DA 17-0536

IN THE SUPREME COURT OF THE STATE OF MONTANA

2019 MT 215

IN THE MATTER OF:

THE DPHHS PETITION CONCERNING
KEVIN J. CAPSER

APPEAL FROM: District Court of the Fourteenth Judicial District,
In and For the County of Wheatland, Cause No. DC-00-11
Honorable Brenda R. Gilbert, Presiding Judge

COUNSEL OF RECORD:

For Appellant:

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For Appellee:

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For Amicus Curiae:

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Decided: September 10, 2019

Filed:

Clerk

Chief Justice Mike McGrath delivered the Opinion of the Court.

¶1 Kevin J. Capser appeals from a July 13, 2017 Fourteenth Judicial District Court order denying the Department of Public Health and Human Services' (the Department) petition to modify Capser's sentence. We reverse.

¶2 We address the following issue on appeal:

Whether the District Court abused its discretion when it denied the Department's petition.

PROCEDURAL AND FACTUAL BACKGROUND

¶3 In 1998, when Capser was a teenager, he began exhibiting symptoms of schizophrenia, a disorder with which his great-grandfather, uncle, and great-aunt had all been previously diagnosed. Capser started laughing at inappropriate times, became guarded and quiet, and made threats of violence at school. Due to his unusual behavior, Capser, then eighteen years old, was placed on a community commitment and prescribed an antipsychotic medication. Capser's symptoms did not subside, and in 1999, following an altercation with his father, he was involuntarily committed to the Montana State Hospital (MSH) where he remained for eighty-six days. During his stay at MSH, Capser agreed to increase his dosage but resisted taking his medication and was too cognitively impaired to participate in treatment or hospital activities. The State extended Capser's commitment for an additional six months. In January 2000, Capser was discharged from MSH on a conditional release. While Capser's condition initially improved, several months after his release his performance in school declined rapidly and he began resisting his medication again. Capser's caregivers determined that his mental illness was

compounded by his dependence on alcohol and marijuana. The conditional release expired on June 23, 2000, and shortly thereafter Capser left school to work on the family ranch. Around this time, Capser began experiencing significant side effects from his medication, including dulled responses and severe memory loss—so severe that he was unable to recall what he watched on television the night before. Capser's doctor suggested a change in medication but when Capser refused, his original regimen continued.

¶4 On December 8, 2000, Capser shot and killed his father, John Capser, while John was watching television. An autopsy concluded that John Capser was shot twice—once in the head and again in the chest. Witnesses later testified that Capser was not taking his medication at the time of the murder. The State charged Capser with deliberate homicide and on February 26, 2002, following competency proceedings, he entered a plea of nolo contendere.[1] On June 5, 2002, Capser was found guilty of deliberate homicide, a felony. The court found that at the time of the offense Capser suffered from a mental disease or disorder that rendered him unable to appreciate the criminality of his behavior or to conform his behavior to the requirements of the law. Capser was committed to the custody of the Department pursuant to § 46-14-312(2), MCA, for one hundred years, with thirty years suspended, and an additional ten years imposed for the use of a weapon.

[1] Immediately after he was charged, Capser was transferred to MSH to determine whether he was fit to proceed—the hospital concluded he was not. The District Court committed Casper to MSH until his fitness could be restored. It wasn't until January 17, 2002, that Capser was deemed competent to proceed.

¶5 Since his conviction, Capser has resided at MSH without incident. In June 2016, the Forensic Review Board at MSH concluded that although Capser continued to suffer from schizophrenia, undifferentiated, he no longer represented a substantial risk of harm to himself or others. On February 16, 2017, the Director of the Department filed a Petition for Review of Sentence with the District Court, pursuant to § 46-14-312(3), MCA, and submitted a supporting report from the MSH Forensic Review Board. At a May 23, 2017 hearing, the District Court heard testimony and received letters from numerous individuals, including Capser's medical providers and family members, advocating for his release to a group home in Missoula, Montana. On July 13, 2017, the court denied the petition after finding that the Department's suggested transition lacked adequate safeguards to ensure the safety of both Capser and the community, and Capser remained a danger to himself and others. Capser now appeals.

