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A Cautionary Tale: The Process of Mental Health Treatment and Restoration to Sanity of Individuals who are found Not Guilty by Reason of Insanity in New Hampshire

Jasper James "JJ" Chen[1,2,3]*, Danielle Dahle[2,3], John Hinck[2,3] and Alex de Nesnera[2,3]

[1]*Behavioral Health Sciences, Cheyenne Regional Medical Center,USA*
[2]*Department of Psychiatry,Dartmouth-Hitchcock Medical Center, USA*
[3]*New Hampshire Hospital, Concord, USA*

***Corresponding author**
Jasper James "JJ" Chen, Department of Psychiatry, Geisel School of Medicine at Dartmouth College, Dartmouth-Hitchcock Medical Center, Lebanon, NH, USA, Tel: 307-509-9516, Email: jasper.chen@crmcwy.org

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Abstract

States vary considerably in their approach to handling the mental health treatment of individuals who are determined to be Not Guilty by Reason of Insanity (NGRI). In New Hampshire, the process is a by-product of both historical and legal precedent. We endeavored to elucidate and understand the current processes by which individuals deemed to be NGRI are cared for in the mental health system. We interviewed key stakeholders and individuals directly involved. We reviewed the aggregate summary data of all known NGRI patients in the state and completed a literature search for studies and descriptions of the NGRI process in other states. The NGRI process in New Hampshire is historically-driven and designed to protect both the general public from potential future harm of individuals who are NGRI as well as allow conservative advancement of privileges in a step-wise manner.

INTRODUCTION

States vary considerably in their approach to handling the mental health treatment of individuals who are determined to be Not Guilty by Reason of Insanity (NGRI) [1]. This is in part due to the overall rarity of being found NGRI. The insanity defense is very infrequently used; only 1% of defendants charged with a felony actually plead insanity [2]. Furthermore, when the insanity defense was raised, the defense was successful only 25% of the time [3]. Over 70% of insanity acquittals result from plea bargains, indicating that only a small number of insanity cases are actually heard by a jury [4]. The difference in approach is also due to the fact that states vary greatly in their mental health systems and available resources.

In New Hampshire, the jury is the entity that defines whether an individual is insane or not, and in virtually all cases in New Hampshire the jury will find defendants guilty as opposed to NGRI. Most individuals found criminally insane are involuntarily committed to a psychiatric facility, where periodic assessments regarding their status are forwarded to the responsible court [5]. Individuals found insane may be released when the court has determined they have met their jurisdictional requirements for safe release into the community, a process known as "restoration to sanity" [5].

Description of the statutes for individuals who are determined to be NGRI in New Hampshire

Specifically, in New Hampshire, "Any person prosecuted for an offense may plead that he is not guilty by reason of insanity or mental derangement. If such a plea is accepted by the state's counsel, such counsel shall certify the same to the court" [6]. Furthermore, "In either of the cases aforesaid the court, if it is of the opinion that it will be dangerous that such person should go at large, shall commit him to the secure psychiatric unit (SPU) for 5 years unless earlier discharged, released, or transferred by due course of law" [7]. Of note, the Secure Psychiatric Unit (SPU)

of the Department of Corrections has been described as the most restrictive setting in the state of New Hampshire [8]. Privileging is also commensurate to the current defined standard of safety [9].

Objective

We endeavored to describe the current processes by which individuals deemed to be NGRI are cared for in the mental health system in New Hampshire, review the literature for descriptions of the processes in several other states, and identify potential process improvement areas.

METHODS

This work was conducted from the one-year time period beginning July 2013 and ending June 2014. We prospectively identified key stakeholders and players in the New Hampshire NGRI process and requested interviews at their convenience, and which lasted, on average, 30 to 60 minutes. We were able to interview numerous individuals of various departments in order to delineate the NGRI process in New Hampshire. Key questions such as the following were asked at each interview: 1) What is your role in the NGRI process? What (if anything) do you think needs improvement in the NGRI process? 2) Is it realistic to look at the NGRI process being improved? In order to obtain the highest quality information, we guaranteed anonymity in reporting the participants responses except for those responses where we had a specific understanding from the participant regarding attribution.

We met with the following individuals of NHH: Dr. Bob MacLeod, CEO of NHH; Lynne Mitchell, Hospital Counsel at NHH. We also met with the following individuals of the DOC: Dr. Daniel Potenza, Medical Director and Psychiatrist at the SPU; Helen Hanks, Director of Medical and Forensics Services, SPU, DOC; and Jeff Wedge, NGRI coordinator, SPU, DOC.

