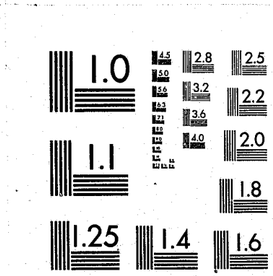

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National Institute of Justice
United States Department of Justice
Washington, D.C. 20531

MK-1

Final Report of a Phase I Assessment of Mental Health Screening and Evaluation for Mental Health Services for Criminal Justice Clientele, Submitted to the Office of Program Evaluation, National Institute of Justice.

MENTAL HEALTH EXAMINATIONS IN CRIMINAL JUSTICE SETTINGS: ORGANIZATION, ADMINISTRATION, AND PROGRAM EVALUATION

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FOREWORD

Every year up to two million individuals facing trial on criminal charges, awaiting sentencing following conviction, or seeking treatment while in prison are screened and evaluated for mental aberration. Such mental health examinations involve determinations of competency to stand trial, judgments about insanity and the degree of responsibility that should be assigned to the defendant, predictions of dangerousness, recommendations for disposition after criminal conviction, and other psycholegal questions. They may be invoked for various patent and latent purposes at several stages in the criminal justice process, and may take place in court clinics, forensic hospitals, community mental health centers, and corrections facilities. This volume is directed to practitioners in the areas of mental health, criminal justice, law enforcement, and corrections who plan, administer, or evaluate mental health examinations in criminal justice settings.

This volume is the culmination of an "evaluability assessment" of forensic mental health examinations in criminal justice which was funded by the National Institute of Justice (Grant No. 79 NI AX0070) as a part of its National Evaluation Program (NEP). The study was conducted by my colleagues and me at the National Center for State Courts in Williamsburg, Virginia between October 1979 and June 1981. Of course, the propositions made in the book, the model process presented, and other views expressed are those of the authors and do not necessarily reflect the positions of the National Institute of Justice or the National Center for State Courts.

As we began our study, our focus was narrowly on the practices and tools of psychiatrists, psychologists, social workers, and other mental health workers, as they are applied to the examination of criminal offenders in the determination of various psycholegal questions. It soon became apparent that any study of forensic mental health examination, as an instrument of the legal system, must take into account the manner in which that system defines the use of that instrument, as well as the ways in which the results of the examinations are communicated within the system. Hence, our broadened focus of inquiry, introduced in Chapter 2, includes the delineation of the psycholegal question and the provision of the acquired information to criminal justice authorities, as well as the actual data acquisition component of the forensic mental health examination process. Although the broadened focus clearly encompasses a very significant interaction of the criminal justice and mental health systems, this volume eschews the analyses of the very complex and abstract psycholegal concepts in criminal law (e.g., criminal responsibility) which have already filled the pages of many books and periodicals. Instead, it is concentrated on the day-to-day practices and procedures of the mental health and criminal justice systems in delineating, acquiring, and providing information about the mental aberrations of criminal defendants.

As with any study of this size and duration, many people helped, besides those of my colleagues noted on the title page. Also, for seeing this volume to completion, I owe thanks to quite a number of persons. Most of them, if not all, do not need the public acknowledgement in these pages that may prove to be, as one astute reader of such acknowledgements put it, a droopy flower in their lapels. Suffice it to say

that I am sincerely grateful to each of them, though unnamed they remain. I hope that they accept this volume as a token of my gratitude, forgive its shortcomings, and claim its merits as their own.

I. K.
Williamsburg, September 1981

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ISSUES, DEFINITIONS, AND A FRAMEWORK OF INQUIRY

Chapter 1

AN INTRODUCTION TO FORENSIC MENTAL HEALTH SCREENING AND EVALUATION

On March 30, 1981, in the Nation's capitol, John Warnock Hinckley, Jr., a 25-year-old gunman described in the media as an "aimless drifter," a "loner," "loser," and a "psycho," shot President Ronald Reagan and three others in the President's party in order to gain the attention of a teenage actress he had never met. The evening of the shooting, former President Gerald R. Ford, himself the target of an attempted assassination during his administration, commented that no protection can be given against a "crazed gunman." He put Hinckley in a class of "loners, kooks, [and] screwballs." A pawnbroker in Dallas, Texas, who apparently sold Hinckley the gun used in the attempt, stated that he knew Hinckley was "nuts." Similar reactions came from the public in letters to newspaper editors and in television interviews.

President Reagan himself, on April 22, in the first interview he gave the press after the shooting acknowledged the possibility of Hinckley's mental illness by making these comments: "I hope, indeed I pray, that we can find an answer to his problem. He seems to be a very disturbed young man. He comes from a fine family. They must be devastated by this. And I hope he'll get well, too." Shortly after these comments were made, Thomas Szasz, the controversial author of The Myth of Mental Illness (1961) who believes that "it is wrong to say that a person is mad or his act is insane when what we really mean is that he is bad or his behavior is offensive" (Szasz, 1970), took the President to task publicly, saying that his remarks about Hinckley were "unfounded and misguided and . . . have gravely prejudiced his trial" (Szasz, 1981).

Undoubtedly, it is a troubled person who thinks that the killing of a President could win him the love of a stranger. Here there can be little disagreement. The complexities, difficulties, and disagreements arise in trying to separate criminal conduct from behavior rooted in mental aberration, badness from madness, if you will. It would be wrong, either as a matter of common or statutory law, or as a matter of moral theory or practice, to convict and punish someone for committing acts of which he or she was unaware and did not consciously choose to commit. Further, common-law doctrine has long held that a person charged with a crime could not be required to stand trial if he or she were so mentally disordered as to be, in effect, mentally absent from the proceedings. And, like any "normal" individual, the mentally disturbed person who is charged with a crime is entitled to the entire panoply of constitutional guarantees and protections under law, such as the presumption of innocence until proven guilty.

But how and when is the fitness of a criminal defendant to undergo the rigors of an adversarial trial tested? How is the legitimacy of the claim that psychological forces impaired a defendant's capacity to refrain from criminal behavior evaluated? Why are these questions raised in some cases and not in others? Who makes these determinations of mental incompetence to stand trial or lack of criminal reponsibility due

to psychological impairment? Controversial cases such as John W. Hinckley, Jr., periodically bring these questions to the public attention in dramatic fashion, but the legal, methodological and moral issues that the questions evoke have troubled the courts for some time.

For many persons facing trial on criminal charges, awaiting sentencing after conviction, or hoping to serve their sentence in a less restrictive environment than a prison, much can hinge on the outcome of a mental health examination conducted by a psychiatrist, psychologist, or social worker. It is estimated that one to two million forensic mental health screenings and evaluations are conducted in the United States each year (National Institute of Law Enforcement and Criminal Justice, 1979; Pollack, 1968). Screening and evaluation may occur for various reasons at any of several stages in the criminal justice process. They may be performed in court clinics, community and regional forensic mental health centers, hospitals, and corrections facilities. The process may be informal (relying primarily on intuitive judgment) or formal (using standardized methods), extensive or circumscribed, and may serve specific disposition, placement, or treatment decisions. The mental health evaluator or examiner may be a policeman, a jail or prison counselor, a probation or parole officer, a social worker, an attorney, a nurse, a psychologist, or a psychiatrist.

The results of such forensic mental health evaluations can have profound effects on the destinies of persons charged with or convicted of crimes. The opinions of mental health professionals routinely form the basis for such determinations as whether a client-offender is competent to proceed to trial or be sentenced, is criminally responsible, is capable of responding to conditions of probation, or simply is more appropriately processed by the mental health system than by the criminal justice system. Indeed, the findings of the mental health professional in large part determine whether a client-offender is to become a patient, a prisoner, or a free person.

We have, no doubt, entered a period of considerable debate regarding the proper stance toward the management of aberrant behavior, a debate that has spawned a considerable literature. For instance, small libraries could be filled solely by the writings concerning the ideological and theoretical underpinnings of the perceived shift from a criminal justice to a "therapeutic justice," where criminal deviance is equated with sickness and punishment is replaced by therapy, and where the authority of the helping professions seems limitless (see, generally, Robitscher, 1980; Miller, 1980; Morse, 1978; Kittrie, 1971). The legal criteria that, to a large degree, define the forensic mental health examination process have not escaped the scrutiny that has generated recent works on competency to stand trial (Roesch and Golding, 1980), insanity (Thornberry and Jacoby, 1979), and dangerousness (Monahan, 1981). Much has been written to weave these criteria into the fabric of mental health law (Wexler, 1981), psychiatry (Halleck, 1980), and psychology (Monahan, 1980). Many state legislatures appear tireless in their seemingly yearly alterations of the semantic formulation of their mental health statutes. And certainly, court decisions in mental health

law have drawn the attentions of an increasing number of psychologists, social workers, and psychiatrists, as well as legal scholars.

However, although much has been written about the subtle points of the language and content of the law that affects forensic mental health screening and evaluation (e.g., the admissability of conclusory statements by a psychiatrist testifying in support of an insanity defense), not much attention has been paid to the day-to-day operations that constitute forensic mental health screening and evaluation, and what Michael Perlin (1980) has termed the "socialization of the law." It is almost as if the central process of forensic mental health screening and evaluation were a "black box" into which the criminal justice system places requests for information (e.g., court-ordered examinations of a defendant's fitness to stand trial) and later retrieves the requested information (as, for example, in expert testimony), but whose inner workings remain mysterious.

Consider the Washington Post's account of the preliminary examination of John W. Hinckley's competence to proceed to trial.

> John W. Hinckley, the drifter accused of shooting President Reagan, was tentatively declared mentally fit to stand trial on assassination charges yesterday. But a federal judge ordered him to undergo further mental examinations, primarily to determine if Hinckley was sane at the time of the shooting.
>
> Hinckley's lawyers--faced with evidence said to include videotapes of him firing at the president and a letter to actress Jodie Foster saying he would shoot Reagan in an effort to impress her--said in court that they were considering entering a plea of guilty by reason of insanity. His parents have said he was under psychiatric care for five months before the shooting.
>
> However, U.S. Attorney Charles F.C. Ruff asked that the government be permitted to thoroughly examine Hinckley's mental state before a team of defense psychiatrists hired by Hinckley's lawyers.
>
> Shortly after yesterday's initial hearing began, a report was presented from James L. Evans, a court-appointed psychiatrist who had examined Hinckley for three hours Wednesday at Quantico Marine Base.
>
> In a brief, one-paragraph statement read to the court, Evans said that he found Hinckley was able to understand the charges against him and was capable of assisting in his own defense--a routine, preliminary finding of mental fitness to stand trial.
>
> Ruff had already requested, however, that a full investigation be made to determine whether Hinckley was sane at the time. But Hinckley's chief defense counsel, Vincent J. Fuller of Williams & Connolly, said such an examination would be premature.
>
> "We are concerned . . . that government [mental experts] not have access to the defendant prior to our having done so on our own terms," Fuller said.
>
> Ordinarily, it is the defense lawyers who request such hospitalization to determine mental competency. Ruff's early

request to do so appeared to indicate that federal prosecutors are anxious to block an insanity plea. . . .

Although Bryant's order gives the defense team equal access to Hinckley, it will be the government staff that has him under constant observation while he is confined in the federal facility--granting them what one observer said yesterday would be "the first crack" at evaluating Hinckley's mental state.

Legal sources familiar with the case said that prosecutors are probably concerned that if the government's mental examination takes place after the defense conducts its evaluation, the defense might later at trial challenge the validity of the government's findings.

"It's the beginning of the battle of the experts. It's the first volley," one source said. (Pichirallo and Kiernan, 1981)

We are told plenty of the complex tactical maneuvers by prosecution and defense lawyers aimed at getting to the "black box" first. First, a judge gives the order for a preliminary examination of Hinckley. Then, James L. Evans, a court-appointed psychiatrist, delivers his terse verdict--Hinckley is fit to stand trial--after spending three hours with Hinckley two days after the shooting. But what tests or procedures did Dr. Evans subject Hinckley to? What mysterious wisdom did he consult to reach a verdict? What was done for three hours to reach a conclusion that might have been self-evident to the public at large? What are the inner workings of the "black box"?

Developing Practice Versus Developing Theory

Bertrand Russell (1961) distinguished between two sorts of knowledge, knowledge of truths and knowledge of things, and he put a lot of stock in the latter, saying that it always involves "some knowledge of truths as its source and ground (p. 218)." Closer to the subject at hand, Roesch and Golding (1980, p. 12), in their very thorough and thoughtful treatise on competency to stand trial, distinguish between observational and theoretical terms in the principles of law. Theoretical terms of law are such constructs as competency, insanity and mens rea. Observational terms are those descriptive of operations and observable behavior. Echoing Bertrand Russell, Roesch and Golding note that "it is important to realize that even 'observational terms' have a low-level inferential abstract quality." As pointed out by Monahan and Loftus (in press) in their review of psychology and law, researchers of equal commitment to the scientific method will differ as to whether it is a more fruitful research strategy to first develop theory and only then proceed to gauge the fit with reality, or first view actual operations and then, perhaps, inductively generate theory.

This book will focus primarily on practice, or knowledge of things, if you will. We hope to guide the reader, at least initially, not by ideology or theory, nor by an analysis of the psycholegal concepts of competency, insanity, or dangerousness, but rather by scrutiny of the day-to-day operations of the criminal justice and mental health systems

in providing forensic mental health screening and evaluation. The purpose of this book is to record, discuss, and evaluate the procedures, involving the often complex alliances of the legal and mental health professions, for making determinations of a defendant's mental aberrations that may affect the course of the criminal proceedings. Simply put, our purpose is to open the "black box" of forensic mental health examination, unravel its mysteries, and connect its inner workings to those procedures that impinge upon it. In this book we do not attempt to examine the consistency of the American system of jurisprudence, nor do we seek to address the broad issues of the role of psychological disturbance in criminality and the efficacy of the helping professions in the area of mental health and the law. Legal issues are not elaborated here in great depth. Our position is that it is better to arrive at propositions for mental health screening and evaluation in the criminal justice context by extrapolating from observation of practices, rather than by logical deduction from a priori assumptions.

We assume, as do other writers (Miller, 1981; Wexler, 1981), that the relationship between theory and practice in mental health law is inconsistent. An inductive approach to the study of forensic mental health examination that looks at what actually happens on a daily basis in court clinics, community mental health centers, jail services, and other facilities that evaluate mentally disabled offenders, seems to us a far more timely and productive approach than a deductive analysis of legal and psychological precedents, rules, and assumptions. And, as has been argued by Morris and Hawkins (1970), "[r]ivers of ink, mountains of printers' lead, and forests of paper have [already] been expended on an issue [insanity] that is surely marginal to the chaotic problems of effective, rational, and humane prevention and treatment of crime. We determinedly insulate ourselves from the realities we are facing (p. 176)." Michael Perlin (1980) put it this way:

> In the practice of law, just as in the practice of other professions or trades, it is often the mores and customs which deserve the attention usually paid to the written rules of substance and procedure. Although thousands of words are written about the subtle points of a significant court decision or statutory revision, usually limited analysis is given to what can be termed the "socialization of the law." (p. 194)

In summary, this book encourages rethinking what is actually done to determine the existence of mental aberration in a defendant that would alter the course of the criminal proceedings. It advocates beginning this rethinking with a hard look at what happens in practice. Consistent with this orientation, the second part of the book is devoted entirely to a detailed description of the practice of forensic mental health screening and evaluation in twenty different forensic units throughout the country. The discovery of practice departing from the legal assumptions will, hopefully, begin to challenge those assumptions and lead the way to reform of practice, and the reformulation of theory "grounded" (see Glaser and Strauss, 1967) in the practice.

Overview of the Book

This book should serve to bound and define forensic mental health screening and evaluation for the reader, provide an understanding and appreciation of its complexity, and finally provide a framework for effectively addressing change and innovation. In the first three chapters of the book, Part I, we attempt to explain the logic of forensic mental health screening and evaluation from a functional perspective. Part I introduces the issues, describes the elements of an operational definition, and provides a logical framework of inquiry useful for viewing and understanding the operations conducted in the name of forensic mental health examination.

This introductory chapter is meant to explain the organization and content of this book, and to communicate its major emphasis on practice, on the "knowledge of things" postulated by Bertrand Russell. It also attempts to show, by citing the case of John W. Hinckley, Jr., that the distinctions made between disturbance and depravity--between madness and badness, if you will--are something that the public has no difficulty expressing itself about. And, while the specialized and technical judgments made by psychiatrists, psychologists and social workers may be foreign and mysterious to them, it has no difficulty in recognizing what is "crazy."

Starting in Chapter 2, the book begins to consider specifically the process of forensic mental health examination. Here is presented the operational definition upon which the strategies, tactics, and contexts discussed later in the book heavily depend. The chapter explains the types of offenders or alleged offenders subject to screening and evaluation; the types of criminal justice authorities who initiate the screening and evaluation process; the process by which criminal justice authorities delineate the information required; the types of mental health personnel who conduct the mental health examination; the mental health information collected; the process by which the mental health information is provided to the criminal justice authorities; and, finally, the manner in which the mental health information is used by the criminal justice authorities. The chapter ends by introducing a functional model of the forensic mental health screening and evaluation process, which is elaborated in Part III of the book.

In Chapter 3, we discuss the rationale and purposes of the method of inquiry called "evaluability assessment" that we used to address four basic questions: What is the nature and scope of the forensic mental health examination process? How does it operate in practice? Can and should it be subjected to disciplined inquiry by evaluation research methods? And if so, how and by what methods? The chapter also presents the results of a telephone survey of 121 selected forensic mental health programs throughout the country by which we intended to generate a preliminary answer to the first of the basic questions in the context of reality, and set the stage for the study of the practice of the forensic examination process. Thus, equipped, in Part I of the book, with an operational definition, a framework of inquiry, and an appreciation of

the issues involved in mental health screening and evaluation, the reader is introduced to the description of the practice in court clinics, jails, mental health centers and other forensic facilities throughout the country.

The detailed descriptions of actual forensic mental health screening and evaluation conducted by means of various types of collaborations between the mental health and criminal justice systems are given considerable prominence in this book. Part II of the book, beginning with Chapter 4, describes the operation of mental health screening and evaluation in five court clinics, four jails, seven community and regional forensic mental health centers, two centralized hospital units, and two community corrections programs throughout the country. Each of the twenty distinct operations is described using the logical framework of inquiry--encompassing the acquisition, delineation, and provision of mental health information--suggested by the operational definition in Part I of the book. Each forensic mental health screening and evaluation program description contains a brief history of the host agency or facility where the program operates; a summary of the program's goals and objectives; an illustration of the flow of client-offenders into and through the program; discussions of how mental health information is delineated by the referral source, acquired by the program staff, and provided to the user; and a review of the procedures and systems used for feedback, quality control, and program evaluation.

The prominence and importance that the detailed descriptions of the practice of screening and evaluation are given here, are based on the premise that knowledge about the actual operations of such programs is lacking. "How do they do it in other places?" is a question we heard asked repeatedly by administrators and practitioners alike, many of whom were well acquainted with the rules, assumptions, and theories in mental health and the law. Another reason for the space given to description of procedure is the hope that improved knowledge about practice, and the discovery of practice departing sharply from theory, will lead to the reform of practice and, perhaps, the clarification of the theory.

Parts I and II of the book provide the conceptual and factual bases for Part III, in which we propose, beginning in Chapter 9, how a model process of mental health screening and evaluation might operate at each step of the process and how it might operate within an actual interagency context. Chapter 9 introduces a model process of forensic mental health screening and evaluation, which is divided into three major components and fourteen steps. This generalized model is articulated in greater detail, and more forcefully, in Chapters 10, 11, and 12 of the book. Each of these chapters discusses a major component of the model process and its operations and includes a number of specific tersely stated propositions. Each proposition is positioned in the model process and discussed in terms of its viability from various perspectives of practice, research, and theory.