STANDARD OF REVIEW

¶6 This Court reviews a district court's denial of a petition for sentence modification pursuant to § 46-14-312(3), MCA, for an abuse of discretion. *State v. Korell*, 222 Mont. 112, 116-17, 720 P.2d 688, 691 (1986). Abuse of discretion occurs only when the court acts arbitrarily, without the employment of conscientious judgment, or exceeds the bounds of reason resulting in substantial injustice. *State v. Wilson*, 2007 MT 327, ¶ 18, 340 Mont. 191, 172 P.3d 1264.

DISCUSSION

¶7 *Whether the District Court abused its discretion when it denied the Department's petition.*

¶8 Montana law provides that a defendant's mental disease or disorder may be considered at all critical stages of a criminal proceeding: pretrial, trial, and sentencing. Section 46-14-101(1), MCA. At sentencing, if the court finds that the defendant suffered from a mental disorder at the time the crime was committed, any mandatory minimum sentence otherwise prescribed by law need not apply and the defendant will be committed to the custody of the Department. Section 46-14-312(2), MCA. Following imposition of sentence pursuant to § 46-14-312(2), MCA, either the director or the defendant may petition the sentencing court for review of the sentence if a professional certifies that "the defendant suffers from a mental disease or disorder or developmental disability but is not a danger to the defendant or others . . . ." Section 46-14-312(3)(c), MCA. The sentencing court may then "make any order not inconsistent with its original sentencing authority, except that the length of the confinement or supervision must be equal to that of the original sentence." Section 46-14-312(4), MCA. If the court agrees to a sentence modification, the defendant will be subject to a yearly status review by a professional. Section 46-14-312(4), MCA.

¶9 At the May 23, 2017 hearing, the Department submitted considerable evidence to support its petition for the modification of Capser's sentence. Namely, testimony established that Capser is by all accounts a model patient who has devoted himself to the improvement of his mental health and readily acknowledges that the stability he has

achieved is attributable to a disciplined regimen of medication and psychiatric therapy. In fourteen-and-a-half years at MSH, Capser advanced through the hospital's tiered system, which allows for gradual increases in a patient's responsibility. He is currently placed at the highest level and possesses the most privileges and responsibility the hospital offers. Capser has maintained this level for over fourteen years with no noted infractions or level decreases—which MSH psychiatrist, Dr. Virginia Hill, testified is highly unusual among hospital patients. Dr. Hill also testified that she has seen "unbelievable improvement" in Capser and attributes a great deal of the improvement to a change in his medication, which occurred in 2001.

¶10 Since his conviction and placement at MSH, Capser has never threatened or assaulted faculty, even when he was "very ill," and has not engaged in any suicidal or violent behavior. In addition to individual, group, and milieu[2] therapy, Capser is an active participant in various groups at the hospital including gym group, yoga, and cardio exercise classes. Capser also regularly engages in spiritual groups at the hospital. Reverend Thomas Wood, the chaplain at MSH, testified that Capser "is the most reliable patient I've ever had in coming to any of my groups. In many ways I would say [Capser] is the anchor of a lot of the groups because I know he's going to be there."

¶11 The Department also confirmed that Capser's family is supportive of the transition to a community placement, in contrast to their previous opposition. In 2002, before sentencing, Capser's sisters wrote to the District Court in support of a lifelong

[2] Milieu therapy was described in testimony as therapy conducted by nursing staff and psychiatric technicians who advise and redirect patients throughout the day.

commitment to MSH, stating that it was "in [Capser's] best interest to remain in [MSH] for the remainder of his life." However, before the hearing on the petition, Capser's sisters wrote in support of the requested transition: "[Capser] has worked very hard to get to where he is today. I have no doubt that he will keep working hard to try to succeed outside of the hospital . . . I do not feel threatened by his moving to a group home. I fully believe that [he] deserves this chance."

