions to authorize mental health treatment of forensic patients who object to treatment. The statute currently permits judicial authorization for the administration of antipsychotic medication or electroconvulsive therapy to objecting patients only if they are subject to an involuntary commitment order issued under § 37.1-67.3. Therefore, patients committed to the custody of the Commissioner pursuant to criminal provisions may be so treated only through the human rights regulations promulgated by the State Board of Mental Health, Mental Retardation and Substance Abuse Services or through the appointment of a guardian, a costly and often unnecessarily intrusive process for the purposes of treatment decision-making.

RELEASE

Current Law and Policy

The statute authorizes both the director of the state hospital treating the committed acquittee and the acquittee himself to apply to the committing court for the acquittee's discharge. The director of the state hospital may apply for discharge whenever he is of the opinion that the acquittee is not insane or mentally retarded and that discharge will not pose a danger to the public peace or safety or to himself. Such determination, by administrative policy, is to be made by the treatment team, Forensic Coordinator, and other appropriate staff, based on a review of clinical status and an evaluation of potential dangerousness. The acquittee may apply for discharge "at yearly intervals commencing six months after the date of confinement."

Upon receipt of an application for discharge, the statute directs the court to appoint at least two psychiatrists, one of whom must be employed by a state mental hospital other than the one in which the acquittee is confined, to examine the acquittee and report as

to his mental condition within sixty days. The statute also requires that the Commissioner facilitate such examination by transferring the acquittee to the state mental hospital nearest where the court sits. Department policy suggests that examiners not be on the acquittee's treatment team.

If the court is satisfied from the report or testimony of the examiners that the acquittee is not insane or mentally retarded and that his discharge will not endanger public peace and safety or himself, then it shall order him discharged. If the court is not convinced that the acquittee meets the standards for discharge, it shall order a hearing to determine whether such standards are met. The statute specifies that the hearing is a civil proceeding and assigns the burden of proof to the acquittee. Depending on the court's determination at the hearing, the acquittee may be discharged or recommitted to the Commissioner's custody. Administrative policy requires that, prior to requesting discharge, the hospital director make appropriate arrangements with the community services board for follow-up care.

In lieu of discharge or recommitment, the statute provides a third option for disposition of an application for discharge. At the request of the Commissioner, the court may permit the acquittee "to be treated as a patient committed pursuant to §§ 37.1-67.1 through 37.1-67.4," subject to such conditions as the court may deem appropriate. Such individuals remain under the jurisdiction of the committing court, subject to further orders of the court. It is unclear on the face of the statute whether this provision authorizes a change in legal commitment status or simply provides additional treatment options for patients committed pursuant to § 19.2-181. In practice, this provision has operated as authority for conditional release, allowing discharge with supervision to ensure that the court's conditions are met.

While the statute does not specifically require or authorize the preparation of a discharge plan and its endorsement by the court for any discharged patient other than those on "civil status," in practice, the Department has required the hospital to prepare such a plan in all cases in collaboration with the community services board, and courts have traditionally incorporated the plans into discharge orders.

Departmental policy suggests that the community services board in the area of the acquittee's residence upon discharge provide appropriate services to discharged acquittees. The board serving the jurisdiction from which the acquittee was committed may provide assistance if appropriate.

The statute assigns jurisdiction over any action for discharge of a committed acquittee to the committing court only. Errors committed by the court in such actions are appealable to the Court of Appeals as in other criminal cases.

Recommendations

While the Commissioner should retain the authority to petition for release of an acquittee at any time he believes he no longer needs hospitalization, the acquittee should be permitted to so petition only once each year in which no annual judicial review takes place. With the provision of an annual formal judicial review of each acquittee's need for inpatient hospitalization for the first five years of commitment and biennial reviews thereafter, the acquittee will have an annual review of his case and condition without an annual opportunity to petition for release.

The evaluation process triggered by a petition for release should conform with that applied in precommitment evaluations. Currently the two processes differ with respect to the number and qualifications of evaluators and the findings which they are asked to make. Because the issues involved are the same, the procedures should be consistent.

Upon receipt of the reports of evaluation, the court should conduct a hearing on the petition, such hearing to be scheduled on an expedited basis, given priority over pending civil matters before the court. Reports submitted to the NGRI Patient Monitoring System indicate that frequently the evaluation report is submitted to the court but that the hearing is not scheduled in a timely fashion. Rather than designate a period within which a hearing must be held, the committee determined that the matter should be given priority in scheduling. Such a provision will expedite the hearing without raising the question of consequences should the hearing not be held within the designated period.

The Commissioner should provide written notice of the release hearing to any victim submitting to him a written request for such notification at his last known address. Public safety considerations prompt provisions for notification of appropriate parties when an acquittee may return to the community. The committee recommends notifying the Commonwealth's attorney whenever the acquittee's condition is to be reviewed by the court but endorses notification of victims only when release is contemplated pursuant to a release petition. This process balances public safety and the administrative difficulty which may be posed by victim notification.

At the conclusion of the hearing, based upon the report and other evidence provided at the hearing, the court shall order the acquittee (i) released from confinement if he does not need inpatient hospitalization and does not meet the criteria for conditional release (see discussion below), and if the court has approved a discharge plan jointly prepared by the hospital staff and the appropriate community services board, (ii) placed on conditional release if he meets the criteria for such release, or (iii) retained in the custody of the Commissioner if he continues

to require inpatient hospitalization. Preparation and approval of a discharge plan, now suggested as policy, should be set forth by statute.

Acquittees committed pursuant to the procedures set forth herein should be released only in accordance with applicable procedures governing release and conditional release. Hospitalized acquittees have on occasion been released on long-term convalescent status and ultimately discharged, circumventing formal release procedures. Such practice provided a means of monitoring community adjustment and rehospitalizing an acquittee if necessary. However, the enactment of conditional release procedures should eliminate the need for this practice. In any event, there is question as to whether the Department's convalescent leave policy, if currently in effect, applies to forensic patients. Patients have also been placed on an unofficial "conditional release" pursuant to § 19.2-181 (3) which authorizes the Commissioner to treat an acquittee "as a patient committed pursuant to §§ 37.1-67.1 through 37.1-67.4, subject to such limitations and restrictions as the court may deem appropriate." Because of ambiguities in the interpretation of this provision and its effect, the committee agreed that it should be eliminated and replaced with specific conditional release procedures, discussed below.

CONDITIONAL RELEASE

As in the criminal justice system, economic and humanitarian concerns have resulted in the development of conditional release programs for insanity acquittees. The American Law Institute pioneered this concept when it included such provisions in its 1962 Model Penal Code. Conditional release programs were endorsed by the National Mental Health Association's National Commission on the Insanity Defense in 1983. A large percentage of insanity acquittees are diagnosed with schizophrenia, which is not subject to cure but may be managed with appropriate treatment. Such persons may function adequately in the community but may for many years require periods of hospitalization for stabilization. Without conditional release, many patients have been denied the opportunity for release because of the risks involved in unsupervised release. While Virginia's statute does not provide for conditional release with a detailed statutory scheme, most states now do so. These programs are designed to serve public safety interests with close monitoring of the acquittee's treatment and adjustment in the community, allowing for prompt rehospitalization when the released acquittee does not comply with release conditions or becomes a safety risk.

Recommendations

At any time the court considers the acquittee's need for inpatient hospitalization, it should place the acquittee on conditional

release if it finds that (i) based on consideration of the factors which the court must consider in its commitment decision, he does not need inpatient hospitalization but is in need of outpatient treatment and/or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization, (ii) appropriate outpatient supervision and treatment are reasonably available, (iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified, and (iv) conditional release will not present an undue risk to public safety. The standard for conditional release provides for consideration of treatment and supervision needs, the availability of resources and services to permit compliance with conditions, the likelihood that the acquittee will comply with conditions, and public safety.

The court should impose such conditions on the acquittee which meet each acquittee's need for treatment and supervision and best serve the interests of justice and society. In some states, conditional release statutes dictate the conditions to which the court subjects the acquittee. The committee agreed that the court should instead have wide discretion in applying conditions to each acquittee's release so that it may serve all competing interests.

The community services board serving the locality in which the acquittee will reside upon his conditional release should implement the conditional release plan and submit written reports to the court on the acquittee's progress and adjustment in the community no less frequently than every six months. The system of community services boards, serving every locality in the Commonwealth, provides an existing resource to ensure that necessary services are provided, whether directly or by contract, to conditionally released acquittees, and to monitor and apprise the court of acquittees' adjustment.

If at any time the committing court finds reasonable ground to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, it may order an evaluation of the person by a psychiatrist, licensed clinical psychologist, or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services, such psychiatrist or psychologist qualified by training and experience to perform forensic evaluations. If the court, based on the evaluation and after hearing evidence on the issue, finds by a preponderance of the evidence that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, the court may revoke the acquittee's conditional release and order him returned to the custody of the Commissioner. A key element in a conditional

release scheme is the availability of procedures for prompt rehospitalization when the acquittee's condition requires it. Provisions are also needed to ensure court notification and review of allegations of the acquittee's noncompliance with conditions. The treatment needs and due process rights of the acquittee necessitate that an evaluation and hearing be provided quickly. The safety interests of the public require that acquittees believed to pose a risk to the community be taken into custody in a timely fashion.