In Chapter 10 we explain, and make a number of propositions about, the process component of delineation including all activities, standards, rules, and established procedure that serve to initiate, focus, and define the legal-psychological question that confronts the criminal justice authorities and is passed on to mental health personnel. The delineation of the forensic mental health screening or evaluation, when done properly, answers the questions "Who is to be examined by whom, when, and for what reasons?" The chapter discusses issues centering on the formal evaluation referral. It suggests, however, that formal procedures, such as the transmittal of a court order, are but one very limited means by which the needs and wishes of the criminal justice system are conveyed to the mental health system. In Chapter 11, we describe and propose several steps in the data collection process by which mental health workers acquire information directly from the defendant by means of interviews or tests, or get information about the defendant from sources (e.g., a family member) other than the defendant. This chapter opens the "black box" and, perhaps, lends at least some credence to the contention of prominent spokespersons of the mental health and legal professions that the judgments made by mental health professionals in deciding between mental illness and criminality are not, in fact, exclusively technical and specialized but moral, social, and political as well (Szasz, 1970; Bazelon, Note 1). Chapter 12 describes the transfer of the information, delineated (as discussed in Chapter 10) and acquired (as discussed in Chapter 11), to the criminal justice authorities. Although the courtroom testimony of psychiatrists and psychologists grabs the headlines, especially in controversial cases, most of the information acquired by mental health workers to support opinions about competence to stand trial, mental state at the time of the offense, sentence disposition, amenability to treatment, dangerousness, and other psycholegal questions are communicated by means of formal (often standardized) letters or reports to the court. The chapter discusses the process of provision, entailing both formal and informal mechanisms whereby the mental health professional responds to the requests by criminal justice authorities for mental health information about defendants.

The last chapter of the book places the model process into a discussion of the context of the systems, agencies, facilities, and situations in which it might be realistically applied. The chapter explains how the complex relationships and alliances formed by the mental health system, law enforcement, and the judicial system are shaped by a number of factors related both directly to the client-offender and his or her entanglements with the law, as well as other factors only indirectly related to the individual, the crime (or alleged offense), and his or her mental state. The propositions articulated in this last chapter have implications for social policy and the program evaluation of forensic mental health facilities. Also discussed are recommended strategies for monitoring, quality control, and program evaluation of forensic mental health screening and evaluation programs. It is argued that the ultimate goal of improved forensic mental health programs may best be served by developing the internal program evaluation capacity of such programs, as opposed to commissioning external evaluation efforts.

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Chapter 2

A DEFINITION AND A FRAMEWORK OF INQUIRY

It has been observed that change depends heavily on how the issues are initially defined (Ryan, 1971; Caplan and Nelson, 1973; Skinner, 1971). Walter Lippmann once said that "[f]or the most part we do not first see, and then define, we define first and then see" (Lippman, 1927, p. 81). In this chapter, we attempt to define forensic mental health screening and evaluation in operational terms. This effort at definition may at first seem antithetical to the suggestion in Chapter 1 that the introduction of the principles and rules of a system before observation and understanding of practice and convention may impede improvement of the system. The definition and framework of inquiry presented here will not, however, attempt to place screening and evaluation in the context of ideology, theory, rules and assumptions but instead ground our understanding of screening and evaluation in operations and procedure.

Definition

Operational definitions describe entities in terms of how they are put to use or how they work. They group specific procedures or operations into particular, clearly identifiable aspects or elements in order to allow for a better understanding of those procedures and the identification of related issues and problems. The general operational definition of forensic mental health screening and evaluation which guided our study is as follows:

> Screening and evaluation is the process conducted by mental health personnel, at the direction of criminal justice authorities, for the purposes of delineating, acquiring, and providing information about the mental condition of client-offenders that would be useful for decision-making in the criminal justice system.

This general statement encompasses all the activities, procedures, and operations occurring in the interaction of mental health and the law, conducted to determine mental disturbances in convicted and alleged offenders. Each of the nine elements, italicized in the above statement, constitutes a distinct aspect of the operation of forensic mental health screening and evaluation.

The elements, presented in a slightly different order than in the general statement for ease of discussion, are further defined in the following pages. The objective is to amplify the full meaning and discuss the import of the individual elements, provide the necessary commentary supporting the concise general statement of definition, and introduce the framework of inquiry discussed in the second part of this chapter.

Process. A particular activity or set of activities, directed toward a client-offender, subsuming many different methods and involving a number of steps or operations.

The screening and evaluation process may include a number of operations that vary in complexity, terminology, and formality and may entail differential allocations of mental health staff resources. For example, the process, as defined above, may be a clinical interview conducted by a psychiatrist or psychologist, a psychological test, a neurological evaluation, a mental status examination, a social history interview, a nursing assessment, a ward observation, or a combination of these. The process may be invoked at various stages of the criminal proceedings for various psycholegal reasons. Staff resources devoted to the process may vary with the professional discipline and training of the personnel involved and the amount of time consumed by the process. A cursory mental status examination may take only twenty minutes, while the administration of a battery of psychological tests may require an entire day or more.

This broad conception of the process of forensic screening and evaluation is reflected in the writings of both the mental health professions and in legal formulations. For example, in his description of a "theoretical ideal model of a psychiatric evaluation," Gerard (1974, p. 26) notes that the model need not be followed as he outlined it since "[e]very mental health professional develops his own style. The crucial question is not the format in which the information is presented, but rather whether all the information has been gathered and considered." The American Law Institute, in their Model Penal Code (1962), propose that the psychiatric examination of a defendant entails "any method . . . which is accepted by the medical profession for the examination of those alleged to be suffering from mental disease or defect."

The process may be given various names. Some observers make clear distinctions between screening and evaluation. For instance, Pelc (1977) views screening as the simplest form of evaluation, one which a paraprofessional is capable of performing. "The purpose of screening is assessment of an offender's suitability of eligibility for a specific intervention or rehabilitation program," writes Pelc, a psychologist (p. 277). In his view, classification is an intermediate step used to select the most appropriate intervention alternative. He suggests that evaluation is "the most psychologically sophisticated process for assessing an offender's psychosocial functioning" (p. 279). The latter is conducted by a professional with graduate training for the purpose of assessing personality development and the likely response to treatment intervention. These differences in terminology may be reflected in a jurisdiction's practices. In the District of Columbia, for example, "screening examinations" are conducted in the Superior Court by staff of the District Forensic Psychiatry Division. If further examination for competency or criminal responsibility is needed, a screening recommends further evaluation.

Information About Mental Condition. Data concerning an individual's physical, emotional, and/or cognitive functioning, and behavioral and social history, including inferences drawn from this information with regard to past, present, and future behavior.

Information about mental condition subsumes almost all that may be known about an individual, including his or her social and physical environment. Included are such observable characteristics as gender and general appearance, speech, mood or affect, orientation, social and family history, and behavioral responses in formal testing settings. Subtle inferences about personality and abnormal mental trends (delusions, hallucinations, toxic states) may be drawn from an individual's reactions to tests like the Rorschach or the Minnesota Multiphasic Personality Inventory (MMPI), or from insights gained by interview of the client-offender. Accumulated documentary and research materials, and medical data gathered during physical examinations, X-ray, and laboratory tests may also contribute to the available information about the mental condition of an individual.

Of course, uncertainty about the mental condition of a client-offender may not be the primary purpose of the psycholegal exercises but only serve to hide latent objectives (Roesch and Golding, 1980; Roth, 1980; Steadman and Braff, 1975). Pretrial requests for mental health screening and evaluation, for example, may be prompted by considerations of legal strategy (e.g., assistance in plea bargaining, test of the court's receptivity to the insanity defense), preventive detention, or a lack of other, clear alternatives (Geller and Lister, 1978). A recent survey of North Carolina judges and defense attorneys is revealing. Two-thirds of the judges responding believed that motions for competency evaluations were used by the defense to delay trial; however, most of the judges said they grant such motions "unless they believed the motion was being used as a transparent delay tactic" (Roesch and Golding, 1978). Questioned about their reasons for requesting competency evaluations, most attorneys were unclear or gave reasons suggesting motives unrelated to concerns about their client's competency to participate in the judicial proceedings.

Client-Offenders. Individuals who are involved in the criminal justice process as convicted criminals or alleged offenders, and whose mental condition has been questioned.

Client-offenders are all those persons suspected or convicted of crimes, whose mental health has been questioned by criminal justice authorities at some point before, during, or after the criminal justice proceedings. This includes, but is not limited to: (1) persons who may have not been previously institutionalized but who have been brought to the emergency room of a hospital by a police officer (who has observed the person engaging in bizarre behavior); (2) individuals detained under an emergency detention statute, awaiting mental health screening; (3) persons suspected to be or found to be incompetent to go ahead with criminal proceedings; (4) defendants found not guilty by reason of insanity; (5) persons adjudicated under special statutes as, for example,

"sexually dangerous individuals"; (6) convicted offenders receiving mental health treatment as part of their probation program; and (7) convicted and sentenced offenders who have become mentally disturbed while incarcerated.

It is acknowledged that "client-offender" may not be the best term to describe individuals somehow involved in the criminal justice system who are in need of mental health services. The word "client," used alone, denotes a voluntary, therapeutic relationship with a mental health professional--a situation seldom applicable in the criminal justice process. The word "offender," used by itself, suggests that the individual already has been adjudged guilty. Terms such as "defendant" and "patient" have similar problems; both have restrictive meaning and usage inappropriate for denoting individuals suspected or convicted of crimes who may also be mentally disturbed.

The problem is not only one of semantics. The disclosure and admissability of data and statements made during mental health screening may hinge on the existence of evidentiary privileges such as the doctor-patient privilege or the attorney-client privilege protecting such information. The argument for the doctor-patient privilege rests on the claim that the quality of the relationship between a patient and doctor is essential to the psychotherapeutic mileau and cannot be threatened by disclosure of privileged communication. While it is doubtful that a case would turn on the correct usage of language, the use of the term "patient," for example, may create the expectation of confidentiality that, in fact, may not exist, thus creating the possibility of self-incrimination. Further, ensuring that a client-offender understands that he or she is not a "patient," even though the examiner is a doctor, and that there will be no privileged communication, may hamper the acquisition of information voluntarily and intelligently given.

Thus, as awkward as it may be, the term "client-offender" is used here to denote those individuals who are both clients of the criminal justice system, as well as actual or potential patients of the mental health system. It encompasses all confirmed and potentially mentally ill and mentally retarded individuals involved in the criminal justice system.

Mental Health Personnel. Persons representing the mental health system who are charged with the responsibility of conducting the process of screening and evaluation.

Mental health personnel may be psychiatrists, psychiatric interns, clinical psychologists, neurologists, psychometricians, social workers, jail nurses, medical security officers, counselors, or their agents. They may be involved in any portion of the process of screening and evaluation and conduct their work in public or private psychiatric hospitals, detention centers, diagnostic centers in jails and courthouses, or community and regional mental health centers.

These individuals may possess no formal mental health experience or training. Or they may be licensed or certified by professional boards

or the state government. The approximate pecking order in practice and in law, according to discipline, is psychiatry, clinical psychology, social work, psychometrics, followed by other disciplines. This order is revealed in the position, pay, and status as expert witnesses reflected in states' laws. Generally speaking, psychiatrists and clinical psychologists conduct clinical interviews and testify in criminal trials on questions involving mental condition or competency to stand trial; psychologists administer, and testify regarding interpretations of psychological tests; social workers conduct social history interviews and very seldom testify, except perhaps in presentence hearings; other mental health personnel support the efforts of psychiatrists, psychologists, and social workers.

Most states authorize only psychiatrists or clinical psychologists to perform evaluations, although at least one state (Tennessee) permits social workers, nurses, and even lawyers to do forensic evaluations in certain circumstances (Petrila, 1980). Connecticut recognizes social workers as experts on the issue of competency, and Illinois recognizes psychiatric nurses, social workers and psychologists as qualified examiners for some examinations (Slovenko, 1977; Fitzgerald, Peszke, and Goodwin, 1978). Laws in some jurisdictions are quite specific regarding who may perform particular types of examinations. In California, court-ordered examinations of "mentally disordered sex offenders" must be conducted by two or three "clinical psychologists, each of whom shall have a doctoral degree and at least five years of postgraduate experience in the diagnosis of emotional and mental disorders," or by a medical doctor who has "directed his professional practice primarily to the diagnosis of and treatment of mental and nervous disorders for a period of not less than five years" (California Welfare Code § 6307). In other states, requirements are more vague. In Virginia, competency evaluations are performed by judge-appointed "psychiatric committees" containing "one or more physicians skilled in the diagnosis of insanity" (Virginia Code § 19.2-169).

At least one court has recognized a minimum degree of proficiency in the English language sufficient to enable effective communication with client-offenders as a necessary qualification for forensic evaluators (Beran and Toomey, 1979, p. 43). Seymour L. Halleck suggests the reality of the issue:

> The issue of psychiatrists understanding the English language is a serious one. Forty percent of American psychiatrists are foreign medical graduates and on the eastern seaboard that number is sixty percent. Many foreign graduates are superb psychiatrists, some of our better psychiatrists, but as a rule they have serious problems with the English language. On a site visit to Florida, I actually saw a patient labeled as delusionary because she told the psychiatrist at the beginning of the interview that she had butterflies in her stomach. These are serious, real issues. Some psychiatrists who work in our forensic units are superb, but many of them have serious problems with the English language. (Commenting on a paper presented by Nicholas Kittrie in Beran and Toomey, 1979, p. 52.)

The expertise of mental health evaluators is often challenged in the courtroom (see Perlin, 1980). According to one prominent forensic psychiatrist, a "growing, zealous, and activist 'mental health bar' has developed which increasingly has challenged psychiatric competence, particularly in state mental health settings and in the legal process" (McGarry, 1980a). Attorneys are coached in model cross-examination techniques and are advised to probe in such areas as past and continuing education, licenses, certifications, employment, professional affiliations and contributions, and facility with statistical techniques and "learned treatises" (Poythress, 1978).

Mental health personnel may provide screening and evaluation services to the courts through a variety of arrangements. They may serve as independent consultants, without large staffs or organizations, acting at the request of the client-offender at their own, or the state's, expense. Court clinics or mental health workers on the court's staff may perform the necessary requested screenings or evaluations, or a contractual arrangement with mental health facilities or individuals may assure the provision of services. Mental health personnel employed to conduct screening and evaluation may be securely enmeshed in the bureaucracy of the mental health system, the criminal justice system, or both.

> Delineating. The procedures involved in defining the psycholegal questions, delimiting the information about the client-offender required by the criminal justice authorities, and determining the scope of the screening and evaluation process.

Clearer questions obviously lead to more relevant answers. A great source of confusion and dissatisfaction of those involved in the process of forensic mental health screening and evaluation is psycholegal questions that are not clearly articulated (McGarry, 1980a).

Mental health laws are often imprecise and may cause confusion in the criminal justice and mental health systems about the meanings of mental illness (a clinical diagnosis), and insanity (a legal definition). While the public thinks it knows quite well what is "crazy," there is longstanding uncertainty and intellectual debate about what legal insanity is and how to deal with it. A judge making a case referral must deal with a complex array of legal and psychological issues, such as the ability of the client-offender to give a statement voluntarily, competency to proceed with trial, diminished responsibility, placement in a mental hospital instead of jail, amenability to supervision on probation or parole, possibility of future dangerousness, and amenability to treatment.

Communication between the judge and mental health personnel should be complete and lucid, but often is incomplete and flawed. As a result, mental health personnel may perform unnecessary evaluations and report their findings in nonlegal terms. Clarification of the questions "What psycholegal question needs to be addressed?" and "Why?" may occur through informal communications or institutionalized practices. Or confusion may

reign, and resources of both the mental health and criminal justice systems may be wasted.

> Acquiring. The actual procedures, techniques, tests, and other data-gathering operations used to collect information about the mental condition of client-offenders.

As noted above in the commentary on the meaning of the term "process," all other factors being equal, the specific methods of forensic mental health screening and evaluation differ among forensic mental health agencies and individual examiners. Of course, each case may dictate a different method of acquiring mental health information, depending on the psycholegal question delineated (e.g., mental state at the time of the offense), the referral source (e.g., judge, defense attorney), the charge and stage of criminal proceedings, the resources available to do the screening or evaluation, and the skills of the examiner or team of examiners. Although preferred or even "ideal" data-gathering methods and procedures have been proposed (cf. Gerard, 1974; Lawrence, 1980; Ruzicka, 1980) there seems to be no consensus on even the minimum criteria for an adequate evaluation and "much research must be carried out before more than tentative proposals can be advanced" (Bonnie and Slobogin, 1980, p. 496).

Methods for acquiring information range from intensive clinical interviews and extensive sophisticated psychological testing to relatively quick subjective judgments. The mainstay of the screening and evaluation process is the clinical interview, typically conducted by a psychologist, social worker, or psychiatrist, supported by psychological testing, compilation of a social history of the client-offender, and other inquiries into other sources of information, including, although rarely, medical examination, credibility assessments (polygraph examination, administration of sodium amytal [truth serum]), and interviews of witnesses. Depending on the psycholegal question posed, the examiner's attention may be focused on the individual's understanding of the alleged crime and surrounding events, present ability to assist an attorney in preparing a defense, or future threats of harm to self or society. An interview with a family member or other person close to the client-offender may be conducted to verify the statements made by the client-offender and gain a fuller appreciation of his or her mental status. The mental status examination entails observations of the client-offender to determine general appearance and behavior, speech, mood, or affect, intelligence, sensorium (e.g., attention span, memory, concentration), and any abnormal mental trends.

The nature and specificity of the psycholegal question posed to the examiner, the policies and resources of the forensic mental health facility, the nature of the case, the client-offender's behavior at the time of the evaluation, as well as the background, experience, and preferences of the examiner, dictate the specific operations performed during the information acquisition phase of screening and evaluation.

Providing. The procedures involved in the creation, transmittal and receipt of information acquired by the mental health system to the criminal justice authorities.

Perhaps nowhere else in the forensic mental health screening and evaluation process is the "gap problem" (Monohan and Loftus, in press)--discrepancies between practice and formal legal requirements and rhetoric--more noticeable than in the provision stage. Often there is little relationship between the information requested by the court and that provided by mental health personnel. The information provided to the court may not only be short of that required by the psycholegal question, delineated by statute, or implied by the referral agent, but also different from what mental health workers actually learned about the client-offender. The observations of Geller and Lister (1978) dramatize persistent difficulties in the provision of information:

> The first step of the commitment process is an evaluation of competency and/or criminal responsibility done at the court by a psychiatrist designated to be forensically qualified. At the central district court in Worcester [Massachusetts], the following instructions appear at the desk where the examining psychiatrist writes his report. "Attention Psychiatrists: There is a question of his competency to stand trial and his criminal responsibility at the time of the alleged crimes. (The above must be put in your statement upon examination of patients.)" In spite of the forensic qualifications of the examining psychiatrists and in spite of the explicit directions supplied, 65% of the reports made no mention of competency, and 93% of the reports made no mention of criminal responsibility.

Although testimony by mental health personnel in open court clearly draws the public's attention, the influence of the helping professions on criminal justice comes not primarily from the witness stand, but much more frequently from written reports and informal oral communications to judges, attorneys, probation and parole officers. The influence of the mental health system on legal proceedings usually begins and ends with the submission of a written report to the court or to the adversaries in a case. Practical guidelines for preparing formal reports have been outlined for psychiatrists and psychologists (e.g., Bromberg, 1979, pp. 33-37; McGarry, 1980b; Lawrence, 1980). Yet mental health personnel are relatively uninformed about how criminal justice authorities review and utilize evaluation reports. For example, the simple procedure of beginning a written report with a terse summary or set of conclusions, rather than having them trail after pages of discussion of past history of the client-offender, review of the purposes of the examination, an account of the alleged offense, etc., seems to be an anathema to mental health personnel, even though such organization has clear advantages to those reading the report. Empirical studies, critical commentaries, and our own data indicate that judges often read only the concluding statement or summary of reports and typically base their decisions on that reading (Bazelon, 1975; Roesch and Golding, 1980). It seems that criminal justice authorities and mental health

personnel rarely discuss the communications between them, except perhaps for an occasional, informal telephone call from a judge seeking clarification of a written report. This state of affairs prevails inspite of the widely acknowledged importance of psycholegal reports in affecting the outcome of legal actions (McGarry, 1980b).

Decisionmaking in the Criminal Justice System. The process of choosing among the options available to the criminal justice system for dealing with suspected mentally ill offenders.

A finite number of legal options are available to the criminal justice system for dealing with mentally aberrant individuals. Brooks (1974) has enumerated seven general categories of such legal options available for dealing with the mentally ill offender: 1) acquittal of criminal charges by reason of insanity, followed by immediate release or continued confinement pursuant to involuntary civil commitment proceedings; 2) criminal commitment after a finding of diminished capacity due to mental illness and conviction of a lesser included offense; 3) confinement in a criminal hospital, and perhaps later in a civil hospital, after a determination of incompetency to stand trial; 4) conviction of the crime charged (perhaps after a "guilty but mentally ill" verdict) and confinement in a special institution or hospital designed to deal with a special category of offenders, such as dangerous offenders, sex offenders, or habitual offenders; 5) original conviction, and subsequent transfer from prison to a hospital for criminally insane persons because of a determination of mental illness during imprisonment; 6) involuntary civil commitment, although offenses and criminal charges may be involved; and 7) straight conviction for offenses, and disposition (probation, parole, etc.) based, to some degree, on the mental condition of the client-offender. Of course, a client-offender may simply be released or placed in a community-based, nonresidential treatment program without criminal sanctions.

