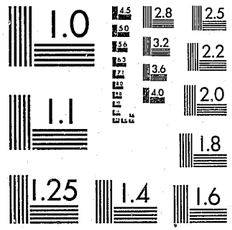

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An Analysis of the Forensic Psychiatric Services Delivery System in Ohio: A Final Report

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AN ANALYSIS OF THE FORENSIC PSYCHIATRIC SERVICES DELIVERY SYSTEM IN OHIO; A FINAL REPORT

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I Introduction

On October 1, 1974, the Program for the Study of Crime and Delinquency (PSCD) began work under a contract with the Office of Program Evaluation and Research of the Ohio Department of Mental Health and Mental Retardation to conduct a systematic analysis of the delivery of forensic psychiatric services in the state. The contract was written to include not only a series of separate studies of individual forensic psychiatric centers in Akron, Cincinnati, Columbus, Hamilton (Butler County), Portsmouth and Zanesville, but also an integrated comprehensive analysis of the total state system, with direct implications for future program planning, development, and administration on the state level.

More specifically, the purpose of the study is to provide data for conclusions and recommendations regarding whether or not the individual forensic centers are:

1. Supplementing the evaluation and treatment services of Lima State Hospital (LSH);
2. Improving the quality of evaluations and treatment conducted at LSH by virtue of lightening its caseload;
3. Providing evaluations to the court in a shorter period of time than required by LSH;
4. Providing more thorough and comprehensive evaluation reports than can be provided by LSH by virtue of greater accessibility to offenders' families, friends, employers, and other social agencies;
5. Preventing the problems of reintegration of offenders released from institutional care;
6. Preventing the negative impact upon the offender and his

family of institutionalization at LSH;

7. Negating the cost incumbent upon institutionalization at LSH:
8. Preventing the social, psychological, and economic disruption to the offender, his family, and the community inherent in uprooting him from his home or job;
9. Easing the time necessary for and monetary problems incumbent upon expert testimony in court;
10. Providing evaluations, recommendations, and outpatient treatment for probation and parole departments;
11. Providing emergency intervention and consultation services for local detention facilities;
12. Educating and training local social agents in the identification and management of mentally disordered offenders;
13. Identifying dangerous or potentially dangerous offenders for the criminal justice system; and
14. Reducing recidivism via accurate evaluations and appropriate recommendations and treatment.

Upon completion of these separate studies, it was agreed that an integrated analysis of the centers would be developed. In an addendum to the original proposal, it was furthur agreed that the PSCD would address the following issues:

1. The total system of forensic psychiatric services in the State, with particular attention to the distribution of services in relation to population base and availability of professional clinical personnel, including number of psychiatrists, hours of psychiatric services, etc.
2. The development, operation, and impacts of the proposed inpatient

forensic psychiatric wings in Columbus, Cincinnati, Toledo, and the Cleveland area as a part of the total state system of forensic services.

3. The appropriateness of various types of referrals to forensic psychiatric units and the related issue of insufficient numbers of referrals in various locales or regions.
4. The responsiveness of forensic psychiatric services to the needs of the criminal justice system, including the judges and other court personnel, and the parolee population and parole system. Such questions will be addressed as the impact of the Courts on operations of the centers, satisfaction of the Courts with services and operations of centers, etc.
5. The role of treatment (as opposed to evaluation) services at the forensic psychiatric centers. The questions of whether or not center personnel feel they have a treatment function and if treatment should be provided, for whom and under what circumstances, and continuity of services to parolees will be addressed.
7. Other salient issues and interests which arise.

The questions raised above represent a synthesis of the concerns expressed by the Division of Forensic Psychiatry and the Office of Program Evaluation and Research. They dictate that the focus of the PSCD study be broad and somewhat exploratory. Without doubt, there is much research to be done in the area of the delivery of forensic psychiatric services both in Ohio and across the nation. The question is whether or not the current unsettled legal and administrative situations allow valid conclusions to be developed.

The work upon which the study reported below is based actually began on March 1, 1973, when the PSCD began an evaluation study of the

Toledo Court Diagnostic and Treatment Center . Through October 1, 1975, a research team with a minimum of three members was continuously and actively involved in evaluative research regarding the delivery of forensic psychiatric services in Ohio. Since October, two staff have devoted part-time efforts to this area. During this period evaluations of six separate forensic centers have been competed, including: the Akron Criminal Courts Psycho-Diagnostic Clinic, the Butler County Forensic Psychiatric Center, the Cincinnati Center, the Columbus Forensic Psychiatry Center, the Dayton Center for Forensic Psychiatry, and the Toledo Court Diagnostic and Treatment Center. The centers at Portsmouth and Zanesville were not included because their operations have not yet reached the point where there is sufficient data for an evaluation. The Springfield Center, though operational for a substantial time period, lacked sufficient data for evaluation.

In the process of conducting these studies, the PSCD has generated a vast quantity of potentially valuable, but somewhat disjointed data. This volume is an attempt to present the data of the last two and one half years work in a logical and systematic manner. It is the hope of the PSCD research team that this information will lead to more informed and effective policy determination. It must be recognized, however, that all the questions in the area under study which have arisen over the last several years cannot be addressed here. Time and resources dictate that difficult decisions concerning the focus of the study must be made. Although the forensic psychiatric service delivery system (FPSDS) in Ohio has historically centered on LSH, the implications of the Davis v. Watkins suit along with severe budgetary problems within Ohio have begun to cast doubt on LSH's continued

central role. This study therefore, focuses on the forensic centers as an alternative to LSH in an attempt to produce findings of benefit to both policy makers and clinical personnel who must cope with changes in the forensic system which are the result of LSH's changing role.

The study which began in October of 1974 has literally evolved during its conduct. The basic questions raised in the original proposal and the addendum were taken as a starting point, but the PSCD personnel did not feel constrained just to them. A number of "other salient interests" arose during the conduct of the study and were pursued, often to an unproductive end, but just as often to interesting conclusions. One of the outstanding observations concerning the research summarized here is that the Ohio forensic service delivery system is heterogeneous, amorphous, and constantly in flux. Currently, there are budgetary and legal considerations of sufficient gravity to reverse forensic policies overnight. It is in this light that we offer our descriptions, conclusions, and recommendations. They are tentative and situational, but they constitute our best judgement based on the information to which we were given access and our assessment of the current situation.

A word on "Systems":

In the proposal, it was stated that we would concentrate on the "total system of forensic psychiatric services in the State," and we believe we have done so. We have attempted to achieve this goal while simultaneously avoiding overly quantitative methods and esoteric concepts. Thus, with few exceptions, the models and descriptions provided in this study are verbal and nonmathmatical. It is felt that the forensic

system in Ohio is currently in such a period of change and evolution that essentially static models of its behavior at best hold only transiently and at worst are downright misleading.

II Delimiting The System

System Definition

It is the firm belief of the Program for the Study of Crime and Delinquency research team that no study of this nature should proceed without a clear conceptualization of the system or phenomenon which is being studied. Thus the first question which must be addressed is: "how shall the forensic psychiatric service delivery system (FPSDS) be defined." The answer to this question is to a large extent determined by the focus of the study, and the answer in turn influences the findings which emerge. In general, we accept the popular notion that a system is a set of elements and the relationships which exist among those elements. We propose to begin with this concept of a system, though as we proceed the concept will become less element-centered to allow greater flexibility in disregarding and modifying element definitions. In addition, we consider human organizations as falling within the category of open systems, i.e. those which exchange energy and information with their environment and seek to maintain some stable internal equilibrium.

There are a large number of entities in Ohio which could be considered as elements in the FPSDS. In a very gross sense, one might define the major elements as: (1) the agencies reporting to the Division of Forensic Psychiatry and/or purporting to offer forensic services; (2) the clinicians in the state who are willing to work with forensic clients, and (3) the aggregate of Ohio's mentally disordered offender population. One can increase the discrimination of these categories by further subdividing them, which in turn enriches any model derived from them by providing more detail. For example, the

agencies might be broken down by type of funding, specific services offered, or size of caseload. The degree of discrimination chosen is dictated by the aim of the study being conducted. In this case, we are interested in providing information for policy making at both the Division level and the individual facility level, thus we have chosen to operate from the lowest applicable level, that of the individual forensic facility.

A second factor which must be considered when defining a system is the issue of focus, or the problem to be addressed. The focus of this study is an exploration of alternative modes for the delivery of forensic services. With this in mind, there are still a number of elements which can be chosen to be included in the system which have some detectable or theoretical effect on the FPSDS. In this study, the major alternative mode is the community based forensic center. The question is: Is this a viable alternative to institutionally based services?

A large portion of the effort expended on this study was directed toward gaining familiarity with the FPSDS. The techniques utilized were direct observation of participants in the system, the questioning and interviewing of persons working in the system and those in contact with it, and the gathering of descriptive data relative to the system. While a concerted effort was made to learn as much as possible about the system from those within it, it was recognized that the danger of being overly influenced by the opinions and biases of those in the system should be avoided. The following section describes the elements and processes within the systems from the researchers' points of view.

These descriptions are abstractions of reality and are thus subject to criticism for being overly simplistic or unrealistic. We feel, however, that they are a useful representation of reality which will serve as the basis of a framework for the presentation of the results of our research.

Overall, the Ohio FPSDS consists of five elements: (1) the community forensic psychiatric centers, (2) the Lima State Hospital, (3) the courts which refer forensic clients, (4) local and state corrections agencies, and (5) civil mental health institutions. The relationships among these elements will be discussed at length in this report. In addition to these five elements, there are also two environments which exercise considerable influence over the FPSDS: the legal and the administrative environments at both the state and local level. These environments in effect set limits on the capability of the FPSDS to perform, and thus can be viewed as constraints on the system.

The Community Forensic Centers

The community forensic centers are a new element of growing importance in the FPSDS. Though two centers have long born a portion of the forensic examination caseload for specific courts in Cincinnati and Cleveland, it was not until 1972 when the state of Ohio began to encourage the establishment of centers that a significant statewide effect was noted. Currently, there are eleven organizations in the state operating as forensic centers. Nine centers which are funded wholely or in part by state or federal funds are located in Akron, Columbus, Cincinnati, Dayton, Hamilton, Portsmouth, Springfield, Toledo,

and Zanesville. In addition, there are centers in Cleveland and Lorain which operate independently of the state and are primarily locally funded.

The establishment of forensic centers was intended to achieve a number of objectives which were previously mentioned in the introduction to this report. This rather lengthy and somewhat vague listing of objectives can be reduced to two categories: treatment objectives and evaluation objectives. Research into the operation of the individual forensic centers indicates that, in general, only the evaluation objectives are being pursued. Lack of resources for treatment, increasing evaluative caseloads, and a narrow conception of mission are all factors which contribute to this situation. Without judging the merits of this narrowing of objectives, it can be said that the primary goal, in fact, of the community forensic centers appears to be the production of information for decision makers in the criminal justice system.

The following provides a general description of the evaluation process at a "typical forensic center." First, the center director receives either an offender or notification that an offender has been referred to the center for examination; at the same time the referral agent, usually a court, notifies the center of the question concerning the defendent which must be answered. Often the question is asked by simply referring to the statute number authorizing the examination and assuming that the examiners will know the question. At other times, the specific question will be posed; for example, "is he sane," "is he competent," "is he dangerous," etc. Once it is determined by the center that the offender will be accepted for exam-

ination, and that the question can be legitmately addressed, the process which follows is geared almost entirely to answering the question. The centers use a variety of methods of generating information. Most begin the process with a social history which is developed by an in-house staff member. In a large number of cases, particularly those involving misdemeanors or referrals from municipal courts, the process ends here. In other cases, however, the process continues to the stage of psychological testing. Testing is frequently though not always handled by outside consultants. In some additional cases there is a psychiatric examination. It most often is conducted by consulting psychiatristsbecause few centers are large enough to justify a staff psychiatrist. Finally, and only rarely, consultants are utilized to address special neurological or psychiatric problems.

The final step in the process is the consolidation of the reports written by the separate individuals in the process into a statement of evaluation results. This statement usually addresses the original question asked, though there are cases in which it does not. The extent to which individual staff members and consultants participate in a particular evaluation varies, but the overall process and the order of intervention seem to generally hold within and between centers.

Once the information has been generated by the center, the use that is made of it is at the discretion of the original referral agent. The agent is free to accept or reject any of the information provided by the center. In practice, we have found a high degree of agreement between the recommended dispositions of defendents by the

centers and the referral agents' dispositions. This agreement appears to reflect two factors. First, the results of the examinations are highly accurate or at least highly acceptable to the referral agents. Second, some referral agents tend to "rubber stamp" the recommendations of the centers out of deference to their expertise. It should be born in mind, however, that the decision to pass responsibility to the center lies with the referral agent and not with the center. The agent has, in effect, decided to act by not acting.

While referral agents ask a number of questions of the centers, the most frequently raised are:

1. Is the defendent competent/incompetent to stand trial?
2. Was the defendent sane/insane at the time of the alleged offense?
3. Is the defendent covered under Ohio's sexual psychopath statute (Ascherman Law)?
4. Is the defendent dangerous?
5. What is the "best" sentence for the defendent, taking into account the likelihood that he will respond positively and also his degree of dangerousness?
6. How can this probationer/parolee best be treated while in the community?
7. Does this person who is being held in a local detention facility have a mental problem?

The quality of the responses of the centers to these questions from the point of view of the referral source determines the effect that the centers have on the other elements of the FPSDS. If the referral agents regard the information provided by the centers as inaccurate or incomplete, they will tend to use less of the centers services and

the relative importance of the centers will decline. This could lead to an increase in the importance of LSH as an information generator or, if LSH continues to be only a limited resource, it could lead to a general denigration of the value of forensic psychiatric information to the criminal justice system. Thus the influence of the centers on the system is directly related to the perceived value of the information that they generate for referral agents.

An extensive discussion of Ohio's forensic psychiatric centers is contained in The Forensic Psychiatric Centers of Ohio: An Integrative Report and the individual reports for each of the six centers. These reports include center caseload and client data along with data for a comparison group of individuals referred to Lima State Hospital rather than the center.

The Lima State Hospital

Lima State Hospital is a critical element in the FPSDS. The institution is a maximum security inpatient psychiatric facility which has for a number of years served as the only major facility for the evaluation, treatment, care, and custody of forensic clients. Setting treatment aside for the moment, LSH has essentially performed two basic functions. First, it has conducted examinations of offenders for the courts in a manner quite similar to that described above regarding the forensic centers. Second, it has served as an institution of custody for offenders committed as "criminally insane," a group consisting primarily of persons found incompentent to stand trial, persons found committable under the sexual psychopath statute, and persons committed after being found not guilty by reason of insanity. LSH has also served as a place of custody for offenders who have been committed to Ohio correctional institutions but have developed mental difficulties while incarcerated which preclude their remaining in that institution, and for inmates of civil institutions who prove dangerous and difficult to handle.

The function most extensively examined in this study is the

examination function. It cannot be totally separated from the custody function, however, because a considerable portion of the facilities and resources at LSH are utilized by examination cases. This has become particularly critical since the interim order in Davis v. Watkins which demands a reduction in population. Clearly, examination capability must be traded for custody capability or vice versa.

The Courts

The courts are another critical element in the FPSDS, particularly from a decision-making point of view. The vast majority of the input into the FPSDS, in the form of offenders, is generated by the courts. The courts are responsible for referring persons both for examination and for custody. In addition to this influence over the input to the system, the courts also exercise considerable influence over the general operation of the system through judicial review and the quasi-legislative powers of the higher courts.

All municipal, county, and common pleas courts in Ohio are potential sources of referrals to the FPSDS. Each has the legal authority, if not functional capability, of ordering defendents into the FPSDS under the auspices of a variety of statutes. This ability to make what are largely discretionary referrals to the FPSDS, on the basis of often vague and poorly articulated legal criteria, places considerable influence over the FPSDS in the hands of the referring courts.

Our evaluations of the individual centers provide some evidence that the standards for referral held by the courts can change markedly in a relatively short period of time, a situation which can lead to a

rapidly fluctuating referral rate. For example, the average referral rate from the courts of Montgomery County increased by over seven times during the time period between 1971 and 1974. If this rapid change were to occur in just a small percentage of Ohio's most populous counties, the result for the FPSDP would be a literal explosion of the forensic caseload which would necessitate rapid administrative and perhaps legislative reaction.

At a more general level, the State and Federal courts are exerting a considerable effect over the operating parameters of FPSDS. There can be little doubt that the interim decision in Davis v. Watkins has had a profound effect on the population level at LSH, and as a direct result also on the offender population in other Ohio institutions, both mental health and criminal.

This dual function served by the courts complicates the analysis of the system because we can no longer simply speak of the influence of the courts, instead we must recognize qualitatively different forms of influence. These can be labeled as "referral influence," which describes the relationship of the courts to individual defendents (i.e. referral to the system, commitment to the system, etc.), and "control influence" which describes the ability of the courts to set standards for the FPSDS which effect all or large groups of defendents. Control influence ranges from relatively gentle hints by the courts that something should be done, which might be apparent through judicial commentary, to direct intervention in the operation of an organization in the FPSDS such as the court actions in the Davis v. Watkins case.

