New York’s Post-Verdict Scheme for the Treatment of Insanity

Acquittees: Balancing Public Safety with Rights of the Mentally Ill

Larry Cunningham
NEW YORK’S POST-VERDICT SCHEME FOR THE TREATMENT OF INSANITY ACQUITTEES:

BALANCING PUBLIC SAFETY WITH RIGHTS OF THE MENTALLY ILL

LARRY CUNNINGHAM*

A person who is acquitted by reason of mental disease or defect—commonly known as the insanity defense—does not get a "free walk." While spared punishment as an "offender," he nevertheless faces years of treatment as a "patient" in the mental health system.1 This Article discusses New York’s procedures following a successful insanity defense.

Insanity acquittees are some of the most dangerous persons to come into contact with the criminal justice system. They have, in many cases, committed unspeakable acts of violence.2 New York law correctly recognizes that these individuals, while ill, are extremely dangerous. Thus, New York Criminal Procedure Law (CPL) § 330.20,3 the governing statute, includes a number of provisions designed to protect the public: automatic commitment of "dangerous" insanity acquittees, a workable definition of "dangerousness" that recognizes that medication compliance is not necessarily indicative of wellness, procedures to protect victims from unwanted contact with patients, a recommitment mechanism for patients

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1 See N.Y. CRIM. PROC. LAW § 330.20(1)(f), (2), (6), (7) (McKinney); N.Y. MENTAL HYG. LAW §§ 9, 15 (McKinney).

2 See, e.g., Matter of David B., 766 N.E.2d 565, 567 (N.Y. 2002) (involving a patient who stabbed his brother in the chest, believing he was responsible for their mother’s death, and then left him to bleed to death).

3 N.Y. CRIM. PROC. LAW § 330.20 was substantially amended as part of the Insanity Defense Reform Act of 1980 (L. 1980, ch. 548). "The amendments were prompted by concern both that the convicting court lacked continuing supervision over the acquitted, and that once committed, acquittees are constitutionally entitled to essentially the same treatment as involuntary patients generally." Matter of Jill ZZ., 629 N.E.2d 1040, 1041 (N.Y. 1994).
who decompensate while at a lower level of custody, and specific provisions that permit the District Attorney to present evidence at any court review. On the other hand, CPL § 330.20 demonstrates a realization that insanity acquitees are, by definition, not criminals but patients in need of treatment. The statute directs that patients are not to be labeled as criminals, they are entitled to biennial reviews, the state bears the burden of proving continued dangerousness, and patients receive the benefit of a special and highly trained cadre of lawyers from the Mental Hygiene Legal Service to represent them in-court and advocate on their behalf at the hospital level. Nevertheless, CPL § 330.20 is not without its faults.

In this Article, I will explore both the statutory workings of the insanity review system in New York and examine ways in which CPL § 330.20 can be improved. In Part I, I will provide a detailed account of how a typical insanity review moves through the system. In Part II, I will explore the ways in which CPL § 330.20, as currently written, protects both the public and individual rights. In Part III, I will propose modest reforms to improve the law.

I. CPL § 330.20 PROCEDURES AND STANDARDS

Pleading insanity is an affirmative defense in New York. The accused has the burden of proving, by a preponderance of the evidence, that "as a result of mental disease or defect, he lacked substantial capacity to know or appreciate either: (1) [t]he nature and consequences of such conduct; or (2) [t]hat such conduct was wrong." A finding of not guilty by reason of mental disease or defect (NGBRMDD) can result either by plea, with the permission of the People and the court, or after a trial verdict.

Once a person is found NGBRMDD, they are acquitted of the crime and are no longer properly characterized a "defendant." Rather, they are considered a "patient" whose future status is decided by an intricate,

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4 See generally N.Y. CRIM. PROC. LAW § 330.20.
5 See id. § 330.20(1)(d) (defining "mentally ill" as "a defendant currently suffering from a mental illness for which care and treatment as a patient, in the in-patient services of a psychiatric center under the jurisdiction of the state office of mental health, is essential to such defendant's welfare").
6 See generally N.Y. CRIM. PROC. LAW § 330.20.
7 See N.Y. PENAL LAW § 40.15 (McKinney).
8 See id. § 25.00(2).
9 See id. § 40.15.
10 N.Y. CRIM. PROC. LAW § 220.15 (McKinney). In negotiating a plea agreement under this section, some prosecutors will require a defendant to agree that if the court does not adjudicate him a Track One acquittee, see infra note 25, the plea will be vacated. This guards against a malingering defendant.
statutory scheme. First, the court must issue an "examination order." The state Office of Mental Health (OMH) must designate "two qualified psychiatric examiners" to evaluate the patient for the purpose of preparing a report for the court on the patient’s current psychiatric state. The examination order is also important because it triggers notification to the Mental Hygiene Legal Service (MHLS). MHLS will then participate in all future proceedings on behalf of the patient.