Criminal Justice Authorities. Prosecutors, defense attorneys, judges, corrections officials, and their agents who are involved in decisionmaking concerning client-offenders.

Depending upon the degree of the client-offender's involvement in the criminal justice system, a variety of criminal justice employees may be instrumental in initiating and facilitating screening and evaluation decisions. For example, if a client-offender is incarcerated, a jail paramedic or sheriff may bring the inmate to the attention of mental health personnel if a mental examination is indicated. In the courtroom, upon motion of either party or upon his or her own initiative, a judge may order a mental examination. State statutes may specify who may raise the issue of a client-offender's competency to stand trial and the procedures for doing so, or the statutes may be silent on the issue. Attorneys, judges, corrections personnel, mental health workers, or client-offenders themselves usually are the ones to raise the issue of mental health. Typically, judges authorize the evaluation and judicial agents communicate the request for screening and evaluation to mental health workers. Judges are the initial recipients of the evaluation

results, and in turn communicate the results to their agent and the parties.

A Framework of Inquiry

There are three elements in the foregoing definition--"delineating," "acquiring," and "providing"--by which the entire process of forensic mental health screening and evaluation can be logically organized. Thus, as we conceived it, the process of forensic mental health screening and evaluation consists of three functional components--delineation, acquisition, and provision (the noun form instead of the gerund form of the words will be used from here on for convenience of discussion)--that occur once the issue of mental health is raised in criminal proceedings but before mental health information is used to affect the outcome of the proceedings. These three components are given equal weight in our framework of inquiry.

Delineation, as noted earlier in the definition, includes all activities, standards, rules, and established proceedings that serve to define and focus the psycholegal question before the criminal justice authorities. Provision, simply, involves the transfer of the information acquired by mental health personnel to the requesting agent or agency. Obviously, the delineation and, later, the provision of mental health information necessitates communication between the two systems. In fact, the delineation and provision of information subsume almost all interactions of the criminal justice system and the mental health system in the screening and evaluation of client-offenders. In the delineation component of the process, the flow of communication is primarily from the criminal justice system to the mental health system; obviously, in the provision component the direction of the flow of communication is reversed.

The delineation and provision components provide, from the perspective of the courts, for example, the greatest opportunity for relatively inexpensive and expedient improvement of the mental health screening and evaluation process. On the other hand, the third component of our conceptual foundation, acquisition, the actual operations of gathering data about the mental condition of a client-offender, is more resistant to change from the "outside" by criminal justice authorities. As mentioned earlier, the acquisition component of screening and evaluation is often viewed by judges, attorneys, law enforcement and corrections workers as a "black box" whose inner workings are known only to the "shrinks."

Even when considerable light is shed on the acquisition component of screening and evaluation--as in the small number of highly publicized cases of Jack Ruby, Patty Hearst, Son-of-Sam, and Dan White--public skepticism and judicial criticism of the validity and reliability of the workings of the "black box" increase every time two or more mental health experts face each other in the courtroom with diametrically opposed positions. Yet, instituting improvements in the actual acquisition of mental information is relatively difficult (though not impossible) for

agents of the criminal justice system, just as it is equally difficult for mental health workers to influence the raising of the issue of mental health in criminal proceedings and controlling the court's use of the information in sentencing. Consider, for example, one judge's insistence that court-appointed psychiatrists in his court are "obsessed with quality" and his recommendation that the personal clinical interview with the client-offender be dispensed with in favor of direct observation of the individual by a psychiatrist during arraignment. Or, conversely, consider the receptivity among judges to the suggestion made by court clinic mental health personnel in one jurisdiction that most of the requests for mental health examination be denied on probable cause grounds, because it was quite obvious that the requests were unwarranted. In the first instance, what may have been a sincere judicial concern for efficiency and economy would likely be viewed by court appointed psychiatrists as an unacceptable intrusion into their business. Likewise, judges would be none too happy, in the second example, about the suggestion that they have not exercised proper discretion in determining the legitimate grounds for requests for mental health examinations. In both instances, the parochial concerns of a profession may have deafened the mental health and criminal justice systems to suggestions for change worthy of a fair hearing.

The purpose of this framework of inquiry is to stimulate and structure change strategies applicable to forensic screening and evaluation, other than along the lines of parochial reactions by mental health professionals and criminal justice personnel. Forensic mental health screening and evaluation process, conceived in terms of logically related operational components of equal weight, rather than as isolated activities guarded by narrow professional interests, may be at the same time more comprehensible and susceptible to change.

In the next chapter, we turn to a brief review of the method of inquiry we used to study the process of forensic mental health examination. An early step in the method was a survey of forensic mental health facilities to determine what constitutes forensic mental health examination, from the perspectives of the management personnel of the facilities. The results of this survey, which provided the context for the operational definition in Chapter 2, are also reported in Chapter 3.

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Chapter 3

A METHOD OF STUDY AND SOME PRELIMINARY RESULTS

What is the nature and scope of the forensic mental health examination process? How does it operate in practice? Can and should it be subjected to disciplined inquiry by evaluation research methods? And if so, how and by what methods? These questions introduced us to the study of mental health screening and evaluation as instruments of the legal system. They also expressed the basic purpose of a type of program evaluation, an "evaluability assessment," of forensic mental health screening and evaluation commissioned by the Office of Program Evaluation of the National Institute of Justice and conducted by my colleagues and me at the National Center for State Courts from October 1979 to June 1981. It is out of this "evaluability assessment" that this book was conceived and derived its primary focus on practice, rather than ideology or theory.

To avoid a possible confusion between our references to the process of forensic mental health evaluation and our references to program evaluation, it might be beneficial to distinguish between these two types of evaluations. The process of forensic mental health evaluation, as defined in the preceding chapter, focuses on the individual client-offender. It is an instrument of the legal system to assist in decisionmaking concerning an individual's fate in the criminal justice system. Program evaluation, on the other hand, is the process of determining the value, worth, or merit of a program or its consequences (Scriven, 1980). It is an instrument of program managers, planners, and policymakers. As confusing as it may sound to the uninitiated, we were in the business of conducting a particular type of program evaluation (i.e., an evaluability assessment) of the then loosely conceived program of forensic mental health screening and evaluation.

Evaluability Assessment and Program Evaluation

"Evaluability assessment"--a term coined by Joseph S. Wholey and his colleagues at The Urban Institute (see Wholey, 1977, 1979; Rutman, 1980)--is an inquiry technique used in advance of the assessment of the effect, outcome, or impact of a particular program. It is a technique that relies on analysis of documents, interviews, and observations of the operations of a program. It is a logical, relatively quick, and inexpensive prelude to program planning, management, and its ultimate evaluation. Evaluability assessment sorts those aspects of a program area for which evaluation is ripe from those which require more study to enhance their "evaluability." It is based on the common-sense premise that it is first necessary to fully understand a program or process before it can be evaluated. Or, as Scriven (1980) has expressed the underlying principle of evaluability assessment: "It is not enough that good works be done, it must be possible to tell that (and, more importantly, when) good works have been done."

Wholey (1980, p. 43) describes the common-sensical, sequential series of steps, each of which has something valuable to bring to evaluability assessment:

(A) Bounding of the program to be studied.

(B) Collecting of program information that defines the programs objectives, activities, and underlying assumptions.

(C) Developoment of a logic model that describes the program and the interrelationships of activities and objectives.

(D) Determining to what extent the program definition, as represented by the model, is sufficiently unambiguous that further inquiry based upon it is likely to be useful.

(E) Feedback of the results of the evaluability assessment to representatives of the intended users.

The emergence of evaluability assessment as a distinctive and legitimate method of inquiry represents a growing concern about the excessive cost and time of program evaluation efforts in relation to their benefits (Evaluation Research Society, Note 1). Moreover, the exploratory and formative nature of evaluability assessment was viewed by many as an answer to impact (summative, outcome, effectiveness) evaluations that reported the alleged impacts of undefined, or worse, nonexisting program interventions (Evaluation Research Society, Note 1; Rutman, 1980). That is, evaluability assessment was seen as a technique to make sense out of a program which is to be evaluated before expending valuable resources to make determinations of its ultimate worth.

Our evaluability assessment of forensic mental health screening and evaluation conformed generally to Wholey's steps outlined above. It conducted under the auspices of the National Institute for Justice's "National Evaluation Program" (NEP) which consisted of a series of phased studies that would collect relevant information in an orderly fashion and avoid the problems of premature and wasteful program evaluation efforts. The first phase of the NEP studies included the collection, synthesis, and assessment of what is already known about a program or topic area, and recommendations for further, more intensive program evaluation to be conducted in a second phase at some later time (see National Institute of Law Enforcement and Criminal Justice, 1977). The first phase of NEP studies are state-of-the-art reviews of major categories of programs such as those involving forensic mental health screening and evaluation; they describe the programs in question, present information gathered in representative program sites, assess the utility and reliability of existing data about program components, and identify aspects requiring further investigation. Although the term "evaluability assessment" is not used by the National Institute, the first phase of its NEP constitutes a version of the evaluability assessment procedure developed specifically for the U.S. Department of Justice by The Urban Institute (Nay, Barnes, Kay, Ratner, and Graham, Note 2). Under their NEP, the

National Institute of Justice has supported 30 evaluability assessments in major categories of programs such as street lighting projects and police liaison offices, and functional program areas such as family counseling activities in the criminal justice system (National Institute of Justice, 1980). In commissioning an evaluability assessment of forensic mental health screening and evaluation programs, the National Institute of Justice acknowledged that impact program evaluation in this area would be prohibitively costly, and the effort itself unrewarding, since the kinds of information necessary for initiating the evaluation of the accomplishment of such programs in this area simply were not available (National Institute of Law Enforcement and Criminal Justice, 1979a).

Our evaluability assessment of forensic mental health examinations, begun in October 1979, entailed three phases of work: a state-of-the-knowledge assessment, field observations, and model development. In the first phase we sought to describe the prevailing attitudes, expectations, and theories in the topic area. We sampled projects funded by the Department of Justice relating to mental health services, conducted telephone interviews with project personnel, performed document and literature searches, and constructed the preliminary operational definition of forensic mental health screening and evaluation presented in the previous chapter. We characterized this first phase of the evaluability assessment as the "read, listen, and think" phase of the study. (The results of the telephone survey are described in detail later in this chapter.)

In the second phase, we literally got on the bus (and airplane) and saw the real world of forensic mental health screening and evaluation, visiting twenty facilities (court clinics, jails, community, regional, and centralized forensic mental health centers, and community corrections programs) throughout the country. We talked to hundreds of people at every level of involvement: management, line staff, client-offenders, and persons outside the facility but allied with program operations; we interviewed judges, lawyers, court administrators, corrections officers, psychiatrists, psychologists, social workers, and other representatives of the mental health and legal systems. We also observed screening and evaluation in these facilities as it occurred when we were permitted. And we recorded this information in graphic and narrative form. This record constitutes the second part of this book.

Finally, in the last phase of the study, we attempted to integrate our state-of-the-knowledge assessment from the first phase with what we had learned on the road in the second phase. We were thus able to compare the programs, or sets of programs, constituting the evaluation of defendants' possible mental disturbances as defined by theorists, managers, and policy makers, with reality. Discrepancies between prevailing theories, attitudes, assumptions and reality were noted. Conspicuous gaps in our knowledge about mental health screening and evaluation were articulated. Lastly, a model process of forensic mental health examinations was developed.

The development of the operational definition and framework of inquiry, the major products of the state-of-the-knowledge assessment of the first phase of our evaluability assessments described in the previous chapter, drew heavily from the results of a telephone survey of 121 forensic mental health programs throughout the country. The survey also served to place the logic of the definition and framework of inquiry safely in reality. It was intended to generate, however, only a preliminary, cautious view of how forensic screening and evaluation were conducted in various settings. We turn our attention to the survey next as a final introduction to the detailed description, in Part II, of the book, of the operation of forensic screening and evaluation in twenty different facilities.

A Survey of Forensic Facilities

The survey was conducted as an initial phase of our evaluability assessment of forensic mental health screening and evaluation. Its focus was on program identification, program description, and hypothesis generation. The selection of programs was much closer to what can described as theoretical sampling than to traditional statistical, representative sampling.

> Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges . . . The initial decisions are not based on a preconceived theoretical framework. (Glaser and Strauss, 1967, p. 45)

The initial focus was on projects funded by the Department of Justice relating to mental health services. The search for projects began with PROFILE printouts of all grants and subgrants awarded in the area of mental health services in recent years. The PROFILE system is a computerized database management system under the control of the Department of Justice. Printouts for individual projects identify grant informa- tion and usually provide a brief abstract of the proposed project.

PROFILE printouts described projects that received "block" grant awards since 1974 or "nonblock" awards since 1969. The listings reviewed were current as of October 19, 1979. Indicated as having received block funding (categorical funds passed to or through state agencies for criminal justice purposes) were 1,583 projects, which were given a total of $102,499,390 in grant monies. The nonblock awards (generally discretionary grants) printouts listed 101 projects, with grant monies totalling $16,843,957.

The procedures used to select projects for examination involved (1) identifying projects with PROFILE titles or summaries con- taining specified key words, and (2) excluding those projects falling into certain categories. Projects having titles or summaries containing at

least one word from each of the lists of key words appearing in Table 1 were initially identified. All projects apparently involving inmate classification or intake screening were also selected, whether or not the key word criterion was satisfied. Of those projects sampled on these bases, any project falling into one of the categories set out in Table 2 was excluded.

By this process, approximately 450 block-funded and 28 non-blockfunded projects were identified. In order to reduce the sample size to a manageable one, projects having received awards before 1977 were excluded from consideration. As a consequence, the sample was reduced to 153 projects, 149 with block awards and four with nonblock awards.

The use of key words and phrases in PROFILE project titles and project abstracts is an imprecise procedure for identifying mental health screening and evaluation projects. PROFILE information was compiled at the time of the grant award, and the project summary was abstracted from the grant application. In general, the information contained in PROFILE descriptions is quite meager, making selection and classification a difficult task. Relevant projects may be excluded, while irrelevant projects may be included. Since the goal of this effort, however, was not to provide a comprehensive survey of such projects but rather to draw a sample from which to define current practices, the initial sample was deemed sufficient with some sample editing. Relevant projects (including those not funded by the Department of Justice) were added to the survey sample when they were suggested by respondents during telephone interviews. These additions partially replaced those projects in the initial sample that were eliminated. By means of this field input, considerable flexibility was provided for eliminating initially selected but irrelevant projects and adding previously undiscovered, relevant ones.

Of the 153 projects initially satisfying the selection criteria, a total of 58 were subsequently excluded from the sample. Twenty exclusions were duplications in the PROFILE sample due to continuation funding; 10 projects were defunct; 25 projects performed no screening and evaluation or served primarily juveniles, alcohol or drug abuse programs, or were projects that appeared to fall into the exclusion categories (Table 2) only after more complete or accurate information was obtained about them; and repeated attempts to obtain information about 3 projects proved unsuccessful.

A total of 26 projects were subsequently added to the sample as a result of responses to telephone survey Question 14: "Do you know of any other criminal justice mental health screening and evaluation programs that seem particularly effective or that are particularly innovative?" The final sample thus consisted of 121 forensic evaluation projects of which 95 were selected from the PROFILE and 26 were added at the suggestion of survey respondents.

Introductory letters were sent to each of the 149 block grantees initially identified in the PROFILE sample in order to identify potential respondents to the survey. (The 4 nonblock grants were already identified

Table 1

Key Words Appearing in PROFILE Titles or Summaries

List A	List B
diagnosis	assessment
forensic	care
mental health	classification
psychiatric	counseling
psychological	court clinic
	evaluation
	placement
	procedure
	program
	referral
	screening
	services
	testing
	therapy
	transfer
	treatment

Table 2

Categories of Excluded Projects

(1)	juvenile justice projects
(2)	projects primarily concerned with education or screening of justice system employees (police, correctional officers, etc.) or other non-offenders (victims, witnesses, etc.)
(3)	projects primarily concerned with alcohol or drug abuse
(4)	projects involving medical screening only
(5)	exclusively research-oriented projects
(6)	primarily treatment-oriented projects (see Note)

Note: Unless the List A key word requirement was satisfied by the word "diagnosis"; or the List B key word requirement was satisfied by "screening," "evaluation," or "testing"; or the word "referral" was used with respect to the mental health aspect of the project (or it appeared that referral to mental health services was an aspect of the project).

by the name of a project director in the PROFILE and therefore did not require the identification of contact persons.) Each letter contained a summary of the goals of the evaluability assessment, a copy of the individual project's PROFILE entry describing the grant award, and a request that the name and telephone number of an individual capable and willing to answer a few questions about the identified project be supplied by return mail. A total of 103 contacts were identified in this manner as a result of two sequential mailings. The names of contacts for the balance of the projects were obtained by telephone search.

The questionnaire requested information about overall project objectives, target populations of the projects, descriptive data specific to screening and evaluation activities, and other supplementary information. Questionnaires were administered informally over the telephone by five interviewers during the period December 1979 through February 1980.

Results and Discussion

The results are presented under eight topics: 1) purposes; 2) stage(s) in the criminal justice process at which screening and evaluation take place; 3) facilities where screenings and evaluations are conducted; 4) caseload; 5) staff size and composition; 6) problems encountered by the project; 7) respondents' views toward innovation; and 8) program evaluation history of the project.

Respondents were asked whether any of seven categories of functions was a purpose of their projects and if so, whether the purpose represented a major or minor purpose. Table 3 summarizes responses to this question. The modal response was in the category of treatment; 105 respondents (87 percent) indicated that a purpose of their project was determining whether client-offenders needed "treatment" for mental health problems; 83 (69 percent) said that treatment was a major purpose. Approximately half of the respondents indicated that facilitating decisions concerning the use of pretrial diversion (47 percent), making input to sentencing decisions (52 percent), or screening for inmate classification and intake (47 percent) were purposes of their projects. About one-third indicated that their projects were aimed at determinations of competency (40 percent), determinations of criminal responsibility (32 percent), or facilitating parole decisions (31 percent). Other purposes indicated were determinations of fitness for vocational education programs, work release programs, examinations of offenders on probation, and post-release treatment referrals.

A comparison of the percentage of respondents reporting competency determinations (40 percent) as a major or minor purpose with the percentage reporting criminal responsibility (32 percent) is intriguing in light of the view that the issue of competency is far more important than criminal responsibility, at least insofar as the issue of competency is called into question more than ten times as often as the insanity defense is used in criminal proceedings (Laban, Kashgarian, Nessa, & Spencer, 1977; Morris & Hawkins, 1970; McGarry, 1971). However, the forensic evaluation for the defense of insanity tends to be more time

Table 3

Percentage of Mental Health Screening and Evaluation Units with Major and Minor Purposes in Various Function Categories

Category	Purpose		
	Major	Minor	Combined
Treatment	69	18	87
Sentencing	29	23	52
Prisoner Intake Screening	36	11	47
Pretrial Diversion	26	21	47
Competency	23	17	40
Criminal Responsibility	17	15	32
Parole	10	21	31
Other	7	8	17

N = 121

consuming and often involves courtroom testimony by mental health personnel (Laban et al., 1977).

Fifty-five (44 percent) of the projects can be characterized as comprehensive in that they were described as having at least five purposes (major and minor purposes combined) or at least three major purposes indicated in Table 3. Twenty-one (17 percent) had more than five purposes, either major or minor. An example of a comprehensive project is the Summit County Forensic Center in Akron, Ohio. This community forensic center provides comprehensive mental health screening and evaluation at various stages in the criminal justice process. The staff performs court-ordered evaluations for competency and insanity hearings, provides presentence reports, and advises the courts on probation and parole supervision. The center serves offenders incarcerated through the municipal and common pleas courts. Its staff of seven, mostly part-time psychiatrists, psychologists, and social workers, handles approximately 35 cases per month.

Screening and evaluation may occur for various reasons at any of several stages in the criminal justice process: before or during trial, between trial and final sentencing, after sentencing and upon first entering jail or prison, and during or after incarceration. Seventy-six of the units surveyed (63 percent) indicated activity at the pretrial stage; 59 (49 percent) provided input to the courts between trial and sentencing; and 67 (55 percent) were involved in general intake screening or inmate classification as offenders first entered jail or prison. Half of the projects conducted screening and evaluation during and/or after a prisoner's confinement in jail or prison: 61 (50 percent) respondents indicated that their programs involved mental health screening and evaluation during incarceration; and 15 projects (12 percent) conducted screening and evaluation at the probation and parole stages, including preparation of inmates for release or transfer to halfway houses.