Local and State Correctional Facilities

Correctional facilities serve as important sources of referrals in the FPSDS. In most areas with community forensic centers it has been accepted that emergency psychiatric problems which occur in the local detention facility will be handled by the center. Depending on the stage in the criminal

justice process which the offender has reached, he may be referred to other appropriate agencies if he is diagnosed as in "need" of furthur custody or treatment. In addition, state correctional facilities have traditionally used LSH as a holding and treatment facility for persons who develop psychiatric problems while incarcerated. A large number of these inter-institutional transfers occurred during the research period.

Corrections also serves a radically different role from referral agent which tends to strongly influence the character of the FPSDS in Ohio. The FPSDS is often viewed as spanning the boundary between the mental health and criminal justice systems. This notion suggests that the trappings of both systems should be apparent, and indeed they are. We suggest, however, that the trappings of corrections are often more in evidence and more influential in the FPSDS than are the trappings of mental health. The traditional heavy emphasis on security for virtually all forensic offenders, regardless of their behavior patterns, is an excellent example of this phenomenon as is a more central concern with the legal status of offenders in the FPSDS than their mental health status.

Civil Mental Health

The importance of the civil mental health organizations and institutions to the FPSDS has only recently begun to be discussed in Ohio. Historically, the systems have been kept largely independent of each other, based primarily on the perceived differences of forensic and civil mental health clients. This independence was preserved and enhanced by the past administrative association of forensic psychiatry with corrections rather than mental health in the state government.

In the past, civil mental health institutions have served two functions in relation to the delivery of forensic services. First, they have

served as a referral source for LSH. Patients who are assaultive or escape-prone are often transfered to LSH. This practice is interesting because it is an explicit recognition of the high level of security-consciousness at LSH. Second, the civil institutions have served as a custody facility for forensic clients who for any number of reasons have fallen out of the criminal justice system. In many areas of the state it is the practice of the courts to allow the dropping of criminal charges against defendents in return for the defendents signing themselves voluntarily into mental institutions.

Recently, civil mental health has been assuming new functions in relation to the FPSDS. The civil mental institutions in Ohio are now performing court ordered forensic evaluations of criminal justice clients at almost one third the rate of LSH. Courts complain either that they are unable to gain admittance to LSH for their clients or that the process at LSH is too slow for their needs. The result has been that civil institutions have begun to assume a portion of the examination role.

Civil mental health is also becoming a dumping ground for offenders previously held at LSH. The court mandated population reduction at LSH is in part being accomplished by the transfer of forensic clients who are not in need of maximum security to the civil institutions.

In addition to these five basic elements in the FPSDS, there are a number of other influences on the system which are too important to be dismissed. Several which emanate from the elements themselves have been discussed above, but there are some additional ones which will be considered under two headings: the "legal" and the "administrative" environments.

The Legal Environment

First, the legal environment includes the statutes under which the FPSDS performs its functions. These include the Ascherman act, the competency/sanity statutes, and the large number of other statutes which allow a defendent in the criminal justice system to be either treated or examined by mental health professionals. These statutes are in essence the constraints on the system; they are intended to define the population to be handled by the FPSDS and the outer boundaries of the permissible processes to be utilized within the system. We assume that these statutes are a reflection of public concern in this area, and that they accurately portray public sentiment.

Secondly, the legal environment which includes the basic values and processes which set the character of American jurisprudence, such as the presumption of innocence until guilt is proven, competence on the part of the defendents at the time of trial, and due process all serves as an important influence shaping the behavior of the FPSDS.

The Administrative Environment

The administrative environment of the FPSDS in Ohio has a number of facets. For the purposes of this brief introduction it might be best to view this environment in terms of state vs. local responsibility. The state Division of Forensic Psychiatry is a separate but not necessarily equal branch of the Department of Mental Health and Mental Retardation. The Division of Forensic Psychiatry is charged with the administration of LSH, the maintaince of psychiatric facilities for the correctional institutions, and the support and coordination of community based forensic services. Since the agency has only recently assumed a role in community based services it is primarily institutionally oriented,

an orientation which may be a source of difficulty when the Division attempts to coordinate community based services.

Traditionally, the most important role of Forensic Psychiatry, from the Division's point of view, has been the operation of LSH. The major portion of its budget and staff resources have been and still are expended there. This focus on LSH has caused the Division to largely ignore its other functions, particularly when problems arise at LSH. The problems at LSH which caused the Davis v. Watkins suit have yielded a steady stream of court orders and threats of orders regarding conditions at LSH which has virtually paralized the Division. The functions of the Division regarding community based services have until recently received only minimal attention.

This situation has resulted in a crisis of leadership within the community based forensic centers. Fortunately, the appointment of a full time employee of the Division as coordinator of forensic centers promises to improve the situation. Concurrently with the appointment of the new coordinator, the directors of the individual forensic centers have formed an association to begin to address a number of the needs which they felt were being ignored by the Division of Forensic Psychiatry.

This general lack of leadership for the forensic centers was probably largely the result of the problems at LSH, but the method of establishing and funding the centers cannot be ignored as a contributing factor. The centers are funded through a variety of sources - local, state, and federal. Individually, they are often funded from a number of sources, in one case as many as six. This is bound to lead to serious questions about who shall influence the operation of the center.

In addition to these multiple funding problems, several of the centers were established through local rather than state action, and consequently their staff feels little loyalty toward state administrators. These problems of "who is responsible to whom" are serious because they have slowed the establishment of standards and guidelines for center operation.

This brief overview of the elements of the system, their interrelationships, and the influences over the system is intended only as an introduction. An extensive discussion of the system and its processes follows.

III Analytical Framework

One way to analyze the activities of the FPSDS in Ohio is to examine the basic functions which it performs. It is our view that the system performs four functions, and the activities of all its elements can be placed in one or more of these categories. This functional typology of activities seems to enhance our view of the system because it allows the commonalities between organizations to be emphasised rather than the divergences. For this discussion we will label the functions information generation, decision-making, custody, and treatment.

Information generation is a function which is performed for persons outside of the FPSDS. When evaluations of defendents for competency to stand trial, Ascherman committability, or drug dependency are performed by an organization in the FPSDS, that organization "acts as if" it were solely in the business of providing information.

Decision-making can be conceptualized in two ways. First, there is decision-making which is concerned with the operation of the forensic system. Decisions to transfer clients within or between institutions, decisions regarding treatment modality, and security decisions are all examples of decisions which concern either the operation of the institutions within the system, or persons who have been committed to the custody of the system by some referral agent. A second form of decision-making is evident when the recommendations of agents of the forensic system are accepted by referral agents as final decisions determining the fate of the offender. This is a case where the decision maker as defined by law has ratified a decision made

in the forensic system.

The custody function requires little explication. A number of clients find themselves indefinitely committed to the care of the FPSDS. These are persons who are committed under the Ascherman Act, the competency/sanity statute, or any of a number of alternative statutes.

The treatment function, though difficult to define, must at least be noted. Clinicians among themselves have difficulty agreeing on just what activities constitute treatment. The recent entry of the courts as standard setters into this area under the concept of "right to treatment" has also failed to provide a clear concept of treatment. For our purposes, treatment is regarded as activity undertaken by FPSDS personnel to improve the offender's ability to cope with his life situation, or to bring his behavior within socially acceptable limits. We are not prepared to discuss treatment at the individual level and this definition is offered only to signify what we mean when the word treatment is used. This function is included in our typology because treatment activities are being carried on in the FPSDS. The controversy surrounding the definition of the term treatment and the questioning of the benefits of the function have led us to avoid the subject as much as possible.

Table 1 is an attempt to illustrate the functions performed by each of the elements in the forensic system. The table includes both the legally mandated and traditional functions as well as functions which have been assumed during the past few years. For example, LSH regularly performs the information generation function when it evaluates offenders referred by the criminal justice system. It also routinely performs the custody function when it holds persons indefinitely

committed. As an adjunct to the custody function, treatment is also provided. Finally, there is some reason to believe that LSH may perform a decision-making function with regard to the labeling of offenders. This occurs when referral agents such as courts abdicate their responsibility to make decisions by deferring to the expertise of examining mental health professionals, and accepting their decisions regarding client mental status without question. This is clearly an assumed function because the courts are charged with the responsibility to make the decision and their choice to not make the decision is a knowing one.

TABLE 1

ELEMENTS OF FORENSIC PSYCHIATRIC SERVICE DELIVERY SYSTEM

Functions of FPSDS	LSH	FP Centers	Corrections	Civil Mental Health	Courts
Information Generation	X	X		O	
Decision-Making (Major Decisions)	O	O		O	X
Custody	X		X	O	
Treatment	X	X	O	O	

X = Mandated
O = Assumed

The Information Generation Function - Forensic Examinations

There are six basic processes carried out in the FPSDS which fall under the information generation or examination function. They

are the Ascherman examination, the examination to determine competency to stand trial or sanity at the time of the offense, the psychiatric presentence examination for mitigation of sentence or recommendation for probation, examinations of probationers and parolees to determine current mental condition and most successful supervision methods, examination to determine drug dependency, and emergency interventions for persons incarcerated in either state or local facilities. The nature of each process is in large part determined by the statute governing its use, though in practice statutory provisions are often ignored or misapplied. The processes are also strongly influenced by applicable executive orders, and the formal and informal policies of the courts, corrections, and the mental health agencies.

In practice the procedures followed for several of these examinations may appear very similar. We feel, however, that they should be discussed separately in light of the very different statutory authorities involved. (See Table 2 for summary data on evaluations performed at LSH and the forensic centers.)

The Ascherman Examination

The Ascherman examination is authorized under ORC 2947.25. It provides for the postconviction examination of all persons convicted of rape, sexual battery, corruption of a minor, importuning, voyeurism or endangering children. In addition, the examination can be ordered in other cases where the court feels it advisable. The examination is intended to determine whether the defendent can be regarded as mentally ill, mentally retarded, or "psychopathic". If the defendent fits any of these categories, appropriate dispositions are provided.

TABLE 2

EXAMINATIONS BY TYPE FOR LSH (1968-1974) AND FORENSIC CENTER SAMPLES

TYPE	LSH	% of Total	Center	% of Total
Ascherman	1839	55.9	315	30.7
Competency/ Sanity	1321	40.1	171	16.7
General Examination			393	38.2
Drug	11	0.3	96	9.3
Probation & Parolee	1	0.1	34	3.3
Penal	1	0.1		
Civil	119	3.6		
Emergency			18	1.8
	3292	100.0	1027	100.0

The actual process of the examination is not defined in the act. The only requirement is that the examination be conducted in a state facility designated by the Department of Mental Health and Mental Retardation (DMH&MR), a psychiatric clinic approved by the department, or by three psychiatrists. The time limit for conducting the examination is 60 days and the report of the examination must be submitted to the court within 30 days following the examination.

The PSCD data indicate that a large percentage of the forensic examinations conducted in Ohio fall into this category. In our sample of admissions to LSH (See section IV), 56 percent of the examinations conducted were under the Ascherman act. For our combined sample of

cases seen at community forensic centers, which reflects operations at Cincinnati, Columbus, Hamilton, and Akron, the proportion of Ascherman examinations to total examinations is 31 percent. It should be pointed out that at LSH, though the absolute number of these examinations has been falling, the percentage of total examinations has remained relatively constant. At the centers the absolute number of these examinations is increasing while the proportion remains constant.

At LSH the process for conducting an Ascherman examination is rather formally prescribed. It involves an initial intake interview by a social worker, followed up by requests for information regarding the criminal justice, mental health and other pertinent records of the defendent. The defendent receives a thorough medical examination by a physician or assistant at intake. There is also an intake psychiatric interview conducted by a psychiatrist and a psychological interview and testing conducted by a psychologist or an assistant. Later, a staffing session is held and a final report prepared for the court which addresses the specific question "is the defendent mentally ill, mentally retarded, or psychopathic". There is no information which indicates that the appropriateness of referrals under 2947.25 is ever questioned.

The process at the centers is more eclectic and less defined. The center directors are often faced with referrals which, though made under the cover of 2947.25 are clearly not intended to be Ascherman examinations. The process at the centers is more flexible to accommodate these inappropriate referrals by addressing the concerns of the referral agent even when he doesn't fully understand the implications

of the statute used for referral. An attempt is made to answer not only the Ascherman questions, but also questions pertaining to dangerousness, probability of repeating, and possible disposition.

These attempts to meet the needs of the courts result in a less structured examination. It usually begins with the intake interview conducted by a social worker, and proceeds to an examination conducted by a psychologist which may or or may not include testing. Frequently, if there are no outstanding problems or the crime involved isn't particularly serious the examination process will end there. The psychologist will serve as the court witness if required. If the case is difficult or the crime particularly severe a psychiatrist will examine the defendent. The decision to utilize psychiatric evaluation is very situational and often determined by the proclivities of the presiding judge. It is clear from our research, however, that psychiatric time is used much more sparingly by the community forensic centers than by LSH.

The Competency/Sanity Examination

Under ORC 2945.37-40 the trial courts of Ohio are authorized to order the examination of any defendent whose competency to stand trial is questioned, whose current sanity is questioned, or whose sanity at the time of the offense is questioned. The process of the examination isn't specified in the act though it appears that the question can be decided by jury or judge on the basis of expert testimony gathered from a court ordered examination. The law states that this examination can be conducted at LSH or a local hospital for the mentally ill. From one to three psychiatrists are to be appointed to act as expert witnesses. There is also a recent

amendment to this law which allows for the substitution of a qualified psychologist for the psychiatrist for section 2945.38 and opens the door for the use of licensed psychologists as expert witnesses for those examinations. The time limit for conducting this examination is 30 days.

PSCD data indicate that this is the second most common examination conducted at LSH, accounting for 40 percent of the examinations conducted during our sample period. For our combined sample of four forensic centers (See section IV) they account for 17 percent of the total which ranks them third in examination type following the category "general examination". This category was created to include examinations which were court ordered but for which no statutory reference was made nor could any be imputed. It's likely that a number of these cases would have been classified as competency/sanity if they had been referred to LSH. The centers, at least initially, were not as demanding of statute numbers for referrals as has been LSH.

At LSH the process for conducting the competency/sanity examination is quite similar to the Ascherman procedure. The major difference is in the questions which have to be answered. There are three distinct questions which can legitimatly be addressed within the bounds of this statute: first, is the defendent competent to stand trial, second was the defendent sane at the time of the offense, and third is the defendent currently sane. The first requires that the defendent understand the nature of the charges against him, appreciate the gravity of the judicial proceedings, and be able to counsel with his attorney to assist his defense. This question can be raised at any time prior to trial or during its conduct. The

second question arises when a defendent enters a plea of not guilty by reason of insanity. Since this plea must be entered before trial, this examination takes place pretrial. The third question, which addresses the current sanity of the defendent, can be raised at any time before or during the quilt determing process. This question of current sanity, which appears to be quite different from the issue of competency to stand trial, nevertheless is usually implicitly if not explicitly addressed during these examinations. There is no way to determine from the statute number which question, competency or sanity, is being raised.

Like LSH, the process at the community forensic centers for conducting competency/sanity referrals is similar to that used for Ascherman referrals. There is some evidence in terms of the number of contacts with mental health professionals that these examinations are somewhat more thorough at the centers than are Ascherman exams, though the trend seems to be to expend less resources, particularly psychiatric time, on this category. This has occurred because the center directors feel they are receiving a significant number of competency/sanity referrals which are inappropriate, and which could better be handled as general presentance examinations. An additional point that should be noted is that the community centers are very reluctant to conduct examinations for which the expressed purpose is to determine the sanity at the time of the offense. Several centers refuse to even accept these referrals because of the difficulty of addressing that question. This is an area that should be addressed by either the legislature or the Department of Mental Health and Mental Retardation. As long as the plea of not guilty by reason of insanity

is a legal defense, it seems that defendents should be entitled to use the facilities of publically supported centers to establish that defense.

As with the Ascherman procedure at the centers, the competency/sanity examination appears to be becoming more flexible over time. The professional resources used to conduct the examinations are largely determined by the difficulty of the case and proclivities of the trial judge.

The Presentence Examination

While the presentence examination is not routinely conducted at LSH, it is one of the most frequently employed procedures at the community forensic centers. For persons convicted of a felony, the authority for this examination lies in section 2951.03 which allows a psychiatric examination as an adjunct to the normal presentence investigation. There are also provisions under 2947.06 for an examination to mitigate sentence if requested by the prosecutor. The PSCD staff could find no clear statutory authority for the use of this examination type for misdemeanor offenses, a situation for which they are frequently employed.