When exigent circumstances do not permit compliance with revocation procedures set forth above, any judge as defined in § 37.1-1 or a magistrate may, upon the sworn petition of any responsible person or upon his own motion based upon probable cause to believe that an acquittee on conditional release has violated the conditions of his release or is no longer a proper subject for conditional release and that such acquittee requires inpatient hospitalization may issue an emergency custody order requiring any such acquittee within his judicial district to be taken into custody and transported to a convenient location to be evaluated by a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness to assess the need for hospitalization. A law enforcement officer who, based on his observation or the reliable reports of others, has probable cause to believe that any insanity acquittee on conditional release has violated the conditions of his release and is no longer a proper subject for conditional release and requires emergency evaluation to assess the need for inpatient hospitalization, may take such acquittee into custody and transport him to an appropriate location to assess the need for hospitalization without prior judicial authorization. Such evaluation shall be conducted immediately. The acquittee shall remain in custody until a temporary detention order is issued or until the person is released but in no event shall the period of custody exceed four hours. If it appears from all evidence readily available that the person has violated the conditions of his release or is no longer a proper subject for conditional release and that he requires emergency evaluation to assess the need for inpatient hospitalization, the judge as defined in § 37.1-1 or magistrate upon the advice of such person skilled in the diagnosis and treatment of mental illness, may issue an order of temporary detention authorizing the executing officer to place such person in an appropriate institution for a period not to exceed forty-eight hours prior to a hearing. Such forty-eight hour period may be extended to allow for intervening week-ends and holidays. The committing court or any general district court shall have jurisdiction to hear the matter. Prior to the hearing, the acquittee shall be examined by a psychiatrist, licensed clinical psychologist or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services, such psychiatrist and psychologist skilled in the diagnosis of mental illness, who shall certify as to whether the acquittee is in need of hospitalization for mental illness. Following the hearing, if

the court determines, based on the evidence presented at the hearing, that the acquittee has violated the conditions of his release or is no longer a proper subject for conditional release and is in need of inpatient hospitalization, the court shall revoke the acquittee's conditional release and place him in the custody of the Commissioner. When any insanity acquittee on conditional release is taken into emergency custody, detained and/or hospitalized, such action shall be considered to have been taken pursuant to provisions governing insanity acquittees, notwithstanding the fact that his status as an insanity acquittee was not known at the time of custody, detention or hospitalization; detention or hospitalization of such acquittee pursuant to provisions of law other than those applicable to insanity acquittees shall not render such detention or hospitalization invalid. If a person's status as an insanity acquittee on conditional release is not recognized at the time of emergency custody or detention, at the time his status as such is verified, the provisions applicable to such persons shall be applied. Emergency provisions are necessary which permit taking into custody an insanity acquittee who appears to require immediate hospitalization. Often, deterioration of an acquittee's condition or public safety threats posed by his behavior will not permit use of procedures governing hearing and rehospitalization described above. Procedures recommended herein conform substantially to those established for civil detention and commitment. Because it is likely that authorities may apprehend an acquittee and take him into emergency custody unaware of his status as an acquittee on conditional release, it is necessary to ensure application of appropriate provisions when the person's status as an acquittee becomes known.

If an acquittee is returned to the custody of the Commissioner for inpatient treatment pursuant to revocation proceedings, and his condition improves to the degree that, within thirty days of resumption of custody following the hearing, the acquittee, in the opinion of hospital staff treating the acquittee, is an appropriate candidate for conditional release, he may be with the approval of the court conditionally released as if revocation had not taken place. If treatment is longer than thirty days in duration, the acquittee shall be returned to the custody of the Commissioner for a period of hospitalization and treatment which is governed by the provisions applicable to committed acquittees. Because patients requiring rehospitalization while conditionally released frequently can be stabilized with antipsychotic medication or other treatment relatively quickly, procedures should provide for return to conditional release in such cases without requiring adherence to formal release procedures, which include petition, evaluation, development of discharge plan and release hearing.

The committing court may modify conditions of release or remove conditions placed on release, ie, release the acquittee unconditionally, upon petition of the supervising community services board, the Commonwealth's attorney, or the acquittee, or

upon its own motion based on the reports of the supervising community services board. While some states place a limit on the period of validity of release conditions, the committee agreed that conditional release status should continue as long as treatment and/or monitoring are needed.

The acquittee's opportunities to petition for modification or removal of conditions should be limited to permit annual petitions commencing six months after the conditional release order is issued. Because the community services board may petition for modification or removal of conditions at any time and the court may take such action on its own motion, the acquittee's right to review of his case is adequately protected without subjecting the court to unnecessarily repetitive petitions from the acquittee.

As it deems appropriate based on the report provided by the supervising community services board and any other evidence presented to it, the court may issue a proposed order for modification or for removal of conditions. The court shall provide notice of the order, and of the right to object to it within ten days of its issuance, to the acquittee, the supervising community services board, and the Commonwealth's attorneys for the committing jurisdiction and for the jurisdiction where the acquittee is residing on conditional release. The proposed order shall become final if no objections are filed within ten days of its issuance. If there is objection, the court shall conduct a hearing at which the acquittee, the Commonwealth's attorney, and the supervising community services board have an opportunity to present evidence challenging the proposed order. The court may require a representative of the supervising community services board to present oral testimony at the hearing. At the conclusion of the hearing, the court shall issue an order specifying conditions of release or removing existing conditions of release. Because the issue of the appropriateness of the acquittee's release to the community has been thoroughly reviewed in the prior review hearing or release hearing at which the conditional release order was issued, and cases requiring emergency attention should be handled pursuant to revocation provisions, public safety issues should not demand an automatic hearing when a petition for modification of conditions is filed. Therefore, such orders can be issued in these cases without a hearing unless one is specifically requested.

APPENDIX A

Legislative Proposals

The legislative proposals were prepared by staff based on the Study Committee's work.

HOUSE/SENATE BILL NO._____

A bill to amend and reenact §§ 19.2-182 and 37.1-67.1 of the Code of Virginia, to amend the Code of Virginia by adding in Chapter 11 of Title 19.2 an article numbered 2, consisting of sections numbered 19.2-182.2 through 19.2-182.11, and to repeal § 19.2-181, the amended, added and repealed sections relating to persons acquitted of criminal charges by reason of insanity.

Be it enacted by the General Assembly of Virginia:

1. That §§ 19.2-182 and 37.1-67.1 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Chapter 11 of Title 19.2 an article numbered 2, consisting of sections numbered 19.2-182.2 through 19.2-182.11, as follows:

§ 19.2-182. Representation by counsel in proceeding for commitment.--~~(a)~~ A. In any proceeding for commitment under this title, the judge before whom such proceeding is being held, or upon whose order such proceeding is held, shall ascertain if the person whose commitment is sought is represented by counsel. If such person is not represented by counsel, the judge shall appoint an attorney at law to represent such person in such proceeding. For his services rendered therein, the attorney shall receive a fee of twenty-five dollars to be paid by the State. If counsel has been appointed to represent the acquittee in trial for charges of which he was acquitted, such counsel shall continue to represent the acquittee in proceedings under Article 2 of this chapter unless relieved of such representation by the court.

~~(b)~~ B. Any attorney representing any person in any proceeding for commitment under this title shall, prior to such proceeding, personally consult with such person.

Article 2

Disposition of Persons Acquitted By Reason of Insanity

§ 19.2-182.2. Verdict of acquittal by reason of insanity to state the fact; temporary custody and evaluation.--When the defense is insanity of the defendant at the time the offense was committed, the jury shall be instructed, if they acquit him on that ground, to state the fact with their verdict, and the court shall place him in temporary custody of the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, hereinafter referred to in this article as the Commissioner, for evaluation as to whether the acquittee may be released with or without conditions or requires commitment. The evaluation shall be conducted by (i) one psychiatrist and (ii) one licensed clinical psychologist or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services. Such

psychiatrist or psychologist shall be skilled in the diagnosis of mental illness and mental retardation and qualified by training and experience to perform such evaluations. The Commissioner shall appoint both evaluators, at least one of whom shall not be employed by the hospital in which the acquittee is primarily confined. The evaluators shall determine whether the acquittee is currently mentally ill or mentally retarded and shall assess the acquittee and report on his condition and need for hospitalization with respect to the factors set forth in § 19.2-182.3 which the court must consider in making a decision regarding commitment of the acquittee for treatment. The evaluators shall conduct their examinations and report their findings separately. The evaluations shall be completed and findings reported to the court within forty-five days of the Commissioner's assumption of custody. Copies of the report shall be sent to the acquittee's attorney, the Commonwealth's attorney for the jurisdiction where the person was acquitted and the community services board serving the locality where the acquittee was acquitted. If either evaluator recommends conditional release of the acquittee, the court shall extend the evaluation period to permit the hospital in which the acquittee is confined and the appropriate community services board to jointly prepare a discharge plan prior to the hearing.