Thirty projects (25 percent) indicated that they conducted forensic mental health screening and evaluation at all four stages, i.e., pretrial through incarceration. An additional 20 projects (17 percent) were active in three stages, i.e., pretrial, sentencing, and during imprisonment. Thirty-three projects (27 percent) conducted their work in only two stages of the criminal process, and 38 projects (31 percent) operated only at a single stage. Of those specialized projects with activities at only one stage in the criminal process, the majority operated at the pretrial or jail/ prison intake stage. These specialized projects tended to have a singular purpose such as determination of treatment alternatives, pretrial diversion, or job placement in the community after release.

If one restricts the earlier definition of "comprehensive" forensic units (i.e., five purposes, major and minor combined, or at least three major purposes) by excluding programs occurring in less than three stages of the criminal process, 34 (28 percent) programs qualify. Thus, a little more than one quarter of the projects surveyed are

comprehensive in that they conduct screening and evaluation for most purposes and involve client-offenders in several stages of the criminal process.

Forensic screening and evaluation are conducted in various locations: mental health institutions, court clinics, community-based correctional facilities or forensic units, community mental health centers, jails, and hospitals. Of a total of 121 projects surveyed, 84 projects (69 percent) conducted screening and evaluation in a single type of facility; 29 (24 percent) in two separate types; and 8 projects in three or more types of facilities. The most common places for screening and evaluation were local jails or detention centers, followed by state prisons and courts. Table 4 summarizes survey respondents' answers to the question of the facilities where most screening or evaluations for their project are conducted.

The relatively large percentage (28 percent) of responses in the "other" category of facilities (see Table 4) suggests a certain makeshift, non-standard character in the conduct of screening and evaluation conducted by many projects. Examples include probation department, city building, private offices of psychiatrist and psychologist, halfway house, "field office," special diagnostic and evaluation center, police building, scene of crisis, public defender's office, converted sorority house, and special project office.

Respondents were asked to indicate the average monthly caseload of the projects that they represented. The total monthly caseload of the 120 projects reporting this information was about 17,000. Figure 1 summarizes the monthly caseload of the surveyed projects as reported by the respondents. More than half of the surveyed units have an average monthly caseload of less than 50 client-offenders, with the modal response category being 0-25. Caseloads range from 3 to 4000 monthly, with a median of 40.

Caseload differences among programs can be understood in the context of debate among mental health personnel about the appropriate role of treatment versus screening and evaluation services provided by forensic units, assuming that treatment is generally more time and resource consuming than evaluation. According to Beran and Toomey (1979), some directors of forensic units in Ohio believe that treatment and evaluation are of equal importance, while others believe that while treatment is a legitimate activity it clearly takes a much lower priority than screening and evaluation services. Others simply believe that treatment has no place in community forensic units. The different views of the relative importance of screening and evaluation, as compared to treatment, may be reflected in the caseloads of two community forensic units described by Beran and Toomey (1979, p. 121): one center's caseload was reported as 50 percent screening and evaluation and 50 percent treatment, while another center's caseload was approximately 1 percent treatment over a 17-month period.

Table 4

Percentage of Projects Involving Forensic Mental Health Screening and Evaluation by Types and Number of Facilities Involved

Facility	N	Percentage
Type		
Court	19	16
Local Jail or Detention Center	71	59
State Correctional Facility	22	18
Community Clinic or Center	16	13
Hospital[a]	9	7
Other	34	28
Total[b]	171	
Number		
Single	84	69
Two	29	24
Three or More	8	7
Total	121	

[a]Including forensic units within hospitals.
[b]A project could operate in more than one facility; multiple responses possible.

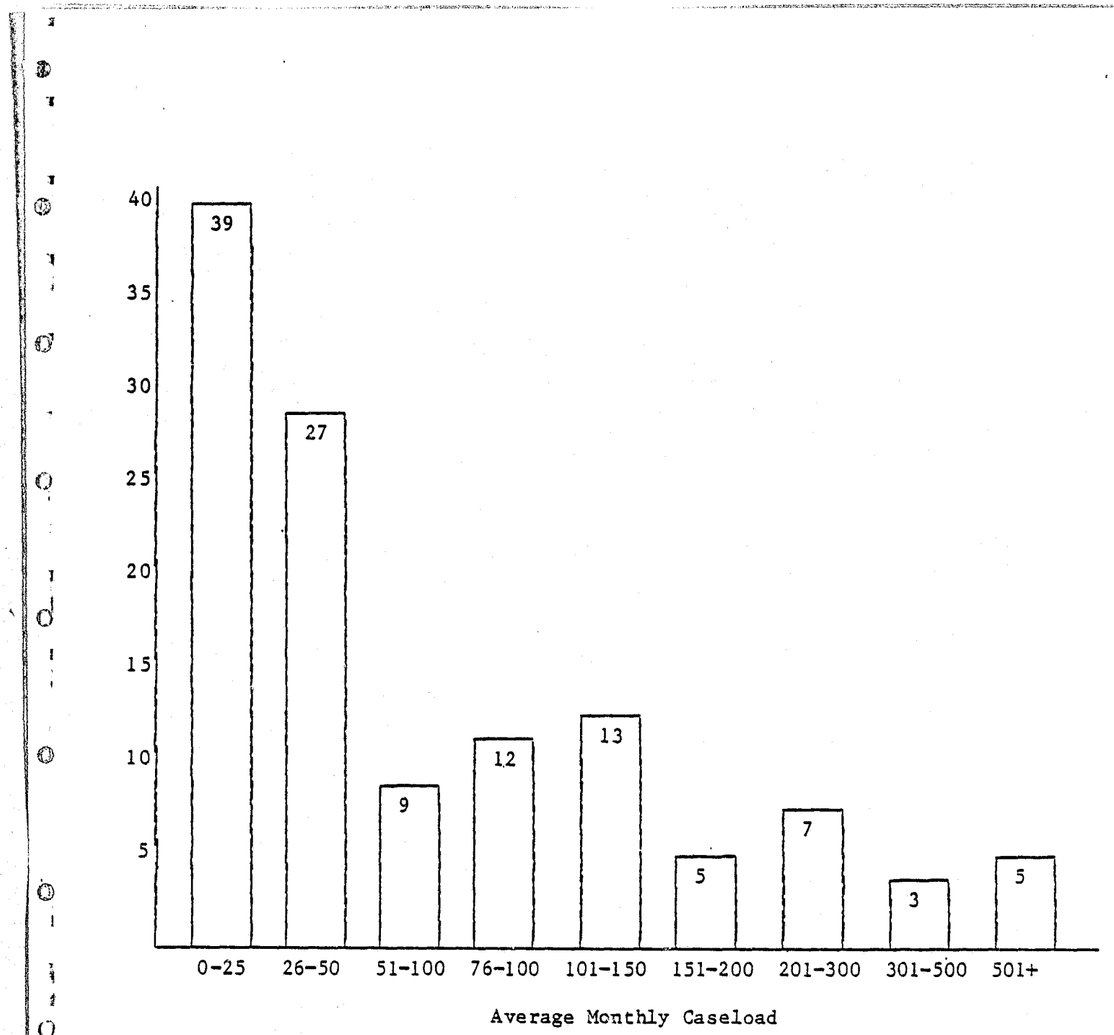

Figure 1. Distribution of monthly caseload of 120 forensic mental health screening and evaluation units.

No clear relationships between caseload size and project purpose, stages in the criminal process and facility type, seem evident. Even the expected relationship between caseload and staff size was not in evidence. An exception occurs in the projects handling extremely large caseloads. The profiles of the eight projects with the reportedly largest monthly caseload, where one might logically expect to see some similarities suggesting patterns of relationships, are displayed in Table 5. Several characteristics common to forensic units with large caseflows are suggested by this table: (1) they tend to be located in large metropolitan areas; (2) they tend to be housed in local jails or state prisons, facilities equipped to accommodate large numbers; (3) their major purposes are inmate screening and classification, treatment, or pretrial diversion; (4) most employ largely psychologists; and (5) they tend to have small staff-client ratios, suggesting only screening and cursory mental health evaluation.

The median staff size of the 121 projects surveyed was 4 persons engaged in screening and evaluation, with a range from the full- time equivalent of less than one staff member to a total of 50 staff members. Only 13 projects had staffs exceeding 15 individuals.

Psychiatrists, psychologists, and social workers were the three professional groups predominantly involved in conducting screenings and evaluations. Forty-six projects (38 percent) employed psychiatrists, 67 (55 percent) employed social workers, and 78 projects (64 percent) employed psychologists. Beyond these three professional groups, the list of personnel types is diverse, including persons with various titles: psychometric technician, counselor (with degree in political science), psychological intern, law enforcement officer, screener, case manager, probation officer, defense attorney, sheriff, treatment team member, behavioral clinician, educational coordinator, mental health nurse, diversion officer, priest, minister, college student, mental health specialist, vocational services counselor, human resource technician, chief of security, counseling therapist, rehabilitation officer, correctional officer, nurse, and attorney.

The staffing patterns of the six community forensic units described by Beran and Toomey (1979) suggest a similar diversity of backgrounds, experience, and disciplines:

> The directors of three centers, Butler, Dayton, and Toledo, possessed master's degrees in social work and the directors of the two other centers, Akron and Columbus, had master's degrees in psychology. The center in Cincinnati was administered by a clinical director with an M.D. and a clinical coordinator with a master's degree in social work. Staff size ranged from 20 to 7, with consultants and part-time employees comprising the majority of the personnel. Typically the full-time personnel were psychologists and social workers. Psychiatrists worked primarily on a consulting, part-time basis. (p. 122)

Table 5

Profiles of Forensic Mental Health Screening and Evaluation Projects with an Average Monthly Caseload of 300+ Client-Offenders

Project	Location	Caseload	Major Purposes	Criminal Process Stage	Facilities	Staff Size	Staff Composition
1	Chicago, IL	4000	inmate screening treatment	pretrial intake incarceration	local jail	10	psychologist psychiatrist social worker
2	Newark, NJ	1500	inmate screening treatment	intake incarceration	state prison	3	psychologist social worker other
3	Frankfort, KY	950	pretrial diversion	pretrial	local jail	3	diversion officer
4	Birmingham, AL	800	inmate screening treatment	pretrial intake	local jail	6	social worker
5	Atlanta, GA	580	sentencing inmate screening parole treatment	pretrial sentencing intake	court local jail state prison other	50	psychologist social worker behavioral specialist
6	Columbia, SC	400	inmate screening parole	intake	state prison	10	psychologist psychometric technician
7	Kansas City, MO	400	pretrial diversion inmate screening treatment	pretrial intake incarceration	local jail	5	psychiatrist intake screeners
8	Cleveland, OH	400	inmate screening treatment	intake	local jail	4	psychiatrist psychologist social worker

The survey was partly designed to provide initial information that might guide later research. Two questions answered by the respondents were particularly relevant: "In your opinion, what aspect of your program is especially noteworthy or unique with respect to screening and evaluation?" (Survey Question No. 11) and "What is the biggest problem, if any, that hinders the program's work?" (Survey Question No. 12). These were designed to draw out facets of the operations of screening and evaluation projects that may not be evident from the literature or other sources of background information. The questions were not, of course, intended to bring forth more than a small portion of the variables that must be considered in an evaluation design. As will be discussed below, one interesting finding, derived partly from responses to Question 11, is that the respondents typically conveyed little knowledge about innovations in the forensic mental health screening and evaluation.

Typically, respondents emphasized problems caused by people or events outside the control of program staff. The great majority of the problems mentioned were, in essence, lack of support of the program by others. Table 6 lists categories of responses and percentages of respondents providing answers in those categories.

It should be expected, perhaps, that the great majority of the problems mentioned are the result of outside forces and not of the programs' personnel. This suggests for evaluators the obvious warning that a participant is likely to stress failures for which he or she is not accountable. This is an important bias. On the other hand, it also suggests that the outside forces--especially adequacy of funding and cooperation by criminal justice officials--should be given considerable attention in an evaluation design. The effectiveness of a program may indeed be largely determined by the friendliness of its peculiar environment. A different environment--e.g., if the program were in another community--may mean a totally different evaluation result.

It is interesting that many respondents said their programs had problems dealing with criminal justice officials. Perhaps in the same vein, seven respondents (11 percent) indicating "noteworthy or unique" aspects of their programs (in answer to Question 11) mentioned efforts aimed at coordination of the program with criminal justice officials, and another five respondents mentioned the program's relationships with community resources. Hence, the problem of meshing operations of the mental health and criminal justice systems appears to be a major trouble spot, alongside the more publicized problem of meshing definitions of mental health defects.

Eleven (or 14 percent) of the respondents did mention problems not clearly outside the control of their programs. The most common, given by five, was dissatisfaction with staff quality. Four respondents stated that, for varying reasons, their programs had trouble conducting sufficiently comprehensive evaluations. That this is a major point is supported by the finding that, in response to Question 11, about half indicated that the comprehensiveness of evaluations or the evaluation procedures used was a noteworthy or unique aspect of their projects.

Table 6

Percentage of Respondents Indicating Problems in Various Program Areas

Problem	Percentage	
More resources needed		
Needs more funds	20	
Needs more staff	15	
Needs more space or facilities	11	
		46
Lack of cooperation or support from others (other than lack of resources given)		
Coordination or, usually, cooperation problems with police, jailors, and others with whom the program interacts	20	
General lack of community support for the program	9	
Problems caused because people outside the program control who gets placed in the program	8	
Delay problems caused by people outside the program	4	
		41
Other special problems caused by the program's environment		
Shortage of places to refer clients, including lack of community supporting services	6	
Travel problems--bringing clients to the program, or staff traveling to clients	5	
Other	8	
		19
Problems potentially under control of the program staff		14

Respondents generally conveyed little knowledge about new or innovative procedures for mental health screening and evaluation. This was indicated primarily in the answers to Survey Question 14, the "snowballing" question, designed to enlarge our sample. The question read: "Do you know any other criminal justice mental health screening and evaluation programs that seem particularly effective or that are particularly innovative?" Only 38 percent of the respondents were able to identify any programs; only 3 percent (four respondents) identified two projects and none mentioned more than two. Many of the references were vague--e.g., a nearby sheriff's office recently initiated a screening program in the local jail.

The answers to Question 14, moreover, suggest that the respondents are insular. Only two mentioned programs outside their own states, suggesting limited information about developments outside their jurisdiction.

Respondents were able to say little about innovative procedures in mental health screening and evaluation. The interpretation of this finding, however, is not clear at this early stage of the study. Perhaps there is little innovation in this area. This would be an important and startling finding. But a more likely interpretation, based on our initial impressions, is that respondents are not cognizant of work outside their sphere of activity. Illustrative is the fact that the programs identified in response to the snowballing question (Question 14) were almost always in-state programs. Another interpretation problem is that the respondents, typically project directors (and often directors of rather small projects) may have less contact with innovations elsewhere than many other officials involved in mental health screening and evaluation, especially psychiatrists (seldom project directors) and upper-level supervisors. Respondents' inability to mention new or innovative procedures (whether caused by lack of innovations or lack of knowledge by respondent) stands in marked contrast to the extreme problems and uncertainties in forensic mental health as described in the literature on the subject.

How should program evaluation of forensic mental health screening and evaluation projects be carried out? This is an essential question for our evaluability assessment. On the assumption that at least partial answers to this question may be found in the reports of completed program evaluation efforts, survey respondents were queried as to the availability of research or evaluation efforts focused on their projects' screening and evaluation efforts.

Of the 84 respondents answering the question of documentation of past evaluation efforts, 43 (51 percent) indicated that they were unaware of the availability of reports describing program evaluation results, this in spite of the mandate for program evaluation of federally funded project activities. (See, for example, Law Enforcement Assistance Administration, 1978.) Fifteen respondents (18 percent) indicated that a program evaluation had, indeed, been conducted but a written report of the results was, unfortunately, not available or easily accessible.

Using the criterion of a completed feedback loop between evaluator and decision makers, the lack of availability to program managers (the majority of survey respondents) of completed evaluation results is the functional equivalent of no program evaluation at all.

Twenty-six respondents (31 percent) indicated that their projects had been evaluated and that written reports of results were available. Reports related to 13 projects were obtained and reviewed. Four of the projects, located in Ohio, were described in a commercially published, widely disseminated evaluation report of a forensic mental health services delivery system in Ohio (Beran and Toomey, 1979). While only four respondents indicated their awareness of this volume and deemed it to be directly germane to program evaluation issues in their project, it has relevance to all 18 Ohio projects surveyed, since it addresses the entire statewide forensic services delivery system.

With the exception of Beran and Toomey, most of the evaluation reports seem to be part of a "fugitive" literature of program evaluation--literature created primarily in service to federal or state requirements for periodic reports under the topic headings of "program evaluation," "monitoring," or "progress reporting" (Breitmeyer, Note 3; Heaton, Note30; Larimer County Community Corrections, Note 5; Metropolitan Criminal Justice Planning Unit, Note 6; Messina, Note 7; Vera Institute of Justice, Note 8; Morgan, Note 9; Franzese, Note 10). Unfortunately, few of these reports seem to provide adequate answers to the question of how forensic screening and evaluation activities can be evaluated.

One such report (one of the more comprehensive ones) of an evaluation of a pretrial services project is illustrative and typical of the fugitive, limited-access literature that is uninspiring for the program evaluator of screening and evaluation projects (Heaton, Note 4). To its credit, the report is valuable in that it contains a description of the objectives of the project, a description of the initial screening interviews and the subsequent more intensive mental health evaluation, a flow chart of the court system served by the diversion project, and samples of forms used at various points in the project. But in terms of useful program evaluation information the report is disappointing. In the descriptions of the mental health evaluations, the utilization of five projective tests (Rorschach, the Thematic Apperception Test, the Bender Motor Gestalt Test, the Goldman Memory Test, and the Rotter Incomplete Sentence Test) and five objective tests (the WAIS, WISC, Beta Intelligence Test, the Competency Screening Test, and the MMPI) are discussed. Of 59 mental evaluations conducted during the first year of the project, 32 were complete mental evaluations utilizing both projective and subjective analysis, and 27 examinations utilized only the MMPI. We are not told what constitutes "complete" evaluation, nor what factors dictated the use of this type of assessment. In describing the underlying rationale and logic of the program evaluation methodology, an outcome sought in the conduct of mental health evaluations was the reduction of the time between arrest and trial. This measure of time or delay between arrest and trial is a potentially interesting standard measure of the effectiveness of screening and evaluation, a fact seemingly

not lost to the authors of the report. Unfortunately, no data are reported relating to this measure. Fifty-six persons were referred to community agencies to be treated during the first year of the project operation, and 36 received counseling from pretrial services personnel. The only evaluation data reported is user-satisfaction information. Twenty-two percent of the judges, district attorneys, probation officers, referral agencies, and other clients responding to the questionnaire reported that mental health evaluations were the most valuable aspect of the service provided by the project, competing with other options such as diversion, release with service, release on recognizance, and investigative services.

The reports documenting evaluation efforts were, on the whole, silent on issues of quality in the delivery of forensic mental health evaluation and screening, dealing primarily with program description comprising discussions of purposes, objectives, procedures, organizational structures, and enrollment figures. Outcome measures discussed were on the broad program level rather than on procedures of screening and evaluation--the focus of the present effort. For example, in his evaluation of a pretrial intervention program in Florida, involving screening of offenders, Messina determined the program's impact on diverting adult defendants from the criminal justice system by assessing the overall percentage of participants who were unsuccessful in completing the program due to rearrest or noncompliance with program rules (Messina, Note 7). A comparison of the program's criteria for selection of participants with those of other pretrial programs concluded that no two programs appear to have identical criteria. Interestingly, when specific measures for evaluating forensic mental health personnel activities were recommended, it was done in the context of an "evaluability assessment"--not an accomplished program evaluation--of a detention-rehabilitation program (Breitmeyer, Note 3).

The most comprehensive (and most effective) program evaluation of forensic mental health services was conducted from 1972 to 1975 by the Ohio State University Program for the Study of Crime and Delinquency. This effort, involving the evaluation of six of the earliest established community forensic evaluation treatment centers of Ohio (i.e., those in Akron, Cincinnati, Columbus, Dayton, Hamilton [Butler County], and Toledo), resulted in the writing of eight monographs, the last of which, representing an analysis of the total state forensic services delivery system, was widely disseminated throughout Ohio to decision makers within the mental health and criminal justice system. This program evaluation effort in Ohio has been further described and placed in a national context by Beran and Toomey (1979). Their volume is a notable exception to the evaluation reports of surveyed projects that were reviewed, in that it directly addresses program evaluation issues.