In spite of some question about the authority to conduct them, these examinations account for 38 percent of the caseload at the forensic centers. The persons who receive these examinations appear to be persons who would not have been examined prior to the opening of the forensic centers, and thus represent additional examinations which have not been drawn away from LSH. The rather large number of misdemeanor offenders in this group is particularly supportive of this conclusion.

Probation/Parole Examinations

Probation/parole referrals constitute a second category of examination type which is relatively rare at LSH. The aim of the examination is to assist the probation or parole officer in supervising his client. This examination is in effect often a psychiatric adjunct to the normal presentence report though it usually takes place after the judge has agreed to place the person on probation. Frequently one of the conditions of probation is that the defendent participate in the examination. Ocassionally, behavior problems which occur while on probation or parole precipitate the examination and the results are utilized to assist in the decision to revoke or continue probation or parole.

The exam itself is often less formal than either the Ascherman or the competency/sanity and it is often conducted entirely by a psychiatric social worker. Only rarely is psychiatric time used. The statutory authority for this exam is unclear, though it could conceivablely fall under the rubric of 2945.40. The Adult Parole Authority holds that it has authority to order examinations under an active executive order, though this may not even be necessary given the questionable legal status of parolees.

In our center sample, only about three percent of the examinations appear to fall into this category. We believe this is an understatement in terms of the use of the exam for probationers because a large number of these referrals appear as treatment rather than examination referrals. We don't feel, however, that the number of parolees is understated. Forensic centers seem to almost uniformly exhibit poor relationships with the Adult Parole Authority.

The Drug Dependency Examination

The drug dependence examination is conducted under the authority of ORC 3719.51. This section authorizes the utilization of probation for a person convicted of any misdemeanor or probationable felony for the purpose of receiving treatment for drug problems. To ascertain whether or not probation is warranted, the defendent receives a medical and psychiatric examination to determine (1) if he is dependent on drugs, (2) if he is in danger of becoming dependent on drugs, or (3) if he may be rehibilitated through treatment. The section requires that the examination be conducted by a "competent physician appointed by the court" in any appropriate institution under the control of the Department of Mental Health and Mental Retardation or at a correctional institution, or any public hospital, clinic, or other proper institution. Within 30 days a report must be presented to the court. This 30 days is generally viewed as amounting to a 30 day committment.

These examinations are conducted at both LSH and the community forensic centers, though at neither have they become a major referral source. During our sample period they accounted for less than one percent of the LSH examinations, and only nine percent of the referrals to the forensic centers.

The actual process of the examination is unclear both at LSH and the centers. This seems to be due to the small number of these examinations and the uncertainty over what their content should be.

The Emergency Examination

The emergency examination occurs only through the forensic centers.

When a person incarcerated in a local lockup exhibits signs of some severe mental disorder, it is common practice in areas with forensic centers to contact the center and request assistance. All the centers studied were willing to handle these problems. The frequency of these examinations is probably understated in the records of the centers. Our data indicate that only about two percent of the exams fall into this category, though we suspect that they frequently are listed as competency/sanity examinations with the court order being written after the initial interview.

The statutory authority for these examinations, though very infrequently stated, is probably 2945.40. The process used in conducting these exams is highly situational though it usually involves an interview with the defendent at the jail or lockup rather than his transportation to the forensic center. The professional making the visit depends on the circumstances surrounding the referral and the availability of staff.

Treatment and Custody

As stated earlier, we recognize that treatment and custody are quite different functions. We have, however, chosen to discuss them in the same section because significant portions of the treatment for offenders in Ohio occurs in a custody situation. In addition, as also stated earlier, it is our intention to avoid a detailed discussion of treatment processes. Thus this section will consist largely of a discussion of the custodial function of forensic psychiatry in Ohio.

Indefinite Commitments to Lima State Hospital

There are at least ten sections of Ohio law which allow the

indefinite commitment of persons to LSH (See Table 3). During the seven year period in which we sampled LSH admissions, the most frequently used was 2947.25, the commitment section of the Ascherman Act. This section accounted for 861 or 34.9 percent of the commitments for the time period. The persons in this group have been found by the committing courts to be either mentally ill, mentally retarded or psychopathic.

TABLE 3

INDEFINITE COMMITMENTS TO LSH BY STATUTE

ORC	N	%
2,947.25	861	34.9
2,945.38	548	22.2
5,125.05,06	591	23.9
5,125.03	223	9.0
2,945.39	126	5.1
5,125.09	105	4.3
3,719.51	11	.4
2,967.22	4	.2
5,120.14	0	0
5,125.04	0	0
Total	2,469	100.00

The second most utilized section is 2945.38. This section allows the commitment of persons found incompetent to stand trial, and accounted for 548 or 22.2 percent of the commitments during the seven

year period. The third most utilized section is 5125.06 which allows the indefinite transfer of a mentally ill prisoner from the Department of Rehabilitation and Corrections to LSH for the maximum term of his sentence. This section accounted for 591 or 23.9 percent of the cases in our sample period.

The fourth most utilized section is 5125.03. This section allows the transfer of dangerous or homicidal patients from civil mental institutions to LSH. During the sample period, 223 of these indefinite transfers were made. The fifth most utilized section is 2945.39. This section covers persons committed after being found not guilty by reason of insanity. During the sample period, 105 commitments fell into this category.

The sixth most utilized section is 5125.09. This section allows the retention of mentally ill transfers from the Department of Rehabilitation and Corrections beyond the expiration of their maximum sentence. It accounted for 105 commitments in our sample. The seventh most utilized section is 3719.51, which allows the commitment of persons dependent on drugs or in danger of becoming dependent on drugs. In our sample, 11 persons were committed under this section. This is a small but interesting number of commitments because it is our understanding that there is no drug treatment program at LSH, and the propriety of these referrals must surely be in question.

During research into potential statutes for indefinite commitment to LSH, two additional sections were found that were not utilized during the sample period. They were 5120.14, which allows the Deptment of Rehabilitation and Corrections (DORC) to transfer any inmate under its control who is insane, feeble minded, or epileptic to the DMH&MR

or their assignment to an institution; and 5125.04 which allows the probate of a mentally ill felon with his subsequent assignment to an institution designated by Mental Health and Mental Retardation, which in practice could be LSH.

The use of the statutes discussed above has resulted in LSH becoming the custody and treatment focus of Ohio FPSDS. Table 4 , which illustrates commitments to LSH for the last seven years categorized by examination and indefinite, clearly indicates that LSH is becoming increasingly custody and treatment oriented. Indefinites as a percentages of commitments rose fairly steadily from 40 percent in 1968 to over 57 percent of the admissions in 1974. This reflects either an increasing concentration of LSH resources on custody and treatment, or a decreasing emphasis on examination, or possibly a combination of both.

Though LSH has been the primary inmate institution for forensic psychiatry in Ohio, the custody and treatment functions have also been carried at the Junction City Treatment Center and the Chillicothe Treatment and Research Center.

Custody and Treatment Alternatives to LSH

The Chillicothe Treatment and Research Center has served primarily as an evaluation unit for inmates of DORC facilities who are being considered for placement in the Junction City program. Recently, however, it has served as a holding facility for persons transferred back to corrections from LSH classified as "not dangerous to self or others and not in need of maximum security". The plan for FY's 1976-77 included provisions to close this facility, though population pressures within the correctional institutions may force changes in the plan.

TABLE 4

COMMITMENTS TO LSH, EXAMINATIONS VS. INDEFINITES

Year	Examinations		Indefinites		Total
1968	664	60.0 / 20.9	442	40.0 / 18.7	1,106
1969	724	66.6 / 22.8	363	33.4 / 15.3	1,097
1970	668	62.8 / 21.0	395	37.2 / 16.7	1,063
1971	500	60.1 / 15.7	332	39.9 / 14.0	832
1972	186	42.9 / 5.9	248	57.1 / 10.5	434
1973	219	42.6 / 6.9	295	57.4 / 12.5	514
1974	217	42.7 / 6.8	291	57.2 / 12.3	508
Total	3,178*		2,366**		5,544

*This number excludes 119 mentally ill and probate cases.
**This number excludes 105 cases held beyond maximum sentence.

N = Row Percent
D = Column percent

The Junction City facility, with a capacity of about 100, has functioned as a small special services facility administering an experimental treatment program designed to reduce recidivism. The small capacity of this unit has precluded its ever being a major custody facility for forensic psychiatry, and serious current budgetary problems raise doubts about its continued operation.

Though LSH, Chillicothe, and Junction City are the primary centers of the custody and treatment function in the Ohio FPSDS, there is some evidence that it may occur in other locations. The Division of Forensic Psychiatry provides funds for some staff who provide forensic services in Ohio's correctional institutions. To the extent that these services allow offenders to remain in their current institution even though they could be considered mentally ill, the services are allowing the institutions to serve a custody function which would otherwise fall to LSH. An example of this is the provision of psychotropic drugs to offenders who would not be able to remain in the institution without them.

The civil mental health institutions also support the custody function of LSH in at least two ways. First, there have been small but substantial numbers of persons indefinitely committed to civil institutions under the authority of the competency/sanity and Ascherman laws. This is a clear assumption of the custody function by civil mental health. Second, there is a significant body of evidence, largely anecdotal, that it is the practice of many courts, prosecutors, and police agencies to practice informal diversion of defendents to the civil mental institutions. This practice, though often questioned from a defendent's-rights point of view, serves to shift a significant

number of persons who would become custody cases for the FPSDS to the civil sphere. The extent of this practice is difficult to ascertain because it often falls within the legitmate areas of descretion available to courts, prosecutors, and police, -- areas which are often discussed only with great reluctance.

Decision-Making in the FPSDS

As previously stated, decision-making can be conceptualized in at least two ways. First, there are a large number of decisions which must be made regarding the operation of the system. In this section we are concerned primarily with decisions which would be made or at least ratified by persons in the position of institutional superintendent or above. Examples would be the decision to intake, transfer, or discharge clients, decisions regarding the level of security, and decisions regarding the conditions under which clients in custody exist.

The most salient observation which can be made regarding this conceptualization of decision-making in the FPSDS is that it is so fractionalized and uncoordinated that the elements of the FPSDS waste a great deal of time working at cross purposes. For example, the interim Davis v. Watkins order in effect mandated that clients be transferred to the least restrictive setting if custody was indeed required. This led to the evaluation of the entire population of LSH and the subsequent transfer of a number of persons back to the correctional system from where they had originally been referred. The problem with this decision, however, is that correctional facilities are already operating at capacity. The correctional system wasn't

prepared to handle the influx of transfers from LSH. The result has been that a chain reaction of transfers, retransfers, and retransferred-transfers has been set off. There is every reason to believe that this process will continue until the legislature or the courts intervene.

This situation was not cited to label any particular segment of the system as villains; like many complicated situations, this is one where there are none. When the court required that clients be transferred to the least restrictive setting it restricted the range of decision-making for the rest of the FPSDS. The decision option at LSH to continue holding particular groups of clients was taken away. The only option available was to return the clients to their point of origin in the system, i.e. corrections or mental health. Unfortunately, these elements were already at capacity. At each point in the process, from the court through corrections, the options just were not available; they are constrained by budgetary limitation, by law, or by public opinion.

A second conceptualization of decision-making concentrates on the individual client and his official entry into the FPSDS. This is a direct outgrowth of the information generation function. In theory, agents of the FPSDS who examine clients under the various statutes are only acting as expert witnesses of the courts. The decision to label a client as a psychopath, mentally ill, drug dependent, or any other status is in the hands of the court. In practice, this may not always be the case. If the courts merely ratify the recommendations of the agents of the FPSDS regarding client disposition a significant change in the locus of the decision-making has taken place.

Our research indicates that there is a high degree of agreement between evaluation recommendations and eventual court dispositon which is not, however, evidence that the courts have abdicated their role. It may be only indicative of the accuracy of examinations. In the course of the research, however, other information emerged which may cast some light on this issue. Evaluators who are unknown to the court, that is those who are not local, tend to be called more frequently into court to testify concerning the condition of the defendent. This suggests at least the possibility that courts have more confidence in local agents of the FPSDS and would tend to ratify their judgements on client disposition more frequently then the judgements of more remote evaluators. The implication of this is that the development of local forensic centers leads to the shifting of disposition decision-making from the courts to mental health professionals.

This framework is offered as a tool for understanding and organizing the issues which have arisen in the area of the FPSDS. The sections which follow are more focused discussions of the issues, though we hope a broader perspective can always be quickly reestablished by referring to this framework.

IV Methodology

Two basic samples of data were used to generate the findings discussed below: a sample of 5792 admissions to LSH, and a sample of 1065 admissions to community forensic centers. The LSH data were gathered primarily to establish the existing pattern of referrals to the hospital. Five pieces of data were collected for each admission to the hospital for the years 1968 through 1974. The source of this information was the "admission book" maintained by the records section at LSH. The data gathering process consisted of the researchers reading the data from the book onto audio tape, and then later transcribing the tape onto IBM punchcards for processing. This method proved fast and accurate and provided the unintended benefit of improving confidentiality. The data recorded did not include any individual identifing characteristics so it was impossible for coders to link data to any person.

The first piece of data gathered was the county of origin for the referral. This reflects the county which originally prosecuted or committed the offender but not necessarily his county of residence. Out of a total of 5792 admissions sampled, there were only five cases in which the county could not be determined.

The second piece of data gathered was the referral source. Basically, this is the agency which commited the offender to LSH. Table 5 lists all possible referral sources, which fall into three categories: the courts, the civil mental health institutions, and the correctional institutions. There were nine admissions for which referral source could not be determined.

TABLE 5

REFERRAL SOURCES TO LSH

1. Common Pleas Court	21. Nelsonville Tuberculosis Center
2. Municipal Court	22. Tiffin State Hospital
3. Allen County Probate Court	23. Toledo State Hospital
4. Other Probate Court	24. Columbus State Institute
5. Juvenile Court	25. Orient State Institute
6. County Court	26. Gallipolis State Institute
7. Cleveland Psychiatric Hospital	27. Broadview Center
8. Fairhill Mental Health Center	28. Mr. Vernon State Institute
9. Fallsview Mental Health Center	29. Apple Creek State Institute
10. Portsmouth Receiving Hospital	30. London Correctional Institute
11. Rollman Psychiatric Hospital	31. Lebanon Correctional Institute
12. Woodside Receiving Hospital	32. Ohio Penitentiary (Columbus)
13. Athens Mental Health Center	33. Ohio State Reformatory (Mansfield)
14. Cambridge State Hospital	34. Ohio Reformatory for Women
15. Cleveland State Hospital	35. Marion Correctional Institute
16. Columbus State Hospital	36. Chillicothe Correctional Institute
17. Dayton Mental Health Center	37. Southern Ohio Correctional Institute
18. Hawthornden State Hospital	38. Junction City
19. Longview State Hospital	39. TRC
20. Massillon State Hospital	

The third piece of data gathered was the statute under which the referral was made. This data is somewhat difficult to interpret, however,

because the admission book lists the statute number which appears on the court order accompaning the defendent, a number which may be inappropriate or in error. The data was recorded as shown and during data processing the incorrect numbers were recoded to the most likely alternatives. After this process, all but 31 cases were assigned to categories covered by current statutes.

The fourth piece of data gathered was the criminal charge of which the client was either convicted or accused. Two problems were encountered here. First, a number of charges had originally been made under statutes which appeared to be municipal and considerable judgement was required to convert them into comparable offenses against state law. Second, a number of offenders were charged with multiple offenses. These were recorded as the "most serious offense" following the general rule that sexual offenses were the most serious, followed by nonsexual personal, property, drug, public order, and other non-specific offenses in that order. In 14 admissions this information was missing. The final piece of data gathered was the number of prior client admissions to LSH.

The sample of 1065 admissions to community forensic centers was a combined sample of admissions to the Akron, Cincinnati, Columbus, and Hamilton centers. The time frames for this sample are listed in Table 6 . There were two reasons for choosing this block of data to characterize the forensic centers. First, it contains the most recent data collected by PSCD, and all data essentially represent the time period encompassed within 1973 and 1974. It was felt that this recent and relatively short period of time minimizes external influences on the centers, e.g. changes

in the law, public opinion, funding, etc. Second, these data were all collected and coded by the same personnel, thus the data gathering and coding conventions were held relatively constant. The data gathered for the center sample were considerably more extensive than the LSH sample because it served as the basic data base for evaluating the centers. This report, however, will only utilize information comparable to that gathered at LSH.

TABLE 6

PSCD DATA COLLECTION PERIODS AND CLIENT N's
FOR COMBINED SAMPLE OF FORENSIC CENTERS

	N	Time Frame
Akron	156	3/74-12/74
Hamilton	155	11/73-2/75
Cincinnati	218	7/73-12/74
Columbus	536	1/73-12/74

In addition to the collection of hard data on the number of referrals for forensic services, a survey of criminal justice and mental health was conducted to elicit their attitudes regarding the provision of forensic services. The groups surveyed and the return rates are listed in Table 7 . The questionnaires are reproduced in Appendix A . The questionnaires were designed to address four basic issues relative to the provision of forensic services. What services are available? How do you rate the quality of the services? What is your demand for these services? What are your attitudes regarding the current statutes governing the delivery of forensic services?