§ 19.2-182.3. Commitment.--Upon receipt of the evaluation report and discharge plan, as applicable, the acquitting court shall schedule the matter for hearing on an expedited basis, giving the matter priority over pending civil matters before the court, to determine the appropriate disposition of the acquittee. The matter may be continued on motion of either party for good cause shown. The acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. The proceeding shall be deemed civil. At the conclusion of the hearing, the court shall commit the acquittee if it finds that he is need of inpatient hospitalization. This decision shall be based on consideration of the following factors:

1. The extent to which the acquittee is mentally ill or mentally retarded, as those terms are defined in § 37.1-1, and the nature of such disability;

2. The likelihood that the acquittee will engage in conduct presenting substantial risk of bodily harm to other persons or to himself in the foreseeable future;

3. The likelihood that the acquittee can be adequately controlled with supervision and treatment on an outpatient basis; and

4. Such other factors as the court deems relevant. If the court determines that an acquittee does not need inpatient hospitalization solely because of treatment or

habilitation he is currently receiving, but the court is not persuaded that the acquittee will continue to receive such treatment or habilitation, it may commit such acquittee for inpatient hospitalization. The court shall order such acquittee released with conditions pursuant to §§ 19.2-182.7 through 19.2-182.9 if it finds that he is not in need of inpatient hospitalization but that he meets the criteria for conditional release set forth in § 19.2-182.7. If the court finds that the acquittee does not need inpatient hospitalization nor does he meet the criteria for conditional release, it shall release such person without conditions.

§ 19.2-182.4. Confinement and treatment.--Upon commitment of an acquittee for inpatient hospitalization, the Commissioner shall determine the appropriate placement for him, based on his clinical needs and security requirements. The Commissioner may make inter-facility transfers and treatment and management decisions regarding acquittees in his custody without obtaining prior approval of or review by the committing court. The Commissioner shall notify in writing the attorney for the Commonwealth for the committing jurisdiction of changes in any acquittee's course of treatment which will involve authorization for the acquittee to leave the grounds of the hospital in which he is confined.

§ 19.2-182.5. Review of confinement.--A. The committing court shall conduct a hearing at yearly intervals for five years and at biennial intervals thereafter, with the first such hearing to be held six months after the date of commitment, to assess each confined acquittee's need for inpatient hospitalization. The court shall schedule such matter for hearing as soon as possible after it becomes due, giving the matter priority over all pending matters before the court.

B. Prior to the hearing, the Commissioner shall provide to the court a report of evaluation of the acquittee's condition and recommendations for treatment, to be prepared by a psychiatrist or a psychologist who is currently treating the acquittee. Such psychologist shall be qualified as a licensed clinical psychologist or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services. Such psychiatrist and psychologist shall be skilled in the diagnosis of mental illness and qualified by training and experience to perform forensic evaluations. If such examiner recommends release or the acquittee requests release, the acquittee's condition and need for inpatient hospitalization shall be evaluated by a second person with such credentials who is not currently treating the acquittee. A copy of any report submitted pursuant to this subsection shall be sent to the attorney for the Commonwealth for the jurisdiction from which the acquittee was committed.

C. The acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the

hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. Written notice of the hearing shall be provided to the Commonwealth for the committing jurisdiction. The attorney for the proceeding shall be deemed civil. According to the determination of the court following such hearing, and based upon the report and other evidence provided at the hearing, the court shall (i) release the acquittee from confinement if he does not need inpatient hospitalization and does not meet the criteria for conditional release set forth in § 19.2-182.7, and the court has approved a discharge plan prepared jointly by the hospital staff and the appropriate community services board, (ii) place the acquittee on conditional release if he meets the criteria for conditional release, and the court has approved a discharge plan prepared jointly by the hospital staff and the appropriate community services board, or (iii) order that he remain in the custody of the Commissioner if he continues to require inpatient hospitalization based on consideration of the factors set forth in § 19.2-182.3.

D. Any person held in custody as mentally ill may by petition for a writ of habeas corpus have the question of the legality of his detention determined by a court of competent jurisdiction as set forth in § 37.1-103.

§ 19.2-182.6. Release; conditional release.--A. The Commissioner may petition the committing court for conditional or unconditional release of the acquittee at any time he believes the acquittee no longer needs hospitalization. Such petition shall be accompanied by a report of clinical findings supporting the petition and by a discharge plan. Such plan shall be prepared jointly by the hospital and the appropriate community services board. The acquittee may petition the committing court for release only once in each year in which no annual judicial review is required pursuant to § 19.2-182.5. The party petitioning for release shall transmit a copy of such petition to the attorney for the Commonwealth for the committing jurisdiction.

B. Upon receipt of such petition for release, the court shall order the Commissioner to appoint two persons in the same manner as set forth in § 19.2-182.2 to assess and report on the acquittee's need for inpatient hospitalization by reviewing his condition with respect to the factors set forth in § 19.2-182.3. The evaluators shall conduct their evaluations and report their findings in accordance with the provisions of § 19.2-182.2, except that the evaluations shall be completed and findings reported within forty-five days of issuance of the court's order for evaluation.

C. Upon receipt of the reports of evaluation, the court shall conduct a hearing on the petition, such hearing to be scheduled on an expedited basis, given priority over pending civil matters before the court. The acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and

during the hearing, and the right to introduce evidence and cross-examine witnesses. Written notice of the hearing shall be provided to the attorney for the Commonwealth for the committing jurisdiction. The Commissioner shall notify of the hearing at his last known address any victim of the act resulting in the charges of which the acquittee was acquitted, provided such victim submits a written request for such notification to the Commissioner. The proceeding shall be deemed civil. At the conclusion of the hearing, based upon the report and other evidence provided at the hearing, the court shall order the acquittee (i) released from confinement if he does not need inpatient hospitalization and does not meet the criteria for conditional release set forth in § 19.2-182.3, and the court has approved a discharge plan prepared jointly by the hospital and the appropriate community services board, (ii) placed on conditional release if he meets the criteria for such release as set forth in § 19.2-182.7, and the court has approved a discharge plan prepared jointly by the hospital and the appropriate community services board, or (iii) retained in the custody of the Commissioner if he continues to require inpatient hospitalization based on consideration of the factors set forth in § 19.2-182.3.

D. Persons committed pursuant to this section shall be released only in accordance with procedures set forth herein governing release and conditional release.

§ 19.2-182.7. Conditional release.--F. At any time the court considers the acquittee's need for inpatient hospitalization pursuant to this section, it shall place the acquittee on conditional release if it finds that (i) based on consideration of the factors which the court must consider in its commitment decision, he does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he would need inpatient hospitalization, (ii) appropriate outpatient supervision and treatment are reasonably available, (iii) there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified, and (iv) conditional release will not present an undue risk to public safety. The court shall subject a conditionally released acquittee to such orders and conditions which it deems will best meet the acquittee's need for treatment and supervision and best serve the interests of justice and society. The community services board serving the locality in which the acquittee will reside upon release shall implement the court's conditional release orders and shall submit written reports to the court on the acquittee's progress and adjustment in the community no less frequently than every six months.

§ 19.2-182.8. Same; revocation.--A. If at any time the committing court finds reasonable ground to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, he may order

an evaluation of the person by a psychiatrist, licensed clinical psychologist, or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services, such psychiatrist or psychologist qualified by training and experience to perform forensic evaluations. If the court, based on the evaluation and after hearing evidence on the issue, finds by a preponderance of the evidence that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release based on application of the criteria for conditional release and (ii) requires inpatient hospitalization, the court may revoke the acquittee's conditional release and order him returned to the custody of the Commissioner. At any hearing on such matter, the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. Written notice of the hearing shall be provided to the Commonwealth's attorney for the committing jurisdiction. The proceeding shall be deemed civil.