We also interviewed myriad individuals: Superior Court Chief Justice Nadeau to get a broad perspective of the judiciary system's role in determination of NGRI status; Eric Riera, Director of the Bureau of Behavioral Health, Department of Health and Human Services; Mike Brown, Esquire, Senior Assistant Attorney General; Mike Skibbie of the Disability Rights Center, and Linda Mallon, Executive Director, of the Office of Public Guardian.

Lastly, we have had the privilege and opportunity to witness firsthand the stories and experiences of many patients who are NGRI on the long-term/continuing care/forensics unit at NHH. In that capacity, we have had the opportunity to care directly for numerous individuals who are NGRI as their primary inpatient psychiatrists. We were able to both formally and informally observe the results of the NGRI process in their overall care.

We also searched the literature through PubMed and Google for relevant descriptions or research of the NGRI process in other states.

RESULTS

Measured results

There are currently 30 individuals who are NGRI in the State of New Hampshire, 26 male and 4 female. Their average age is 52.3 (range 25 to 70). Of these 30 individuals, 10 are at the Secure Psychiatric Unit (SPU) of DOC, 8 are at Transitional Housing Services (THS), 5 are at NHH, 1 is at a group home, 1 is in elder care, and 5 are in independent community living situations. Six of the 30 individuals have guardians. Index offenses included 9 first degree murders, 6 second degree murders, 3 first degree assaults, and 11 others (Table 1).

The median length of stay of each individual at the SPU, from time of being determined NGRI until leaving the SPU, was 2 years (range 1 year to 5 years). The median length of stay of each individual at NHH, from the time leaving the SPU to the time leaving NHH, was 0.5 years to 5 years. The median duration of time for each individual who was determined to be NGRI until conditional discharge back to the community (defined as release to transitional housing, group home, or independent living with community mental health support) was 4 years (range 2 to 9 years). There has been one known absolute discharge back to the community.

PROCESS RESULTS

Description of the overall process by which individuals in the State of New Hampshire are determined to be NGRI

In New Hampshire, once individuals are adjudicated to be NGRI there is a hearing regarding dangerousness to self or others (presumptive by virtue of NGRI). The defense must rebut this argument by clear and convincing evidence that this is not the case or else the individual is committed. As previously alluded to, New Hampshire State Law states that such individuals who are NGRI "Shall be committed" to the SPU for 5 years. The Law also states that every 5 years there is a Gibbs hearing regarding ongoing danger to self or others and mental illness.

There are two possible outcomes: 1) The individual is determined not to be a danger to self/others OR not mentally ill, in which case the individual is released. 2) The individual is determined to be a danger to society or self and mentally hill, in which case the individual is committed for another 5 years in the least restrictive environment.

The least restrictive environment is recommended by the treatment team at the SPU/DOC based on information obtained from both the evaluation of the treatment team at the SPU and independent forensic risk evaluations. Less restrictive options than SPU (in order of decreasing restrictiveness) include transfer to NHH, transitional housing, group home, or independent home in the community. This determination of the least restrictive environment requires Superior Court approval which also seeks input from the prosecutors in regards to the recommendation. Transfers from SPU to NHH are made according to a Memorandum of Understanding between SPU (DOC) and NHH (DHHS). While physical custody and health treatment responsibility is transferred to NHH, the DOC still maintains responsibility for safety and thus privileging (i.e. whether the NGRI is allowed off a unit for therapy groups, etc.) decisions.

DISCUSSION

On the condition of anonymity, one individual interviewed at

Table 1: Demographic Characteristics of Patients in New Hampshire who are Not Guilty by Reason of Insanity. July 2013 to June 2014.

Index Offense for which each individual was originally determined to be NGRI	Number	Details
1st degree murder	9	1 individual had an additional attempted murder charge; 2 individuals were also charged with arson; 2 individuals had 2 counts of first degree murder and one of these two were also charged with 7 attempted murders ; (The individual awaiting NGRI acquittal is charged with murder)
2nd degree murder	6	1 individual was charged with 2 counts of second degree murder
1st degree assault	3	
Attempted murder	2	
Felonious sexual assault with minor children (2 counts)	1	
Attempted murder and first degree assault	1	
Criminal threatening and reckless conduct	1	
Attempted murder and reckless conduct	1	
Criminal threatening and attempted kidnapping	1	
Arson	1	
Assault by a prisoner and attempted escape	1	
Felony, reckless conduct	1	
2nd degree assault and criminal threatening	1	
Total number of patients who are NGRI in New Hampshire	**30**	

NHH stated that "Patients who are NGRI are a real tension around here" [10]. Furthermore, although "95% of the time, they have worked out the consent decree prior [and the NGRI ruling] is not as contested as you might think", the NGRI process in New Hampshire has been variously described as "very subjective", with "no definition legally of mental illness" [11].