TABLE 7

GROUPS INCLUDED IN PSCD SURVEY OF FORENSIC SERVICE ATTITUDES AND RATIOS OF RETURN

All common pleas court judges, non-center counties (52%)

All county judges, non-center counties (48%)

All municipal court judges, non-center counties (43%)

Sample of common pleas court probation officers, non-center counties (57%)

Sample of municipal probation officers, non-center counties (57%)

State parole regional and unit supervisors and senior officers (53%)

Sheriffs of all non-center counties (54%)

Directors of all other jail facilities, non-center counties (54%)

Superintendents of all state correctional institutions (100%)

Superintendents of all state mental health and mental retardation institutions (64%)

Executive directors or board chairman of all 648 boards (77%)

All mental health district managers (53%)

All common pleas court judges, center counties (50%)

All municipal court judges, center counties (50%)

All center county sheriffs (50%)

All other directors of center county detention facilities (50%)

Forensic Services - Issues of Demand and Supply

The first issue to be addressed is the demand for forensic examinations. Since LSH is very important in this process, the first step is to gain a notion of the role which it plays. Table 8 lists the commitments to LSH from 1968 through 1974 by county, dichotomized into examinations and indefinite commitments. The column totals which reflect the annual

TABLE 8

ADMISSIONS TO LSH BY COMMITMENT TYPE, COUNTY, AND CALENDAR YEAR FOR ALL OHIO COUNTIES

	1968		1969		1970		1971		1972		1973		1974		Total	
	E	I	E	I	E	I	E	I	E	I	E	I	E	I	E	I
Adams	0	0	0	0	0	0	0	0	1	0	2	0	2	1	5	1
Allen	12	8	8	4	9	6	17	14	15	7	5	7	9	6	75	52
Ashland	3	0	2	0	3	1	2	0	1	0	1	0	2	1	14	2
Ashtabula	1	0	3	2	5	2	2	2	0	0	1	1	1	0	13	7
Athens	2	4	3	1	1	3	1	2	2	1	0	0	0	0	9	11
Auglaize	2	0	0	0	0	0	3	1	5	1	5	3	4	1	19	6
Belmont	4	1	4	3	6	1	4	2	0	0	4	1	3	2	25	10
Brown	0	1	3	1	1	2	1	1	0	1	1	0	2	0	8	6
Butler	36	9	33	13	48	16	32	8	8	6	10	5	2	4	169	61
Carroll	0	1	1	0	0	1	1	0	0	0	0	0	2	0	4	2
Champaign	0	0	3	0	2	0	2	1	0	0	0	1	0	1	7	3
Clark	8	4	15	5	19	9	7	8	10	5	7	6	6	4	72	41
Clermont	11	7	6	3	2	1	3	1	1	1	3	3	0	1	26	17
Clinton	4	2	0	1	1	0	1	0	0	0	1	0	1	0	8	3
Columbiana	5	2	12	1	8	2	3	2	0	0	1	1	3	2	32	10

Table 8 , Admissions to LSH by Commitment Type, County, and Calendar Year for all Ohio Counties (continued)

	1968		1969		1970		1971		1972		1973		1974		Total	
	E	I	E	I	E	I	E	I	E	I	E	I	E	I	E	I
Coshocton	2	1	7	2	6	0	4	2	2	1	0	0	0	0	21	6
Crawford	2	1	0	0	2	0	2	0	0	1	1	0	1	2	8	4
Cuyahoga	8	64	8	55	17	66	6	65	2	49	5	68	8	55	54	422
Darke	0	0	5	1	1	2	2	2	0	1	1	0	1	2	10	8
Defiance	4	1	0	0	0	0	2	0	0	1	2	0	1	0	9	2
Delaware	4	0	7	4	1	0	0	0	2	0	1	0	1	1	16	5
Erie	10	7	21	6	16	8	4	2	0	1	2	1	1	0	54	25
Fairfield	5	3	8	1	6	2	8	1	3	1	2	0	2	2	34	10
Fayette	4	1	1	2		1	3	0	0	0	1	6	0	0	9	10
Franklin	59	35	53	23	54	35	43	29	3	33	3	39	4	34	219	228
Fulton	1	1	7	1	3	0	7	1	0	0	4	0	1	1	23	4
Gallia	1	2	1	1	1	1	2	2	2	0	1	1	0	0	8	7
Geauga	0	0	5	3	0	1	1	0	0	0	1	0	1	0	8	4
Greene	2	4	2	1	4	5	2	0	5	4	0	2	0	2	15	18
Guernsey	2	3	7	3	4	5	6	2	4	0	1	2	2	0	26	15
Hamilton	50	40	70	43	42	28	39	40	15	24	21	33	21	34	258	242
Hancock	6	3	4	1	5	3	4	1	1	1	3	1	4	1	27	11

Table 8 , Admissions to LSH by Commitment Type, County, and Calendar Year for all Ohio Counties (continued)

	1968		1969		1970		1971		1972		1973		1974		Total	
	E	I	E	I	E	I	E	I	E	I	E	I	E	I	E	I
Hardin	1	0	1	0	4	0	0	1	2	0	0	0	0	0	8	1
Harrison	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Henry	0	1	0	0	4	1	2	1	1	1	0	0	1	2	8	5
Highland	2	3	4	0	4	2	2	1	0	0	3	2	1	0	16	8
Hocking	0	1	1	0	1	1	0	0	0	1	0	0	1	0	3	3
Holmes	1	0	2	1	0	0	0	0	0	0	0	0	0	0	3	1
Huron	11	1	3	4	3	0	1	0	0	0	0	0	0	1	18	6
Jackson	4	2	2	1	0	0	1	1	1	0	2	0	2	0	12	4
Jefferson	2	1	2	3	2	1	3	2	2	0	7	2	2	4	20	13
Knox	3	4	10	5	1	1	1	3	0	2	1	1	0	2	16	18
Lake	9	15	17	7	12	5	6	4	0	5	0	0	0	1	44	37
Lawrence	2	1	4	1	7	4	1	1	0	2	5	1	4	1	23	11
Licking	8	3	5	0	14	3	18	5	3	2	4	2	4	1	56	16
Logan	8	4	5	1	11	4	5	2	4	1	7	2	0	1	40	15
Lorain	32	10	26	12	26	9	22	5	4	5	5	5	9	5	124	51
Lucas	49	52	45	29	48	31	29	21	10	11	3	14	6	22	190	180
Madison	2	1	4	0	8	0	4	1	2	0	0	0	0	0	20	2

Table 8 , Admissions to LSH by Commitment Type, County, and Calendar Year for all Ohio Counties (continued)

	1968		1969		1970		1971		1972		1973		1974		Total	
	E	I	E	I	E	I	E	I	E	I	E	I	E	I	E	I
Mahoning	22	6	10	8	18	9	20	8	9	1	17	4	16	10	112	46
Marion	7	1	8	0	8	1	6	3	0	3	0	0	4	2	33	10
Medina	2	0	3	2	0	1	1	2	1	1	0	0	2	0	9	6
Meigs	1	0	1	0	0	0	0	1	0	0	0	0	0	0	2	1
Mercer	0	1	1	1	1	0	0	0	0	0	0	0	0	0	2	2
Miami	14	10	10	1	5	3	4	1	0	0	0	0	0	0	33	15
Monroe			5	0	4	0	0	0	0	0	0	0	0	0	9	0
Montgomery	57	25	63	25	52	26	47	24	13	24	23	31	15	27	270	182
Morgan	4	2	1	2	4	0	0	0	1	0	0	0	0	0	10	4
Morrow	1	0	3	0	5	3	3	0	2	3	0	1	3	0	17	7
Muskinghum	3	4	5	3	4	3	4	2	1	3	1	4	1	0	19	19
Noble	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Ottawa	2	2	3	0	0	1	1	1	0	0	2	0	0	0	8	4
Paulding	1	0	2	0	0	2	1	0	0	0	1	0	0	0	5	2
Perry	1	0	2	0	0	1	0	0	1	0	0	1	1	1	5	3
Pickaway	6	3	4	2	10	3	4	0	4	2	2	2	1	2	31	14

Table 8 , Admissions to LSH by Commitment Type, County, and Calendar Year for all Ohio Counties (continued)

	1968		1969		1970		1971		1972		1973		1974		Total	
	E	I	E	I	E	I	E	I	E	I	E	I	E	I	E	I
Pike	1	1	0	0	1	0	4	2	0	0	2	0	0	0	8	3
Portage	12	6	5	8	7	3	3	5	3	1	2	6	1	2	33	31
Preble	1	0	1	0	0	0	0	0	1	0	0	0	0	0	3	0
Putnam	1	0	0	0	1	0	2	0	1	0	0	0	0	0	5	0
Richland	5	7	16	9	17	5	11	5	1	4	3	0	5	3	58	33
Ross	2	2	6	1	3	4	3	1	4	2	2	1	4	3	24	14
Sandusky	2	1	3	1	6	1	4	2	2	1	2	2	0	0	19	8
Scioto	6	3	15	2	8	4	0	4	5	2	3	2	4	1	41	18
Seneca	0	1	0	1	1	0	0	0	0	0	2	0	2	1	5	3
Shelby	7	5	7	1	4	0	3	0	1	0	0	0	2	0	24	6
Stark	30	18	25	7	19	13	13	8	3	9	11	4	11	12	112	71
Summit	59	34	52	29	41	28	29	20	9	19	3	19	10	20	203	169
Trumbull	4	0	11	2	5	1	8	1	5	1	4	1	8	2	45	8
Tuscarawas	3	0	3	4	1	0	1	0	0	0	0	0	6	2	14	6
Union	1	0	4	0	1	1	1	0	0	0	1	1	0	0	8	2
Van Wert	0	0	3	1	9	7	5	1	0	0	1	1	2	1	20	11
Vinton	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	1

Table 8 , Admissions to LSH by Commitment Type, County, and Calendar Year for all Ohio Counties (continued)

	1968		1969		1970		1971		1972		1973		1974		Total	
	E	I	E	I	E	I	E	I	E	I	E	I	E	I	E	I
Warren	7	4	8	2	8	4	8	2	0	0	2	1	1	1	34	14
Washington	6	1	2	0	4	4	0	1	0	0	0	1	0	0	12	7
Wayne	4	0	6	2	3	3	0	0	0	0	3	2	0	1	16	8
Williams	1	0	3	2	0	0	3	1	1	0	0	0	0	0	8	3
Wood	8	0	3	1	4	0	0	0	7	3	4	1	1	2	27	7
Wyandot	0	0	0	1	2	1	1	0	0	0	1	0	2	1	9	3
Column Total	664	442	724	363	668	395	500	332	186	248	219	295	217	291	3,178	2,366
Column Percentage	20.9	18.7	22.8	15.3	21.0	16.7	15.7	14.0	5.9	10.5	6.9	12.5	6.8	12.3		
Total Commitments	1,106		1,087		1,063		832		434		514		508			
Total Percentage	19.9		19.6		19.2		15.0		7.8		9.3		9.2			

E = Examination
I = Indefinite

totals graphically illustrate the sharp drop-off in commitments which occurred in late 1971 and 1972 as a result of charges of patient abuse and generally poor conditions at LSH. The number of examination commitments in 1972 dropped to 28 percent of what they had been in 1968. This decrease is particularly significant first, because it occurred in spite of a steady increase in criminal prosecutions during that period and second, because the forensic centers had not yet begun to pick-up a major portion of the examination load from LSH.

If the level of examination commitments seen from 1968 through 1972 is indicative of the demand for examination services by the courts of Ohio, it is important to discover what happened to the cases not sent to LSH from late 1971 on. Clearly, a considerable number of cases were involved. If the average for 1968 through 1970 of 6853 is taken as a base then 1972 was 499 cases below base, 1973 was 466 below, and 1974 was 468 below for a total of 1433 under what would have been expected given a straight line projection of the prior three years.

Table 9 illustrates the numbers of clients referred to forensic centers supported by state effort. During 1972, given the low case-load, it's unlikely that the centers absorbed a significant portion of the excess cases from LSH, with the possible exceptions of the Toledo and Lucas county area. During 1973 and 1974, the volume of referrals to forensic centers grew to the point where the latter were probably absorbing a considerable portion of referrals which would have gone to LSH had the difficulties of 1971 not occurred. The number of referrals is so large, in fact, that either the centers were encouraging a significant number of referrals on their own, or the referral agents

are referring persons who would not have previously been examined. The 914 referrals which occurred in 1973, were considerably more than one would have expected to find at LSH based on 1968 through 1970 performance.

TABLE 9

CLIENT FREQUENCIES FOR SIX FORENSIC CENTERS

	1971	1972	1973	1974	1975 P.T.*
Akron		3	98	198	260
Hamilton (Butler)				124	160
Cincinnati			60	156	284
Columbus			194	306	450
Dayton			162	283	324
Toledo	71	268	400	433	368
TOTAL	71	271	914	1500	1846

*Projected total

Table 10 lists the referrals to civil mental health institutions for examination and indefinite commitments by year. The trend here is toward a significant increase in referrals, though the trend doesn't seem to be radically altered by the changes at LSH during 1971. Indeed, it appears that this trend was well established before the LSH problems of 1971. Interestingly enough, very little is known about the referrals which are appearing at the civil mental health institutions. Discussion with the superintendant of one institution suggests that these referrals are largely misdemeanor offenders from local county and municipal courts.

TABLE 10

COMMITMENTS TO CIVIL INSTITUTIONS BY
TYPE, YEAR, AND PRESENCE OR ABSENCE OF LOCAL FORENSIC CENTERS

	1968	1969	1970	1971	1972	1973	1974
Center Counties*							
Examinations	27	61	109	161	232	353	236
Indefinites	0	6	21	17	8	107	20
Non-Center Counties							
Examinations	10	19	11	25	57	254	97
Indefinites	5	1	3	5	6	122	14
Total							
Examinations	37	80	120	186	209	607	333
Indefinites	5	7	24	22	14	229	34

*Butler, Franklin, Hamilton, Lucas, Montgomery, Summit

The most common referral reason suggested was alcoholism. These cases appear to represent a significant increase in forensic referrals and not referrals which would previously have gone to LSH.

This discussion suggests that two phenomena are occuring. The examination function of the FPSDS is being shifted radically among the elements of the system. There are indications that the forensic centers and possibly the civil mental health system are picking up the load from LSH. At the same time, however, the total examination load or demand is increasing. Table 11 is an attempt to demonstrate this increasing demand. In an absolute sense, the table is far from accurate since it contains estimated figures, mixed calendar and fiscal year data, and does not include some examinations at Springfield and Cincinnati for which data was unavailable. Nevertheless, it represents our best estimate of the total number of forensic examinations conducted in the state from 1971 through 1974 by examining institution. The important feature of the table is the steady rise in examinations after 1972, which is reflected in the column totals. It is interesting to note that this rise is significantly greater than any increase in the total population of the state.

Predictions of the demand for forensic examinations are currently very risky business because the total number which occur can be heavily influenced by administrative decisions, such as the one in 1971 to restrict the availability at LSH. Our data indicate, however, that given time referral agents can overcome restrictions by locating alternative suppliers of services. It is unclear what would have happened to demand had the Division chosen not to support the development of community based forensic centers. One possibility is that private psychiatrists would have received an increase in the demand for these

TABLE 11

ESTIMATED TOTAL FORENSIC EXAMINATIONS 1971-1975

	1971	1972	1973	1974	1975
Forensic Centers	171	271	914	1500	1864*
LSH	500	186	219	217	218*
Civil Institutions	186	289	607	333	333*
Cuyahoga County	575	508	530	530*	530*
Lake County	12	30	48	48*	48*
Total	1344	1284	2318	2628	2975*

*Projected Figure

services, a second alternative would have been a more rapid growth in referrals to civil institutions, and a third alternative would have been the performance of fewer examinations in total with the courts becoming increasingly selective in terms of the offenders examined. The consequences of each of these alternatives should be explored because resource shortages could precipitate the adoption of one of them. Finally, policy makers should not neglect the possibility that provisions of these services has in effect created a demand which would otherwise not have been manifested.

The PSCD explored several methods for predicting the demand for forensic services. Early in the research stable relationships between forensic examinations and commitments appeared to be emerging. As data for additional years was gathered, however, the nature of the relationships appeared to change. The most likely explanation for this is the influence of policy decisions on reported caseloads. Decisions such as those limiting the intake at LSH cannot be forseen with accuracy sufficient to allow useful prediction. This appears to be a situation where the simplest of forecasting techniques such as those utilizing straight line projection are as good if not better than any more sophisticated technique. If and when admission and examination policy stabilize in this area, further projection studies should be done.