B. When exigent circumstances do not permit compliance with revocation procedures set forth above, any judge as defined in § 37.1-1 or a magistrate may, upon the sworn petition of any responsible person or upon his own motion based upon probable cause to believe that an acquittee on conditional release (i) has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) requires inpatient hospitalization, may issue an emergency custody order requiring any such acquittee within his judicial district to be taken into custody and transported to a convenient location where a person designated by the community services board who is skilled in the diagnosis and treatment of mental illness shall evaluate such acquittee and assess his need for inpatient hospitalization. A law enforcement officer who, based on his observation or the reliable reports of others, has probable cause to believe that any insanity acquittee on conditional release has violated the conditions of his release and is no longer a proper subject for conditional release and requires emergency evaluation to assess the need for inpatient hospitalization, may take such acquittee into custody and transport him to an appropriate location to assess the need for hospitalization without prior judicial authorization. Such evaluation shall be conducted immediately. The acquittee shall remain in custody until a temporary detention order is issued or until he is released but in no event shall the period of custody exceed four hours. If it appears from all evidence readily available (i) that the acquittee has violated the conditions of his release or is no longer a proper subject for conditional release and (ii) that he requires emergency evaluation to assess the need for inpatient hospitalization, the judge as defined in § 37.1-1, or magistrate upon the advice of such person skilled in the diagnosis and treatment of mental illness, may issue an order of temporary detention authorizing the executing officer to place such person in an appropriate institution for a period not to

exceed forty-eight hours prior to a hearing. If such forty-eight hour period terminates on a Saturday, Sunday or legal holiday, the acquittee may be detained until the next day which is not a Saturday, Sunday or legal holiday, but in no event may he be detained for longer than seventy-two hours or ninety-six hours when such legal holiday occurs on a Monday or Friday. For purposes of this section, a Saturday, Sunday or legal holiday shall be deemed to include the time period up to 8:00 a.m. of the next day which is not a Saturday, Sunday or legal holiday. The committing court or any general district court shall have jurisdiction to hear the matter. Prior to the hearing, the acquittee shall be examined by a psychiatrist, licensed clinical psychologist, or licensed psychologist registered with the Virginia Board of Psychology with a specialty in clinical services, such psychiatrist and psychologist skilled in the diagnosis of mental illness, who shall certify as to whether the person is in need of hospitalization for mental illness. At any hearing on such matter, the acquittee shall be provided with adequate notice of the hearing, of the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing. Following the hearing, if the court determines, based on a preponderance of the evidence presented at the hearing, that the acquittee has violated the conditions of his release or is no longer a proper subject for conditional release and is in need of inpatient hospitalization, the court shall revoke the acquittee's conditional release and place him in the custody of the Commissioner. When any insanity acquittee on conditional release is taken into emergency custody, detained or hospitalized, such action shall be considered to have been taken pursuant this section, notwithstanding the fact that his status as an insanity acquittee was not known at the time of custody, detention or hospitalization. Detention or hospitalization of such acquittee pursuant to provisions of law other than those applicable to insanity acquittees shall not render such detention or hospitalization invalid. If a person's status as an insanity acquittee on conditional release is not recognized at the time of emergency custody or detention, at the time his status as such is verified, the provisions applicable to such persons shall be applied and the court hearing the matter shall notify the committing court of the proceedings.

C. If an acquittee is returned to the custody of the Commissioner for inpatient treatment pursuant to revocation proceedings, and his condition improves to the degree that, within thirty days of resumption of custody following the hearing, the acquittee, in the opinion of hospital staff treating the acquittee, is an appropriate candidate for conditional release, he may be, with the approval of the court, conditionally released as if revocation had not taken place. If treatment is required for longer than thirty days, the acquittee shall be returned to the custody of the Commissioner for a period of hospitalization and treatment which is governed by the provisions of this article applicable to committed acquittees.

§ 19.2-182.9. Same; modification or removal of conditions.--A. The committing court may modify conditions of release or remove conditions placed on release, in accordance with procedures set forth in this section, upon petition of the supervising community services board, the attorney for the Commonwealth, or the acquittee or upon its own motion based on reports of the supervising community services board. However, the acquittee may so petition only annually commencing six months after the conditional release order is issued. Upon petition of any of the aforementioned parties, the court shall require the supervising community services board to provide a report on the acquittee's progress while on conditional release.

B. As it deems appropriate based on the community services board's report and any other evidence provided to it, the court may issue a proposed order for modification or for removal of conditions. The court shall provide notice of the order, and their right to object to it within ten days of its issuance, to the acquittee, the supervising community services board and the attorneys for the Commonwealth for the committing jurisdiction and for the jurisdiction where the acquittee is residing on conditional release. The proposed order shall become final if no objections are filed within ten days of its issuance. If there is objection, the court shall conduct a hearing at which the acquittee, the attorney for the Commonwealth, and the supervising community services board have an opportunity to present evidence challenging the proposed order. At the conclusion of the hearing, the court shall issue an order specifying conditions of release or removing existing conditions of release.

§ 19.2-182.10. Representation of Commonwealth; appeals.--The attorney for the Commonwealth for the jurisdiction in which the acquittee was acquitted shall represent the Commonwealth in all proceedings held pursuant to this article. Notwithstanding the provisions of §§ 17-116.05:1 or 19.2-398, the Commonwealth or the acquittee may appeal errors committed or allowed by the court having jurisdiction over the commitment or release proceedings set forth in this article to the Court of Appeals as in criminal cases.

§ 19.2-182.11. Authority of Commissioner.--The Commissioner may delegate any of the duties and powers imposed on or granted to him by this article. He may establish an administrative board composed of persons with demonstrated expertise in such matters, to which he may delegate such authority. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall assist such board in its administrative and technical duties. Members of such board shall exercise their powers and duties without compensation and shall be subject to personal liability while acting within the scope of their duties only for intentional misconduct.

[Insert § 37.1-67.1]

2. That § 19.2-181 of the Code of Virginia is repealed.

3. That this act shall become effective July 1, 1992.

HOUSE/SENATE BILL NO._____

A bill to amend and reenact § 37.1-155 of the Code of Virginia and to amend the Cod of Virginia by adding in Chapter 5 of Title 37.1 a section numbered 37.1-151.1, relating to escape from the custody of the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services.

Be it enacted by the General Assembly of Virginia:

1. That § 37.1-155 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Chapter 5 of Title 37.1 a section number 37.1-151.1 as follows:

37.1-151.1 Escape of persons committed pursuant to 19.2-181.-- Any person committed to the custody of the Commissioner pursuant to § 19.2-181 who escapes from such custody shall be guilty of a Class 6 felony.

37.1-155. Penalty. - ~~Any,~~ Except as otherwise specified, any person who violates any provision of this Chapter shall be guilty of a Class 1 misdemeanor.

HOUSE/SENATE BILL NO._____

A bill to amend and reenact § 37.1-134.5 of the Code of Virginia, relating to judicial authorization of treatment of persons incapable of making an informed decision.

Be it enacted by the General Assembly of Virginia

1. That § 37.1-134.5 of the Code of Virginia is amended and reenacted as follows:

§ 37.1-134.5. Judicial authorization of treatment and detention of certain persons. -- A. An appropriate circuit court, or judge as defined in § 37.1-1, may authorize on behalf of an adult person, in accordance with this section, a specific treatment or course of treatment for a mental or physical disorder, if it finds upon clear and convincing evidence that (i) the person is either incapable of making an informed decision due to a physical or mental disorder, and (ii) the proposed treatment is in the best interest of the person.

B. For purposes of this section:

"Disorder" shall include any physical or mental disorder or impairment, whether caused by injury, disease, genetics, or other cause.

"Incapable of making an informed decision" shall mean unable to understand the nature, extent or probable consequences of a proposed treatment, or unable to make a rational evaluation of the risks and benefits of the proposed treatment as compared with the risks and benefits of alternatives to that treatment. Person with dysphasia or other communication disorders who are mentally competent and able to communicate shall not be considered incapable of given informed consent.

C. Any person may request authorization of a specific treatment, or course of treatment, for an adult person by filing a petition in the circuit court, or with a judge as defined in § 37.1-1, of the county or city in which the allegedly incapable person resides or is located, or in the county or city in which the proposed place of treatment is located. Upon filing such a petition, the petitioner shall deliver or send a certified copy of the petition to the person for whom treatment is sought, and, if the identity and whereabouts of the person's next of kin are known, to the next of kin.

D. As soon as reasonable possible after the filing of the petition, the court shall appoint an attorney to represent the interests of the allegedly incapable person at the hearing, However, such appointment shall not be required in the event that the person, or another interested person on behalf of the person, elects to retain private counsel at his own expense to represent

the interests of the person at the hearing. In the event that the allegedly incapable person is indigent, his counsel shall be paid by the Commonwealth as provided in § 37.1-89 from funds appropriated to reimburse expenses incurred in the involuntary mental commitment process. However, this provision shall not be construed to prohibit the direct payment of an attorney's fee either by the patient, or by an intersted person on his behalf, which fee shall be subject to the review and approval of the court.

E. Following the appointment of an attorney pursuant to subsection D above, the court shall schedule an expedited hearing of the matter. The court shall notify the person who is the subject of the petition, his next of kin, if know, the petitioner, and their respective counsel of the date and time for the hearing. In scheduling such a hearing, the court shall take into account the type and severity of the alleged physical or mental disorder, as well as the need to provide the person's attorney with sufficient time to adequately prepare his client's case.

F. Evidence presented at the hearing may be submitted by affidavit in the absence of objection by the person who is the subject of the petition, the petitioner, either of their respective counsel, or by any other interested party. Prior to the hearing, the attorney shall investigate the risks and benefits of the treatment decision for which authorization is sought and of alternatives to the proposed decision. The attorney shall make a reasonable effort to inform the person of this information and to ascertain the person's religious beliefs and basic values and the views and preferences of the person's next of kin.