Both of the examiners must prepare individual reports on the patient’s mental status, which the Commissioner of OMH will review. If the reports differ in their conclusions as to the patient’s dangerousness, a third examiner is brought in to evaluate the patient. In any event, the Commissioner will forward all of the examination reports to the court, which will in turn provide copies to the prosecutor, defense counsel, and MHLS.

The court then conducts an "initial hearing" for the purpose of adjudicating the patient’s current mental status. The People bear the burden of proving the patient’s status "to the satisfaction of the court." At the conclusion of the hearing, the court must determine which of three "tracks" to place the patient:

11 Nevertheless, the statute refers to insanity acquittees as defendants. See generally N.Y. CRIM. PROC. LAW § 330.20.
12 § 330.20(2).
13 Id. Qualified psychiatric examiners are either: (1) physicians, including osteopaths, who are board-certified or board-eligible in psychiatry; or (2) licensed psychologists. § 330.20(1)(q), (s). Examiners need not be OMH employees. § 330.20(1)(s).
14 See § 330.20(2). Usually the insanity acquittee will be confined in jail—either remanded or unable to post bail—and will simply be moved from jail to a secure OMH facility for the examination. If the defendant is on release status, the examination can be conducted on an out-patient basis or, if OMH certifies that an in-patient examination is necessary, the court must commit the patient to a secure facility. § 330.20(3). The examination must be conducted within thirty days, unless OMH can demonstrate good cause for an extension. § 330.20(4). The defendant may retain his own psychiatrist or psychologist, who may attend the examinations with the court’s permission. § 330.20(5).
15 § 330.20(5).
16 See N.Y. CRIM. PROC. LAW § 330.20(2). The Mental Hygiene Legal Service represents and advocates for the mentally ill in New York. See N.Y. MENTAL HYG. LAW §§ 47.01(a), 47.03. MHLS is administratively located in the judiciary and is independent of any state agency. § 47.01(a). There is an MHLS office in each of the four departments of the Appellate Division. Id. A department’s MHLS director and staff are appointed by the Presiding Justice of that particular department. Id.
17 § 330.20(2).
18 § 330.20(5)
19 Id.
20 Id.
21 N.Y. CRIM. PROC. LAW § 330.20(6). The hearing must take place within ten days of the court’s receipt of the reports from the Commissioner. Id.
22 § 330.20(6). In People v. Escobar, 462 N.E.2d 1171, 1174–76 (N.Y. 1984), the Court of Appeals held that this statutory language means that dangerousness must be proved by a preponderance of the evidence.
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<th>Track</th>
<th>Finding</th>
<th>Proof</th>
<th>Orders</th>
<th>Placement</th>
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<tbody>
<tr>
<td>1</td>
<td>Dangerous mental disorder (DMD)</td>
<td>Patient suffers from: (1) a mental illness; and (2) &quot;because of such condition he currently constitutes a physical danger to himself or others.&quot; CPL § 330.20(1)(f).</td>
<td>Commitment order. CPL § 330.20(1)(f).</td>
<td>Secure facility (Kirby P.C. or Mid-Hudson P.C.)</td>
</tr>
<tr>
<td>2</td>
<td>Mentally ill (MI)</td>
<td>(1) Patient suffers from a mental illness for which in-patient care and treatment “is essential to such [his] welfare and that his judgment is so impaired that he is unable to understand the need for such care and treatment”; and (2) minimal, constitutional level of dangerousness. CPL § 330.20(1)(d); <em>Matter of David B.</em>, 766 N.E.2d 565, 571 (N.Y. 2002) (reading into the statute a constitutional requirement of dangerousness).</td>
<td>(1) Civil commitment order under Mental Hygiene Law; and (2) Order of conditions under CPL</td>
<td>Non-secure facility</td>
</tr>
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This initial determination is critically important. A “Track One” acquittee is placed, at least initially, in one of two secure OMH facilities: Kirby Forensic Psychiatric Center or Mid-Hudson Forensic Psychiatric Center. Both hospitals are “secure” in every sense of the word: They have fences, barbed wire, and guards. A “Track Two” acquittee is in effect treated as a civil commitment patient. Patients in non-secure facilities enjoy more freedom than their counterparts in secure facilities. A “Track Three” placement is the nightmare scenario for prosecutors, since a patient who is neither DMD or MI must be released into the community. The court can, however, impose an order of conditions that requires outpatient treatment and monitoring.