The responses to several of the questions in the survey of criminal justice and mental health personnel are relevant to this discussion and provide an alternative method of assessing demand and supply issues for forensic services. All common pleas, municipal and county court judges were asked to indicate the resources they use for evaluation of the mental status of defendants. Table 12 summarizes

TABLE 12

SOURCES OF FORENSIC SERVICES USED BY OHIO COURTS

Question: When a defendant's mental status has come under question in your court, where might he be sent for evaluation? If more than one of the following options are employed, please check all that are used and indicate which one is used most frequently. If you were on the bench prior to 1972, answer this question as it relates to the situation from 1972 to the present.

	Non-Center Counties		Center Counties		Total	
	N	%	N	%	N	%
LSH	63	(21)	12	(14)	75	(19)
State Civil MH*	66	(22)	19	(22)	85	(22)
Cty. Civil MH	13	(4)	2	(2)	15	(4)
Private MH	11	(4)	5	(6)	16	(4)
Gen. Hospital	8	(3)	2	(2)	10	(3)
Private Psych.	49	(17)	15	(17)	64	(17)
Civ. MH Outpatient	59	(20)	9	(10)	68	(18)
Forensic Center	27	(9)	24	(27)	51	(13)

*
MH = Mental Health
Cty. = County or city
Gen. = General
Psych. = Psychiatrist(s)
Civ. = Civil
% = Percent of responses

the results broken down into judges presiding in counties with forensic centers and judges presiding in counties without centers. One of the most interesting aspects of the responses to this question is that more judges listed the state civil mental hospitals as a source of evaluations than LSH. Some explanation of this can be found by dichotomizing judges into "common pleas" and "other"; 63 percent of the "common pleas" judges listed LSH as a resource with only 33 percent listing civil mental health hospitals, while only 15 percent of the "other" (county and municipal) listed LSH as a resource and 36 percent civil mental health. This probably results from the fact that LSH has not regularly been available to municipal and county judges. It should also be noted though, that even within the counties which have local forensic centers only 67 percent of the judges list them as a resource. This seems to indicate that the service coverage of the centers is less than complete. In a similar vein, judges were also asked if they "approved of the use of civil mental health facilities for the evaluation of criminal offenders" Eighty percent of those replying indicated the affirmative which suggests there is very little opposition to the use of civil mental health facilities for this purpose.

When the judges were asked if their needs for psychiatric evaluation were being met, 61 percent replied that they were not. The result was somewhat better within center counties, where only 24 percent replied that their needs were not being met. This response clearly indicates a significant unmet need for evaluation services.

The judges were also asked to estimate the percentage of defendents which passed through their courts in the last 12 months who

were found in need of psychiatric evaluation or treatment. The mean of the responses fell between six and seven percent. Fifty-nine percent of the respondents felt that the percentage was "increasing over time," 40 percent felt it was "remaining about the same." and less than one percent felt it was decreasing.

Probation and parole officers responded to comparable questions in a very similar manner. The only significant difference was that they see a greater number of defendants as being in need of psychiatric services, with the mean lying near 10 percent.

Admittedly, these responses are only subjective, but they indicate that there is a strong opinion among the criminal justice system personnel in Ohio that adequate psychiatric services are not yet available to the courts.

These results taken in conjunction with the trend of increasing referrals strongly suggest that any reduction of the examination function for the FPSDS will have to come from the forensic system. There is no indication that the referral agents in the criminal justice system are willing to reduce their demands for the services either in terms of their actions or their opinions.

An important issue in the supply of all forensic services, is the population served by the forensic facility. There are currently nine forensic psychiatric centers in Ohio which receive all or a portion of their funding through the Ohio Department of Mental Health and Mental Retardation. These nine centers are located in Butler, Clark, Franklin, Hamilton, Lucas, Montgomery, Muskingum, Scioto, and Summit counties. In addition to these centers over which the Department of Mental Health and Mental Retardation exercises some control,

there are also centers in Cuyahoga and Lake counties which have been organized and funded through local county and city effort.

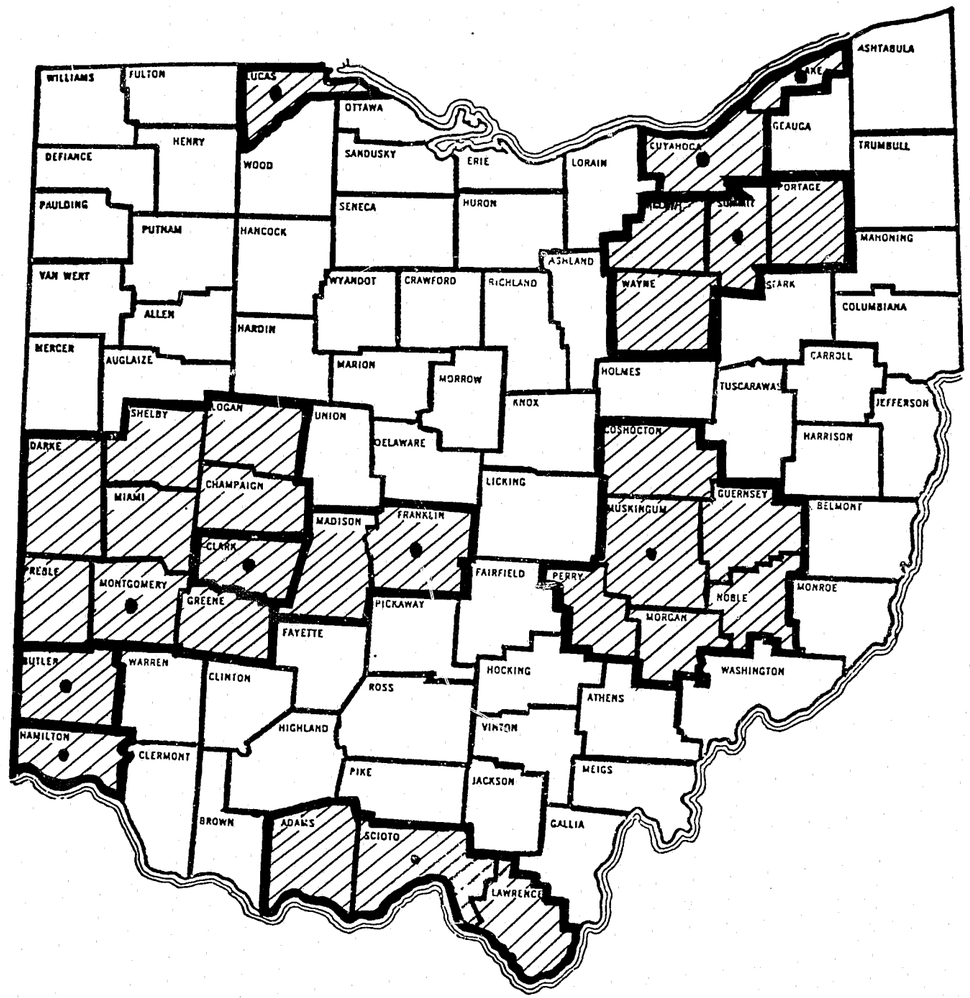
Basically, there are three approaches to defining the service areas of forensic centers: by geographic area served, by proportions of the State population served, and by the courts served and their caseloads. Each of these methods will be discussed here.

The first, and probably least informative, is to define service areas in geographic terms. Eleven of Ohio's 88 counties contain a forensic center. In addition, these centers serve courts in 17 additional counties for a totalof 26. These 26 counties contain 12,888 square miles or 31 percent of Ohio's land area. Figure 1 , which indicates the counties served, graphically illustrates the relatively small amount of area covered, and the clustering of the counties which are served. Though this type of analysis ignores the location of the population of the state, it clearly illustrates the geographic remoteness of forensic services to a large portion of the state. This is particularly true of west north-central Ohio, north-central Ohio, east-central Ohio, and south-central Ohio.

A second approach to defining service areas is in terms of the population of the areas served. When this strategy is used the coverage of the centers appears much more favorable. The total estimated population within the counties where the centers are located numbers 4,321,810 or 40 percent of the 1972 Ohio Population estimate. This is an impressive figure for only 11 centers, and it is indicative of the concentration of Ohio's population in those nine counties. Whether by plan or accident Ohio's forensic centers are well placed in terms of population. The above figure is, however, only a portion of the

Figure 1

Location of Ohio Forensic Psychiatric Centers



population actually served, because as previously noted several centers serve more than their home counties. The additional counties served are: Adams, Champaign, Coshocton, Darke, Greene, Guernsey, Lawrence, Logan, Madison, Miami, Morgan, Noble, Portage, Perry, Preble, Shelby, and Wayne. When these additional counties are included in the total population served the number increases to 5,181,410 or 48 percent of the 1972 Ohio population estimate.

When Ohio's counties are ranked by population and then compared with center coverage, it is interesting to note that the counties which rank seventh through tenth are not covered. These counties are Stark, Mahoning, Lorain, and Trumbull which have a total population of 1,175,400. If these counties which are located in the northeastern quadrant of the state were to be included in the service areas of existing centers, or additional centers were established, the total population covered would climb to 6,356,810 or 73 percent of the state population. This reasonably high percentage can be obtained while still only serving approximately one third of the counties in the state.*

Though it does not appear particularly difficult to serve a relatively large portion of Ohio's population with community based forensic services, a considerable problem will still exist for a number of the smaller counties. Table 8 indicates that there were 37 counties which made 14 or fewer referrals for examinations to LSH during the period 1968 through 1974. Due to their low populations it's highly unlikely that these counties will ever generate enough referrals to support a center

*These coverages exist in theory only since the replies to the survey discussed previously indicated that the presence of a center doesn't assure its availability to all clients.

designed for strictly forensic services. This is complicated by the fact that there are pockets of these rural counties which don't generate sufficient referrals to support a central facility within a reasonable distance; for the forseeable future their caseload will probably have to continue to be sent to LSH. Herein lies a problem, for as other more populous counties develop their local forensic services the quality variation across the state can potentially become wider and wider. If community based forensic services continue to provide the quality of services of which they appear capable, this issue will have to be addressed, if from no other point of view than "equal justice".

The third approach to defining service areas is in terms of the courts served and the proportion of the criminal justice clientele served by those courts. At the present time this is an extremely difficult task because the centers are undecided as to whom they will serve. Basically, the centers serve the common pleas courts of their areas, though frequently they will handle municipal or county court referrals on a space-available basis. There are also centers with fee-for-service contracts with courts in counties outside their own. There is also some question about the legal authority of the lower courts to order examinations and services under existing statutes. These questions confront both the personnel at the centers and the courts. They are particularly sharp when relatively minor mis-deameanants or juveniles are involved. Given these complications, it should not be assumed that all the courts in the area served by a forensic center receive all or even a portion of the services the center has available.

Though much work remains to be done in this area, several general service patterns seem to exist. First, with the exception of Cincinnati, which was a center originally established by the municipality, the municipal courts and county district courts are most likely not to be served by the forensic centers. Second, if more than one county is served by a forensic center, it is likely that only the common pleas courts in the outlying counties will be served. Third, as center caseload grows, the cases referred by common pleas courts will assume top priority. Fourth, cases referred by parole will tend to be assigned low priority. It's anticipated that furthur study of this phenomeon will be conducted with respect to a particular center. Study of this issue, however, is somewhat hampered by the poor caseload records kept by some of the lower courts and the reluctance of some center directors to discuss referrals that have been refused and their client acceptance priorities.

Although this discussion has focused primarily on the examination function of the FPSDS, the custody and treatment functions cannot be ignored. The PSCD recognizes that the custody function, in particular, is undergoing dramatic change in terms of the institutions handling the function. Information relating to this function is more difficult to obtain, however, because it is a much less visible process.

It appears that the level of indefinite commitments to LSH has varied much less than the examination level. Table 8 indicates that although indefinite forensic commitments decreased significantly in 1972, the decreasing trend seems to have been established prior to 1971. Indefinites in 1972 had decreased to 56 percent of their level in 1968 which contrasts quite markedly with the decrease to 28

percent for examination commitments.

Table 13 is an attempt to capture all indefinite forensic commitments in the state. In addition to LSH, commitments to civil institutions are included. These commitments to civil institutions are a small but increasing phenomenon. The total commitment level is somewhat erratic, but there is the suggestion of a slight downward trend. This is contrary to what one would expect, given generally increasing trends in population, in crime, and in persons receiving mental health services. There are several possible explanations for the decrease. First, courts are becoming much more discriminating in their decisions to commit offenders indefinitely, The difficulty courts experience in having persons admitted to LSH may serve as informal pressure to avoid these commitments. The increased concern over the moral and legal ramifications of the indefinite commitments may also operate as a check. Second, the clinicians may be reassessing their position concerning the efficacy of institutional treatment and recommending less of it. This is in line with the creation of community based facilities and the highly treatment oriented alternatives to institutions being developed.

Table 14 breaks down the indefinite commitments to LSH by type, and illustrates the changes which have occurred over the sample period. Prison transfers and civil commitments have remained relatively constant as a proportion of annual indefinites. Drug and parole commitments have never really been significant. Ascherman and competency/sanity are particularly interesting because they have almost reversed as a proportion of annual referrals. In 1968, 50 percent of the indefinite commitments to LSH were Ascherman while only 18 percent were competency/sanity.

TABLE 13

TOTAL FORENSIC INDEFINITE COMMITMENTS

	1968	1969	1970	1971	1972	1973	1974
LSH	442	363	395	332	248	295	291
Civil Institutions	5	7	24	22	14	229	34
Total	447	370	419	354	262	524	325

TABLE 14

INDEFINITE COMMITMENTS TO LSH BY YEAR BY TYPE

	Ascherman	C/S	Drug	Parole	Corrections Transfer	Civil	Total
1968	221 (50)	81 (18)	0 (0)	0 (0)	105 (24)	34 (8)	441
1969	152 (42)	85 (23)	0 (0)	0 (0)	73 (20)	53 (15)	363
1970	161 (41)	84 (21)	0 (0)	0 (0)	96 (24)	54 (14)	395
1971	107 (32)	91 (27)	5 (2)	1 (1)	104 (31)	24 (7)	332
1972	59 (24)	94 (38)	6 (2)	1 (1)	60 (24)	28 (11)	248
1973	87 (29)	108 (37)	0	1 (1)	82 (28)	16 (5)	294
1974	74 (25)	131 (45)	0	1 (1)	71 (24)	14 (5)	291
Total	86 (36)	674 (29)	11 (1)	4 (0)	591 (25)	223 (9)	2,364

In 1974, 45 percent were competency/sanity and only 25 percent Ascherman. This reversal somewhat complicates the custody function of the FPSDS because a relatively larger proportion of its clients are persons who have not been found guilty of any crime, i.e. not guilty by reason of insanity, or incompetent to stand trial. This situation may also have implications for the type of treatment and security required to deal with the forensic custody population, though they are far from clear.

The issue of facilities available for the custody function was raised in the questionnaire sample by asking all judges surveyed if they "felt there was a need for a local inpatient unit." Seventy-nine percent expressed the need for this service. Probation and parole officers responded with a 76 percent "yes." The directors of the local forensic centers and their staffs were all questionsed about the need for local custody facilities and the response was mixed. Several said it was very important to have them because they need facilities for custody during examination or short periods of intense treatment; others felt there was no need for local inpatient facilities.

The availability of treatment in the FPSDS is an issue that has generated more questions than answers. The difficulty of defining the term is probably a significant contributor to the problem, though even when there is agreement over what treatment is, there is disagreement over where it should be conducted. The directors of the local forensic centers have grappled with the issue and each seems to pursue a different policy. Several directors believe that the provision of treatment services is as important as conducting evaluations. At one center the evaluation/treatment split in the caseload is about 50/50. Other directors assign a low priority to treatment, some reasoning

that they are not mandated to do it, others that evaluators and treators cannot in good conscience be the same person. In any event, when judges were asked if they felt "that the court's need for psychiatric treatment services is currently being adequately met", seventy-six percent replied that it was not, when in counties with no forensic centers, the judges who felt most strongly that their needs were unmet were the municipal court judges.

There appear to be several options available for the provision of treatment locally. There is the option of the local forensic center, local civil mental health institutions and community mental health centers, along with other local public and private facilities. Local civil mental health institutions are somewhat limited in the services they can offer, however, because they are geared to providing inpatient services and because they are only located in a limited number of areas. Community mental health seems like the best potential source of treatment services for forensic clients. The problem seems to revolve around persuading community mental health personnel to accept forensic clients. Again and again the researchers encountered the situation where community mental health either flatly refused to accept persons with criminal-legal problems or accepted them reluctantly and provided very few services. There are strong arguements on both sides of this issue, but in the end there doesn't seem to be any justification for community mental health refusing these clients. This subject was raised on the survey questionnaire and the responses are rather interesting. When asked if they"approved of the use of civil

mental health facilities for the treatment of criminal offenders," 64 percent of the superintendents of mental health and mental retardation institutions replied "yes." Eighty-seven percent of the 648 board directors approved. Eighty-eight percent of the mental health district managers approved. Judges approved of using civil facilities by 72 percent. The question which begs for an answer is why with all this support there is so little visible treatment of criminal offenders by the civil mental health system at both the community and institutional levels. The PSCD recognizes that a great deal of the contact of the civil institutions with offenders may not be apparent because clients are informally diverted out of the criminal justice system to them. At the local level with regard to community mental health, however, we don't believe this rationale applies and we suggest that the local mental health centers must begin to more willingly accept responsibility for these clients.