G. Prior to authorizing treatment pursuant to this section, the court shall find:

1. That there is no legally authorized guardian or committee available to give consent;

2. That the person who is the subject of the petition is incapable either of making an informed decision regarding a specific treatment or course of treatment or is physically or mentally incapable of communicating such a decision;

3. That the person who is the subject of the petition is unlikely to become capable of making an informed decision or of communicating an informed decision within the time required for decision; and

4. That the proposed treatment or course of treatment is in the best interest of the patient. However, the court shall not authorize a proposed treatment or course of treatment which is proven by a preponderance of the evidence to be contrary to the person's religious beliefs or basic values unless such treatment is necessary to prevent death or a serious irreversible condition. The

court shall take into consideration the right of the person to rely on nonmedical, remedial treatment in the practice of religion in lieu of medical treatment.

H. The court may not authorize the following under this section:

1. Nontherapeutic sterilization, abortion, or psychosurgery.

2. Admission to a mental retardation facility or a psychiatric hospital, as defined in § 37.1-1. However, the court may issue an order under this section authorizing a specific treatment or course of treatment of a person whose admission to such facility has been or is simultaneously being authorized under §§ 37.1-65, 37.1-65.1, 37.1-65.2, 37.1-65.3, 37.1-67.1 or § 37.1-67.2, or of a person who is subject to an order of involuntary commitment previously or simultaneously issued under § 37.1-67.3.

3. Administration of antipsychotic medication for a period to exceed 180 days or electroconvulsive therapy for a period to exceed sixty days pursuant to any petition filed under this section. The court may authorize electroconvulsive therapy only if it is demonstrated by clear and convincing evidence, which shall include the testimony of a licensed psychiatrist, that all other reasonable forms of treatment have been considered, and that electroconvulsive therapy is the most effective treatment for the person. Even if the court has authorized administration of antipsychotic medication or electroconvulsive therapy hereunder, these treatments may be administered over the person's objection only if he is subject to an order of involuntary commitment previously or simultaneously issued under § 37.1-67.3 or the provisions of Chapter 11 (§ 19.2-167 et seq.) of Title 19.2.

4. Restraint or transportation of the person, unless it finds upon clear and convincing evidence that restraint or transportation is necessary to the provision of an authorized treatment for a physical disorder.

I. Any order authorizing treatment pursuant to subsection A shall describe the treatment or course of treatment authorized and may authorize generally such related examinations, tests, or services as the court may determine to be reasonable related to the treatment authorized. The order shall require the treating physician to review and document the appropriateness of the continued admission of antipsychotic medications not less frequently than every thirty days. Such order shall require the treatment physician or other service provider to report to the court and the person's attorney any change in the person's condition resulting in probable restoration or development of the person's capacity to

make and to communicate an informed decision prior to completion of the authorized treatment and related services. The order may further require the treating physician or other service provider to report to the court and the person's attorney any change in circumstances regarding the authorized treatment or related services which may indicate that such authorization is no longer in the person's best interests. Upon receipt of such report, or upon the petition of any interested party, the court may enter such order withdrawing or modifying its prior authorization as it deems appropriate. Any petition or order under this section may be orally presented or entered, provided a written order shall be subsequently executed.

J. Any order hereunder of a judge, or of a judge or magistrate under subsection L, may be appealed de novo within ten days to the circuit court for the jurisdiction where the order was entered, and any such order of a circuit court hereunder, either originally or on appeal, may be appealed within ten days to the Court of Appeals.

K. Any licensed health professional or licensed hospital providing treatment, testing or detention pursuant to the court's or magistrate's authorization as provide din this section shall have no liability arising out of a claim to the extent it is based on lack of consent to such treatment, testing or detention. Any such professional or hospital providing, withholding or withdrawing treatment with the consent of the person receiving or being offered treatment shall have no liability arising out of a claim to the extent it is based on lack of capacity to consent if a court or a magistrate has denied a petition hereunder to authorize such treatment, and such denial was based on an affirmative finding that the person was capable of making and communicating an informed decision regarding the proposed provision, withholding or withdrawal of treatment.

L. Upon the advice of a licensed physician who has attempted to obtain consent and upon a finding of probable cause to believe that an adult person within the court's or a magistrate's jurisdiction is incapable of making an informed decision regarding treatment of a physical or mental disorder, or is incapable of communicating such a decision due to a physical or mental disorder, and that the medical standard of care calls for testing, observation or treatment of the disorder within the next twenty-four hours to prevent death, disability or a serious irreversible condition, the court or, if the court is unavailable, a magistrate may issue an order authorizing temporary detention of the person by a hospital emergency room or other appropriate facility and authorizing such testing, observation or treatment. The detention may not be for a period exceeding twenty-four hours unless extended by the court as part of an order authorizing treatment under subsection A. If before completion of authorized testing, observation or treatment, the physician determines that a person subject to an order under this subsection has become capable of making and communicating an informed decision, the physician determines that a person subject

to an order under this subsection has become capable of making and communication an informed decision, the physician shall rely on the person's decision on whether to consent to further observation, testing or treatment. If before issuance of an order under this subsection or during its period of effectiveness, the physician learns of objection by a member of the person's immediate family to the testing, observation or treatment, he shall so notify the court or magistrate, who shall consider the objection in determining whether to issue, modify or terminate the order.

M. The provisions of § 37.1-89 relating to payment by the Commonwealth shall not apply to the cost of detention, testing or treatment under this section.

N. Nothing in this section shall be deemed to affect the right to use, and the authority conferred by, any other applicable statutory or regulatory procedure relating to consent, or to diminish any common law authority of a physician or other treatment provider to provide, withhold or withdraw services to a person unable to give or to communicate informed consent to those actions, with or without the consent of the person's relative, including but not limited to common law or other authority to provide treatment in an emergency situation; nor shall anything in this section be construed to affect the law defining the conditions under which consent shall be obtained for medical treatment, or the nature of the consent require. (1989, c. 591.)

APPENDIX B

APPENDIX B

CURRENT RESEARCH--COMMUNITY TREATMENT

A body of current research on the treatment of insanity acquittees in the community may be useful in developing appropriate release provisions which address the goals of providing effective treatment for acquittees and protecting the public. One of the most important considerations in release decisions is the potential dangerousness of the releasee. Current research on the ability of mental health professionals to predict dangerousness and its implications for release decisions is summarized below. A number of studies have assessed rates of recidivism of releasees, and, with the caveat that recidivism is not necessarily a measure of the success or failure of treatment programs, such data have been used to identify several successful community treatment programs.

Predicting Dangerousness

A number of studies in the 1970's assessing the accuracy of predictions of violent behavior in individuals resulted in consistent findings that about one third of those predicted to be violent actually were; about 10% predicted to be safe committed a subsequent violent act. To achieve this level of accuracy, the best predictors were found to be demographic variables such as age, gender, social class and history of violence. The poorest predictors were clinical variables such as diagnosis, severity of disorder, personality traits. These same indicators applied in prediction of dangerousness among the mentally disordered and among the general criminal justice population. (Monahan, 1989)

The American Psychiatric Association, in the report of its task force on dangerousness, noted that because dangerousness is the result of multiple forces, there is no test for dangerousness and no way to examine to find it in the absence of an actual history of a violent assault on another person. However, some tests, used in conjunction with clinical material, can give clues for prediction. (Roth, 1974) Other researchers concur. Kozol, et. al., states that prediction is based on an "overall subjective impression which is based upon an understanding of the interrelatedness of many factors." These include a clinical exam, psychological tests, and reconstruction of life history from multiple sources. Most important, though, is a description of an actual assault committed by the subject; violence cannot be predicted in the absence of an actual instance of violence. In their study using this information to predict dangerousness, they found that the criminal recidivism of those released on and against recommendations resulted in findings indicating an 8% recidivism rate for the former and a 34% recidivism rate for the latter.

While some recent studies show improved accuracy in predicting dangerousness, especially among those with extensive histories of past criminality and violence, ultimate decisions regarding confinement of an individual based on the risk he poses involve trade-offs between liberty and public safety interests. Monahan has described the decision as a legal public policy determination, not a clinical decision.

Safety and Effectiveness of Community Treatment

A number of studies have attempted to assess the accuracy of the decision regarding dangerousness as applied in release decisions by examining criminal recidivism rates of released acquittees. Following is a summary of some of the research on recidivism of insanity acquittees released into the community. The data represents releasees who were and were not receiving treatment in the community and may provide an indication of the efficacy of treatment, both before and after release, the threat that this population may pose to the public, and some implications for development of treatment programs.