¶12 Presently, Capser resides in the Johnson House at MSH, which is the least restrictive group home on the hospital campus. The Johnson House has a staffing ratio of one staff member for every eight patients, and the staff "develop long term relationships with their patients." Staff members are highly trained and able to identify and be "sensitive to the very slight nuance of any instability or safety problem." Further, every morning and evening a psychiatric technician observes each patient as they take their medication to ensure dosages are not missed. At the Johnson House, Capser receives four hours of unsupervised time on campus each day and is allowed four supervised visits to the community each year, following prior approval by the program manager. The Department emphasized the similarities between Capser's current placement at MSH and the requested placement in Missoula to support the petition. The requested placement, called the Stephens House, is a group home where Capser would live independently, albeit with twenty-four-hour monitoring. The Stephens House has a staffing ratio of one staff member to every seven patients and a staff member also observes the patients take their medication.

¶13 Despite the significant similarities between the placements, and Capser's unrefuted stabilization, the District Court denied the Department's request. In its order denying the petition, the District Court remarked that none of the witnesses testified Capser was "cured of his mental illness" and noted that Capser's medications "are among the strongest psychotropic medications that exist." Schizophrenia cannot currently be medically "cured," it can only be treated by medication. Further, regardless of their relative strength, Capser's medications have shown to work effectively—and have done so for well over a decade. Capser's medication regimen, if anything, provides support for Capser's conditional release. Capser's antipsychotic medication requires monthly blood testing to assure a therapeutic level and to monitor for potential medical complications. The proposed conditional release also provided for Capser's parole officer to order random testing to ensure Capser's compliance with drug and alcohol restrictions. At the hearing, uncontroverted testimony established that the Stephens House staff members closely supervise the distribution of medication. Although they do not always check a patient's mouth to ensure a dosage is not being "cheeked," they do ensure that a patient ingests his or her medication if it is suspected that the patient is skipping dosages. While Capser does have a history of medication resistance, that history is from nearly twenty years ago and involves an entirely different medication that was ineffective on a teenage Capser. Since Capser's medication was changed in 2001, Capser has zero history of medication resistance and has had no disciplinary infractions whatsoever at MSH.

¶14 The District Court found that the Stephens House "could offer no protocol for dealing with a violent offender." However, Ashton McNair, the program manager at the

Stephens House, testified that the Stephens House does have a protocol for handling a resident's aggressive behavior to staff or other residents. Significantly, in addition to the aggressive behavior policy, Mr. McNair further testified that the Stephens House would follow any specific conditions required by a violent offender's parole or probation officer. The undisputed evidence at the hearing established that the Stephens House has a protocol for dealing with violent offenders like Capser, as well as the ability to incorporate any additional conditions imposed by his parole officer.

¶15 The District Court also noted that all of the witnesses at the hearing "qualified their opinion regarding the safety of such a release on Mr. Capser continuing on his medication regime[n] and/or refraining from drug and alcohol use." While schizophrenia is not currently curable, the mental illness can be effectively managed by medication. Barring a medical advance that can "cure" schizophrenia, Capser will need to continue his medication regimen for the rest of his life. The Department's petition—unanimously supported by all of the medical professionals involved in Capser's case—readily acknowledged Capser's continued need for medication. The District Court concluded that since Capser's safety can only be guaranteed if he takes his medication, Capser cannot be conditionally released to the Stephens House because his "medication regime[n] and his mental health status cannot be appropriately monitored by the [Stephens] Group Home and his supervising officer." The evidence does not support this conclusion. The unanimous determination of every witness presented was that Capser's medication regimen and his mental health status could—and would—be appropriately monitored by the Stephens House and Capser's parole officer.

¶16 The District Court based its decision on a finding that "Mr. Capser was, however, on conditional release from MSH when he stopped taking his medications and killed his Father." This finding is inaccurate—Capser was not on conditional release from MSH when he killed his father. The District Court's decision to deny the Department's petition is based on the idea that Capser has been conditionally released before, stopped taking his medications, and committed murder, and if he is conditionally released again, the same thing may happen. It is a significant error for the District Court to base its decision to deny the Department's petition on something that did not happen. Capser was not on conditional release from MSH when he killed his father. When Capser killed his father, he was a teenage boy in the grips of untreated schizophrenia. Since Capser became appropriately medicated in 2001, he has had no history of non-compliance with his medication. Capser attained the highest level of privileges at MSH over fourteen years ago and has had no infractions.