Another issue to be addressed is the availability of clinical personnel and its distribution relative to the offender population. At the outset it must be stated that information in this area is very sparse. Despite considerable effort, the PSCD was able to obtain no information regarding the distribution of social workers in the state. Information is available on psychiatrists and psychologists who are licensed, but its usefulness for planning is very questionable because there are a large number of professionals who refuse to handle forensic cases and it's not clear who they are. In any event, in 1974 there were 538 licensed psychiatrists in Ohio; they were licensed in the 40 most populous counties and the number per county ranged from one to 163. During this same period there were 1570 licensed psychologists in 70

counties ranging from one to 321 per county. Basing any statements about the distribution of these professionals on these incomplete figures is tenuous. Probably the most informative statement which can be made is that when the number of psychiatrists per county is correlated with county population the Pearson R is .95; with psychologists the R is .97. Thus, to the extent that forensic clients are distributed in accordance with population the professional staff is available.

Quality of Forensic Services

There appears to be no satisfactory objective way to address quality issues in the FPSDS given the current state of research in the mental health and criminal justice fields. As an alternative, some subjective measures of quality were attempted through the PSCD questionnaire.

Table 15 is a compilation of the responses ranking the overall quality of the LSH examinations. The mental health district managers rated the quality of the examinations the lowest followed by center county judges and 648 board directors. The remaining groupings of respondents ranked the quality about average. The quality of examinations seems to be ranked lowest by mental health professionals and highest by the courts which use the services of LSH. An interesting facet of this table is that judges from center counties who are familiar with the forensic center as an alternatvie to LSH rate the quality of LSH's evaluations lower than judges who have no access to forensic centers. Table 16 specifically addresses the comparability of LSH's evaluations to some alternative. The difference in responses of judges who use forensic centers vs. those who don't is dramatic. There can be little

TABLE 15

QUESTIONNAIRE RESPONSE RANKING, OVERALL QUALITY OF LSH EVALUATIONS BY RESPONSE GROUP

	"How would you rank the overall quality of evaluations performed at Lima State Hospital?"							
	Very Good	1	2	3	4	5	Very Bad	$\bar{x}$
Mental Health District Managers				1	3	1		4.0
All Non-Center County Judges		9	17	31	12	5		2.3
All Center County Judges			3	3	5	3		3.6
All CPC Judges		7	15	24	11	3		2.8
All County Judges		1	0	3	1	0		2.8
All Municipal Judges		1	2	2	0	2		3.0
Probation Officers		6	5	4	7	5		3.0
Parole Officers		1	0	2	2	0		3.0
Mental Health and Mental Retardation Superintendents		0	3	3	3	1		3.2
648 Board Directors		0	4	8	6	6		3.6

TABLE 16

Questionnaire Response Ranking Quality of LSH Examinations vs. a Known Alternative by Response Group .

	If you have received evaluations from both LSH and at least one other source, how does the alternative compare with regard to overall quality and value to you?						
	Much Better	1	2	3	4	5	Much Worse	$\bar{x}$
All Non-center County Judges		4	6	39	19	2		3.0
All Center-county Judges		12	2	1	0	0		1.3
All Common Pleas Judges		4	5	31	17	2		3.1
All County Judges		0	0	4	0	0		3.0
All Municipal Judges		0	1	5	2	0		3.1
Probation Officers		5	4	17	7	2		2.9
Parole Officers		1	0	2	2	0		3.0

CONTINUED

1 OF 2

doubt that judges' standards of quality change radically when alternatives to LSH are regularly provided.

Table 17 presents the rankings of the overall quality of LSH treatment services. In general the quality ranked well below average, much lower than did the quality of evaluation services. The mental health district managers were again the grouping most critical of the quality of LSH services.

An important dimension of the quality of evaluation services is the promptness with which the reports are rendered to the agency requesting the information. Table 18 presents the responses to the question regarding the promptness of evaluation. In all groups except the center county judges, 80 percent or more of the respondents agreed that LSH met the time limits imposed. Again it must be stated that judges in counties with forensic centers seem to adopt higher standards of performance and thus tended to rate LSH lower. How accurately the evaluations address the questions posed by the referral agent is another issue of quality. The responses presented in Table 17 indicate that LSH performs well in this dimension. The final question presented in Table 18 addresses the general usefulness of the LSH evaluations and again LSH is rated favorably.

The same three questions just discussed with regard to LSH were asked of the judges presiding in counties with forensic centers with respect to the performance of the centers. Ninety-six percent of the center county judges responded that the centers performed their evaluations within time limits, one hundred percent agreed that centers addressed the questions posed, and 100 percent found the evaluations to be of assistance in decision-making. Overall the centers are rated positively

TABLE 17.

QUESTIONNAIRE RESPONSE RANKING, OVERALL QUALITY OF LSH TREATMENT BY RESPONSE GROUP

	How would you rank the overall quality of LSH treatment services?							
	Very Good	1	2	3	4	5	Very Bad	X
Mental Health District Managers		0	0	1	0	4		4.6
Mental Health and Mental Retardation Superintendents		0	1	3	5	3		3.8
648 Board Directors		0	2	4	7	12		4.2

TABLE 18

Questionnaire Responses: Specific Dimensions of LSH Evaluations by Response Groupings

Response Group	Do Evaluations at LSH Usually Address the Questions Posed in the Referral ?		Are Evaluations at LSH Completed Within Time Limits Imposed by Law or the Court ?		Are LSH Evaluations of Assistance in Decision Making Regarding the Offender?	
	Yes	No	Yes	No	Yes	No
CommonPleas Court Judges	51 (96)	2	44 (79)	12	54 (93)	4
County Court Judges	5 (100)	0	5 (100)	0	5 (83)	1
Municipal Court Judges	6 (75)	2	7 (89)	1	6 (75)	2
All Center County Judge	12 (92)	1	9 (69)	4	10 (83)	3
All Now Center County Judge	66 (94)	4	56 (80)	14	67 (93)	6
Parole Officers	3 (60)	2	4(100)	0.	4 (80)	1
Probation Officers	27(79)	7	30(83)	6	27 (79)	7

(percent affirmation)

on these dimensions by a larger proportion of judges than was LSH.

The only conclusions which can be drawn from these subjective ratings are that evaluation service users or referral agents seem to be relatively satisfied with the services of LSH until they are provided a regular alternative. The treatment services of LSH are generally rated lower than the evaluation services. Non-users of LSH's services seem to rate them more negatively than users. In total there appears to be some unhappiness with LSH, but whether it is caused by something which can be altered is another question. The unhappiness may be just an expression of discontent with the FPSDS in general which has become focused on LSH.

Multiple Admissions to LSH

This final issue is one that was not apparent during the early phases of the forensic study. In the field of corrections the concern is frequently expressed that as alternatives to incarceration are developed the persons who remain in the institutions will become increasingly more difficult to deal with. They will be the "hard core" who can't qualify for alternatives to incarceration. The PSCD researchers wondered if this situation might also be occurring in institutions such as LSH which are in the process of reducing their populations.

Table 19 presents the patients in our LSH sample by number of admissions to the hospital and the year of admission. In 1968, 62 percent of the admissions were first admissions, however, in 1974 only 33 percent were there for the first time. In 1968, 23 percent were second admissions and in 1974, 28 percent were second admissions. Third time admissions increased form 10 percent in 1968 to 17 percent in 1974. The proportion of fourth time admissions increased threefold between 1968 and 1974

TABLE 19

PATIENTS ADMITTED TO LSH, BY YEAR AND NUMBER OF ADMISSIONS

	Number of Admissions to LSH									
YEAR	1	2	3	4	5	6	7	8	9	TOTAL
196 8	692 (62)	264 (23)	111 (10)	33 (3)	11 (1)	6 (1)	3 (0)	0 (0)	3 (0)	1123
1969	726 (66)	259 (23)	75 (7)	27 (3)	10 (1)	3 (0)	0 (0)	0 (0)	2 (0)	1102
1970	681 (63)	268 (25)	91 (9)	20 (2)	9 (1)	3 (0)	3 (0)	1 (0)	0 (0)	1070
1971	535 (62)	205 (23)	90 (10)	27 (3)	20 (2)	2 (0)	2 (0)	1 (0)	2 (0)	884
1972	288 (61)	95 (20)	58 (12)	16 (3)	14 (3)	3 (1)	2 (0)	1 (0)	0 (0)	477
1973	215 (38)	151 (26)	103 (13)	53 (9)	26 (4)	12 (2)	7 (1)	4 (1)	4 (1)	575
1974	177 (33)	149 (28)	90 (17)	56 (10)	25 (5)	17 (3)	9 (2)	6 (1)	8 (1)	537

(Row Percent)

from three to 10 percent, and fifth time admissions increased fivefold from one to five percent. In 1968, 15 percent of the admissions were persons who had been there at least twice before. In 1974, 39 percent of the admissions had been there at least twice before. Clearly, if number of admissions can be taken as at least one dimension in defining whether or not a "hard core" custody population is being created, then this data strongly suggests that it is.

Summary and Conclusions

The major elements of the forensic psychiatric service delivery system (FPSDS) are the community forensic psychiatric centers, Lima State Hospital, the courts which refer forensic clients, local and state corrections agencies, and the civil mental health institutions. The activities of these elements and the relationships among them are heavily influenced by the legal and administrative environments at both the state and local levels. The activities and processes which occur within the FPSDS can be interpreted in terms of the functions which the system performs. These functions include information generation, decision-making, custody, and treatment.

The information generation function, which is most visible in the form of forensic examinations for the courts, is currently shifting from an institutional base at LSH to facilities less remote from the home communities of the clients which it serves. Community forensic centers are of growing importance in conducting examinations, but the dramatic increase in examinations being performed by civil mental health institutions should not be overlooked. Professionals within the criminal justice and mental health field are divided on their opinions regarding this function. The PSCD data indicate that there are significant unmet needs for psychiatric services to courts even in areas which are served by community based forensic facilities, but at the same time our analysis indicates that the provision of the services may be the stimulus to even more demand. There are currently no critera which unambiguously define a person as being in need of these services. Even the laws which govern these examinations are of little help, because they are largely discretionary.

More specifically, our data tend to indicate that referral sources which regularly use the facilities of LSH are reasonably satisfied with the quality of its examination services. LSH is rated favorably on the dimensions of timeliness, usefulness of results, and overall quality of reports. Referral sources which don't regularly use LSH tend to rate it lower on these same three dimensions, while at the same time giving high rating to local forensic centers.

The decision-making function, though not explicity investigated in this study, appears to be shifting from the courts to the mental health professionals, particularly in those geographic areas served by community forensic centers. Future research should address this issue.

The custody function is also in the process of shifing its base within the system. There can be no doubt that persons now housed in correctional and civil mental health facilities would have remained at LSH had the Davis v. Watkins suit not occurred. The impact of this shift is most directly evident in terms of increasing populations in corrections and civil mental health institutions, though there are a number of less evident indirect effects which deserve further study.

The treatment function, which is performed in conjunction with the custody function, is currently only poorly defined. This definitional problem (i.e. what constitutes treatment activity), appears to be a significant block to meaningful studies of this function and it must be addressed. Furthermore, which agency is responsible for treatment is unclear. When the community forensic centers were established, there was widespread claim that they would begin to assume this function. There is little evidence to suggest that they either have or intend to assume this responsibility. The PSCD data suggest that there is a

significant desire, on the part of Ohio courts, for more treatment services. This need, which doesn't necessarily manifest itself in a demand for inpatient services, seems to result from a general dissatisfaction with the quality of treatment services offered at LSH.

The PSCD believes that its description of the FPSDS in terms of the above functions demonstrates the pervasiveness of each function and suggests that all functions must be provided for a coherent system. The value of this analysis lies in the fact that it demonstrates that functions do not disappear just because they have shifted to another part of the system. They change form, and they impact on different groups, but the functions themselves and the demands for them remain.

Overall, we feel there are at least four highly significant conclusions which can be drawn from this report:

1. The decrease in examination commitments to LSH after 1971 has more than been made up by the increasing commitments to community forensic centers and civil mental health institutions. However, the question of whether LSH and the alternative examining institutions are serving the same client population is still in doubt. The possibility exists that a number of the cases which are now being examined would not have been examined several years ago, because they would not have been considered serious enough. The proportion of persons examined who have been convicted or accused of misdemeanors appears to be rising over time, while those accused of felonies appears to be decreasing. Without regard to the makeup of the client population being served, however, the trend toward ever increasing referrals for forensic services shows no sign of abating and the users of the services report significant unmet needs for services.

2. There is a serious lack of coordination among the elements of the FPSDS. The Divison of Forensic Psychiatry has been unable to serve as a coordinating body for a variety of reasons. Clearly, its personnel are occupied with problems at LSH which at times threaten to consume all the energies of the Division. The control which the Division is able to exercise over referrals to its facilities is minimal. The Division can only play a gatekeeper role which can easily be thwarted by persistent and insistent courts. The forensic centers are funded in a manner which limits the control which can be exercised over them. Finally, even coordination with Corrections is difficult because Corrections views the Department of Mental Health and Mental Retardation as an equal but not the Division of Forensic Psychiatry.

3. The nature of LSH's population is changing. In one sense it is becoming more "hard core" while at the same time it consists more and more of persons on competency commitments who have not been convicted. An increasing percentage of its commitments are indefinites.

4. As community forensic centers become more widespread, the dependance of the courts upon them can be expected to increase. The role of the centers appears to be in the provision of information, but there is some evidence that they may become the decision makers by default. Thus the quality of the information they provide must be as high as possible.

In line with these stated conclusions and other which are implied in the report, we offer the following recommendations:

1. The forensic centers are a viable alternative to LSH for conducting most forensic examinations and should be encouraged. There is, however, the need for inpatient facilities for a number of clients. Additionally, clients referred from correctional institutions for whom security is an issue will require special facilities or an examination capability within the correctional institution. In areas where there are insufficient referrals to justify a forensic center, special units in civil facilities to provide these services should be considered.

2. The Division of Forensic Psychiatry should be absorbed more closely into the structure of the Department of Mental Health and Mental Retardation. Both forensic and civil personnel need to be apprised of the similarities of clients served and services offered. Efforts should be made at the highest level to increase the acceptance of forensic clients by civil mental health, particularly at the community level.

3. The association of Forensic center directors should continue to be encouraged by the State. The association should be viewed as an organization for policy recommendation and implementation, but not as an administrative body.

4. The State should develop standards and guidelines for the conduct of forensic examinors and the certification of forensic centers.

5. Uniform policies for the acceptance of forensic examination referrals at civil institutions should be developed. Priorities for acceptance should be established and a specific staff assigned to forensic duty. Referrals should only be accepted from areas without forensic clinics.

6. Increased caseloads may prevent treatment from being a major role for the forensic clinics. Community mental health and the local civil institutions should be "persuaded" through any acceptable means to assist in this area. Additionally, the possibility of community treatment facilities modeled after correctional halfway houses should be explored.

7. It should be recognized that LSH may be becoming a holding institution for difficult cases and that treatment and review procedures will have to reflect that fact. In addition, the current overcrowding of Ohio's correctional institutions bodes ill for the FPSDS. The temptation to shift clients from corrections to mental health and vice-versa must be recognized and dealt with.

8. The rights of persons who receive forensic examinations must be recognized and scrupulously protected. An initial step would be to require that all reports which pass from forensic center personnel to the courts be in writing and that clients rights of access to these reports be recognized.

9. Legislation to correct vague and conflicting statutes in the forensic area is required. A permanent advisory panel of interested persons should be utilized by the Department of Mental Health and Mental Retardation to provide timely suggestions for legislative change.

APPENDIX A

SURVEY QUESTIONNAIRES

QUESTIONNAIRE FOR JUDGES

1. Are you a common pleas, municipal, or county court judge? Common pleas _____
   Municipal _____
   County _____

   How long have you been on the bench? _____ months or _____ years

2. When a defendant's mental status has come under question in your court, where might he be sent for evaluation? If more than one of the following options are employed, please check all that are used and indicate which one is used most frequently. If you were on the bench prior to 1972, answer this question as it relates to the situation from 1972 to the present.

   _____ Lima State Hospital
   _____ State civil mental hospital or mental health center
   _____ County or city civil mental hospital
   _____ Private mental hospital
   _____ General hospital
   _____ Private psychiatrist(s)
   _____ Civil mental health outpatient clinic
   _____ Forensic psychiatric center (court clinic)
   Please specify the clinic by name _____
   _____ Other
   Please specify _____

   NOTE: If you have never obtained a mental status evaluation from Lima State Hospital, please proceed to question 8.