The purpose of the Ohio evaluation project was to compare the services provided in the various community forensic centers with those of each other and with those services previously arranged with the centralized forensic units within the state institution. Evaluation research questions, relevant to this discussion, were the following:

- Who referred clients to the centers, what kinds of clients were being served, and how did they differ from those served in the institutional setting?
- What professional staff were involved in the variety of diagnostic and treatment services? Was there an optimal mix of disciplines for meeting services needs?
- What were the qualifications of staff members?
- What were the costs and benefits of using community rather than institutional settings for evaluations?
- What coordination and cooperation were necessary to facilitate the most efficient operation of the total forensic system? (Beran and Toomey, 1979, p. 112)

The above questions were addressed comprehensively by the Ohio evaluation project. Multiple measurements were made for and about various groups, including clients, consultants, referral agents, and administrators. A comparative descriptive design guided the acquisition of objective data on clients (i.e., demographic characteristics, charges, current court status, previous record, previous mental health involvement, referral source, referral reason, types of evaluations performed, recommendation of evaluator, and court disposition), attitudinal data from mental health personnel, judges, probation and parole officers, and systems data (e.g., costs, staff size and composition, and length of time for processing clients). Beran and Toomey summarize the findings of the Ohio evaluation project which support the development of community-based programs for disordered offenders:

> The findings presented clearly indicate that the anticipated benefits of forensic psychiatric centers . . . are in large measure being realized by the centers in Akron, Butler County, Cincinnati, Columbus, Dayton, and Toledo. The caseload sizes of significantly greater proportions than served by LSH [Lima State Hospital] prior to the centers' openings are clear testimony that the centers are supplementing the evaluation and treatment services of LSH, lightening LSH's caseload from the counties served by the centers, and preventing the institutionalization of some individuals and thus the disruptive influence on the client, his family, and the community of such institutionalization, not to mention the easing of the reintegration problem. Cost analyses demonstrated that the centers negate a sizable proportion of costs incumbent upon institutionalization at LSH. Generally speaking, the centers are providing not only evaluations, recommendations, treatment, and emergency intervention services, but also consultation and education services for local criminal justice system

> agents. The centers are performing Ascherman [post-conviction examination to determine whether an offender is mentally ill, mentally retarded, or psychopathic] and competency/sanity evaluations in significantly shorter spans of time than typical of LSH, and the periods between referral and admission and release and court disposition are also much shorter for the centers. Given all this, it is not too surprising that most criminal justice system referral agents strongly endorse the centers and describe them as quite superior to LSH. (pp. 139-140, text in brackets added)

In spite of the relatively comprehensive nature of the Ohio evaluation effort, the former associate director of the Ohio project states that "[t]here appears to be no satisfactory objective way to address quality issues in the FPSDS (forensic psychiatric service delivery system), given the current state of research in the mental health and criminal justice fields" (Carlson, 1979, p. 170). Carlson's statement reinforces a basic premise of the present evaluability assessment of forensic mental health evaluation and screening throughout the country, as well as impressions drawn from the dearth of documented program evaluation efforts gleaned from the telephone survey: namely, that the current state-of-the-art in program evaluation has not yet advanced to a level where large-scale program evaluation seems sensible; that standard measures of program quality are yet to be identified, developed, and communicated; and that such measures must yet be placed in the context of viable measurement and program evaluation systems. In short, program evaluation models for forensic mental health evaluation and screening remain to be developed and demonstrated.

Conclusions

Growing out of the operational definition and framework of inquiry described in the previous chapter and the programs analysis presented in this chapter is something of a forensic programs typology, or more modestly stated, a categorization of forensic mental health programs. A number of characteristics of forensic programs might be considered elements in such a categorization, such as the stated purposes of the program; the reasons for referral of client-offenders to the program; the criminal justice agencies that are served by the program; the stages in the criminal process at which the program is active; the type of facility in which the program is located; staff size and composition; caseload; governing statutes; and resident population. Yet the development of typologies based on these sorts of unidimensional characteristics seems fraught with problems. For example, a typology based on client-offender populations may be quite fragile because of the difficulty one encounters in defining, dividing up, and managing the deviant population. There is significant controversy about whether to maintain separate facilities for "mental patients," "criminals," and those who may be identified by both labels. One study committee, for example, has proposed that defendants found to be incompetent should be treated as would any patient in civil proceedings (Brakel and Rock, 1971, p. 416).

Another set of characteristics that might form the basis for a categorization of forensic mental health screening and evaluation programs relates to the basic elements of the forensic service delivery system. The forensic service delivery system generally consists of five elements (cf. Carlson, 1979): centralized state institutions, local and state corrections agencies, court clinics, community-based mental health centers, and civil mental health institutions and training schools.

Perhaps the oldest element of the forensic mental health service delivery system is the centralized institution. This type of forensic unit, a maximum security, inpatient facility located within a prison or hospital for the criminally insane, typically serves an entire state or region. Client-offenders for whom mental health services are required may have to travel long distances and be hospitalized for weeks or months for relatively simple procedures such as evaluations to assess competency to stand trial. Lima State Hospital in Ohio and Central State Hospital in Virginia are examples of centralized forensic mental health evaluation units. Centralized facilities generally have two main purposes. First, they serve as institutions of custody for "criminally insane" offenders (including those persons found incompetent to stand trial, persons committed under some psychopath statute, and those committed after being found not guilty by reason of insanity). Second, they serve as centers for the screening and evaluation of offenders (cf. Carlson, 1979).

There are strong national trends moving towards community-based services as an alternative to institutionalization for most human service needs. Forensic mental health screening and evaluation is no exception to this trend. For example, in 1971 Ohio established its first community forensic center; by early 1974, six state-supported centers were in operation; and, as of August 1978, Ohio had established 16 community forensic centers across the state (Roth, 1979). State legislation designates the community centers, rather than a central facility, as the setting for court-ordered mental health evaluations for competency and criminal responsibility. Some states plan to phase out central institutional facilities entirely and develop smaller forensic centers on the grounds of existing state civil hospitals and training schools for the retarded (Roth, 1978; Petrila, 1980).

State and local corrections agencies also may conduct forensic mental health screening and evaluations. These decentralized programs typically differ from the centralized institutional programs in terms of comprehensiveness of purpose, reasons for referral, type of client-offender (i.e., mentally ill, mentally retarded, or psychopathic offender), and caseload. They differ from the community-based forensic centers in terms of security, caseload, and type of offender.

The final element in the forensic mental health delivery system is the court clinic. Court clinics generally are located within the environment of a courthouse and thus are community-based, but they differ from the four other elements with respect to the stage in the criminal justice process at which their work is focused (usually almost entirely pretrial) and the thoroughness of their forensic examination (some only

screen offenders to determine whether or not further evaluation may be necessary). As late as 1966, a national survey by Guttmacher (cited in Beran and Toomey, 1979, p. 109) identified only 27 court clinics in the entire United States. By 1974, a single state, Massachusetts, had 30 such clinics in operation (Lipsitt, 1974, cited in Beran and Toomey, 1979, p. 110).

A tentative typology based on the primary elements of a forensic mental health delivery system--court clinics, civil institutions, local and state corrections agencies, community-based mental health centers, and centralized institutions--has several advantages. It is ordered along a practical dimension with centralization of services on one end and decentralization on the other. It is grounded in political and administrative reality. The discrimination within basic types can easily be sharpened; and a program evaluation approach based on the logical components of the examination process--delineation, acquisition, and provision--enriched by subdividing them according to purposes, reasons for referral, stages of use, caseload, staff size, and staff type, is quite feasible. Similarly, the differences between types can be highlighted by ordering the types according to such primary functions as information- generation, decision-making, custody, and treatment (cf. Carlson, 1979).

A final advantage, for the evaluation, of a tentative typology of forensic programs based on the primary elements of the forensic service delivery system is that such a typology is consistent with the procedural emphasis of program evaluation. Themes and issues in the interaction of the mental health system and criminal justice systems seem to be too fluid and complex and may be partly to blame for the grossly inadequate communication among various sectors of these systems (see Beran and Toomey, 1979, p. 178). A typology based on the delivery system--apart from themes, issues, and even purposes and aims--may not entirely avoid complexity, but it should at least provide a common lexicon, grounded in procedure, capable of facilitating program evaluation in the area of forensic mental health screening and evaluation.

In Part II of this book, which we will turn to next, twenty forensic mental health programs are grouped according to the typology described above. Although there were clear disadvantages to this typology (as we will see) the advantages outlined above clearly outweighed the disadvantages.

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PART II

THE PRACTICE OF FORENSIC MENTAL HEALTH SCREENING AND EVALUATION

The issues, definitions, framework of inquiry, and categorization of forensic programs described in Part I of the book, set the stage for the detailing of practice. Part II of the book describes the in-depth study of 20 forensic facilities in 17 states and the District of Columbia which was conducted in the second phase of our evaluability assessment. Although no systematic attempt was made to sample programs representative of the population of forensic programs, or the subset which we surveyed by telephone (see Chapter 3), a number of loose criteria were considered and applied to the selection of the 20 in-depth study sites. The majority of these criteria were drawn directly from the results of the telephone survey or stimulated by them. However, as was the case in the sample of the telephone survey, the criteria were not based on any preconceived theoretical framework. Specifically, the 20 sites were selected from the 121 programs identified in the telephone survey in consideration of the following broad criteria:

(1) Comprehensiveness: Programs that satisfied this criteria were those that involved forensic mental health screening for various legal purposes at a number of points in the criminal proceedings.

(2) Specialization: Programs that are restricted to a particular psycholegal purpose, a specific stage in the criminal process, or to a particular referral source.

(3) Academic Affiliation.

(4) Longevity: Programs that have been in existence for some time.

(5) Microcosm: Programs in small states that can be readily studied as a microcosm (e.g., programs in Alaska, Hawaii, and, perhaps, Arizona).

(6) Representation of Key States: Programs in states particularly active or innovative in their mental health laws.

(7) Representation of Metropolitan Areas.

(8) Innovativeness: Programs that represent particularly new developments.

(9) Representation of Nontraditional Staff: Programs that utilize mental health personnel deviating from the traditional disciplines (i.e., psychiatry, psychology, and social work).

(10) Centralization: Programs involving forensic examination of client-offenders from a broad geographical area, perhaps an entire state.

(11) Proximity to the Community: Decentralized, noninstitutional programs in the community.

Twenty-eight programs were identified that generally satisfied these criteria, including five that were highly recommended by project consultants but were not represented in the telephone survey. Letters of initiation, followed by telephone calls, were sent to key persons at the site. The original list was subsequently reduced to 20 programs where cooperation for in-depth study was assured.

The in-depth study design called for on-site interviews with various program role representatives: administrator, director, or coordinator, examiner, "screener," referral agent, and various support staff (see the definitions of "mental health personnel" and "criminal justice authorities" in Chapter 2). When permitted, personal interviews with client-offenders, and case conferences were observed. Relevant documents, reports, and forms were studied. Typically, two or three days were spent on-site followed by several telephone calls and an exchange of written communications.

The five chapters in Part II describe program representatives in each of the five categories in a forensic mental health delivery system--court clinics, jails, community and regional forensic mental health centers, centralized forensic mental health facilities, and community corrections (see Chapter 3). Each of the twenty forensic mental health programs profiled in Part II conform generally to the framework of inquiry--i.e., delineation, acquisition, and provision--outlined in Chapter 2. Each program is described in general accordance with the following outline:

- Brief Description of Program
  - History
  - Description of Host Court or Agency
  - Goal and Objectives of Program
    - Clientele
    - Purposes
    - Stages in Criminal Process
- Case Process Flow
  - Diagram
  - Text
- Delineation of Mental Health Information Requirements
  - Referral Sources, Agencies, and Agents
  - Referral Mechanisms
  - Referral Instruments
- Acquisition of Mental Health Information
  - Staff
  - Procedures and Techniques
    - Admissions
    - Interviews
    - Social History
    - Psychological Testing
    - Case Conferences
    - Report Preparation
  - Data Gathering Instruments
- Provision and Use of Mental Health Information
  - Reporting Source, Agencies, and Agents
  - Mechanisms
    - Reporting Instruments
    - Timing
  - Target Audiences
  - Use in Decision Making
- Feedback, Monitoring, and Program Evaluation

Chapter 4

COURT CLINICS

This chapter describes one type of arrangement between the criminal justice system and the mental health system--the court clinic. The most significant and substantial portions are the descriptions of five such court clinics: the Medical Office of the Supreme Bench of Baltimore (Maryland), the Cambridge (Massachusetts) Court Clinic, the Forensic Psychiatry Clinic (New York City), the Pima County (Arizona) Court Clinic, and the Court's Diagnostic Clinic (Hartford, Connecticut).

In a number of jurisdictions throughout the country, mental health questions of immediate concern to the court are referred to outpatient mental health clinics located in or near courthouses and designed to serve exclusively the courts and their agencies. The first known survey of court clinics in the United States was conducted in 1966 by Manfred S. Guttmacher (Guttmacher, 1966). Guttmacher, a psychiatrist and director of the Medical Service of the Supreme Bench of Baltimore (described later in this chapter) from 1930 to 1966, identified 30 psychiatric clinics of varying descriptions serving adult criminal courts throughout the country. The responses to another survey taken in 1970 of community mental health clinics in the United States indicated 53 court clinics in ten states and the District of Columbia; 21 were in Massachusetts; 12 in New York; 5 in California; 3 each in Maryland, Missouri, and Ohio; 2 in Pennsylvania; and one each in Florida, Hawaii, Utah, and the District of Columbia (McGarry, 1980). Many more such clinics are probably operating today. By 1974, Massachusetts alone had 30 court clinics in operation (Lipsitt, 1974, cited in Beran and Toomey, 1979, p. 110). Only two of the clinics profiled in this chapter appeared in Guttmacher's original survey. One forensic mental health facility identified as a court clinic by Guttmacher, the San Mateo County Courts and Corrections Unit, was studied by project staff but not described as a court clinic because it seemed to be functioning today more as a community forensic mental health center not primarily aligned with courts. (A description of the San Mateo program appears in Chapter 6.)

Jonas Robitscher, a psychiatrist, characterized court clinics as "groups of psychiatrists, psychologists and other professionals attached to trial courts to provide advice on medical issues in the cases being tried" (Robitscher and Williams, 1977). Court clinics differ in their organization and operation. Some are funded totally by the court systems which they serve; others are allied with courts but receive only a portion of their funds from the courts; still others are agencies of local or state departments of mental health. Some provide relatively extensive evaluative services, and a few provide limited treatment for criminal defendants, witnesses, and their families; others still are designed merely to provide advisory opinions on specific mental health questions for judges and other court personnel. Court clinics can be differentiated on the basis of caseload, sources of referral (e.g., courts, probation departments, and police), time of referral (e.g.,

pretrial, at sentencing, or postconviction), staff, budget, type of reporting mechanisms (testimony and written reports), treatment options, data collection methods, and many other factors (cf. Guttmacher, 1966, Table 1).

In this chapter, the described forensic mental health programs are referred to as court clinics; however, this classification is tenuous at best. Several of these programs are, in many ways, like other programs examined by project staff and classified differently (e.g., community forensic mental health centers, jail services, inpatient mental hospitals, usually with security facilities, and community corrections programs). The characteristic best distinguishing court clinics from other types of facilities where forensic mental health is practiced seems to be their setting within, or within close proximity of, a courthouse. But this characteristic does not distinguish court clinics from other forensic programs in all cases--the Wyandotte County (Kansas) Pretrial Services Project, for example, is located in the county courthouse and performs many of the functions performed by court clinics. Perhaps the feature that most clearly distinguishes these programs from the others are the words "clinic" or "court" in their names.

The primary function of most court clinics is to examine criminal defendants and render opinions regarding competency to stand trial, suitability for pretrial release, and the psychosocial condition of the client-offender (bearing on sentencing and probation decisions). With regard to certain forensic questions (e.g., competency to stand trial), some clinics perform a threshold screening function, advising the court whether the question merits further evaluation (perhaps more prolonged evaluation in a hospital setting); other clinics are authorized to conduct thorough evaluations and address ultimate mental health-legal questions. Virtually every court clinic works closely with area psychiatric hospitals, and most recommend in-patient evaluation of difficult cases.

The staff of a typical court clinic consists of a core group of full-time mental health professionals (including psychiatrists, psychologists, and social workers) and support personnel and any number of part-time, consulting psychiatrists and psychologists. Some clinics have large, full-time staffs well coordinated as a team, while others rely heavily on consultants who function relatively independently.

Although the process by which mental health information is acquired varies from clinic to clinic, most clinics rely upon the clinical interview as the primary means for assessing the mental state of client-offenders. Most court clinics compile background information about the defendant, conduct clinical interviews, and perform psychological testing, the latter including objective tests of intelligence and subjective personality inventories. Neurological testing and other more extensive procedures generally are typically performed on a referral basis in area hospitals.

THE MEDICAL SERVICE OF THE SUPREME BENCH OF BALTIMORE CITY

The Medical Office of the Supreme Bench of Baltimore City (SBMS) was instituted in 1920 to provide psychiatric evaluations to the judges of the Supreme Bench of Baltimore City at various stages of the court proceedings. The SBMS is a department of the Supreme Bench, supported by city taxpayers, and its services are reserved solely for city judges. The Chief Medical Officer of SBMS reports to the Chief Judge of the Supreme Bench. The Supreme Bench of Baltimore City is the Eighth Judicial Circuit of the Maryland Circuit Court. The Eighth Judicial Circuit consists of the Supreme Bench of Baltimore City, which includes the Superior Court of Baltimore City, the Court of Common Pleas, the Baltimore City Court, the Circuit Court of Baltimore and the Criminal Court of Baltimore. Baltimore City judges serve these courts on a rotating basis. Judges are elected by the voters of Baltimore. The Circuit Court is the court of general, unlimited trial jurisdiction in Maryland.

From 1918 to 1930 John Rathbone Oliver served as the chief medical officer of the Supreme Bench of Baltimore City, initially as a friend of the judges, performing without compensation "mental examinations" consisting primarily of intelligence testing of delinquents; then as "a bailiff, acting as 'psychiatrist to the court'"; and finally, as official head of the Medical Service of the Supreme Bench of Baltimore City (Oliver, 1929).

> [I]n founding it, we laid down certain lines of development that have been of the utmost importance. Hitherto, in other cities, like Boston and Chicago, the court clinics, so called, had been devoting their entire time to the mental examination of the cases referred to them. They were mental clinics and nothing else. In Baltimore, we wanted our clinic to be a medical service and to cover the whole domain of legal medicine. We planned to examine footprints and blood stains; for, even though I had no money for microscopes, I was still a member of the Out-Patient Staff of the Phipps Clinic, and I had its marvelous laboratories at my disposal. We determined also not to restrict ourselves to mental tests and examinations. Every patient that came to us for a mental test must be physically examined also. Whatever his or her handicaps might be, mental or physical, it was our business to discover them and to make them known to the court.
>
> In fact, our ideal was, in a sense, a social one. Our service was to give the destitute offender as well as the delinquent of moderate means the same opportunities before the court that had hitherto been the privileges of the rich. The accused who has money can pay a physician to examine him and to come into court to testify to his mental or physical condition. The poor man cannot afford this, and so his real condition often remains unknown to the court. We intended that in Baltimore, so far as in us lay, the poor offender should have the same chance as the rich to make his physical or mental handicaps known to his judges (p. 18).

Oliver, who achieved wide prominence as a psychiatrist, prolific author, lecturer, priest, and criminologist, was succeeded as chief medical officer by Manfred Guttmacher. Guttmacher, a psychiatrist trained at Johns Hopkins, headed SBMS from 1930 to 1966, expanding its operation from mentally deficiency and bastardy, to issues of criminal responsibility and competency. Guttmacher was an internationally eminent forensic psychiatrist; he was involved in several controversial cases (cf. Bromberg, 1979, pp. 124-141), wrote textbooks (e.g., Guttmacher and Weihofen, 1952), and drafted standards for courts and legislatures (cf. Guttmacher, 1955; Note 1). After his death in 1966, this tradition of national and international leadership in forensic psychiatry by the Chief Medical Officer of SBMS was continued when the court employed Jonas R. Rappeport in 1967, who has maintained that position until the present.