¶17 The District Court ultimately concluded that Capser "continues to suffer from a mental disease or disorder and is a continuing danger to [himself] and others." This conclusion is inconsistent with the unanimous determination of the MSH Forensic Review Board that Capser is not a danger to himself or others. While decisions of this type are among the most difficult made by a district court judge and while the District Court was understandably apprehensive and fearful of the future which could not be fully known, this apprehension should not take the place of the evidence actually presented. The District Court's finding infers that a person suffering from schizophrenia will always be deemed a danger to themselves or others—regardless of unanimity of professional

opinion otherwise—as it is impossible to eliminate any chance that the person will stop taking his or her medications. If the District Court's decision were upheld, it would mean that for those suffering from a mental illness that cannot be "cured," the statute allowing for a review of sentence essentially does not exist.

¶18 The District Court found the sufficiency of the uncontroverted evidence by medical experts inadequate when it denied the Department's petition. As noted, the District Court heard testimony from: Capser's psychiatrist at MSH, Dr. Virginia Hill;[3] MSH forensic discharge planner, Shelley Emerson; Western Montana Mental Health Center, the Stephens House group home program manager, Ashton McNair; and MSH chaplain, Reverend Thomas Wood. No witness testified in opposition to the Department's unanimous recommendation that Capser be discharged to a group home in the community. No witness testified that Capser is a danger to himself or others. While Capser continues to suffer from a mental disease or disorder, uncontested evidence established that he is no longer a danger to himself or others. The court's decision to deny the petition was not within its discretion but was instead based on a generalized apprehension that something unfortunate might occur in the future. As such, the decision was an abuse of discretion.

[3] While the Dissent notes the reservations expressed by Dr. Hill, it must be noted that irrespective of those reservations, Dr. Hill recommended the placement.

CONCLUSION

¶19 The District Court's decision is reversed. This matter is remanded to the District Court with instructions to fashion an appropriate order consistent with the holding of this Opinion.

Chief Justice

We Concur:

Justices

Justice Jim Rice, dissenting.

¶20 I believe the Court's reversal of the District Court is a significant error, premised upon factual and legal misstatements. I would conclude the District Court acted well within its discretion, and affirm.

¶21 The process was legally flawed from the beginning, starting with the petition filed by DPHHS for review of Capser's sentence. The Department sought relief under § 46-14-312(3)(c), MCA, which authorizes the Department to seek review of a defendant's sentence upon certification by a professional person that:

> (c) the defendant suffers from a mental disease or disorder or developmental disability but is not a danger to the defendant or others;

However, the petition did not allege that this statutory standard, under which it sought relief, had been satisfied. Instead, the petition alleged something critically different about Capser:

> Defendant suffers from a mental disease or defect but is no longer a danger to the defendant or others *with continued treatment* in a community setting, *as long as Defendant complies* with the proposed conditions of release, *under the supervision of* the Adult Probation and Parole Division of the Montana Department of Corrections. [(Emphasis added.)]

Thus, the Wheatland County Attorney alertly filed an objection to the petition, arguing the petition "does not conform to the requirements of § 46-14-312 M.C.A. due to the qualifying language used. . . ." Lacking a certification that facially satisfied the statutory standard under which relief was sought, the proceeding was subject to dismissal on legal grounds. Generously, the District Court conducted a hearing on the petition, and considered the evidence. While the merits of the petition were entertained, the correct articulation of the

statutory standard underscores the necessity of proving adequate safeguards are in place to ensure that Capser was not a danger to himself and others. In that regard, this Court has clearly misinterpreted the evidence in determining to reverse the District Court.

¶22 The Court states the evidence offered by experts was "uncontroverted" and no testimony was offered "in opposition." Opinion, ¶ 18. However, first, "the court is not limited by the opinion of any expert and the judge can form her own opinion." *In re G.T.M.*, 2009 MT 443, ¶ 21, 354 Mont. 197, 222 P.3d 626 (citation omitted). Thus, the District Court was not bound to the expert testimony offered in the hearing. But, further, the Court fails to credit the record. The Forensic Review Board Report noted that Capser continues to suffer from "*severe* mental illness" and Dr. Hill testified that Capser "must continue his medication to maintain his psychiatric stability." (Emphasis added.) Hill explained that Capser's lengthy medication list includes Clozaril, "our most powerful anti-psychotic medication." The District Court found that Capser was "an outstanding example" of rehabilitation "*so long as* he is in a *fully structured setting.*" (Emphasis added.) A critical component of a structured setting is a system ensuring that Capser properly maintains his medication regimen. At the State Hospital, Capser functions under a tightly controlled environment and takes his medication while "the psychiatric technician is watching." Hill testified that Capser needed a "very similar" environment to be successful in the community, with "24/7 supervision, monitoring of medications," and "quite restrictiv[e]." She cautioned about the risks to Capser of exposure to drugs and alcohol. However, the following evidence was given about the proposed plan for Capser:

The proposed placement is not a locked facility.