3. How would you rank the overall quality of evaluations performed at Lima State Hospital? (Circle).

   Very Good 1 2 3 4 5 Very Bad

4. Do evaluations performed at Lima State Hospital usually address the questions (statutory and otherwise) posed in the referral?

   Yes _____ No _____

5. Are evaluations performed at Lima State Hospital generally completed within the time limits imposed by the law or suggested by the court?

   Yes _____ No _____

NOTE: Continue to BACK of this page.

6. Are evaluations performed at Lima State Hospital of assistance to you in your decision-making regarding the offender?

Yes _____ No _____

7. If you have received evaluations from both Lima State Hospital and at least one other source, how do they compare with regard to overall quality and value to you?

Lima State Hospital's evaluations are:

Much better _____ Somewhat better _____ About the same _____
Somewhat worse _____ Much worse _____

8. Do you approve of the use of civil mental health facilities for the evaluation of criminal offenders?

Yes _____ No _____

9. Do you approve of the use of civil mental health facilities for the treatment of criminal offenders?

Yes _____ No _____

10. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's evaluation services?

Yes _____ No _____

11. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's treatment services?

Yes _____ No _____

12. Do you feel the need in your locale for an inpatient unit for the evaluation and/or treatment of defendants whose mental status has come under question?

Yes _____ No _____

13. Do you feel that the court's need for psychiatric evaluation services is currently being adequately met in your locale?

Yes _____ No _____

14. Do you feel that the court's need for psychiatric treatment services is currently being adequately met in your locale?

Yes _____ No _____

15. Do you believe that mental status examiners should couple their evaluation results with specific recommendations to the court?

Yes _____ No _____

16. Are you satisfied with Ohio's law regarding criminal insanity and incompetency to stand trial (ORC 2945)?

Yes _____ No _____

If No, feel free to elaborate:

17. Are you satisfied with the current version of the Ascherman Act (ORC 2947)?

Yes _____ No _____

If No, feel free to elaborate.

18. Approximately what percentage of defendants that passed through your court within the last twelve months were found in need of psychiatric evaluation or treatment either at the pretrial or presentence stage? _____ percent. Approximately how many defendants does this percentage represent? _____ number.

19. In your impression, does the percentage of defendants in need of psychiatric evaluation or treatment appear to be increasing _____, decreasing _____, or staying about the same _____, over time? Check one.

NOTE: Continue to BACK of this page.

20. Please indicate which district you are in:

District 1 [ ]
- Brown
- Butler
- Clermont
- Clinton
- Hamilton
- Warren

District 2 [ ]
- Champaign
- Clark
- Darke
- Greene
- Logan
- Montgomery
- Preble
- Shelby

District 3 [ ]
- Allen
- Auglaize
- Hancock
- Hardin
- Putnam
- Mercer
- Van Wert

District 4 [ ]
- Defiance
- Erie
- Fulton
- Henry
- Lucas
- Ottawa
- Paulding
- Sandusky
- Williams
- Wood

District 5 [ ]
- Ashland
- Crawford
- Huron
- Marion
- Morrow
- Richland
- Seneca
- Wyandot

District 6 [ ]
- Delaware
- Fairfield
- Fayette
- Franklin
- Knox
- Licking
- Madison
- Pickaway
- Union

District 7 [ ]
- Adams
- Callia
- Highland
- Jackson
- Lawrence
- Pike
- Ross
- Scioto
- Vinton

District 8 [ ]
- Athens
- Hocking
- Meigs
- Morgan
- Perry
- Washington

District 9 [ ]
- Belmont
- Carroll
- Coshocton
- Guernsey
- Harrison
- Jefferson
- Monroe
- Muskingum
- Noble
- Tuscarawas

District 10 N [ ]
- Cuyahoga
- Geauga
- Lake
- Lorain

District 10 S [ ]
- Holmes
- Medina
- Portage
- Stark
- Summit
- Wayne

District 11 [ ]
- Ashtabula
- Columbiana
- Mahoning
- Trumbull

THIS FORM ALSO SENT TO BUTLER, FRANKLIN, HAMILTON, LUCAS, AND MONTGOMERY COUNTY JUDGES (CENTER COUNTIES)

QUESTIONNAIRE FOR JUDGES: SUMMIT COUNTY

1. Are you a common pleas, municipal, or county court judge?

   common pleas _____ municipal _____ county court _____

   How long have you been on the bench? _____ months, or _____ years.

2. When a defendant's mental status has come under question in your court, where might he be sent for evaluation? If more than one of the following options are employed, please check all that are used and indicate which one is used most frequently. If you were on the bench prior to 1972, answer this question as it relates to the situation from 1972 to the present.

   _____ Lima State Hospital
   _____ State civil mental hospital or mental health center
   _____ County or city civil mental hospital
   _____ Private mental hospital
   _____ General hospital
   _____ Private psychiatrist(s)
   _____ Civil mental health outpatient clinic
   _____ Forensic psychiatric center (court clinic)
   _____ Other
   Please specify _____

3. Do you approve of the use of civil mental health facilities for the evaluation of criminal offenders?

   Yes _____ No _____

4. Do you approve of the use of civil mental health facilities for the treatment of criminal offenders?

   Yes _____ No _____

5. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's evaluation services?

   Yes _____ No _____

6. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's treatment services?

   Yes _____ No _____

NOTE: Continue on BACK of this page.

7. Do you feel the need in your locale for an inpatient unit for the evalutation and/or treatment of defendants whose mental status has come under question?

Yes _____ No _____

8. Do you feel that the court's need for psychiatric evaluation services is currently being adequately met in your locale?

Yes _____ No _____

9. Do you feel that the court's need for psychiatric treatment services is currently being adequately met in your locale?

Yes _____ No _____

10. Approximately what percentage of defendants that passed through your court within the last twelve months were found in need of psychiatric evaluation or treatment either at the pretrial or presentence stage? _____percent. Approximately how many defendants does this percentage represent? _____number.

11. In your impression, does the percentage of defendants in need of psychiatric evaluation or treatment appear to be increasing _____, decreasing _____, or staying about the same _____, over time? Check one.

12. Do you believe that mental status examiners should couple their evaluation results with specific recommendations to the court?

Yes _____ No _____

13. Are you satisfied with Ohio's law regarding criminal insanity and incompetence to stand trial (ORC 2945)?

Yes _____ No _____

If No, feel free to elaborate.

14. Are you satisfied with the current version of the Ascherman Act (ORC 2947)?

Yes _____ No _____

If No, feel free to elaborate.

15. If you have never obtained a mental status evaluation from Lima State Hospital, please proceed to Question 16.

a. How would you rank the overall quality of evaluations performed at Lima State Hospital?

Very Good 1 2 3 4 5 Very Bad

b. Do evaluations performed at Lima State Hospital usually address the questions (statutory and otherwise) posed in the referral?

Yes _____ No _____

c. Are evaluations performed at Lima State Hospital generally completed within the time limits imposed by the law or suggested by the court?

Yes _____ No _____

d. Are evaluations performed at Lima State Hospital of assistance to you in your decision-making regarding the offender?

Yes _____ No _____

16. Do you ever refer defendants to the Akron Criminal Psycho-Diagnostic Clinic?

Yes _____ No _____

IF YES, PLEASE PROCEED TO QUESTION 17. IF NO, PLEASE CHECK THE REASON OR REASONS BELOW, AFTER WHICH THE QUESTIONNAIRE WILL BE COMPLETED.

_____ Have never heard of the Akron Criminal Courts Psycho-Diagnostic Clinic
_____ Have heard of the Akron Criminal Courts Psycho-Diagnostic Clinic but don't know enough about it to consider using it
_____ Have heard bad reports of the Akron Criminal Courts Psycho-Diagnostic Clinic from others
_____ Have had bad firsthand experience with the Clinic in the past
_____ Don't have many cases needing services provided by the Clinic
_____ Have other resources for meeting needs for services provided by the Clinic
_____ The Clinic is too far away
_____ It is our court policy to not use the Clinic
_____ Others: Please Specify _____

17. Approximately how many defendants have you referred to the Akron Criminal Courts Psycho-Diagnostic Clinic? _____number.

18. Since the Clinic has become available to the courts, do you consider it your primary resource for the psychiatric evaluation of defendants?

Yes _____ No _____

NOTE: Continue to BACK of this page.

19. Generally speaking, how well do you think the Clinic is doing in achieving its purposes?

Very Good 1 2 3 4 5 Very Bad

20. How would you characterize your working relations with the Clinic?

Very Good 1 2 3 4 5 Very Bad

21. Do Clinic personnel appear to understand the specific questions they are legally bound to answer with regard to sanity at the time of the offense, competency to stand trial, and Ascherman evaluations?

Yes _____ No _____

22. We're particularly interested in your evaluation of the Clinic's performance and responsiveness to your needs.

a. How would you rank the overall quality of their evaluations?

Very Good 1 2 3 4 5 Very Bad

b. Do their evaluations usually address the questions you posed in the referral?

Yes _____ No _____

c. Do they generally complete their evaluations within the time limits imposed by the law or suggested by the court?

Yes _____ No _____

d. Are their evaluations of assistance to you in your decision-making regarding the offender?

Yes _____ No _____

23. Overall, how do the evaluations performed at the Akron Criminal Courts Psycho-Diagnostic Clinic compare to those conducted at Lima State Hospital?

The Clinic's evaluations are:

Much better _____ Somewhat better _____ About the same _____
Somewhat worse _____ Much worse _____

24. Do you have any problems whatsoever with regard to the Akron Criminal Courts Psycho-Diagnostic Clinic or any suggestions for change or improvement?

QUESTIONNAIRE FOR DIRECTORS
OF DETENTION FACILITIES: SELECTED COUNTIES

1. Please circle the appropriate institution type:

   county jail city jail workhouse

2. How long have you been the Director of this institution? _____months, or _____years

3. When an offender at your institution needs psychiatric intervention, from whom do you obtain assistance? If more than one of the following options apply, please check all that are used and indicate which is used most frequently.

   _____ State civil mental hospital or mental health center
   _____ County or city civil mental hospital
   _____ Private mental hospital
   _____ General hospital
   _____ Private psychiatrist, psychologist, or social worker
   _____ Civil mental health outpatient clinic
   _____ Forensic psychiatric center (court clinic)
   _____ Other
   Please specify _____

4. Do you feel that your need for psychiatric intervention services is currently being adequately met?

   Yes _____ No _____

5. Has the opening of a court clinic in your area assisted you in your need for psychiatric intervention services?

   Yes _____ No _____

6. Approximately what percentage of offenders (accused or convicted) that passed through your institution within the last twelve months needed some sort of psychiatric intervention while at your facility (whether you were able to obtain such intervention or not)? _____ percent. Approximately how many offenders does this percentage represent? _____ (number).

7. In your impression, does the percentage of offenders in need of psychiatric intervention appear to be increasing _____, decreasing _____, or staying about the same _____, over time? Check one.

NOTE: Continue to BACK of this page.

NOTE: These next three questions are for sheriffs only.

8. Approximately how many offenders did your office have to transport to or from Lima State Hospital within the last twelve months? _____ (number).

9. Approximately how many man-hours of your staff time did these transports consume? _____ hours.

10. Has the opening of a court clinic in your area reduced the number of transports to Lima State Hospital?

Yes _____ No _____

11. FOR ALL RESPONDENTS: Please indicate which district you are in:

District 1 [ ]
- Brown
- Butler
- Clermont
- Clinton
- Hamilton
- Warren

District 2 [ ]
- Champaign
- Clark
- Darke
- Greene
- Logan
- Montgomery
- Preble
- Shelby

District 3 [ ]
- Allen
- Auglaize
- Hancock
- Hardin
- Putnam
- Mercer
- Van Wert

District 4 [ ]
- Defiance
- Erie
- Fulton
- Henry
- Lucas
- Ottawa
- Paulding
- Sandusky
- Williams
- Wood

District 5 [ ]
- Ashland
- Crawford
- Huron
- Marion
- Morrow
- Richland
- Seneca
- Wyandot

District 6 [ ]
- Delaware
- Fairfield
- Fayette
- Franklin
- Knox
- Licking
- Madison
- Pickaway
- Union

District 7 [ ]
- Adams
- Gallia
- Highland
- Jackson
- Lawrence
- Pike
- Ross
- Scioto
- Vinton

District 8 [ ]
- Athens
- Hocking
- Meigs
- Morgan
- Perry
- Washington

District 9 [ ]
- Belmont
- Carroll
- Coshocton
- Guernsey
- Harrison
- Jefferson
- Monroe
- Muskingum
- Noble
- Tuscarawas

District 10 N [ ]
- Cuyahoga
- Geauga
- Lake
- Lorain

District 10 S [ ]
- Holmes
- Medina
- Portage
- Stark
- Summit
- Wayne

District 11 [ ]
- Ashtabula
- Columbiana
- Mahoning
- Trumbull

QUESTIONNAIRE FOR PROBATION OFFICERS

1. Are you a common pleas or municipal probation officer? Common pleas _____ Municipal _____

   How long have you held this position? _____months or _____ years

2. When the mental status of a probationer (or potential probationer) has come under question, where might he be sent for evaluation? If more than one of the following options are employed, please check all that are used and indicate which one is used most frequently. If you were a probation officer prior to 1972, answer this question as it relates to the situation from 1972 to the present.

   _____ Lima State Hospital
   _____ State civil mental hospital or mental health center
   _____ County or city civil mental hospital
   _____ Private mental hospital
   _____ General hospital
   _____ Private psychiatrist, psychologist, or social worker
   _____ Civil mental health outpatient clinic
   _____ Forensic psychiatric center (court clinic)
   Please specify the clinic by name _____
   _____ Other
   Please specify _____

NOTE: If you have never obtained a mental status evaluation from Lima State Hospital, please proceed to question 8.

3. How would you rank the overall quality of evaluations performed at Lima State Hospital? (Circle).

   Very Good 1 2 3 4 5 Very Bad

4. Do evaluations performed at Lima State Hospital usually address the questions (statutory and otherwise) posed in the referral?

   Yes _____ No _____

5. Are evaluations performed at Lima State Hospital generally completed within the time limits imposed by the law or suggested by the court?

   Yes _____ No _____

NOTE: Continue to BACK of this page.

6. Are evaluations performed at Lima State Hospital of assistance to you in your decision-making regarding the offender?

Yes _____ No _____

7. If you have received evaluations from both Lima State Hospital and at least one other source, how do they compare with regard to overall quality and value to you?

Lima State Hospital's evaluations are:

Much better _____ Somewhat better _____ About the same _____

Somewhat worse _____ Much worse _____

8. Do you approve of the use of civil mental health facilities for the evaluation of criminal offenders?

Yes _____ No _____

9. Do you approve of the use of civil mental health facilities for the treatment of criminal offenders?

Yes _____ No _____

10. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's evaluation services?

Yes _____ No _____

11. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's treatment services?

Yes _____ No _____

12. Do you feel the need in your locale for an inpatient unit for the evaluation and/or treatment of probationers and potential probationers whose mental status has come under question?

Yes _____ No _____

13. Do you feel that the probation department's need for psychiatric evaluation services is currently being adequately met in your locale?

Yes _____ No _____

14. Do you feel that the probation department's need for psychiatric treatment services is currently being adequately met in your locale?

Yes _____ No _____

15. Do you believe that mental status examiners should couple their evaluation results with specific recommendations to the probation officer?

Yes _____ No _____

16. Approximately what percentage of probationers on your caseload within the last twelve months were in need of psychiatric evaluation or treatment either at the presentence or postsentence stage? _____percent. Approximately how many probationers does this percentage represent? _____(number).

17. In your impression, does the percentage of probationers (and potential probationers) in need of psychiatric evaluation or treatment appear to be increasing _____, decreasing _____, or staying about the same _____, over time? (Check one).

18. Please indicate which district you are in:

District 1 [ ]
- Brown
- Butler
- Clermont
- Clinton
- Hamilton
- Warren

District 2 [ ]
- Champaign
- Clark
- Darke
- Greene
- Logan
- Montgomery
- Preble
- Shelby

District 3 [ ]
- Allen
- Auglaize
- Hancock
- Hardin
- Putnam
- Mercer
- Van Wert

District 4 [ ]
- Defiance
- Erie
- Fulton
- Henry
- Lucas
- Ottawa
- Paulding
- Sandusky
- Williams
- Wood

District 5 [ ]
- Ashland
- Crawford
- Huron
- Marion
- Morrow
- Richland
- Seneca
- Wyandot

District 6 [ ]
- Delaware
- Fairfield
- Fayette
- Franklin
- Knox
- Licking
- Madison
- Pickaway
- Union

District 7 [ ]
- Adams
- Gallia
- Highland
- Jackson
- Lawrence
- Pike
- Ross
- Scioto
- Vinton

District 8 [ ]
- Athens
- Hocking
- Meigs
- Morgan
- Perry
- Washington

District 9 [ ]
- Belmont
- Carroll
- Coshocton
- Guernsey
- Harrison
- Jefferson
- Monroe
- Muskingum
- Noble
- Tuscarawas

District 10 N [ ]
- Cuyahoga
- Geauga
- Lake
- Lorain

District 10 S [ ]
- Holmes
- Medina
- Portage
- Stark
- Summit
- Wayne

District 11 [ ]
- Ashtabula
- Columbiana
- Mahoning
- Trumbull

QUESTIONNAIRE FOR PAROLE SUPERVISORS

1. Please check your title:

   Regional Supervisor _____ Unit Supervisor _____ Senior Parole Officer _____

2. In the event of an Executive Order 33, where might a parolee under your supervision be sent for evaluation? If more than one of the following options are employed, please check all that are used and indicate which is used most frequently.