Most insanity acquittees are found to have a dangerous mental disorder. What follows is a series of progressively longer review periods. The initial “commitment order” lasts six months and is issued by the court that took the plea or verdict after the initial hearing. Subsequent orders are usually issued by a superior court in the county of the patient’s commitment or, if

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<td>3</td>
<td>Neither DMD nor MI</td>
<td>People are not able to prove either DMD or MI</td>
<td>Order discharging the patient either with or without an order of conditions. CPL § 330.20(7).</td>
<td>Released into community</td>
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23 Kirby is located on Ward’s Island in the East River. It is part of New York County. Mid-Hudson is located in Orange County.

24 A Track Three adjudication is rare because most insanity patients committed violent offenses and it is not likely that they would suddenly be cured of the mental illness that caused their violent acts. A patient is most likely to be Track Three if there was a lengthy delay between the offense and trial or if the offense involved some sort of “temporary insanity.” Alternatively, a Track Three determination may result because of malingering.

In plea bargain cases, prosecutors have two tools at their disposal to guard against malingering. First, the People can make the plea conditional on a Track One adjudication. If, at the initial hearing, the court does not find the patient to be dangerous, the plea can be vacated. Second, if the People can demonstrate malingering, the plea can be vacated. For example, in Matter of Lockett v. Juvier, 480 N.E.2d 378 (N.Y. 1985), the defendant claimed he was not responsible for several robberies because he was suffering from post-traumatic stress disorder as a result of serving in the Vietnam War. After the defendant’s plea was accepted, the People learned that the defendant had not, in fact, served in Vietnam. The trial court vacated the plea and the defendant brought an Article 78 proceeding to prohibit the prosecution from proceeding. On appeal, the Court of Appeals held that a trial court has inherent authority to vacate a plea obtained by fraud or misrepresentation. Id. at 381.

25 See § 330.20(7).

26 See N.Y. CRIM. PROC. LAW § 330.20(1)(f).
the patient is on release status, the county of his residence. Following the initial commitment period, the court must determine if the patient still has a dangerous mental disorder. If so, it must issue a "first retention order," which can be for up to one year. Thus, up to eighteen months after the initial commitment, the patient will come up for another review. If the court is satisfied that the patient remains dangerous, it must issue a "second retention order," which can authorize commitment for up to an additional two years. Reviews are then conducted every two years, unless the court orders a shorter period between each "subsequent commitment order."

Each of these reviews shares similar features. The movant for each proceeding is the Commissioner, represented by the Attorney General. The Commissioner must make his application at least thirty days prior to the expiration of the previous order and provide notice of the application to the People, the patient, and MHLS. The patient, represented by MHLS, has a right to demand a hearing on the application. The court can also order a hearing on its own motion. If the application proceeds to a hearing, three parties are given a right to be heard and present evidence: the Commissioner, represented by the Attorney General; the People, represented by the District Attorney or another prosecuting attorney; and the patient, represented by MHLS. Although the statute speaks of both the District Attorney and OMH having the ability to present evidence, in practice the Attorney General presents the evidence for retention and the District Attorney asks follow-up questions or presents supplemental evidence. Typically, the Attorney General calls one or more members of

27 A first retention order can also be issued by the court that issued the commitment order, which must be the court that took the plea or verdict. § 330.20(8). In turn, a second or subsequent commitment order can be issued by the court that issued the first retention order, and so on. § 330.20(9). In theory, then, the court that took the plea or verdict could issue the first retention order. If it does, it can issue the second retention order, and so on. However, I am aware of only one case where subsequent retention applications were made before the trial judge rather than a court in the county of commitment.

28 § 330.20(1)(g).
29 § 330.20(1)(h).
30 See id., see also § 330.20(9). Counsel will sometimes negotiate an agreed retention order but stipulate a shorter retention period. The shorter time between reviews is the carrot that induces the patient to waive a hearing. In general, OMH will not agree to a retention order length of less than 12 months, since there is a great deal of preparation that goes into their retention applications.