There is controversy as to whether recidivism is a valid measure of the success of treatment. It has been argued that the relation of symptoms being treated to criminal behavior has not been proven; if it exists, it may be incidental. The only correlation demonstrated was that between recidivism and sex, race, socioeconomic status and history of past criminal activity. Further, reducing recidivism is not a primary goal in treatment of mental illness and, therefore, recidivism does not necessarily indicate a failure of treatment. (Steadman, 1983) However, some researchers recognize a link between cognitive impairment of the disease process and criminal activity. These findings have been interpreted to indicate that treatment programs can address recidivism through attention to mental status and to issues of compliance and by careful use of revocation and rehospitalization. (Bloom, 1986)

The earliest studies of recidivism included work by Morrow and Peterson (1966), who found that 37% of 44 NGRI patients were rearrested within three years of release. Fifty-four percent of the offenses were economic; assaults accounted for 18% and homicides for 11%. The corresponding recidivism rate for a large federal prison sample was 35%. Because of the lack of relationship seen in the study between recidivism and either diagnosis at the time of acquittal or the number of previous psychiatric hospitalizations, the researchers concluded that insanity acquittees more closely resembled criminal offenders than they did psychiatric patients.

Steadman (1983) and others reported similar recidivism rates in a study of persons acquitted in New York from 1965 through 1978. The study followed 107 of the 278 acquittees discharged during this period. Twenty percent (21) of the 107 were later arrested; arrests totaled 66. Thirty-six were for property crimes and 20%

for crimes against the person. The acquittees were generally charged with crimes less serious than the offenses of which they were acquitted. This recidivism rate was lower than the rate for felons released from prison but was higher than for those released from New York mental hospitals. Steadman concluded that, contrary to Morrow and Petersen's conclusions, NGRI acquittees look like neither mental patients nor offenders.

Several more recent studies have examined the rearrest rates of insanity acquittees on conditional release. Maryland acquittees were followed for 15 years after discharge. (Spodak, 1984) The 86 persons in the sample were hospitalized an average of two years with a mandatory 5-year conditional release period. Eighty-one of 86 were acquitted of offenses indicating potential for physical harm in the community. Forty-eight persons (56%) accumulated 130 arrests; prior to hospitalization, the same group was arrested twice as often. The 130 arrests resulted in 170 criminal charges, most within the first five years of conditional release. However, less than half resulted in convictions; 32 charges resulted in the incarceration of 11 persons, representing 13% of the sample. Most of the convictions were for less serious offenses with less potential for physical harm than the acquittal offense.

Bogenberger (1987) reported on 107 acquittees released in Hawaii, some conditionally and some without conditions. Sixty-seven percent were rearrested, 56% of those on felony charges. Again, however, the rearrest offenses were less serious than the acquittal offense; the most serious felonies comprised 36% of the acquittal offenses but only 7% of the post-acquittal arrests. Interestingly, the restrictiveness of the disposition was not correlated with later arrests; persons released with and without conditions were equally likely to be rearrested.

Another study of New York acquittees (Bieber, 1988) found that of 132 discharged acquittees, 29% were arrested after discharge. Only 17% of those without pre-hospitalization arrests were rearrested, but 45% of those arrested prior to hospitalization were later arrested. The study showed some correlation between recidivism and number of prearrests, severity of charges for which arrested, psychotic diagnosis, and NGRI offense of homicide.

It is difficult to draw conclusions from the data described above. Generally, rearrested releasees were arrested for crimes less serious than those of which they were acquitted. They were arrested less often after hospitalization than they were before their commitment. A correlation seems to exist between demographic factors and rearrest. The effect of treatment, either in the hospital or community, is unclear. Most of the studies report arrest rates rather than conviction rates; arrests may be a questionable measure of recidivism. In addition, in assessing the significance of this data, factors such as the characteristics of the population studied; the nature of treatment provided, if any, before and after release; the length of follow-up period and other factors must be considered.

Data collected pursuant to evaluation of NGRI treatment programs described below address some of these issues. Studies evaluating outpatient or nonsecure programs in Oregon, Wisconsin and Illinois claim to demonstrate success in minimizing criminal behavior in insanity acquittees as a result of treatment.

Oregon

Bloom (1986) described treatment provided in an outpatient treatment program designed to address the needs of the chronically mentally ill. Treatment included group, individual and family therapy, medication management, occupational therapy, crisis services, home visits, and voluntary hospitalization as needed. Participants were selected for motivation and interest in the program. Ninety-one percent of the 91 participants in the evaluation sample were acquitted of felonies; 53% were diagnosed with schizophrenia. There were only 11 instances of commission of new crimes, only 4 of which were felonies. The offenses were less serious on the average than the offenses of which subjects were acquitted. Bloom concluded that treatment can address recidivism through careful attention to mental status and to issues of compliance and by careful use of revocation and rehospitalization. Recommendations for improvement of conditional release adjustment included improved crisis and psychiatric services to address crises associated with decompensation and noncompliance with treatment. The program's success was attributed to the same services which have demonstrated success in treating the chronically mental ill generally. These include continuity of care from the inpatient to outpatient setting, monitored treatment, and inpatient treatment readily available to handle decompensation and noncompliance.

Illinois

Cavanaugh (1985) reported on an assessment of treatment provided at the Isaac Ray Center, a university-based program specializing in outpatient treatment of mentally disordered offenders, supported by a state grant. The program employs a multidisciplinary staff which provides an eclectic therapeutic model, tailoring the intervention to the individual patient's motivations and needs. Interventions range from monitoring community adjustment and arranging social services to indepth individual psychotherapy. Staff continually assess patients' living circumstances for similarity to conditions at the time of prior decompensation and other violent or illegal acts; family involvement is encouraged. The center recommends conditions which become a part of court orders. Staff reports periodically to the court, providing notification if orders are violated. Rehospitalization or conviction for contempt of court may result. The center accepts patients who have major mental disorders, have community supports, and agree to conditions and program requirements. Prospective patients are rejected if they need inpatient treatment, have antisocial personality disorders or drug abuse disorders.

The study included 85% (44) of all discharged insanity acquittees in the locality. Most had committed murder and had major psychiatric disorders. Over 2 years studied, there were no arrests for violent crimes or other crimes against the person; there was one shoplifting arrest and one charge of failure to comply with court orders for treatment. Discharged patients not receiving outpatient treatment were rearrested at rates of from 15-37% following discharge over three years. Tests administered to program subjects showed a trend toward improvement in overall adjustment. Improvements were demonstrated in occupational and educational training, independent living skills, and development of fulfilling intimate relationships. A decrease in psychiatric symptoms was noted. The evaluators concluded that safe effective outpatient treatment is possible.

Wisconsin

Maier (1989) studied outcomes for a 23-bed community preparation program for insanity acquittees and sex offenders operated in an unlocked ward on the grounds of a state hospital. Security safeguards found necessary to successful community treatment included careful patient selection; no patient was accepted with a history of escape or aggression in the previous six months. Patients spend three months in the unit and enter the community with an escort in the third month. When patients pass a community living skills program test on budgeting, use of buses, housing, diet, etc., they may enter the community unescorted. A patient buddy system is employed for orientation and mentoring. Patients are required to sign in and out of the unit. Police are notified when patients are in the community unescorted. Patients report to staff on leaving and returning to the unit to debrief on stress, mood, and attitude. Staff meet with employers, educators, and merchants to inform them of "released" patients' crimes, mental disorders, and treatment goals, as appropriate. Hospital administrators, community leaders and law-enforcement officials were oriented on the program before starting operation; the group endorsed the program. In 11,000 excursions of patients into the community over 24 months, 55% unescorted, only 7 breaches of security were reported, with only one resulting in commission of a crime (sexual assault on the grounds of the hospital).

REFERENCES

ABA Criminal Justice Mental Health Standards, American Bar Association, Washington, D.C., 1989.

Bieber, Stephen L., Richard A. Pasewark, Katherine Bosten, and Henry J. Steadman, "Predicting Criminal Recidivism of Insanity Acquittees," International Journal of Law and Psychiatry 11:105-112, 1988.

Bloom, Joseph D., Mary H. Williams, Jeffrey L. Rogers, and Peter Barbur, "Evaluation and Treatment of Insanity Acquittees in the Community," Bulletin of the American Academy of Psychiatry and Law 14:231-244, 1986.

Bloom, Joseph D., Jeffrey L. Rogers, Spero M. Manson, and Mary H. Williams, "Lifetime Police Contacts of Discharged Psychiatric Security Review Board Clients," International Journal of Law and Psychiatry 8:189-202, 1986.

Bogenberger, Robert P., Richard A. Pasewark, Howard Gudeman, and Stephen L. Beiber, "Follow-up of Insanity Acquittees in Hawaii," International Journal of Law and Psychiatry 10:283- 295, 1987.

Brakel, Samuel Jan, "After the Verdict: Dispositional Decisions Regarding Criminal Defendants Acquitted by Reason of Insanity," 37 DePaul Law Review 181, 1988.

Cavanaugh, James L. and Orest E. Wasyliw, "Treating the Not Guilty by Reason of Insanity Outpatient: A Two-Year Study," Bulletin of the American Academy of Psychiatry and Law 13:407-415, 1985.