Compared to other states, there may be relatively very few individuals who are NGRI due to the shift in burden to the defendant to prove insanity. The oversight of the New Hampshire Superior Court, which is a felony jurisdiction (crimes where the penalty is > 1 yr), indicates the severity of the dangerousness of individuals who are NGRI. Once individuals are NGRI, their care and privileging is contingent on the opinions of experts, including those providing the periodic forensic risk assessments required for consideration of transition to the least restrictive environment.

The inherent caution in determination of least restrictive environment is protection of the public at large from as well as protection of the individual who is NGRI. In terms of deciding upon what the law reads as "a reasonable treatment plan," it is often easier for an individual who is NGRI to step down from SPU to NHH than from SPU to the general community. Factors that increase the reasonableness of treatment plans include the administration of injectable or depot formulations of psychopharmacologic treatments, daily monitoring of adherence to oral psychopharmacologic treatments, permanent residence, and family who are supportive and who live in the area.

Ultimately, NGRI is associated with criminality, and for that reason, conservatism must be the overarching approach. The "reasonableness" of the treatment plan is contingent on a very careful orchestration of increases in privileging. "We need a predetermined mechanism to [determine privilege increases] when there is no agreement between SPU and NHH" [12] as one staff member, on the condition of anonymity, at NHH pointed out. Some have argued that "the level of security is not tantamount to the level of restriction" and that often it is possible to conflate these two very important concepts. The NGRI process is perhaps not about what is therapeutically best for individuals who are NGRI, but what may be the safest and most conservative approach for the community at large.

Some states have instituted forensic oversight boards, which is a formal collaboration amongst various departments and which aims to spread out the overall risk burden amongst several groups as opposed to one group or a very limited group of individuals. However, the justification of having such a forensic oversight board in the state of New Hampshire would require that there are more individuals with NGRI than are currently in the system and a tipping point of both clinicians and administrators that are dissatisfied with the current process.

We argue that a forensic oversight board would provide formal mechanisms—aligned with the World Health Organization's Mental Health Action Plan 2013-2020 [13]—for monitoring, promoting and protecting the rights of all individuals with mental disabilities. This is now timely and relevant not only in the USA, but also in the United Kingdom where investigations of proper boundaries of criminal liability regarding those with questionable mental capacity underway. For instance, the Law Commission for England and Wales are quite aware of inherent complexities in the fair attribution of criminal culpability to those whose mental faculties may or may not have caused their decisions, either at the time of the offense or during trial [14]. Also of particular significance is that a comparison of disposal attitudes towards forensic psychiatric patients among police

officers, psychiatrists, and community members in China found that the majority of those surveyed, particularly police officers, found that individuals with mental illness should receive violence risk assessments regularly due to their propensity for violence [15]. The researchers of the aforementioned Chinese study noted that it was imperative to educate the public regarding mental health and to provide legal knowledge to those with less legal training, including psychiatrists and community members at large [15].

In terms of our own experiences with individuals who are NGRI, we have encountered various inconsistencies which are difficult for clinicians to explain to their patients: for instance, how an individual who is NGRI may suddenly "lose privileges" during the transition from the SPU to NHH in the form of no longer being able to meet with family members, or allowed to go outside the building to attend "fresh air groups" for a period of time before such privileges are approved by the DOC. At times, patients who are NGRI and who are experiencing frustrations in what they thought were both reasonable and therapeutic privileges have had to meet with their attorneys to inquire as to the timing of step-wise privilege increases.

Potential changes to improve and make the existing process more efficacious

Our investigation identified several process improvement areas, bearing in mind that we are dealing with two systems—the SPU of DOC and NHH—working together to balance treatment and community safety. Therefore, implementation of these process improvements may be difficult. Nevertheless, two potential overarching areas for improvement areas consist of the following: 1) more prompt and regular risk assessment (e.g., not every 6 months or every year, but at more frequent intervals) including a systematic rationale for what would trigger the next risk assessment. 2) Having more regular meetings between key NHH administrative staff and DOC/SPU staff to streamline and coordinate the NGRI process for individual patients who are NGRI. These two aforementioned strategies would decrease the current time-lag in the processing of petitions to increase privileges, which can often take ~1-2 months at a time—meanwhile, a patient who is NGRI may be wondering why they couldn't all of a sudden see their niece on the weekends anymore at NHH when they could do so at SPU, a higher restrictive setting.