31 See N.Y. CRIM. PROC. LAW §§ 330.20(8), (9).
32 Id. The statute also requires notice to defense counsel. Id. However, I am aware of only one case where trial counsel has remained involved after MHLS notes its appearance for the patient.

33 Id. Curiously, the statute also permits the Commissioner and the District Attorney to demand a hearing. Id. However, in practice the patient is the only party with an interest in having a hearing. The Commissioner and the People are typically satisfied if the matter is disposed of without a hearing.

34 Id.
35 See id.
36 Id.
the hospital’s forensic committee or the patient’s treatment team to testify about the patient’s current mental status. MHLS will sometimes call an expert witness to rebut OMH’s experts. Often, however, MHLS will seek to establish that the patient is no longer dangerous by cross-examining OMH’s doctors or by pointing to specific items in the patient’s medical record. At the conclusion of the hearing, the court must issue a new retention order if the patient is deemed to be still dangerous, and the patient will then remain in a secure facility. If the patient is no longer dangerous, but is still mentally ill, the court must issue a retention order and, in addition, a “transfer order,” which transfers the patient to a non-secure facility, and an order of conditions. If the patient is no longer dangerous or suffering from a mental illness, the court must issue a release order and an order of conditions.

Some patients remain dangerous for the rest of their lives. Every two years, they nevertheless come up for review. Often their dangerousness is so apparent (even to them) that they consent to continued retention in a secure facility.

Some patients, however, become well enough that OMH recommends transfer to a non-secure facility. To make a transfer application, OMH must state pursuant to statute:

[T]he [C]ommissioner is of the view that the defendant does not have a dangerous mental disorder or that, consistent with the public safety and welfare of the community and the defendant, the clinical condition of the defendant warrants his transfer from a secure facility to a non-

37 OMH maintains a “medical record” for each patient. It is divided into sections, and contains contemporaneous notes from nurses, doctors, social workers, and others. It might show, for example, if a patient refused medication, got into a fight, acted out during group therapy, or reported hearing voices—all facts that would show continued dangerous. Alternatively, it might show medication compliance, an absence of disputes with staff and other patients, and progress during individual and group therapy. Since the information is necessary for diagnosis and treatment, the entries are admissible as business records. See generally Williams v. Alexander, 129 N.E.2d 417 (N.Y. 1955). While patients sometimes raise privilege arguments, judges typically rule that they have waived privilege either by asserting the insanity defense at trial, entering an insanity plea, or making a demand for a retention hearing. See Koump v. Smith, 250 N.E.2d 857, 864 (N.Y. 1969) (holding that when a party places his mental or physical condition “in controversy,” he will be deemed to have waived physician-patient privilege); People v. Al-Kanani, 307 N.E.2d 43, 44 (N.Y. 1973) (stating that “where insanity is asserted as a defense and, as here, the defendant offers evidence tending to show his insanity in support of this plea, a complete waiver is effected, and the prosecution is then permitted to call psychiatric experts to testify regarding his sanity even though they may have treated the defendant. When the patient first fully discloses the evidence of his affliction, it is he who has given the public the full details of his case, thereby disclosing the secrets which the statute was designed to protect, thus creating a waiver removing it from the operation of the statute.”) (citation omitted).

38 N.Y. CRIM. PROC. LAW §§ 330.20(8), (9).
39 Id.
40 N.Y. CRIM. PROC. LAW §§ 330.20(7), (9).
secure facility.\textsuperscript{41}

Here the alignment of the three parties—OMH, the People, and the patient—changes radically. In a transfer application, OMH and the patient are aligned, since both are seeking transfer. It is the People who oppose the application. The burden at a transfer hearing is on the People to prove that the patient is still dangerous "or that the issuance of a transfer order is inconsistent with the public safety and welfare of the community."\textsuperscript{42} If the People fail to meet their burden, the court must issue a transfer order.\textsuperscript{43}

If a transfer order is granted, the patient is moved to a non-secure facility, of which there are several scattered throughout New York. These are known in the vernacular as "civil hospitals": state-run hospitals typically used for the civil commitment of the mentally ill. A transfer order is also the first instance in which a court must issue an "order of conditions":