   _____ Lima State Hospital
   _____ Junction City Treatment Center
   _____ Chillicothe Treatment and Research Center
   _____ State civil mental hospital or mental health center
   _____ County or city civil mental hospital
   _____ Private mental hospital
   _____ General hospital
   _____ Private psychiatrist, psychologist, or social worker
   _____ Civil mental health outpatient clinic
   _____ Forensic psychiatric center (court clinic)
   Please specify the clinic by name _____
   _____ Other
   Please specify _____

NOTE: If you have never obtained a mental status evaluation from Lima State Hospital, please proceed to question 8.

3. How would you rank the overall quality of evaluations performed at Lima State Hospital? (Circle).

   Very Good 1 2 3 4 5 Very Bad

4. Do evaluations performed at Lima State Hospital usually address the questions (statutory and otherwise) posed in the referral?

   Yes _____ No _____

5. Are evaluations performed at Lima State Hospital generally completed within the time limits imposed by the law or suggested by the Adult Parole Authority?

   Yes _____ No _____

6. Are evaluations performed at Lima State Hospital of assistance to the Adult Parole Authority in decision-making regarding the parolee?

   Yes _____ No _____

NOTE: Continue to BACK of this page.

7. If you have received evaluations from both Lima State Hospital and at least one other source, how do they compare with regard to overall quality and value to you?

Lima State Hospital's evaluations are:

Much better _____ Somewhat better _____ About the same _____
Somewhat worse _____ Much worse _____

8. Do you approve of the use of civil mental health facilities for the evaluation of criminal offenders?

9. Do you approve of the use of civil mental health facilities for the treatment of criminal offenders?

Yes _____ No _____

10. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's evaluation services?

Yes _____ No _____

11. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's treatment services?

Yes _____ No _____

12. Do you feel the need in your locale for an inpatient unit for the evaluation and/or treatment of parolees whose mental status has come under question?

Yes _____ No _____

13. Do you feel that the Adult Parole Authority's need for psychiatric evaluation services is currently being adequately met in your locale?

Yes _____ No _____

14. Do you feel that the Adult Parole Authority's need for psychiatric treatment services is currently being adequately met in your locale?

Yes _____ No _____

15. Do you believe that mental status examiners should couple their evaluation results with specific recommendations to the court?

Yes _____ No _____

16. Approximately how many requests for an Executive Order 33 did you receive from your subordinates within the last twelve months? _____(number). Approximately what percentage of the total caseload under your direction does this number represent? _____percent.

17. In your impression, does the percentage of parolees in need of psychiatric evaluation or treatment appear to be increasing _____, decreasing _____, or staying about the same _____, over time? Check one.

QUESTIONNAIRE FOR DIRECTORS OF DETENTION FACILITIES

1. Please circle the appropriate institution type: County jail _____
   City jail _____
   Workhouse _____

   How long have you been the Director of this institution? _____ months or _____ years

2. When an offender at your institution needs psychiatric intervention, from whom do you obtain assistance? If more than one of the following options apply, please check all that are used and indicate which is used most frequently.

   _____ State civil mental hospital or mental health center
   _____ County or city civil mental hospital
   _____ Private mental hospital
   _____ General hospital
   _____ Private psychiatrist, psychologist, or social worker
   _____ Civil mental health outpatient clinic
   _____ Forensic psychiatric center (court clinic)
   Please specify the clinic by name _____
   _____ Other
   Please specify _____

3. Do you feel that your need for psychiatric intervention services is currently being adequately met?

   Yes _____ No _____

4. Approximately what percentage of offenders (accused or convicted) that passed through your institution within the last twelve months needed some sort of psychiatric intervention while at your facility (whether you were able to obtain such intervention or not)? _____percent. Approximately how many offenders does this percentage represent? _____(number).

5. In your impression, does the percentage of offenders in need of psychiatric intervention appear to be increasing _____, decreasing _____, or staying about the same _____, over time? Check one.

NOTE: The next two questions are for sheriffs only:

6. Approximately how many offenders did your office have to transport to or from Lima State Hospital within the last twelve months? _____

NOTE: Continue to BACK of this page.

7. Approximately how many man-hours of your staff time did these transports consume? _____

FOR ALL RESPONDENTS: Please indicate which district you are in:

District 1 [ ]
- Brown
- Butler
- Clermont
- Clinton
- Hamilton
- Warren

District 2 [ ]
- Champaign
- Clark
- Darke
- Greene
- Logan
- Montgomery
- Preble
- Shelby

District 3 [ ]
- Allen
- Auglaize
- Hancock
- Hardin
- Putnam
- Mercer
- Van Wert

District 4 [ ]
- Defiance
- Erie
- Fulton
- Henry
- Lucas
- Ottawa
- Paulding
- Sandusky
- Williams
- Wood

District 5 [ ]
- Ashland
- Crawford
- Huron
- Marion
- Morrow
- Richland
- Seneca
- Wyandot

District 6 [ ]
- Delaware
- Fairfield
- Fayette
- Franklin
- Knox
- Licking
- Madison
- Pickaway
- Union

District 7 [ ]
- Adams
- Gallia
- Highland
- Jackson
- Lawrence
- Pike
- Ross
- Scioto
- Vinton

District 8 [ ]
- Athens
- Hocking
- Meigs
- Morgan
- Perry
- Washington

District 9 [ ]
- Belmont
- Carroll
- Coshocton
- Guernsey
- Harrison
- Jefferson
- Monroe
- Muskingum
- Noble
- Tuscarawas

District 10 N [ ]
- Cuyahoga
- Geauga
- Lake
- Lorain

District 10 S [ ]
- Holmes
- Medina
- Portage
- Stark
- Summit
- Wayne

District 11 [ ]
- Ashtabula
- Columbiana
- Mahoning
- Trumbull

QUESTIONNAIRE FOR SUPERINTENDENTS OF CORRECTIONAL INSTITUTIONS

1. What is your policy regarding the transfer of inmates to Lima State Hospital?

2. Does your institution ever transfer mentally disturbed inmates to any of the other six state correctional institutions?

   Yes _____ No _____

3. Does your institution ever transfer mentally disturbed inmates to civil mental health or retardation institutions?

   Yes _____ No _____

4. Does your institution ever employ the services of a general hospital for mentally disturbed inmates?

   Yes _____ No _____

5. Does your institution ever bring psychiatrists, psychologists, or social workers from the community into your facility to evaluate or treat mentally disturbed inmates?

   Yes _____ No _____

6. Do you feel that your need for psychiatric evaluation and treatment services is currently being adequately met?

   Yes _____ No _____

7. Approximately what percentage of the inmates currently in your institution are in need of psychiatric evaluation or treatment? _____percent

8. In your impression, does the percentage of inmates in need of psychiatric evaluation or treatment appear to be increasing _____, decreasing _____, or staying about the same _____, over time? Check one.

QUESTIONNAIRE FOR SUPERINTENDENTS
OF MENTAL HEALTH AND RETARDATION INSTITUTIONS

1. What is your policy regarding the transfer of patients to Lima State Hospital?

2. What is your policy regarding the acceptance of criminal offenders into your institution for the purposes of evaluation and treatment?

3. Do you approve of the use of civil mental health facilities for the evaluation of criminal offenders?

Yes _____ No _____

4. Do you approve of the use of civil mental health facilities for the treatment of criminal offenders?

Yes _____ No _____

5. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's evaluation services?

Yes _____ No _____

6, Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's treatment services?

Yes _____ No _____

NOTE: Continue on BACK of this page.

7. How would you rank the overall quality of Lima State Hospital's evaluation services?

Very Good 1 2 3 4 5 Very Bad

8. How would you rank the overall quality of Lima State Hospital's treatment services?

Very Good 1 2 3 4 5 Very Bad

9. Do you believe that professional clinicians, when conducting mental status examinations for the criminal courts, should couple their evaluation results with specific recommendations to the courts?

Yes _____ No _____

10. Approximately how many criminal offenders did your institution evaluate for the courts within the last twelve months? _____ (number).

11. In your impression, does the number of criminal offenders referred to your institution for evaluation appear to be increasing _____, decreasing _____, or staying about the same _____, over time? Check one.

12. Approximately how many criminal offenders did your institution accept into treatment within the last twelve months? _____(number).

13. In your impression, does the number of criminal offenders referred to your institution for treatment appear to be increasing _____, decreasing _____, or staying about the same _____, over time? Check one.

QUESTIONNAIRE FOR DIRECTORS OF 648 BOARDS

1. Below is a list of mental health resources:

Col. 1	Col. 2	Col. 3	
_____	_____	_____	State civil mental hospital or mental health center(s)
_____	_____	_____	County or city civil mental hospital(s)
_____	_____	_____	Private mental hospital(s)
_____	_____	_____	General hospital(s)
_____	_____	_____	Private psychiatrist(s)
_____	_____	_____	Private psychologist(s)
_____	_____	_____	Private social worker(s)
_____	_____	_____	Civil mental health outpatient clinic(s)
_____	_____	_____	Forensic psychiatric center (court clinic)
_____	_____	_____	Other: Please specify _____

First, in column 1, please place a checkmark next to each resource that is available within the geographical area served by your 648 Board.

Next, in column 2, place a checkmark next to each resource that is available, within your area, to the criminal justice system for psychiatric evaluation or treatment of offenders.

Finally, in column 3, place a checkmark next to each resource for which you believe a need exists for additional psychiatric services for the criminal justice system. That is, if the resource is nonexistent in the area, and you believe a need exists for this resource to assist criminal justice personnel, check next to the resource in Col. 3. Similarly, if the resource exists in the area but is not providing what you believe to be needed assistance to criminal justice personnel, check next to the resource in Col. 3.

2. Generally speaking, do you believe that the criminal justice system's need for psychiatric evaluation of offenders is being adequately met in your area?

Yes _____ No _____

3. Generally speaking again, do you believe that the criminal justice system's need for psychiatric treatment of offenders is being adequately met in your area?

Yes _____ No _____

4. In your impression, is the criminal justice system's need for psychiatric evaluation services for offenders increasing _____, decreasing _____, or staying about the same _____, over time in your area? Check one.

NOTE: Continue to BACK of this page.

5. Is the criminal justice system's need for psychiatric <u>treatment</u> services for offenders increasing _____, decreasing _____, or staying about the same _____, over time in your area? Check one.

6. Do you approve of the use of civil mental health facilities for the <u>evaluation</u> of criminal offenders?

Yes _____ No _____

7. Do you approve of the use of civil mental health facilities for the <u>treatment</u> of criminal offenders?

Yes _____ No _____

8. Some people argue that the evaluation and treatment of criminal offenders actually falls within the charter of community mental health centers which, therefore, should be willingly providing psychiatric assistance to the courts. Do you agree with this argument?

Yes _____ No _____

9. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's <u>evaluation</u> services?

Yes _____ No _____

10. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's <u>treatment</u> services?

Yes _____ No _____

11. How would you rank the overall quality of Lima State Hospital's <u>evaluation</u> services?

Very Good 1 2 3 4 5 Very Bad

12. How would you rank the overall quality of Lima State Hospital's <u>treatment</u> services?

Very Good 1 2 3 4 5 Very Bad

13. Please indicate which district(s) you are in:

<u>District 1</u> [ ]
- Brown
- Butler
- Clermont
- Clinton
- Hamilton
- Warren

<u>District 2</u> [ ]
- Champaign
- Clark
- Darke
- Greene
- Logan
- Montgomery
- Preble
- Shelby

<u>District 3</u> [ ]
- Allen
- Auglaize
- Hancock
- Hardin
- Putnam
- Mercer
- Van Wert

<u>District 4</u> [ ]
- Defiance
- Erie
- Fulton
- Henry
- Lucas
- Ottawa
- Paulding
- Sandusky
- Williams
- Wood

<u>District 5</u> [ ]
- Ashland
- Crawford
- Huron
- Marion
- Morrow
- Richland
- Seneca
- Wyandot

<u>District 6</u> [ ]
- Delaware
- Fairfield
- Fayette
- Franklin
- Knox
- Licking
- Madison
- Pickaway
- Union

<u>District 7</u> [ ]
- Adams
- Gallia
- Highland
- Jackson
- Lawrence
- Pike
- Ross
- Scioto
- Vinton

<u>District 8</u> [ ]
- Athens
- Hocking
- Meigs
- Morgan
- Perry
- Washington

<u>District 9</u> [ ]
- Belmont
- Carroll
- Coshocton
- Guernsey
- Harrison
- Jefferson
- Monroe
- Muskingum
- Noble
- Tuscarawas

<u>District 10 N</u> [ ]
- Cuyahoga
- Geauga
- Lake
- Lorain

<u>District 10 S</u> [ ]
- Holmes
- Medina
- Portage
- Stark
- Summit
- Wayne

<u>District 11</u> [ ]
- Ashtabula
- Columbiana
- Mahoning
- Trumbull

QUESTIONNAIRE FOR MENTAL HEALTH DISTRICT MANAGERS

1. Below is a list of mental health resources:

Col. 1	Col. 2	Col. 3	
_____	_____	_____	State civil mental hospital or mental health center(s)
_____	_____	_____	County or city civil mental hospital(s)
_____	_____	_____	Private mental hospital(s)
_____	_____	_____	General hospital(s)
_____	_____	_____	Private psychiatrist(s)
_____	_____	_____	Private psychologist(s)
_____	_____	_____	Private social worker(s)
_____	_____	_____	Civil mental health outpatient clinic(s)
_____	_____	_____	Forensic psychiatric center (court clinic)
_____	_____	_____	Other: Please specify _____

First, in column 1, please place a checkmark next to each resource that is available within the geographical area served by your District.

Next, in column 2, place a checkmark next to each resource that is available, within your District, to the criminal justice system for psychiatric evaluation or treatment of offenders.

Finally, in column 3, place a checkmark next to each resource for which you believe a need exists for additional psychiatric services for the criminal justice system. That is, if the resource is nonexistent in the District, and you believe a need exists for this resource to assist criminal justice personnel, check next to the resource in Col. 3. Similarly, if the resource exists in the District but is not providing what you believe to be needed assistance to criminal justice personnel, check next to the resource in Col. 3.

2. Generally speaking, do you believe that the criminal justice system's need for psychiatric evaluation of offenders is being adequately met in your District?

Yes _____ No _____

3. Generally speaking again, do you believe that the criminal justice system's need for psychiatric treatment of offenders is being adequately met in your District?

Yes _____ No _____

4. In your impression, is the criminal justice system's need for psychiatric evaluation services for offenders increasing _____, decreasing _____, or staying about the same _____, over time in your District? Check one.

5. Is the criminal justice system's need for psychiatric <u>treatment</u> services for offenders increasing _____, decreasing _____, or staying about the same _____, over time in your District? Check one.

6. Do you approve of the use of civil mental health facilities for the <u>evaluation</u> of criminal offenders?

Yes _____ No _____

7. Do you approve of the use of civil mental health facilities for the <u>treatment</u> of criminal offenders?

Yes _____ No _____

8. Some people argue that the evaluation and treatment of criminal offenders actually falls within the charter of community mental health centers which, therefore, should be willingly providing psychiatric assistance to the courts. Do you agree with this argument?

Yes _____ No _____

9. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's <u>evaluation</u> services?

Yes _____ No _____

10. Are you in favor of the development of regionally-based forensic psychiatric court clinics as supplements or alternatives to Lima State Hospital's <u>treatment</u> services?

Yes _____ No _____

11. How would you rank the overall quality of Lima State Hospital's <u>evaluation</u> services?

Very Good 1 2 3 4 5 Very Bad

12. How would you rank the overall quality of Lima State Hospital's <u>treatment</u> services?

Very Good 1 2 3 4 5 Very Bad

<u>Comments</u>

As a District Manager, you are in the unique position of having contact with both local agencies and facilities and the state mental health care delivery system. By virtue of this position, you may have identified problem areas that we have not anticipated and may therefore have valuable suggestions regarding forensic psychiatric services. If so, we would appreciate the benefit of your thinking on these matters, if you would care to elaborate below. We are also available to discuss any issues with you at 614-422-9250.

END