The proposed facility has never housed a person committed of deliberate homicide.

The proposed facility has a specific protocol for aggressive behavior but, contrary to the Court's statement, there is no protocol for violent offenders. Problems are reported to the offender's parole or probation officer.

There is no testing for drugs and alcohol.

Within two weeks of arriving at the proposed placement, Capser could be permitted to leave and spend hours of unsupervised time in the community "on the honor system," a fact unknown to the MSH discharge planner.

The facility staff received no specialized training on detecting decompensation of mental health of the residents.

The facility does not ensure that medication is properly consumed.

¶23 This last point is likewise contradicted by the Court, Opinion, ¶ 15, but the testimony is revealing. The prosecutor questioned a representative of the proposed facility about the distribution of medications to a resident:

> Q. Now, after the medications are distributed to the resident, is the resident physically checked to insure he is taking his meds, for instance, he isn't cheeking them or doing something else with them? Do you physically check the resident?
> A. Not unless that is something that has been asked to do by their provider due to there being reason to believe that they are cheeking medications or not taking them.
> Q. But in a normal situation you're not doing those kind of checks on people, are you?
> A. No.
> Q. Okay. So to some degree even the distribution of medications is on the honor system, correct?
> A. To a certain degree.

Indeed, the MSH discharge coordinator, under questioning by Capser's counsel, testified that at the proposed facility, "they expect patients to take medications."

¶24 The District Court carefully reviewed the evidence, recognizing the "continuum of observation and care" Capser is receiving, and that, though not cured, Capser's "mental illness is so controlled by his medication and treatment regime," but noting how all of the medical experts had "qualified their opinion regarding the safety" of the proposed release of Capser upon the continuation of his medication regime. The District Court found that Capser's substantial progress "is commendable and has been given a great deal of consideration in this matter." The Court states that the District Court concluded that because Capser's safety cannot be "guaranteed" unless he takes his medication, a conditional release must be denied. Opinion, ¶ 15. However, this overstates the District Court's ruling, because the court never required safety to be "guaranteed" for Capser to be released. Rather, the District Court was concerned that a plan with appropriate safeguards be put in place. The Court's statement that "[t]he evidence does not support" the District Court's conclusion, Opinion, ¶ 15, that sufficient safeguards were not in place here misstates the record.

¶25 At the very least, the evidence clearly raises a question about whether the proposed placement was, in Dr. Hill's words, a "very similar" environment to MSH, "quite restrictiv[e]," with "24/7 supervision" and "monitoring of medications." It was this evidence that led the District Court to find that Capser's "medication regime and his mental health status cannot be appropriately monitored" at the proposed facility, and that

"inadequate safeguards" had been built into the plan "to address the effects of an abrupt transition from MSH[.]"

¶26 This was not a decision that Capser could never be placed in the community because of his mental illness. Rather, the District Court concluded that the proposal did not yet sufficiently address all of the necessary issues to ensure a proper transition and the continuation of proper care. The District Court's decision was based upon substantial evidence, and the Court's statement that "uncontested evidence established that [Capser] is no longer a danger to himself or others" misstates the record. As even the petition states, Capser is not a danger to himself or others "with continued treatment . . . as long as [he] complies . . . under the supervision of . . . ."

¶27 I agree with the Court that these decisions "are among the most difficult made by a district court judge," and for that very reason we should be careful to permit courts the discretion to make such difficult calls. I believe the District Court carefully considered the evidence in a very serious matter, and did not abuse its discretion by denying the petition.

Justice

Justices Dirk M. Sandefur and Laurie McKinnon join in the dissenting Opinion of Justice Rice.

Justice