[The order] direct[s] a defendant to comply with this prescribed treatment plan, or any other condition which the court determines to be reasonably necessary or appropriate, and, in addition, where a defendant is in custody of the commissioner, not to leave the facility without authorization.\textsuperscript{44}

Once a patient is transferred to a non-secure facility, he will continue to come up for retention reviews every two years or less, since he is still in the custody of OMH.\textsuperscript{45} At this stage, however, the burden on OMH and the People is substantially less. Instead of having to prove that the patient is dangerous, they need only prove that he is "mentally ill." Under the statute,\textsuperscript{46} there are three requirements for a defendant to be found "mentally ill": (1) the patient has an illness that requires inpatient treatment; (2) treatment is necessary for the patient's welfare; and (3) the patient's "judgment is so impaired that he is unable to understand the need for such care and treatment."\textsuperscript{47} This statutory definition is incomplete, however, since it fails to require explicitly any finding of dangerousness. The Supreme Court has made clear that civil commitment, even for insanity

\textsuperscript{41} N.Y. CRIM. PROC. LAW § 330.20(11).
\textsuperscript{42} Id.
\textsuperscript{43} Id.
\textsuperscript{44} § 330.20(1)(o). An order of conditions can also include a "special order of conditions," which is essentially an order of protection for the victims and witnesses in the underlying criminal case. Id.
\textsuperscript{45} See § 330.20(9).
\textsuperscript{46} § 330.20(1)(d).
\textsuperscript{47} Id.; Matter of David B., 766 N.E.2d 565, 571 (N.Y. 2002).
acquitting[sic]ees, must include some showing of dangerousness. A mere showing of mental illness is insufficient.

However, the constitutional "dangerousness" requirement for a "mentally ill" finding is less than that required for a "dangerous mental disorder." "Danger" is not "coterminous with violence." It can be showed by the necessity of treatment for the "physical or psychological welfare" of the patient, the individual's inability to understand the need for treatment, and the need to prepare the patient for a "safe and stable transition from non-secure commitment to release." Among the factors the court can consider are:

[T]he nature of the conduct that resulted in the initial commitment, the likelihood of relapse or a cure, history of substance or alcohol abuse, the effects of medication, the likelihood that the patient will discontinue medication without supervision, the length of confinement and treatment, the lapse of time since the underlying criminal acts and any other relevant factors that form a part of an insanity acquittee's psychological profile.

While these may be similar to the factors courts used to determine if a patient has a dangerous mental disorder, the factors "need not be as pronounced in the case of retention in a non-secure facility."

The ultimate goal of CPL § 330.20 is to transition the patient back into the community, if possible. Accordingly, the treatment team may wish to ease the patient's re-entry with furloughs: temporary visits into the community. Furloughs typically begin with short 1:1 escorts by an OMH psychologist or social worker. The patient might visit a supermarket, bank, or park. The experience gives the mental health professional an opportunity to observe how the patient responds to stressors. Gradually, the patient may go on group escorts and eventually unsupervised and overnight visits into the community. Any furlough, however, requires court permission. Only OMH, not the patient, can apply for a furlough order. Notice must be given to the People, who can object and demand a

49 David B., 766 N.E.2d at 572.
50 Id. at 279.
51 Id.
52 Id.
53 See N.Y. CRIM. PROC. LAW § 330.20(10).
54 See id.
hearing. The court must grant the application and issue a furlough order “containing any terms and conditions that the court deems necessary or appropriate” if

the court finds that the issuance of a furlough order is consistent with the public safety and welfare of the community and the defendant, and that the clinical condition of the defendant warrants a granting of the privileges authorized by a furlough order.

The patient can be released from the non-secure facility on a permanent basis only if the court issues a “release order.” Again, only OMH can petition for a release order. The application papers must be accompanied by:

- a description of the defendant’s current mental condition, the past course of treatment, a history of the defendant’s conduct subsequent to his commitment, a written service plan for continued treatment which shall include the information specified in subdivision (g) of section 29.15 of the mental hygiene law, and a detailed statement of the extent to which supervision of the defendant after release is proposed.

Written notice must be provided to all parties, including the People. Unlike the other sections of the statute, a hearing is mandatory and does not depend on one of the parties making a demand. If the court finds the patient is not dangerous and is not “mentally ill,” it must issue a release order, along with an order of conditions.