Kozol, H.L., R.J. Boucher, R. F. Garofalo, "Diagnosis and Treatment of Dangerousness."

Maier, Gary J., Barbara R. Morrow, Rodney Miller, "Security Safeguards in Community Rehabilitation of Forensic Patients," Hospital and Community Psychiatry 40:529-531, 1989.

Monahan, John and Saleem A. Shah, "Dangerousness and Commitment of the Mentally Disordered in the United States," Schizophrenia Bulletin 15:541-553, 1989.

Roth,L.H., Task Force Report, American Psychiatric Association Task Force on Dangerousness, 1974.

Spodak, Michael K., Stuart B. Silver, and Christine U. Wright, "Criminality of Discharged Insanity Acquittees: Fifteen Year Experience in Maryland Reviewed," Bulletin of the American Academy of Psychiatry and Law 12:373-382, 1984.

Steadman, Henry J. and Jeraldine Braff, "Defendants Not Guilty by Reason of Insanity," in Mentally Disordered Offenders: Perspectives from Law and Social Science, Monahan, J. and H.J. Steadman, Ed., New York, Plenum, 1983, pp. 109- 133.

APPENDIX C

Comments by Study Committee Members

COMMONWEALTH ATTORNEY

Amherst County
P.O. Box 358
Circuit Court Building
Amherst, Virginia 24521

W. EDWARD MEEKS, III
Commonwealth Attorney

W. STARKE MUNDY, III
Assistant

BEVERLY N. LEONARD
Victim Advocate

Phone: 946-9316
929-9316

6

October 14, 1990

Russell C. Petrella, Ph.D.
Mental Health, Mental Retardation and
Substance Abuse Department
P. O. Box 1797
Richmond, Virginia 23214

Re: Comments on the REPORT OF THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES ON THE MANAGEMENT AND RELEASE OF INDIVIDUALS FOUND NOT GUILTY BY REASON OF INSANITY TO THE GOVERNOR AND THE GENERAL ASSEMBLY

Dear Dr. Patrella:

I have reviewed the materials forwarded to me. I choose to direct my comments to the main Report; to the extent that my comments affect the Executive Summary and proposed Code changes, they are to be interpreted as applying to them as well. My comments are as follows:

1. TEMPORARY CUSTODY AND EVALUATION: My notes do not reflect that the Committee agreed that the report of either evaluator would trigger the automatic extension of the evaluation period by the court and the preparation of a discharge plan. Such action directed by the law and executed by the court would seem to presume a discharge resulting from the conflicting evaluations. I oppose the law requiring discharge plans to be implemented until the court determines that discharge is imminent or proper. The law should not force the direction of a proceeding because of conflicting evaluations. Additionally and to the extent this issue was not discussed, it should not be reported.

2. COMMITMENT: The Report suggests that the commitment hearing should be scheduled as to give it priority in scheduling over all other pending matters before the court. My notes reflect that the committee agreed that the commitment hearing was to be given priority in docketing. If the law was as stated in the report, the court would potentially be required to remove scheduled matter from the docket to make room for a commitment. This type of priority is excessive; as the committee discussed, commitment hearings should be given priority similar to criminal cases. See

Va. Code Section 19.2-241.

The Report lists three (3) factors which the court is to consider in determining the need of the acquitted for hospitalization; it is my recollection that the committee agreed upon a fourth general factor which should be added to the Report. That factor was "and such other matters as the court may deem material on the issue of need of hospitalization."

The Report states that the term "dangerous" should be replaced with the standard that the acquitted "will engage in conduct presenting a substantial risk of bodily harm to other persons or to himself in the foreseeable future." This is inconsistent with the elements establishing need on page 7 of the Report; there the court is to consider the likelihood of such a risk and not the certainty as suggested on page 8. This shift in dealing with "dangerousness" as a certainty, and not a probability or "likelihood", should be amended to reflect the committee's feelings. Moreover, I do not recall that risk to the public was limited to the injury of persons or that a time frame of the "foreseeable future" was placed on the concept. Risks to public property can be just as destructive to public safety, e.g., a pyromaniac can pose not only a risk to lives, but to substantial property. I do not concur in the limitations of the Report and recommend that risk to the public be allowed to be interpreted by the court and that time be limited only to the future and not the "foreseeable future." Courts will not approach infinity in setting time as an element of the risk; however, they should be allowed to determine what is a reasonable period for risk prediction.

It should be pointed out that the committee left open the issue of appeals by the Commonwealth. If commitment hearings are civil (as the law views them), the Commonwealth shares an equal right to appeal. Also, it should be pointed out that the committee bypassed the issue of whether the Attorney General or Commonwealth's Attorney would bear the appellate responsibility. These issues should be addressed if this area of the law is to be complete.

3. RELEASE: As stated above in my comments on commitment, my notes reflect that the committee agreed that the commitment hearing was to be given priority in docketing. If the law was as stated in the report, the court would potentially be required to remove scheduled matter from the docket to make room for a commitment. This type of priority is excessive; as the committee discussed, commitment hearings should be given priority similar to criminal cases. See Va. Code Section 19.2-241.

4. CONDITIONAL RELEASE: I do concur with police officers, having probable cause as defined in the Report, having the authority to take a person on conditional release into custody. I do not recall that the committee placed on the officer the responsibility of deciding to take the acquitted to a mental health professional; I advise against such a practice. The commitment for

evaluation should be a judicial function either determined by a magistrate and immediately appealable to a court, or by a court.

I also do not recall the committee agreeing to a four (4) hour limitation on custody. Limitations need to be stated in more general terms to allow for all factual situations as may arise in different jurisdictions.

The Commonwealth should have the right to appeal any special justice decision that terms of conditional release have not been violated or that the acquitee should again be release to the court having placed the individual originally in a conditional release status. Release back to the community should not be accomplished until that appeal is heard.

I am absolutely opposed to mental health professionals deciding to reinstate conditional release status on the acquitted if his condition improves within thirty (30) days without court approval. In these cases, court approval is not just a matter that arises by the passage of the time that the acquitted is in custody. It is the court that set the conditional release terms in the first place; it is the same court that can best determine whether a violation is sufficiently significant that the court, <u>not a group of mental health care providers</u>, as to no longer subject the public to the risk of the acquitted's conditional release. This material was not, according to my recollection, determined by the committee and represents a serious change in the thrust of the decisions made by the committee. The author of the Report is attempting to have mental health professionals make judicial decisions where it is unnecessary and unwise to do so. I recommend that the provisions changing the committee's deliberations be removed from the Report. Whether short term hospitalization has sufficiently stabilized the acquitted to return him or her to the public is clearly a judicial matter; it is not dissimilar to courts determining when a probationer has sufficiently violated the terms of probation to effect incarceration.

5. PROPOSED LEGISLATIVE CHANGES: The committee did not discuss the wording of legislative changes. Care should be taken in the Report to advise the Governor and the General Assembly that the legislative proposals represent staff interpretations of the committee's work and are <u>not</u> any legislative proposals made by the committee or approved by the committee.

I thoroughly enjoyed working with you and your staff; I hope that I shall have the opportunity to do so in the future. If you have any questions concerning my comments, please feel free to call. I will forward copies of the Report to the Virginia Association of Commonwealth's Attorneys and to the other Commonwealth's Attorney who participated in the committee hearings, the Honorable Robert F. Horan, Jr., of Fairfax County.

Sincerely yours,

W. Edward Meeks, III

WEMIII:rhm
cc: Honorable Lawrence R. Ambrogi, President, VACA
Honorable Robert F. Horan, Jr., Fairfax

COMMONWEALTH of VIRGINIA
DEPARTMENT OF
Mental Health, Mental Retardation and Substance Abuse Services

KING E DAVIS, Ph D LCSW
COMMISSIONER

MAILING ADDRESS
P O BOX 1797
RICHMOND VA 23214
TEL (804) 786-3921

November 26, 1990

The Honorable W. Edward Meeks, III
P.O. Box 358
Amherst, VA 24521

Dear Mr. Meeks:

Thank you for your letter and comments on the first draft of the report of the committee studying the management of insanity acquittees. I also appreciate your discussing the issues you raised over the telephone with Susan Ward. I am enclosing the latest draft of the report, which includes several of the changes you suggested. I hope that by explaining provisions of the report which you have questioned, we may narrow or eliminate areas of disagreement.

1. TEMPORARY CUSTODY AND EVALUATION

A majority on the committee agreed to a 45-day limit on the evaluation period with an extension of such period to 60 days if either of the evaluators recommended release. Such a provision would expedite disposition of cases; currently policy dictates that evaluations be completed in 60 days. The committee thought 60 days was too long in most cases, but that 45 days would not permit the preparation of a discharge plan. By allowing an extension when it appeared that discharge was likely to be an issue, the plan could be prepared prior to the hearing, eliminating the necessity of hearing the case once, then continuing it for preparation of a plan and rehearing the case. The court would of course be free to order release in any case, but the number of cases delayed for preparation of the plan would be minimal. The court could also order commitment if appropriate regardless of the clinical recommendation of release and the existence of a discharge plan.