The SBMS provides consultative psychiatric evaluations to the Supreme Bench of Baltimore City (the Eighth Judicial Circuit Court), the Maryland District Court Number 1 (the District Court is a court of limited jurisdiction and includes the City of Baltimore), and the Federal District Court. SBMS makes treatment recommendations and referrals but conducts no treatment on its own. Evaluations performed at the request of Supreme Bench judges are financed as part of the Supreme Bench budget. Evaluations requested by the other referral courts are conducted by SBMS on a fee basis of $225 per evaluation. SBMS performs three types of basic evaluations: pretrial, presentence, and post-sentence. It also conducts evaluations in some civil cases, such as complex custody disputes.

Pretrial evaluations typically involve questions of NGRI (not guilty by reason of insanity), dangerousness, or incompetency and result in pretrial reports or consultations with judges. Presentence evaluations represent the major work of SBMS, assisting judges to make appropriate dispositions. Post-sentence evaluations are requested when a judge wishes to consider a change in sentence, to alter conditions of probation, or to consider feasibility of a referral to an institution. Probation officers, with the judge's approval, may also request post-sentence evaluations.

A separate component of SBMS, the Pretrial Screening Services Program, performs pretrial competency screening solely for the District Court of Maryland Number 1 (Baltimore City). Although located within SBMS and administered by SBMS, this program functions as an agent of the Maryland Department of Health and Mental Hygiene. It differs from the SBMS evaluation procedures in its scope of referral sources (i.e., it serves only the District Court of Maryland Number 1), initiation and coordination of referrals (e.g., referrals are initiated by a commitment order to the Department of Health and Mental Hygiene for the purpose of competency evaluation), and reporting mechanisms. This chapter will exclude a description of the Pretrial Screening Services Program (see Note 2 for a description of procedures of this unit).

The professional staff of SBMS includes psychiatrists, psychologists, and social workers supported by administrative and clerical staff. In 1979, a total of 1,101 cases were referred to SBMS, a figure

comparable to that referred in the three previous years; 81 percent of the referrals in 1979 were from the Supreme Bench of Baltimore, and 18 percent from the District Court of Maryland Number 1.

A Function Model

Figures 2-4 capture the flow of cases, operations, choice points and processes in the evaluation of accused individuals in the SBMS, for all the basic evaluations performed by SBMS. Figure 2 presents events before the accused individual's entrance into SBMS, and the activities and events involved in the delineation of the information sought about the individual case. Figure 3 shows the process of acquisition of the mental health information about the accused individual. Finally, Figure 4 shows the provision of information to those requesting it. This function model of SBMS simplifies a complex evaluation process; it represents a conceptualization, hopefully sufficiently simple enough to allow later validation of elements and relationships represented, yet sufficiently complex to persuade knowledgeable people that it is a close approximation of reality.

Figure 2 illustrates the process of delineation, how a defendant comes to be seen by SBMS and how prior information is readied to prepare for the evaluation. The initial decision to involve mental health professionals in a case is made by a judge in a referral court for SBMS, i.e., the Supreme Bench of Baltimore City, the District Court of Maryland Number 1, and the Federal District Court. A request takes the form of a referral form submitted by a judge or a telephone call by a judge to the Medical Administrator of SBMS. The referral form or the telephone call establish why the case is being referred to SBMS for evaluation. Once a referral form has been received by SBMS, procedures to prepare the case are implemented, including a check of whether the defendant or accused individual has been evaluated by SBMS before and the gathering of indictment folders, offense reports, and prior arrest records. The case is scheduled to accommodate a 30-day time limit from the receipt of the referral to provision of the final evaluative report. The Criminal Assignment Office of the Supreme Bench automatically schedules a case thirty-five days from the day of referral to provide the judge five days to study the report. Once the case has been prepared and scheduled, it is assigned to a staff psychiatrist.

Figure 3 depicts essential operations and events wherein SBMS acquires evaluative information about the defendant. This acquisition of information directly from the defendant begins with a clinical interview of the individual by a staff psychiatrist who has at his disposal all case materials and other information sought by the courts. The psychiatrist's clinical interview typically consists of a face-to-face session with the defendant in which mental status is assessed and a clinical decision is reached. Such evaluations range in duration, but rarely exceed two hours. Approximately one-third of the cases referred to SBMS require no further case data acquisition beyond the psychiatric interview.

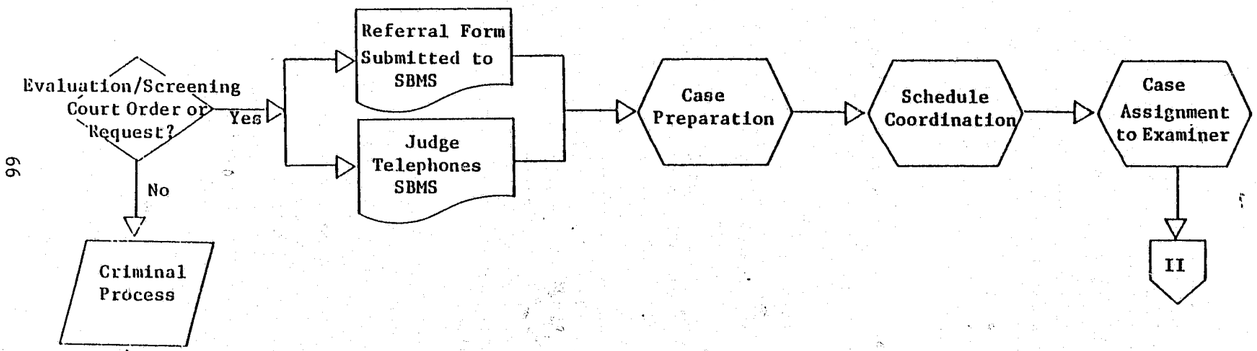


Figure 2. Case processing function model of the Medical Service of the Supreme Bench of Baltimore: Delineation of Evaluation Information.

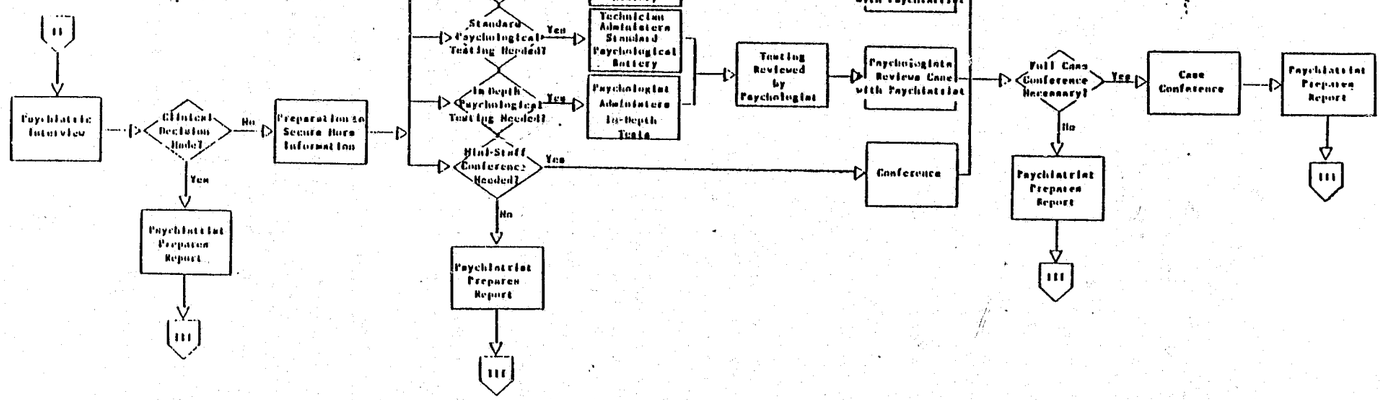


Figure 3. Case processing function model of the Medical Service of the Supreme Bench of Baltimore: Acquisition of Case Information.

If a clinical decision is not reached at this stage, preparations are made to secure additional information, including the social history of the defendant, standard psychological test results, and responses to projective psychological instruments. Also, the counsel of other professional staff in SBMS may be sought by the psychiatrist assigned to the case. If the psychiatrist still feels that there are insufficient grounds upon which to base a clinical decision, a case conference is held. Following the conference, a report is written, thus completing the process of acquisition of case information.

Clearly, Figure 3 is a simplification of a process to which there are exceptions, such as in controversial cases that may require much more dialogue between SBMS and the judges, or in cases involving sexual offenses in which clinical decisions always follow the full process depicted in Figure 3. Further, Figure 3 suggests a formality and, perhaps, inflexibility that are not the norm.

The final phase of the SBMS forensic screening and evaluation, the provision of the case information to judges is depicted in Figure 4. The findings of the evaluation conducted by SBMS are transmitted in a written report to the judge who originally referred the case. The SBMS reports address the specific issues raised (e.g., competency and criminal responsibility); make specific recommendations (e.g., defendant is competent but not responsible; defendant is dangerous; defendant is amenable to treatment); present the bases of the recommendations (psychological, social, medical, and legal history; diagnosis); and include relevant facts of the case (case name, charge, referring judge and court, examination date and examiner[s]). Reports are typically no longer than three pages, written and signed by the examining psychiatrist or physician (e.g., in cases of electroencephalogram examination), and usually are not appended by supporting documents. The judge receives three copies of the report and distributes copies as he sees fit. If more information on the case is requested, or if clarification is needed, the judge calls the medical administrator.

Once the judge has reviewed the report and has made any necessary informal follow-up contact with SBMS, the case exits the forensic mental health system of SBMS.

Delineation of Mental Health Information Requirements

When an arrest takes place within the jurisdictions of the referral courts for SBMS, the defendant is taken to a police station in the district where the alleged crime took place. There the defendant is booked and processed, informed of the charges, and notified of the right to counsel. A preliminary trial date is set initially in arraignment in the District Court (District Court of Maryland Number 1). The defendant is released on bail or on his own recognizance, incarcerated in the Baltimore jail without bail having been set, or incarcerated in the Baltimore jail in lieu of posting bail.

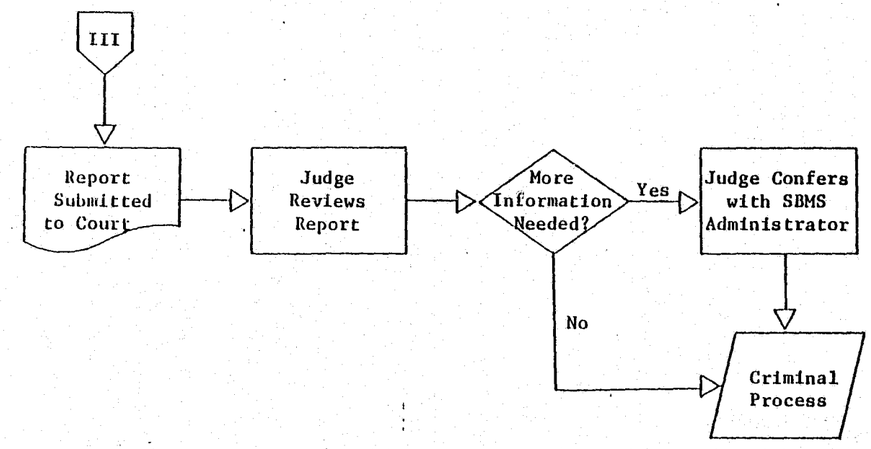


Figure 4. Case processing function model of the Medical Service of the Supreme Bench of Baltimore: Provision of Evaluation Information.

Various pretrial issues are addressed at this stage in the District Court: criminal responsibility (NGRI), competency to stand trial, determination of jurisdiction, assurance of proper counsel, continuances, motions, and requests for jury trials. The pretrial issues of competency and criminal responsibility are addressed by the District Court by having the defendant sent to a regional hospital, or by making a request for evaluation to SBMS if (1) the defendant is a juvenile or (2) the alleged crime is punishable by more than three years of imprisonment. If the defendant was originally charged with a felony, the case is sent directly to the Supreme Bench of Baltimore (the court of general jurisdiction) after processing at the District Court. After Supreme Bench arraignment, pretrial mental health issues may again result in a request to SBMS for evaluation of the defendant. Defendants may also be referred by judges of the referral courts for SBMS when the court has a concern during the trial proceedings that the defendant has mental deficiencies.

Formal delineation of mental health information requirements with regard to issues of competency and criminal responsibility is provided by Maryland statute. Relevant sections of Maryland law (Maryland Annotated Code Article 59, Sections 23-28) as it applies to competency, criminal responsibility, judicial release, copies of important cases dealing with these issues, and a U.S. attorney's paper on these issues are contained in an operations manual available to SBMS staff (see Note 2.).

The types of evaluations referred to SBMS are delineated in detail in the procedural manual of SBMS (An Overview of the Medical Office, Revised May 24, 1979; see Note 2, pp. 1-2):

Pretrial: These referrals involve two types of cases: (1) determination of bail risk (habeas corpus); and (2) cases in which the court has agreed to allow SBMS to do a full pretrial evaluation in order to answer the questions of competence to stand trial or responsibility at the time of the crime.

Presentence: These cases represent the major work of SBMS. The goal is to assist judges in making appropriate dispositions. Each report includes a lengthy social, medical, and legal history. If called for by the psychiatrist, psychological tests and social work interviews are also included. The report further includes a summary and recommendations, hopefully as realistic and meaningful as staff is able to accomplish. SBMS attempts to answer the court's requests, as well as give impressions of the individual's dangerousness, amenability to treatment, and facilities that might offer such treatment.

Post-Sentence: Such requests usually occur when the judge wishes to consider a change in sentence within the allowable period of time, or to alter conditions of probation, or to consider feasibility of a referral to Patuxent Institution. Probation Officers, with the judge's approval, may also request a post-sentence evaluation if such an evaluation seems warranted. These reports are of the same depth as presentence reports.

Record Reviews: On occasion a judge may request a review of hospital reports (medical or psychiatric) in order to interpret certain statements or decide whether other evaluations are indicated. In reports, SBMS usually only answers the specific questions asked by the court.

Emergency: These cases usually require an immediate visit to either the courtroom, Baltimore city jail lock-up in the courthouse, or the sheriff's lock-up. They may range from a psychiatric emergency to a physical problem that requires medical attention. Such evaluations are followed by a phone call and brief written report.

Consultations: SBMS will, when the situation arises, provide a judge, probation officer, attorney, police officer, or citizen a consultation on medical legal matters. No formal request is required or report rendered. All information is handled on an "off the record" basis.

Of 1101 cases in 1979, 41 percent resulted in pretrial reports, 32 percent pre-sentence reports, 7 percent post-sentence reports, and 18 percent custody reports.

Referral Courts

Formal requests for evaluations are made only by judges in the three formal referral jurisdictions for SBMS: the Supreme Bench of Baltimore, the District Court of Maryland Number 1, and the Federal District Court of Maryland. The Supreme Bench is the largest of the Maryland Eighth Judicial Circuit with 12 criminal courts, 10 civil courts, 1 motions court; and 23 judges, including 1 administrative judge. SBMS formally serves the Supreme Bench as an arm of the court.

The second referral court is the District Court of Maryland Number 1 (Baltimore Police Court) with 8 criminal court judges, 10 civil court judges, and 6 traffic judges. The District Court has jurisdiction in non-felony cases in which the penalty does not exceed three years' imprisonment. SBMS serves this court on a fee basis of $225 per evaluation report. Requests for evaluations from the Federal District Court, the third and most infrequent referral court, are also handled by SBMS on a referral basis. All but a few referrals are made to SBMS by the Supreme Bench and the District Court. Of a total of 1,101 cases referred to SBMS in 1979, 889 came from the Supreme Bench and 196 came from the District Court, together accounting for over 98 percent of the evaluation referrals.

Referral Procedures

Once a request is initiated, the work of SBMS to provide mental health evaluation to the courts is conducted within 30 days. Typically, SBMS receives a referral form along with the formal court order for evaluation or telephone request by a judge. The form is usually hand

delivered by a court law clerk, except in referrals from the Federal District Court, which are mailed and only very seldom complemented by telephone contact with SBMS.

The referral form that initiates most evaluations indicates standard case information (e.g., defendant's name, birth, offense(s), attorney, and present status), type of evaluation requested (pretrial, presentence, or post-sentence), and a checklist of reasons for the referral (see Appendix A). As soon as SBMS receives a referral form, case preparatory procedures are initiated.

Once received, evaluation referral forms are date-stamped immediately, initiating the 30-day time frame for the completion of evaluations. Frequently, the referral form is, at this stage, routed to the medical administrator, who may make informal telephone contact with the referring judge, especially in controversial cases. SBMS records are reviewed to check whether the case is "old," that is, whether it has been previously referred to SBMS for evaluation. Simultaneously, the case is given a number, and a folder is prepared.

On the day of the receipt of the referral, or immediately thereafter, court personnel are telephoned in order to obtain the following case information: (1) history of previous hospitalizations; (2) a brief history of where the patient has lived; (3) the name of a family member who might be interviewed for additional information about the patient; and (4) verification of current address as listed on the referral form and verification of patient's current location (Baltimore city jail, Department of Corrections, etc.). Requests are directed to police or State's Attorney's office for past record, offense report, and indictment folder. Psychiatric and medical records are subpoenaed if necessary.

At this stage the case is placed into a "cases to be seen" file and assigned by administrative staff to an examiner, who maintains responsibility for the case. Finally, appropriate arrangements are made for the client to be examined in the SBMS. If the client is in custody or hospitalized in an institution, he or she is escorted to SBMS for evaluation; clients not in custody are sent letters requesting their appearance in SBMS on a particular date.

Acquisition of Mental Health Information

Staff

The staff of SBMS includes psychiatrists, psychologists, social workers, and administrative and support personnel. Case responsibility rests primarily with "medical officers," physicians who are licensed in the state of Maryland and have completed a residency in psychiatry, and state-licensed clinical psychologists. Both full-time and consulting (part-time) psychiatrists and psychologists serve on the SBMS staff. The social work staff consists of a chief of social work (who also is the SBMS Administrator), three consultant social workers, and several social

work students from local colleges and universities. Students representing various disciplines (medicine, social work, psychiatry, and psychology) are integrated into the work of SBMS, assisting in much of the evaluation work and performing special projects. Most students work without monetary compensation, to gain experience in a court clinic with a history of providing good experience in forensic mental health evaluation.

The clinical and administrative organization of SBMS overlap, with most staff members doing "double duty."

Procedures and Techniques

Examination of a defendant focuses first on a clinical interview, conducted by the psychiatrist or clinical psychologist assigned responsibility for the case. Case assignment is made on the basis of staff availability except in rare controversial cases when case responsibility may be totally assumed by the Chief Medical Officer. The responsible examiner, psychiatrist, or psychologist initially determines the resources of SBMS to be used on the case. Incoming referrals are screened by a social worker who determines in which cases social work evaluations would most probably be necessary. Typically, the social worker schedules and conducts a one- to two-hour interview with one member of the defendant's family. The purpose of the interview is to develop a dynamic view of the defendant's social structure. In all presentence, postsentence, and pretrial cases involving serious offenses, social workers conduct evaluations before the clinical interview. Typically, the social worker gives a one- to two-page report to the responsible psychiatrist or psychologist, and often discusses the case as well.

The actual clinical interview of the client by the responsible psychiatrist or psychologist is preceded by a review of past arrest records, witnesses' statements, and case documents of past medical and psychiatric histories. The interview is typically conducted by one examiner, although in some complex cases more than one examiner may interview the client simultaneously. The interview usually lasts about 60 minutes and seldom exceeds 90 minutes, and is concluded in one sitting. The format of the clinical interview is a relatively unstructured question-answer dialogue in which the clients' mental state is examined, with special regard to the issue(s) at hand, i.e., criminal responsibility, competency, bail release, amenability to treatment, probation, and incarceration. If the findings on examination are sufficient to allow a clinical decision, and if no more information is necessary for reaching a conclusion about the case, the examiner proceeds to prepare a written report. Operationally, the question of sufficiency of information after only the clinical review is, "Would I be able to give live courtroom testimony on this case under direct and cross-examination?" Approximately 30 percent of the cases are concluded after only the clinical interview by a psychologist or psychiatrist.

In the remaining 70 percent of the cases requiring (according to the determinations of the responsible examiner) further evaluation, the

responsible psychiatrist or psychologist arranges additional SBMS resources to assist in reaching a decision preparing a report. In cases involving possible sexual psychopathy or charges of sexual crimes, all the appropriate available evaluation resources are brought to bear on a clinical decision.

All or any combination of the following resources may be used in a case, at the request of the responsible examiner:

(1) Social worker interviews with family, community persons, and others.

(2) Administration of a standard battery of tests including the Minnesota Multiphasic Personality Inventory, the Bender Visual, Motor Gestalt Test, a figure drawing test, and the Competency Screening Test (National Institute of Mental Health, 1973,) by non-certified administrative personnel.