Assuming a patient is doing well in release status, OMH may petition for the patient to be released of all supervision. This is done through a “discharge order” and is the final step in the step-down process. A petition may only be filed after the patient has been an out-patient for three years. The court must grant the application and issue a discharge order if
the court finds that the defendant has been continuously on an out-patient status for three years or more, that he does not have a dangerous mental disorder and is not mentally ill, and that the issuance of the discharge order is consistent with the public safety and welfare of the community and the defendant."

Once granted, the order has the effect of “terminating an order of conditions or unconditionally discharging a defendant from supervision.”

Following a hearing at any stage of the process, aggrieved parties have appellate rights. They may appeal to an intermediate appellate court, “but only by permission of that court.”65 Likewise, a losing party in the intermediate court may seek permission to appeal to the Court of Appeals.66 Appeals are civil in nature.67

There is also a unique procedure that allows a patient to seek a “rehearing and review” of any commitment, retention, or recommitment order.68 This triggers a de novo hearing before a different judge or, if the patient elects, a jury.69 However, a rehearing or review is only for the purpose of determining if the patient is “mentally ill.”70 No rehearing or review is possible on the question of whether a patient has a dangerous mental disorder.71

II. HOW CPL § 330.20 BALANCES PUBLIC SAFETY AND INDIVIDUAL RIGHTS

New York’s system for handling insanity acquittees strikes an effective balance between public safety and the rights of such individuals. CPL § 330.20 has several characteristics that contribute to this balance.

A. Automatic triggering of commitment procedures.

Once a defendant either pleads guilty to the insanity defense or is found not responsible by reason of mental disease or defect after a trial, CPL § 330.20 requires a psychiatric evaluation and proceeding to determine the patient’s level of dangerousness. This process is automatic, rather than discretionary, and follows promptly after the plea or trial verdict.

65 Id.
66 § 330.20(21)(b).
67 N.Y. CRIM. PROC. LAW § 330.20(21)(c).
68 § 330.20(16).
69 See id.; N.Y. MENTAL HYG. LAW § 9.35.
71 Id.
Likewise, a court must automatically commit a patient to a secure facility if it finds the patient has a dangerous mental disorder. These provisions ensure that the dangerously mentally ill do not fall through the cracks while waiting for the government to petition for evaluation and commitment. On the other hand, the plea or finding of NGBRMDD triggers notifications to OMH and MHLS, ensuring that the mentally ill do not languish in local jails without receiving appropriate treatment and legal advocacy.

B. Workable and commonsense definition of "dangerous mental disorder."

Dangerousness is at the heart of CPL § 330.20 determinations. It is the standard used to determine a patient’s track, to continue retention in a secure facility, and to recommit a patient.

At the initial and retention stages, there is a paradox to determining whether a patient is dangerous. Under the statute, a patient is dangerous only if “because of [his] condition he currently constitutes a physical danger to himself or others.”\(^7\) Literally applied, the statutory definition would not cover many section 330.20 patients while they are in secure facilities. They receive psychotropic medications on a regular basis, have frequent contact with treatment team members, and are under close supervision. As a result, they are often compliant and non-violent in this institutional setting. If the statute was literally applied, therefore, many patients in secure facilities would have to be transferred or released, since their mental illness is, effectively, in remission.

In Matter of George L.,\(^7\) the Court of Appeals recognized that the word “currently” must mean something broader. A patient who is well-managed in a secure facility is not cured; rather, he has achieved “synthetic sanity.”\(^7\) What is really at issue is whether he will be dangerous if released. A narrow reading of dangerousness is, according to the court, “contrary both to common sense and to substantial justice.”\(^7\) The court noted that a restrictive application “would lead to the absurd conclusion that a

\(^7\) N.Y. CRIM. PROC. LAW § 330.20(1)(c).

\(^7\) 85 N.Y.2d 295 (1995).

\(^7\) Id. at 304.

\(^7\) Id. The court quoted from a decision of the Kansas Supreme Court:

Let us suppose a court is called upon to determine whether a shipment of nitroglycerine can be stored in the center of a large city. The experts testify that nitroglycerine is not dangerous as long as it is stored at temperatures below 180 degrees Fahrenheit and is not jiggled. No evidence is admitted as to the conditions under which the nitroglycerine is proposed to be kept, or supervision thereof. It would obviously be error for the court to conclude the explosive presented no risk as long as its needs were met, and to delegate determination of proper conditions to others.

Id. (quoting Matter of Noel, 226 Kan. 536, 555, 601 P.2d 1152, 1167 (1979)).
defendant in a straightjacket, surrounded by armed guards, is not currently
dangerous under the statute.”