VOICE/TDD (804) 371-8977
FAX (804) 786-4146

2. COMMITMENT

Your suggested changes in the report and legislation addressing priorities in scheduling hearings have been effected as per your discussion.

The fourth factor, including general matters which the court deems relevant, which the committee agreed that the court is to consider in making its commitment decision was inadvertently left out of the report and has been inserted. Inconsistencies in the definition of "dangerousness" have been corrected, addressing this risk throughout the report and the legislation as a probability and not a certainty.

With respect to the court's consideration, in its commitment decision, of likelihood of risk to the public, the committee discussed the criteria of "bodily harm" in the "foreseeable future," which the proposal included in the materials provided to the committee prior to each meeting. I don't recall a vote on the issue, but this factor was included as the committee identified the factors which the court should consider in determining the need for hospitalization. There were no changes suggested in the criteria as it was originally proposed. I believe there was a consensus that risk to property, while arguably constituting "dangerousness," was not to be included in the proposal before us.

The report and legislation have been amended to reflect the committee's consensus that the Commonwealth should be permitted to appeal all commitment and release decisions. The Attorney General's Office was to investigate the issue of who would bear appellate responsibility. They have not yet done so and advised that we use the language currently in the bill. This issue will need to be resolved.

3. RELEASE

Your suggested changes in the report and legislation addressing priorities in scheduling hearings have been effected as per your discussion.

4. CONDITIONAL RELEASE

The emergency procedures set out in the report and legislation to initiate revocation of conditional release were discussed and agreed to in general terms at the committee's final meeting. We developed a procedure for taking custody and committing conditional releasees who local authorities may not know are acquittees on conditional release. Because we could not ensure that their identity as such would be determined at any time prior to hospitalization, we designed a process that parallels the civil emergency detention and commitment process. We believe that conditional releasees not identified as such will be committed pursuant to this procedure. We then "deem" releasees so committed to have been committed pursuant to the procedure established for them in our bill. At any time their identity as acquittees is known, the provisions applicable to them will be applied. The provisions that you question are those "borrowed" from the civil process which will be used only when they are not yet identified as acquittees.

The reinstatement of conditional release status within 30 days was agreed to by the committee at its last meeting. Such action will only be taken with the approval of the court; this provision is included in the report and the legislation.

I hope that this information addresses your concerns. If you have other questions, please call me by December 3, 1990 at 804/786-4837. If you will provide us with a statement as to any provisions with which you continue to disagree, we will include such statement in the appendices to the report. We need your response as soon as possible.

Thank you for your important contribution as a member of the committee. It has been a pleasure working with you on this project. We look forward to hearing from you.

Sincerely,

Russell C. Petrella, Ph.D.
Director of Mental Health Services

RCP/jya
WPS2-25

COMMONWEALTH ATTORNEY
Amherst County
P.O. Box 358
Circuit Court Building
Amherst, Virginia 24521

W. EDWARD MEEKS, III
Commonwealth Attorney

W. STARKE MUNDY, III
Assistant

BEVERLY N. LEONARD
Victim Advocate

Phone: 946-9316
929-9316

December 19, 1990

Russell C. Petrella, Ph.D.
Mental Health, Mental Retardation and
Substance Abuse Department
P. O. Box 1797
Richmond, Virginia 23214

Re: Comments on the REPORT OF THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES ON THE MANAGEMENT AND RELEASE OF INDIVIDUALS FOUND NOT GUILTY BY REASON OF INSANITY TO THE GOVERNOR AND THE GENERAL ASSEMBLY

Dear Russ:

I have reviewed your letter of November 26, 1990; I appreciate your explanation of the items about which I expressed concern. I also appreciate you extending your time constraints to allow me to review your letter and respond. I suppose it is helpful to continue to respond on a category-by-category basis so that some order can be followed in our discussions; accordingly, I will do so as follows:

1. TEMPORARY CUSTODY AND EVALUATION: I continue to appose the law requiring discharge plans to be implemented until the court determines that discharge is imminent or proper. The law should not force the direction of a proceeding because of conflicting evaluations. I understand the need for shortening the time limit; my objections are to the impetus that the procedure creates towards release.

2. COMMITMENT: I still maintain that risks to public property can be substantially destructive to public safety. I also continue to oppose limitations of the Report and recommend that risk to the public be allowed to be interpreted by the court and that time be limited only to the future and not the "foreseeable future." Courts will not approach infinity in setting time as an element of the risk; however, they should be allowed to determine what is a reasonable period for risk prediction.

The failure to assign appellate responsibility to either Commonwealth's Attorneys or the Attorney General's office will

leave the law open to interpretation, and encourage a dispute about responsibility that could have been avoided at the outset.

3. CONDITIONAL RELEASE: My concerns remain the same as set forth in my October 14, 1990 letter, and I will incorporate them by reference herein.

4. PROPOSED LEGISLATIVE CHANGES: The committee did not discuss the wording of legislative changes. Care should be taken in the Report to advise the Governor and the General Assembly that the legislative proposals represent staff interpretations of the committee's work and are not any legislative proposals made by the committee or approved by the committee.

Again, I have thoroughly enjoyed working with you on these matter; I appreciate your consideration and courtesy. I personally extend to you and your staff my wishes that your holiday season will be joyous. I hope to be able to work with you in the future.

Sincerely yours,

W. Edward Meeks, III

WEMIII:rhm
cc: Honorable Lawrence R. Ambrogi, President, VACA
Honorable Robert F. Horan, Jr., Fairfax

COMMONWEALTH of VIRGINIA

CENTRAL STATE HOSPITAL
P.O. Box 4030
Petersburg, Virginia 23803

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION
AND
SUBSTANCE ABUSE SERVICES

Telephone (804) 861-7000

October 18, 1990

Russell Petrella, Ph.D.
Susan Ward, J.D.
Department of Mental Health/MRSAS
P.O. Box 1797
Richmond, Virginia 23214

Dear Dr. Petrella and Ms. Ward:

Thank you for allowing me to participate in the Task Force on the disposition of insanity acquitees. I found the meeting stimulating, productive, and admired your leadership. I believe the resulting proposal from the Task Force is a considerable improvement over the current system, and attempts to balance public safety and concern for individual patients. However, as you requested, I am writing to note several differences of opinion I have with the final proposal. My first concern is the application of the proposed NGRI management scheme to misdemeanants. I believe that, in general, an insanity acquittal for misdemeanants is a miscarriage of justice. These defendants usually spend considerably more time in a maximum security unit of a hospital, for offenses such as shoplifting or abusive language, than they would have spent in jail had they been found guilty. Most often, defendants under these circumstances would not serve any time at all in jail, as they usually have spent considerable time in the hospital already prior to their trials. I believe that the usual civil commitment process is most appropriate for these defendants, offering them protection from prolonged incarceration, and providing for their treatment needs and public safety.

Another major concern that I have is over the indefinite length of the conditional release. As I understand it, persons acquitted NGRI could be on conditional release for many years. I believe that, for felonies, there is sufficient justification early in the process to treat this group of persons different from the usual group of civil committees. However, after a sufficient period of time has elapsed, I believe the clinical and legal characteristics of these persons begin to resemble those those of ordinary psychiatric patients. We have many patients who enter our state hospitals through civil processes who have backgrounds which

include felony convictions. These patients are entitled to the usual protection of our civil commitment process. For the NGRI acquitees, I believe that after enough time has passed, their legal status should more closely resemble that of civil committees. Thus, I believe that there should be a finite period of time of conditional release. If the person continues to need involuntary monitoring and treatment, I believe the outpatient commitment statute provided for in the Code of Virginia is adequate.

If we fail to provide for this protection, there is the potential for considerable abuse. It is possible, even likely, that the Commonwealth will pursue an NGRI acquittal in order to "commit" a person for life. While this might be more reasonable in some instances, in general, I believe it would represent a substantial violation of individual rights.

Another serious concern I have over the proposal is the lack of a specified standard for commitment after the acquitee has been placed in the temporary custody of the Commissioner. I believe courts will want clearer standards, and that such clarity can be provided through the use of language similar to that found in our civil commitment statutes. I believe that the current proposal will lead to a much greater variation in commitment, and will make it difficult to advise patients of the likely outcome of an insanity acquittal.

My final major concern would be the inclusion of a criterion for conditional release which specifies that "there is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified." I believe the purpose of conditional release in many instances would be to ensure that patients complied with treatment, and it would be expected that these patients would have a previous history of non-compliance.

Once again, thank you for asking me to participate in this study. If I can help in any way, or if you would like clarification of these comments, I would be happy to meet with you at your convenience.

Sincerely,

Richard Elliott

Richard L. Elliott, M.D., Ph.D.
Medical Director, Central State Hospital
and
Associate Professor and Assistant Chairman
Director, MCV Forensic Evaluation Program
Department of Psychiatry

RLE/vn