(3) Further psychological testing administered by a psychologist, including administration of standard I.Q. tests and projective instruments (Thematic Apperception Test, Rorschach, etc.) and/or interview of client by psychologist.

(4) Staff conference(s), size and duration determined by need.

(5) Special testing or examinations such as electroencephalography, neurological work-up, etc. Special examinations are typically arranged with outside facilities (e.g., University of Maryland, School of Medicine) on a consultation basis.

Social casework, as indicated earlier, and the administration of a standard battery of psychological tests may actually be performed prior to, simultaneously with, or after the clinical interview, depending on the complexity of the case and the wishes of the responsible examiner. Some SBMS examiners request the standard battery of tests in all cases (although they may not actually utilize the results in reaching a clinical decision or preparing the written report), others use the battery sparingly. Results of the battery of standard tests are communicated to the responsible examiner by a psychologist. Similarly, the social worker's results are sometimes communicated to the examiner informally, often followed up by a report of one or one and a half pages.

In approximately 10 percent of the cases, further psychological testing and interviewing by a psychologist is requested for the purpose of sorting out the "antisocial criminal from the sick." In rare cases, a psychologist and a psychiatrist simultaneously interview a client. Although the delineation and provision of psychological information requested by the responsible examiner may involve the transmission of the "Psychological Evaluation Referral Sheet" (see Appendix B), these processes are commonly handled informally by SBMS staff.

Small, informal "mini-conferences" of psychiatrists, psychologists, social workers, and other clinical staff occur frequently as needed and initiated by the examiner. Rarely, full staff conferences are held to discuss controversial or complex cases. Some very controversial, "V.I.P." cases are spearheaded by the Chief Medical Officer, Chief Psychologist or the Medical Administrator; in such cases, most details of the evaluation effort, including psychological testing and social histories, are documented in a formal evaluation report, followed by live courtroom testimony.

Provision and Use of Evaluation Information

As discussed in an earlier section, there are basically three separate types of formal evaluation reports: pretrial, presentence, and post-sentence.

Pretrial cases involve two types of evaluations. In the first, the psychiatrist determines the degree of dangerousness of the patient in a question of bail risk (habeas corpus). In the second, the psychiatrist is asked to answer the questions of competence (the ability of the defendant to assist counsel in his defense) and responsibility (substantial capacity to appreciate the criminality of his conduct and to conform his conduct to the requirements of law).

The presentence evaluations represent the major work of the SBMS. The goal in these cases is to assist judges in making appropriate dispositions. The evaluation reports include a lengthy description of social, medical, and legal history as well as a summary and recommendations. An attempt is made to answer the court's specific request, as well as to give an impression of the individual's dangerousness and amenability to treatment and to suggest facilities that might offer such treatment.

A post-sentence referral is made when the judge wishes to consider a change in sentence within the allowable period of time, or to alter conditions of probation, or to consider the feasibility of a referral to an institution (e.g., Patuxent Institution).

The format of the written reports usually follow the medical tradition, covering history, abstracts of documents from other physicians and hospitals, findings on examinations, analysis of current problems, summary, and recommendations. The average length of the reports is approximately two to three pages; however, presentence reports generally are three to four pages and have a separate summary and recommendation page. Except in controversial cases or special testing cases (e.g., neurological work), reports are concise summaries without addenda. The SBMS procedures manual (Note 2) suggests the following outline for reports:

Statement of problem
Early and family history and physical history
School

CONTINUED

1 OF 8

Work
Military service
Sex and marital history
Recent activities
Current offense and defendant's statement
Previous offenses
Mental status
Psychological
Social work
Summary and recommendation

Recommendations in Written Reports

Table 7 suggests the variety of recommendations in the various reports prepared by SBMS. The degree of specificity of the recommendations in the reports ranges from no recommendation, or only very vague recommendations, to multiple but specific recommendations. According to past evaluation reports (see, for example, Note 5) and the judgment of SBMS staff, agreement between SBMS recommendations and court disposition is good, the court disposition of the case being largely in accord with the recommendation in four out of five cases.

Distribution of Reports

The following is the official dissemination of SBMS evaluation reports as stated in the SBMS procedures manual (Note 2):

Pretrial Reports

(A) An original copy of the report is sent to the referring judge.

(B) A carbon copy of the pretrial report is filed with the court clerk.

(C) Copies are sent to the attorneys via the judge.

Presentence and Post-Sentence Reports

(A) The original copy is to be sent to the referring judge.

(B) A copy of the report is filed with the clerk of the Criminal Court. SBMS then checks on the disposition of the case. Depending on the disposition, one of two things is done by SBMS:

- o A copy of the report will be sent to the Reception Center at the Maryland Penitentiary.
- o A copy of the report will be mailed to the Probation Department.

Table 7

Categories of Recommendations in Various Types of Written Reports by SBMS

Report Type	Recommendation
Pretrial Reports	
Competency/Responsibility	o Competent and criminally responsible o Competent, not responsible o Not competent, not responsible
Bail Risk (habeas corpus)	o Release on bail o Release on bail not recommended
Other	o Reverse waiver to Juvenile Court o Alcohol substance abuse
Presentence Reports	o No recommendation o Treatment o Incarceration o Incarceration with early parole and treatment o Special offender clinic o Probation o Probation and community agency o Community agency o Hospitalization o Self-support unlikely
Post-Sentence Reports	o Continued incarceration o Treatment

(C) Reports are available to the attorneys only through the judge and may not be distributed directly by the Medical Office.

Psychiatric evaluation to assist in outpatient or inpatient treatment of patients seen by SBMS are available to treatment facilities and are generally released at the discretion of the Chief Medical Officer and/or the Medical Administrator.

In approximately ten percent of the cases the evaluation continues beyond the 30-day limit for completing evaluation reports. Delays occur only in very complex cases, and are communicated to and anticipated by the judge. In the cases in which delay occurs, it typically does so for the following reasons:

(a) special testing or examination (e.g., electroencephalography);

(b) especially broad psychological testing;

(c) in-depth family, social history determinations; and

(d) the need for staff conferences and, generally, the allocation of greater than normal SBMS resources.

Quality Control and Program Evaluation

Quality control and overall program evaluation of SBMS services take three basic forms: (1) management, monitoring, and informal feedback to SBMS staff; (2) routine statistical reporting; (3) special studies and reports.

Management, Monitoring, and Feedback

A main concern of SBMS is responsiveness to the judges of the referral courts, both in terms of timeliness and in quality of reports. A procedures manual (see Note 2) guides the staff in matters of law and procedures to be followed in delineation, acquisition, and provision of evaluation information; also, numerous examples of actual written reports are provided in the manual.

As discussed earlier, formal procedures involving the receipt, recording, and scheduling of cases are accomplished within the 30-day limit for completion of reports. Memoranda stipulating case deadlines and special circumstances, and requesting that involved staff contact administration immediately should problems occur, are routinely circulated.

The Medical Administrator reviews each report subsequent to the filing of a report with the referring judge. If the report is generally satisfactory, i.e., consonant with SBMS policies and delineation of requested information, no further action is taken. If he discovers problems with a report, he discusses those problems with the author. If

similar problems persist in subsequent reports, the reports are brought to the attention of the Chief Medical Officer, who may further discuss the matter with the author. If the problem or its resolution is of larger significance, beyond difficulties specific to the individual, a staff conference may be called to discuss the legal, psychiatric, and management issues involved.

In some cases, informal quality control is involved in responses to telephone inquiries made by judges who request clarifications or explanations of specific reports. This type of informal contact is reinforced by SBMS; it is viewed as integral to its service to its "clients," the judges of the referral courts, and is consonant with the history of SBMS.

Routine Statistical Reporting

The following statistics are routinely compiled, reported, and distributed: (1) total number of calendar year referrals from courts, compared to previous years; (2) monthly breakdown of cases referred in the calendar year; (3) average monthly caseload; and (4) monthly breakdown by type of report (i.e., pretrial, post-sentence, etc).

Special Studies

Most of the efforts that may be described as "program evaluation," (i.e., and not management, monitoring, and other process quality control procedures) derive from (1) special studies conducted by students under fellowship programs, assistanceships, or other relationships forged by SBMS with teaching institutions, or (2) studies pursuant to, or as a result of grants from, state or federal agencies. Five of these reports, which were available for review, are discussed briefly below, with special emphasis on measurement points and measures used in the study. It should be noted that our discussion of the following reports is not meant to be a critical review but rather an attempt to explicate measurement points, measures, and variables that may prove to have future usefulness in constructing forensic program evaluation studies.

An Evaluation of the Medical Service of the Supreme Bench of Baltimore (Olsson, Note 4). This 1972 study was supported by a grant from the Governor's Commission on Law Enforcement and Administration of Justice to the Supreme Bench Medical Services. The main purpose of the study was to investigate the referral-evaluation-disposition process for cases referred to SBMS. The report details the findings of the study, describes the changes prompted by the study, and makes recommendations for further changes. Although this report is eight years old, it delineates measurement points and measures that may be useful.

One goal of the study was to categorize and assess the referrals received by SBMS from the courts. Referrals were divided into seven categories: no information, vague statement of referral, question of mental condition, question of dangerousness, question of treatment options, question of diagnosis, and, finally, question of disposition.

The study concluded that many referrals did not contain enough information about the reasons for examination.

The study also categorized and evaluated SBMS recommendations to the courts, and evaluated the extent to which recommendations were followed by the state's attorney's office and other offices in the courts and by the probation department. Pretrial evaluation recommendations were divided into legal categories, i.e., competent, not competent, responsible, release on bail (habeas corpus), bail release not recommended, and witness competent. Presentence recommendations were categorized as follows: no recommendation, incarceration, probation only, probation and community agency, hospitalization, community agency only, dangerous individual, and miscellaneous. The degrees of specificity or vagueness of the recommendations were categorized as follows: no recommendation, very vague recommendation, general alternatives given, specific alternatives given, one or more general recommendations, multiple but specific recommendations, and one specific recommendation. The study concluded that most recommendations gave generally adequate and appropriate suggestions to the judges, but that improvements could be made in presenting clearer, more specific, and more practical recommendations.

In assessing the agreement between SBMS recommendations and court dispositions, complete agreement, partial agreement, and total disagreement were noted. Partial agreement in a case meant, for example, that the court agreed to place an offender on probation, but did not agree to include a treatment recommendation in the disposition. Perhaps, as the report indicates, a judge may have intended the individual to receive such treatment, but did not consider it necessary to make treatment a condition of probation.

A sample of 104 cases involving follow-up of probation officers was assessed. An interesting finding in this portion of the study was that SBMS evaluation reports were part of the probation department case files in only 67 percent of the cases. According to the report, the "apparent reason for reports not reaching the Probation Department is that bailiffs and clerks in many instances, either neglect or are not completely informed as to the procedure involving in forwarding Medical Service reports to probation departments" (p. 7).

A follow-up of probationers in the community was also conducted as part of the study, involving interviews with offenders, their ratings of the evaluation and screening services provided by SBMS, as well as their rating of the probation officers themselves. Seven rating categories were used, ranging from "very harmful/negative" to "very helpful/positive." The study concluded that, by their own admission, probation officers only fully implemented one-half of the SBMS recommendations. "While there may be many varied and complex reasons for lack of implementation of the recommendations, it is obvious that much could be done in this area to increase the number of cases in which some implementation is actually carried out" (p. 19).

An attempt was also made in this study to contact agencies serving probationers since their evaluation by SBMS. A follow-up was conducted with 26 different agencies and 5 individual practitioners who had served 58 individuals. Data were collected by telephone and visits to agencies and by requesting records by mail. The number and percent of probationers using 13 community agencies and facilities was reported in the study; further, the frequency of treatment visits by probationers to agencies or private practitioners was documented. Recidivism data were obtained from both FBI records and the Baltimore City Police Department records for the period between SBMS evaluation and the time of the follow-up. Measures included the number of offenses and convictions for the probationers sample, and the length of time between SBMS evaluation and the first offense. The results of the follow-up of probationers are summarized as follows:

> Follow-up interviews with probationers who could be located in the community indicated that, while they generally favorably rated probation officers and community agencies, complaints centered around the inability of probation officers and agency personnel to help the probationer in a relevant way. Although it was difficult to determine probationers' contact with agencies in many cases, it appeared that contact was nonexistent or minimal in most instances. Recividism for a sample of 104 cases was just over one half for follow-up period averaging almost three years. Individuals who purportedly received treatment in agencies did not have a lower recividism rate than those individuals not having such treatment. (p. 22)

An Evaluation of the Presentence Aspect of the Medical Service of the Supreme Bench of Baltimore (Panitz & Phillips, Note 5). The essential question of this 1978 study was whether or not screening evaluations are accurate in identifying those persons who are incompetent to stand trial and not criminally responsible. This study followed the establishment of a two-phase pretrial evaluation system utilizing the services of SBMS to reduce unnecessary hospitalization in the Clifton T. Perkins Hospital Center in Jessup, Maryland and to reduce delays in the criminal justice system. A measure used was the percentage of agreement between opinions of SBMS and those of the Clifton T. Perkins Hospital Center. The first phase was a two- to four-hour outpatient evaluation by SBMS. Approximately 70 percent of the cases evaluated in this first phase were found to be clearly competent and responsible. A second phase was instituted for the remaining 30 percent who were believed to be possibly not competent and not responsible.

Records of all pretrial cases seen in the calendar years 1975 to 1976 by SBMS and subsequently sent to Clifton T. Perkins were reviewed. Of these 113 (28 percent) were thought to be possibly not comptetent or not responsible. Sixty-five were referred to regional hospitals. Thirty-nine were referred to Clifton T. Perkins for further evaluations. All medical information and recommendations were obtained from the files of SBMS and Clifton T. Perkins Hospital. The final opinions of SBMS staff and Clifton T. Perkins staff were used in assessing the results.

There was generally concurrence in the recommendations of SBMS, Clifton T. Perkins, and the courts. The reasons for disagreements, according to the study, were generally based on a change in the patients' observed behaviors. The study concluded that the effectiveness of a pretrial screening procedure and selectively reducing the number of hospital admissions had been demonstrated.

Pretrial Screening--Is It Effective? (Rappeport, Golombek and Zimmerman, Note 6). This report was prepared in 1979 by two student researchers (Golombeck and Zimmerman) who were at that time attending the Johns Hopkins University School of Medicine in Baltimore. The goal of the study was to assess the extent to which SBMS evaluations were used by judges in their disposition decisions. A sample of presentence cases was drawn from 1978 cases seen between January and October of that year. The following data were drawn from each of 30 cases sampled: name of offender, date of birth, sex, race, case number, charge, referring judge, referral date, psychiatrist, and indictment number. The study found that in 80 percent of the cases sampled the recommendations were used by judges in their dispositions.

Medical Service Project: Improvement of Medical Service Reports and Recommendations (Grau, Note 7). This 1974 report was prepared as part of a summer research assistantship and was designed to improve the quality of SBMS reports and recommendations. Dispositions for each case were researched through the various dockets in the clerk's office. Each disposition was recorded along with the date of disposition. To determine comparability, dispositions were then compared with the recommendations i.e., whether the recommendations suggested incarceration, probation, or special conditions, and whether the recommendations were actually included in the dispositions. The court records were also reviewed to determine whether special conditions were included. The probation officers and several judges were notified and meetings were scheduled to discuss respective cases. A total of 363 cases were assessed.

Correlations of recommendations with dispositions were categorized according to total agreement, partial agreement, disagreement, and not applicable. A simple agreement percentage was also noted for correlation of recommendations of probation-with-special-conditions with their respective dispositions. The report noted various problems and concluded with specific recommendations for change.

The Supreme Bench Medical Service Pretrial Psychiatric Screening Service: Description and Evaluation (Note 8). This most recent report (currently in preparation), and perhaps the most sophisticated study reviewed in this report, attempts to add to the body of knowledge of alternatives to hospitalization for pretrial psychiatric examinations; these hospitalizations often involve 60 to 90 days of observation, with concomitant large expenditures of time, money, and trial delays. The study describes the process of pretrial psychiatric evaluations conducted by SBMS; describes the population of defendants that are served; and attempts to categorize the differences between those judged not competent to stand trial, or those found not responsible for their crime, and those

who are determined to be competent and responsible. The study also attempts to construct a predictive "equation" of demographic characteristics that may distinguish between these two groups.

The following variables and measures were used to conduct several analyses:

(1) disposition trends for 1975 and 1976, i.e., competent, responsible, not competent, etc;

(2) distribution of competency disposition by responsibility disposition;

(3) referral of defendants after SBMS disposition;

(4) distribution of offense by competency disposition; offenses included homicide, rape, robbery, assault, theft, arson, sex offense, narcotics and "other";

(5) distribution of offense by responsibility disposition;

(6) primary and secondary diagnoses according to psychiatric categories: neuroses, personality disorder, schizophrenia, other psychosis, mental retardation, OBS (non-psychotic), alcoholism, drug dependence, etc;

(7) distribution of diagnosis by offense;

(8) court-relevant variables including offense, source of court referrals, type of psychiatric interview (patient only or patient and others), psychological services (psychologist used or no psychologist), type of psychiatric interview (test only or test and interview), social worker services (social worker used or no social worker used), and type of social worker interview (patient only or other informants);

(9) demographic variables of defendants including age, sex, race, place of birth, education (in grades), occupation at time of arrest, best job, number of jobs held, longest time at one job;

(10) domestic information including marital status, living with spouse, living with parents or in-laws, living with siblings, living with children, living with other relatives, living with friends, living alone, and family background; and

(11) psychiatric history variables including present degree of alcohol use, history of drug abuse, alcohol treatment, drug treatment, number of hospitalizations in a mental institution, length of time spent in mental institutions, outpatient treatment history.

Using univariate analysis, the report outlined major differences found between defendants with different competency dispositions, ignoring the dimension of criminal responsibility. Similarly, using the above-named variables, the report attempted to distinguish between defendants judged responsible and those found not responsible.

Using discriminant analysis, an attempt was made to find the best combination of variables that discriminate between the various disposition groups (i.e., responsible, not responsible, disposition deferred, etc.). The discriminate analysis resulted in high percentages of correct classification in the major disposition categories, and relatively unsuccessful attempts at classification in the "deferred" groups for both competency and responsibility dispositions.

NEW YORK CITY'S FORENSIC PSYCHIATRY CLINIC

Forensic psychiatry in New York City had its beginnings in colonial times at Bellevue Hospital. As the city grew, Bellevue became overcrowded, and several of its functions were given over to regional hospitals and agencies throughout the city. In 1967, a clinic was established at the Criminal Courts Building in the borough of Manhattan for the purpose of screening court-referred defendants suspected of incompetency to stand trial. The clinic was staffed by Bellevue psychiatrists. The screenings would result in either a judicial finding of competency to stand trial or a court referral to Bellevue Hospital for further evaluation to assess competency. In 1968, a second psychiatric clinic was established in the court. This clinic was operated by the Department of Probation and was responsible for assessing the mental health treatment needs of client-offenders to assist judges in fashioning probation plans upon disposition. In 1970, these two clinics were combined to form the Forensic Psychiatry Clinic.

The Clinic is administratively responsible to the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services. The clinic serves the New York City Criminal Court, the New York State Supreme Court (the general trial court), and the New York City Department of Probation. It provides three basic services: assessments of fitness to proceed (competency to stand trial), assessments of mental health needs for probation purposes, and general mental health assessments as requested by judges on an informal basis ("court assessments"). The Clinic is not responsible for conducting evaluations to assess criminal responsibility; such evaluations are arranged by the defense with private psychiatrists.

Fitness-to-proceed assessments are made at the pretrial stage, while assessments for probation and general assessments upon informal judicial request may be made posttrial as well as pretrial. All evaluations are conducted on an outpatient basis in the Clinic's offices in the Criminal Courts Building in Manhattan. Evaluations of persons under the jurisdiction of the Criminal Court are conducted in a secure area on the twelth floor; evaluations of persons under the jurisdiction of the Supreme Court are conducted on the first floor. The Clinic's

administrative staff are located on the fifth floor. The staff numbers 24 (some part-time) and includes psychiatrists, psychologists, paraprofessionals, an administrator, and clerical personnel.

In 1979, the Clinic received 657 referrals for evaluations to assess fitness to proceed: 411 from the New York Criminal Court, and 246 from the New York State Supreme Court. In all, 536 persons were evaluated for fitness to proceed. Of this total, 355 were recommended as fit, 82 were recommended as not fit, and 99 were referred to Bellevue Hospital for more extensive evaluation. The Clinic received 655 referrals for evaluations related to probation in 1979. The number of probation-related evaluations performed was 545, of which 211 related to Criminal Court Cases and 334 related to Supreme Court Cases. No statistics were available with respect to the number of "court assessment" cases processed; however, it has been estimated that there were "very few" such referrals in 1979.