Nevertheless, evidence of dangerousness cannot be based on mere
speculation. Rather, there must be objective evidence that the patient
“poses a risk of relapse or reverting to violent behavior once medical
treatment and supervision are discontinued.” The court can consider the
“nature and recency” of the crime, as well as:

- History of prior relapses into violent behavior, substance abuse
  or dangerous activities upon release or termination of psychiatric
  treatment, or upon evidence establishing that continued medication is necessary to control defendant’s
  violent tendencies and that defendant is likely not to comply
  with prescribed medication because of a prior history of such
  noncompliance or because of threats of future
  noncompliance.

Notably, the relevant question is not whether the patient can be safely
managed in a non-secure facility. The statute does not require or permit a
review court to determine the best location for a patient’s treatment. The
inquiry is, instead, more limited: whether the patient has a dangerous
mental disorder.

C. A gradual, step-down process.

Recognizing that full rehabilitation from a serious mental illness does
not occur immediately, the statute provides for a gradual, step-down
process from secure commitment. As the patient’s mental health improves
and his level of risk to the community decreases, the statute allows for
transfer to a non-secure facility, furloughs, release, and, eventually,
discharge.

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76 Id. at 304.
77 Matter of George L., 85 N.Y.2d at 307-08.
78 Id.
79 Id. at 306. However, neither the underlying criminal act nor statistical probability of relapse are
sufficient, by themselves, to establish current dangerousness. Id. at 308.
80 Id. at 308. The patient in George L. was dangerous because his underlying criminal act had
occurred recently and was violent, he had relapsed after a prior hospitalization, he violated hospital
rules by possessing matches, he responded aggressively when confronted with the contraband, and there
was statistical evidence indicating that paranoid schizophrenics have a high likelihood of relapse. Id. at
305-08.
81 Id. at 308 n.6.
However, this step-down process is not automatic. In fact, some patients are so dangerous and so incurably ill that they never leave secure facilities. The step-down process is patient and fact-specific. In theory, patients may do so well in a secure facility that they can bypass a non-secure facility altogether. If OMH and the People fail to prove that a patient in a secure facility is not mentally ill, let alone dangerous, the patient must be released. In addition, there is nothing that requires OMH to petition for furloughs before seeking release, although prudence and sound medical practice would probably dictate that the hospital see how a patient does on temporary furloughs before seeking to release him outright to the community.

D. Regular reviews of a patient’s continued need for retention.

CPL § 330.20 does not lock up patients and throw away the proverbial key. Instead, it provides for regular reviews to determine whether patients need to be retained in custody and, if so, what level of security is necessary
to protect the public. Since psychiatric treatment can, in some cases, successfully treat even the most dangerous patients, thus obviating the need for continued retention, CPL § 330.20 prohibits retention for longer than two years at a time. At the end of each retention period, OMH or the People must prove that the patient is still dangerous or mentally ill in order to support continued retention. The regularized review schedule has the added benefit of ensuring that both the parties and the court continually monitor the patient’s progress. This prevents a patient from getting lost in the system.

E. Due process protections for the insanity acquittee at every stage of the process.

The statute requires notice of every application to be made not only to MHLS, but also to the patient himself. The patient has a right to contest retention applications, have the assistance of an MHLS attorney through his time under OMH supervision, and obtain expert witnesses. In addition, published judicial opinions refer to the patient only by his first name and last initial.

F. The District Attorney as a party-in-interest.

Prior to CPL § 330.20’s enactment in its current form, the District Attorney was not a party to post-acquittal insanity proceedings. This left out of the process an important voice: the public. While OMH arguably considers public safety before it makes decisions to seek transfer, furlough, or release, the agency does not always strike the appropriate balance between public safety and transitioning the patient to eventual release. In addition to presenting these important arguments, the District Attorney also has the ability to put forth important evidence that the other parties do not have access to: a defendant’s statement, police reports, crime scene photos, and other evidence that shows the nature of the crime, an important factor in any retention hearing.

G. A recommitment procedure.

The statute recognizes that sometimes patients decompensate while in non-secure facilities or in release status. The community is nevertheless protected because OMH or the People can petition for the patient to be

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82 For the reasons stated in Part III, however, this period is too short and should be extended.
recommitted. If the state can prove that the patient has become “dangerous,” he can be “stepped up” to a secure facility. Thus, transfer and release are not one-way processes. In appropriate cases, the public and the patient can be protected from future harm.