Furthermore, a formal data-driven mechanism of inquiry could allow a more scientific approach as to when a court hearing should occur regarding stepped privileging or stepping down from the NHH environment to transitional housing and ultimately consideration of discharge to the community, whether conditionally or absolutely. One potential mechanism is a protocolized one-year long treatment plan that is built in with room to adjust, knowing that risk assessment schedule will potentially slow down the process of step-wise privileging.

Given the reality of continued budget cuts in mental health, it is not as likely that New Hampshire will be able to implement Forensic Assertive Community Treatment teams comprised of individuals who are especially trained in working with individuals who are NGRI so that they may be more closely monitored in the community at large. Neither is it forseeable in the very near future that the creation of a forensics review panel such as in the states of Connecticut or Virginia could occur in New Hampshire. Rather, the goal has been to minimize delays to treatment and to encourage patients to adhere to treatment regimens that are more likely for increased privileging to continue.

Risk assessments are perhaps the most anxiety-provoking events imaginable for both patients who are undergoing them and clinicians utilizing them alike. Ever since the Tarasoff [16] decision in California and other related cases, mental health professionals have been given a duty to determine whether "a patient poses a serious danger of violence to others". Should the mental health professionals fail, there is of course the threat of malpractice liability. Despite the propensity to fail, wrong guesses about the potential for violence of an individual who is NGRI can have a devastating effect on the patient, the victim, and the mental health care treatment team [17,18].

Mental health professionals once thought that the prediction of violence—especially long-term predictions are inaccurate [18-20]. In fact, in his The Clinical Prediction of Violent Behavior (1981), John Monahan summarized the then available research to conclude that "psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior" [18,21]. However, with the advent of such risk assessment instruments as the HCR-20 [21,22], an evaluator consistently has a better-than-chance ranking of the likelihood of future violence in a mental health population [17]. The HCR-20 [22] is a straightforward example of the process of assessing risk by combining data [18]. The acronym HCR directs the clinician's attention toward 20 factors, all associated with violence: 10 historical items, 5 clinical items, and 5 risk management items.

In actuality, there is no guarantee that a patient who is NGRI, once able to go at large, will never commit any further violent acts. Thus, the most conservative approach would be to never release patients who are NGRI to the public; however, this may not be the most therapeutic option from the standpoint of the individual who is NGRI and who may be demonstrating lower and lower scores of standardized risk assessments. We may all agree that there is little to no societal agreement as to what risk of violence is low enough to ignore [22].

Conditional release as a means of recovery-oriented care rather than coercive intervention

However, many individuals are unjustifiably maintained at facilities and may languish for periods of time. The public policy approach underlying conditional release is to allow individuals the least restrictive alternative with appropriate oversight; in this manner the individual may be prevented from recidivism or rehospitalization [23]. Conditional release may also be utilized to save costs in response to public burdens and societal costs of hospitalization and incarceration [23]. Studies have found that conditional release was maintained in over 70% of individuals [24]. Predictors of success on conditional release was predicted by financial resources and not having a personality disorder [24]. Therefore, conditional release programs should consider empirical factors to develop risk management approaches to improve successful maintenance of community-centric forensic treatment options [24]. Furthermore, the myriad challenges

faced by evaluators when conducting readiness evaluations for conditional release highlight the importance for improved training techniques, standardized evaluation algorithms, statutory guidance, and legislative action.

CONCLUSION

In New Hampshire, a specific court order in the form of a Superior Court Commitment (as opposed to Probate Court, whose domain is guardianship), the higher court indicative of the higher level of dangerousness involved, is required for the mental health treatment plans of all individuals who are NGRI. In addition, periodic forensic risk assessments are required for consideration of transitioning individuals who are NGRI to the least restrictive environment.

The NGRI process in New Hampshire is geared towards collective risk management on behalf of the entire citizenry. "Some folks are dangerous no matter what if they are to go at large" [9]. By extension, we are obligated to society to prevent the recurrence of dangerousness, and thus the rule of conservatism has applied to the NGRI process in New Hampshire.

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