H. Notification to law enforcement in the event of escape.

In the event that a patient escapes from a secure or non-secure facility, or does not return from a furlough, various people must be notified, including:

(a) the district attorney, (b) the superintendent of state police, (c) the sheriff of the county where the escape occurred, (d) the police department having jurisdiction of the area where the escape occurred, (e) any person the facility staff believes to be in danger, and (f) any law enforcement agency and any person the facility staff believes would be able to apprise such endangered person that the defendant has escaped from the facility.

III. PROPOSED REFORMS

Overall, CPL § 330.20 is a commonsense, workable, and practical statute that adequately takes into account the competing policy interests of public safety and individual freedom. There are some modest reforms, however, that would improve the statute even further.

A. Automatic access to medical records for the District Attorney.

The District Attorney is a full, co-equal party in CPL § 330.20 cases with OMH and MHLS. Yet, the People are the only party without an automatic right to access a patient’s OMH medical record in preparation for a hearing. The Mental Hygiene Law provides that MHLS has a right to examine a patient’s medical record at any time. OMH can, of course, examine its own records. Under current law, however, the District Attorney must

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83 See N.Y. CRIM. PROC. LAW § 330.20(14); Matter of Francis S., 663 N.E.2d 881, 885 (N.Y. 1995) (holding that the recommitment statute is constitutional and does not deprive a patient of due process).
84 See N.Y. CRIM. PROC. LAW § 330.20(1).
85 N.Y. CRIM. PROC. LAW § 330.20(19).
86 § 330.20(10).
87 N.Y. Mental Hyg. Law § 33.13(c)(2).
88 N.Y. MENTAL HYG. LAW § 33.13(c)(2).
petition the court for access.\textsuperscript{89} Whether to grant the application is discretionary with the trial court. The medical record is critical in preparing for CPL § 330.20 hearings, particularly when OMH is seeking transfer or release and the District Attorney is the only party arguing for continued retention. The medical record is a gold mine of facts. Progress notes detail medication non-compliance, fights, disruptions, statements by the patient, attendance at therapy, and violations of facility rules. These facts, which show continued dangerousness, would ordinarily be unknown to the District Attorney. Providing the People with access to the medical record would reduce fishing expeditions at hearings, facilitate settlement, and even consent, to transfer and release applications, and enable the People’s experts to testify in a more accurate and comprehensive fashion.

Naturally, any amendment to the Mental Hygiene Law should include proper restrictions on secondary disclosure and require safekeeping of the medical record in order to protect the patient’s legitimate privacy concerns.

B. Longer retention periods, particularly at the initial and first commitment stages.

An initial commitment order is valid for up to six months; a first retention order for up to 12 months; and a second and subsequent retention order for up to 2 years.\textsuperscript{90} In practice, these periods are too short. By the time one review is completed, OMH must prepare for the next review, which includes multiple layers of agency review. In the meantime, little may have changed in the patient’s status. While one of CPL § 330.20’s strengths is its process of regular reviews, which guard against indefinite confinement, expanding slightly the time between reviews would alleviate administrative burdens on the agency while still ensuring patients are not warehoused without judicial review. The initial commitment period could be one year, followed by a two year first retention period, and up to four years for second and subsequent retention orders without losing efficacy.

C. Automatic appeal mechanism for parties, without the need to obtain permission.

Appeal is not as of right in CPL § 330.20 cases; instead, the aggrieved party must seek permission from the Appellate Division to appeal. Given

\textsuperscript{89} See § 33.13(c)(1) (noting that an individual without an automatic right to access must show “the interests of justice significantly outweigh the need for confidentiality”).

\textsuperscript{90} See N.Y. CRIM. PROC. LAW §§ 330.20(1)(f), (g), (h), (i).
the important issues involved both to the community and to the patient in these cases, one level of appeal should be as of right and the appeals should be given preference in calendaring.

CONCLUSION

On balance, CPL § 330.20 is a comprehensive and workable statute with a clear and logical approach to the rehabilitation of insanity acquittees. Employing a step-down process from secure confinement to discharge, without a rigid and artificial timeframe, ensures that patients are given additional freedoms only when they are ready to take the next step in their recovery, thus protecting the public from unwarranted danger and maximizing the chances of a successful rehabilitation.