In addition to the three basic evaluation services described above, the Clinic conducts an interdisciplinary weekly training seminar on issues pertinent to the fields of psychiatry and law. Sessions are attended by personnel from both courts, the Department of Probation, the District Attorney's Office, and the New York City Police Department.

Case Process Flow

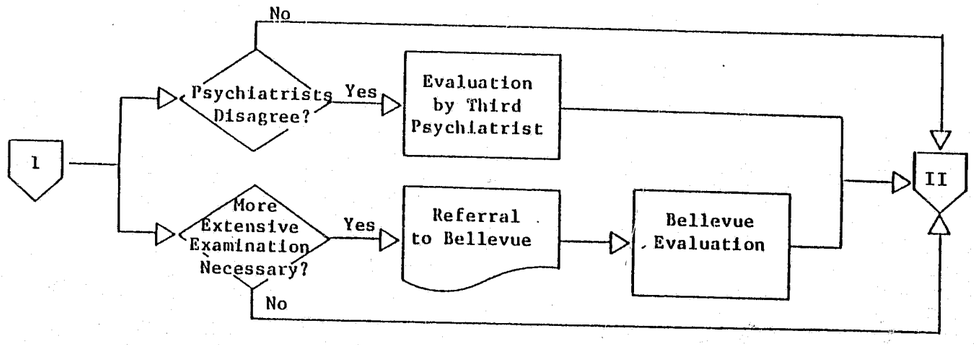
The flow of mental health evaluation cases into, through, and out of the Clinic is depicted in Figures 5 through 8.

Fitness to Proceed

Figure 5 and 6 illustrates the process by which the question of fitness to proceed is raised, referred to the Clinic, addressed by Clinic staff, and resolved.

The issue of fitness to proceed may be raised by the defense, the prosecution, or the court. If the court determines that the defendant should be evaluated for his fitness to proceed to trial, it will order that he be so evaluated at the Forensic Psychiatry Clinic. When the Clinic receives the order, an appointment is made for the defendant to visit the Clinic and be evaluated by two psychiatrists. If a defendant who is on bail (i.e., is not incarcerated) fails to meet his appointment, the court is notified. The court is not notified in cases involving incarcerated defendants until those responsible for transporting the defendant have failed to meet appointments on at least three occasions. As an alternative to scheduling new appointments, the Clinic occasionally will refer cases to Bellevue Hospital for evaluation, particularly if it is anticipated that serious mental health questions will be presented or the defendant will be unusually difficult to control.
In such cases, Bellevue conducts the evaluation and reports to the court.

When the defendant arrives for his appointment, he is interviewed by two psychiatrists. The psychiatrists may conduct their evaluations



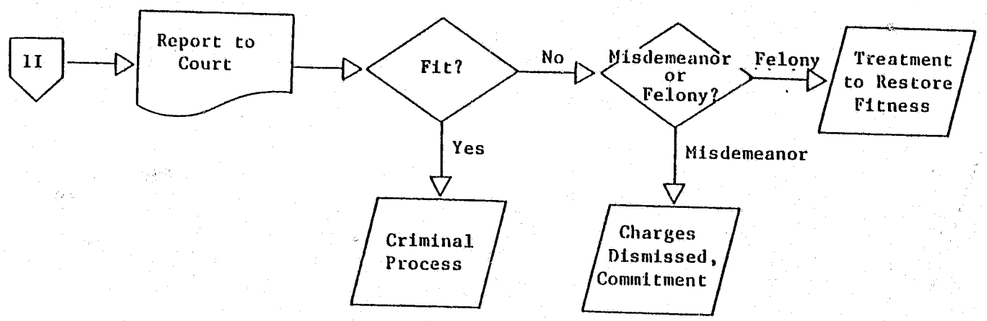


Figure 5. The Process Flow of Cases Referred to the Forensic Psychiatry Clinic for Assessment of Fitness to Proceed. (Continued)

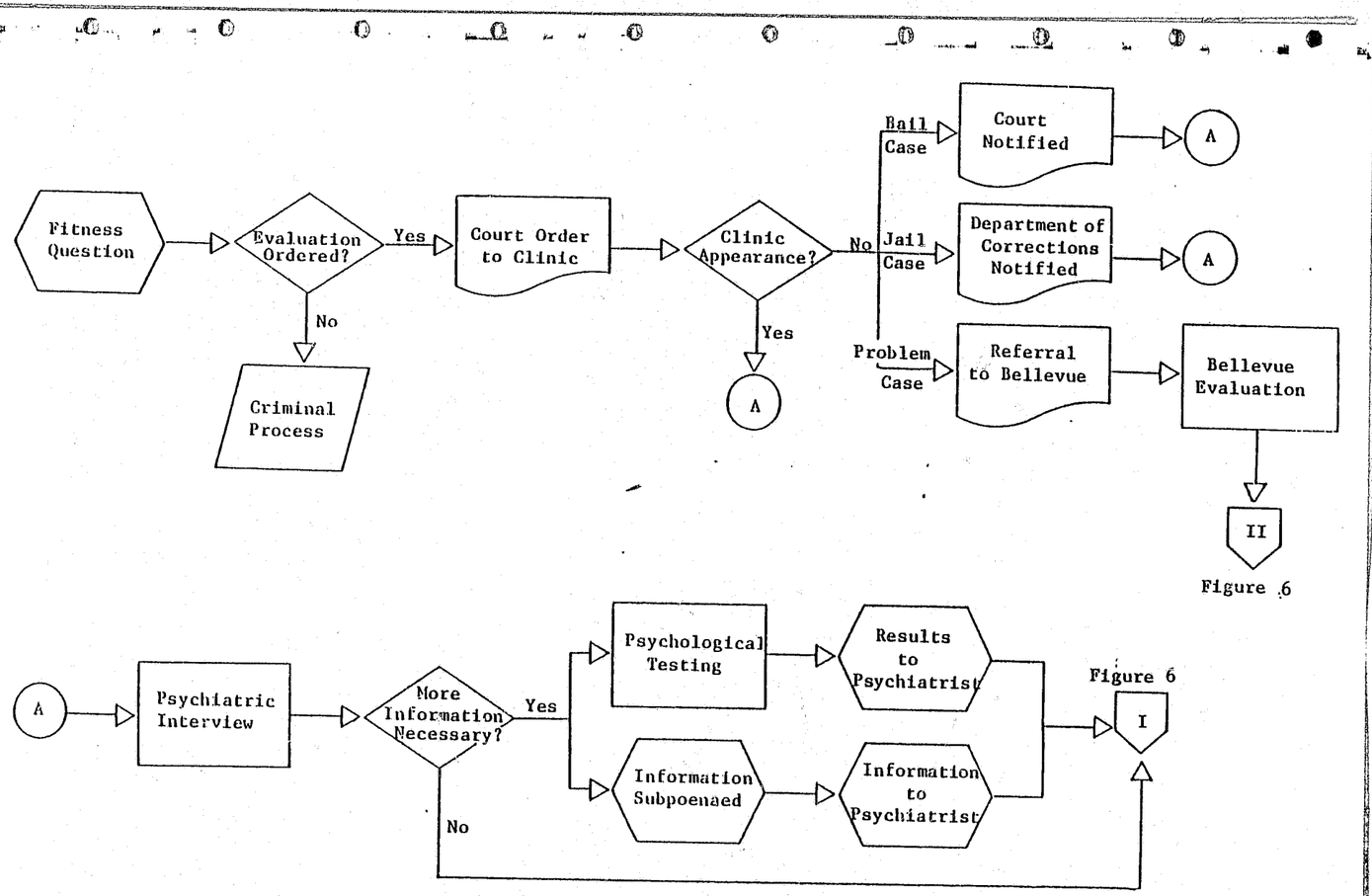


Figure 6. The Process Flow of Cases Referred to the Forensic Psychiatry Clinic for Assessment of Fitness to Proceed.

simultaneously, or they may interview the defendant at different times. At any time during the interview(s), a psychiatrist may request that a Clinic psychologist administer psychological testing. Also, a psychiatrist may request the paraprofessional staff to subpoena particular information. If either psychiatrist believes that the case presents unusually difficult mental health questions or if for some other reason he is unsatisfied with the results of the Clinic's evaluation, he may refer the case to Bellevue Hospital for a more extensive evaluation.

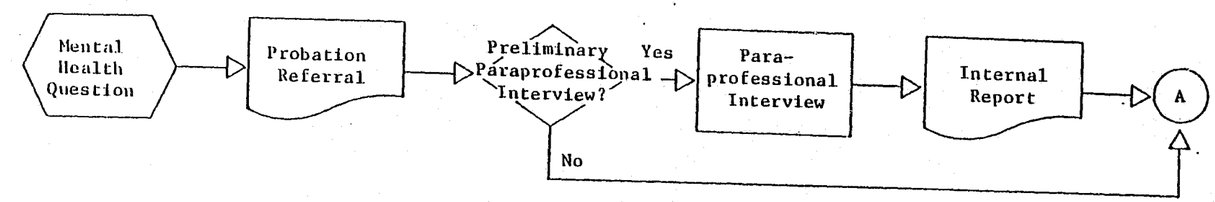
If the evaluation is completed at the Clinic, each psychiatrist prepares a report summarizing his findings and submits it to the court. If the two psychiatrists are in disagreement as to the defendant's fitness to proceed to trial, a third psychiatrist will also evaluate the defendant, and his opinion will be submitted to the court to serve as a "tie-breaker."

Upon receipt of the reports of the psychiatrists, the court determines the question of fitness to proceed to trial. Any one or all psychiatrists submitting evaluation reports may be called to testify regarding the defendant's fitness to proceed. If the court determines that the defendant is fit, the case proceeds to trial. If the court determines that the defendant is unfit, the defendant is processed in one of two ways: (1) if the charge is a misdemeanor, the court issues a "final order of observation," charges are dropped, and the person is remanded to the custody of the Commissioner of Mental Hygiene, who may or may not institute proceedings to have the person civilly committed to a city mental health facility; (2) if the charge is a felony, the court issues a "temporary order of observation," charges are not dropped, and the defendant is sent to Mid-Hudson State Hospital (in upstate New York) for treatment designed to restore fitness.

Probation Assessments

Figure 7 illustrates the process by which the Forensic Psychiatry Clinic receives referrals, conducts evaluations, and reports its findings regarding the mental status of persons on or being considered for probation.

Referrals of this nature come from the New York City Department of Probation. The probation officer making the referral may be seeking mental health information to include in a presentence report for the court or may be investigating the mental health treatment needs of an offender already on probation. The probation officer makes the referral initially by telephone call and then sends the Clinic a copy of the Probation Department's preliminary report. An appointment is scheduled for a Clinic psychiatrist or psychologist to interview the offender. Periodically, the Clinic's Chief Psychologist examines the files of pending probation evaluation cases and selects appropriate cases to be reviewed by a paraprofessional prior to the clinical interview. The paraprofessional conducts an interview and obtains medical and social information to supplement the preliminary report of the probation department. A psychiatrist conducting an evaluation may request that a



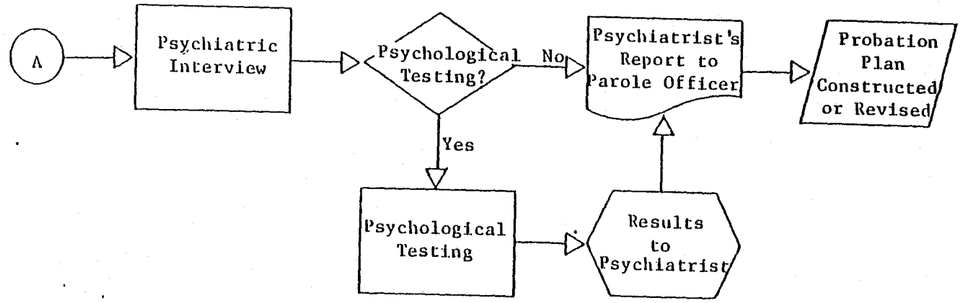


Figure 7. The Process Flow of Cases Referred to the Forensic Psychiatry Clinic by Probation Officers for Mental Health Evaluations.

Clinic psychologist conduct psychological testing. (Psychological testing is scheduled automatically if the offender is 21 years of age or younger.) Upon completion of the evaluation, the psychiatrist or psychologist primarily responsible for the evaluation prepares a report of his findings and submits the report to the referring probation officer. The report may be used to supplement a presentence report prepared by the probation officer or to fashion recommendations to the court for a change in conditions of probation for someone already on supervised probation.

Court Assessment Cases

Figure 8 illustrates the process by which the Clinic receives referrals, conducts evaluations, and reports its findings regarding the mental status of client-offenders informally referred by a judge for a clinical assessment.

Court assessment referrals are made informally over the telephone by the judge or his clerk. The Chief Psychologist arranges for a paraprofessional to conduct an initial interview with the offender or alleged offender. Following the paraprofessional's interview, a psychiatrist or psychologist conducts an interview similar to that conducted for probation cases. The psychiatrist or psychologist responsible for the evaluation prepares a report of his findings and submits it to the judge who made the referral. Judges use the information provided in making pretrial or presentence release determinations and in sentencing.

Delineation Of Mental Health Information Requirements

The Courts

The Forensic Psychiatry Clinic provides its services for the New York Criminal Court, the New York State Supreme Court, and the New York City Department of Probation. The New York City Criminal Court has trial jurisdiction over misdemeanors and ordinance violations. The judges also act as arraigning magistrates for all criminal offenses. The Supreme Court is New York's highest court of original jurisdiction and has unlimited original jurisdiction, but it generally hears cases outside the jurisdiction of other courts, such as civil matters beyond the jurisdiction of lower courts; divorce, separation, and annulment proceedings; equity suits such as mortgage foreclosures and injunctions; and criminal prosecution of felonies and indictable misdemeanors only exercised in New York City, where there is no county court. The court may issue writs relevant to its jurisdiction.

The Law

The standard for determining whether a defendant is fit to proceed to trial is whether he "as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense" (New York Criminal Procedure Law, §730.10). The law provides that two psychiatrists be appointed to evaluate the defendant by

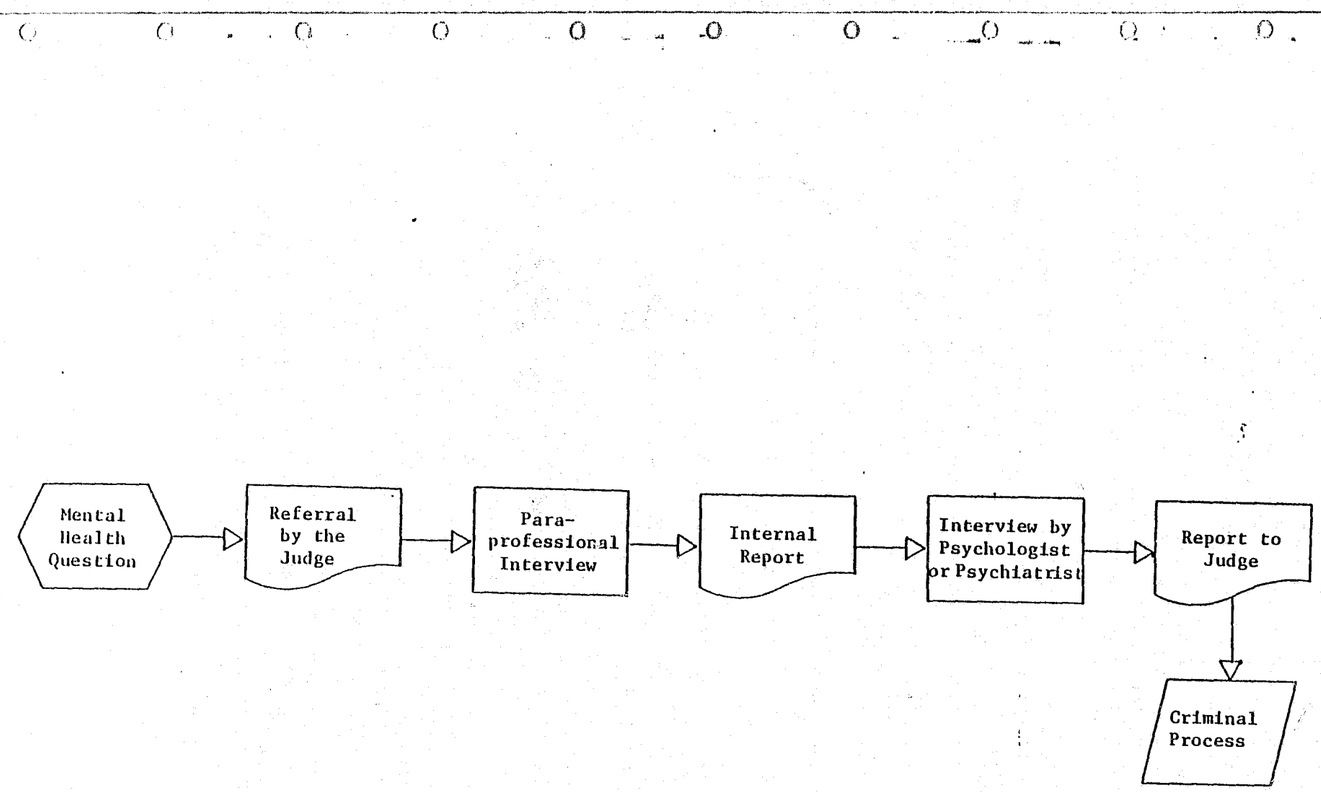


Figure 8. The Process Flow of Cases Referred for Mental Health Evaluations to the Forensic Psychiatry Clinic by Judges

"any method which is accepted by the medical profession for the examination of persons alleged to be mentally ill or mentally defective." The examination may be performed on an outpatient basis, in a hospital, or in a jail. A psychiatrist or psychologist retained by the defendant may be present during the examination. When a defendant is examined for his fitness to proceed to trial, "any statement made by him for the purpose of the examination or treatment shall be inadmissible in evidence against him in any criminal action on any issue other than that of his mental condition, but such statement is admissible upon that issue whether or not it would otherwise be deemed a privileged communication" (New York Criminal Procedure Law, §730.20).

> In any case where a person is convicted of a felony, the court must order a presentence investigation of the defendant and it may not pronounce sentence until it has received a written report of such investigation . . . Where a person is convicted of a misdemeanor a presentence report is not required, but the court may not pronounce any of the following sentences unless it has ordered a pre-sentence investigation of the defendant and has received a written report thereof:
>
> (a) A sentence of probation;
>
> (b) A reformatory or alternative local imprisonment;
>
> (c) A sentence of imprisonment for a term in excess of ninety days;
>
> (d) Consecutive sentences of imprisonment for terms aggregating more than ninety days. (Criminal Procedure Law, §390.20)

The presentence investigation consists of the gathering of information with respect to the circumstances attending the commission of the offense, the defendant's history of delinquency or criminality, and the defendant's social history, employment history, family situation, economic status, education and personal habits. Such investigation may also include any other matter which the agency conducting the investigation deems relevant to the question of sentence, and must include any matter the court directs to be included. . . . Whenever information is available with respect to the defendant's physical and mental condition, the presentence investigation must include the gathering of such information. In the case of a felony or class A misdemeanor, or in any case where a person under the age of twenty-one is convicted of a crime, the court may order that the defendant undergo a thorough physical or mental examination in a designated facility and may further order that the defendant remain in such facility for such purpose for a period not exceeding thirty days. (Criminal Procedure Law, §390.30)

The Delineation Process

The question of the defendant's fitness to proceed to trial may be raised at any stage of the proceedings by the defense, the prosecution, or the court. The question most often arises at arraignment. If the court believes the question is properly raised, it will issue a written order directing two psychiatrists to evaluate the defendant and assess his fitness to proceed to trial. The order indicates whether the defendant is incarcerated and specifies the date on which he is scheduled to return to court. Copies of the charges against the defendant and the defendant's criminal record ordinarily accompany the order; however, not infrequently the order arrives without these materials, and the Clinic's clerical staff must arrange to receive these. Fitness referrals from the Supreme Court are hand-delivered by court personnel; Criminal Court referrals are routed through the inter-building mail in the Criminal Courts Building, which houses both the Clinic and the Court.

Referrals for probation assessments may be made post-trial/presentence or during an offender's period of probation. Such referrals most commonly are made to assist probation officers in developing presentence reports or supervising persons already on probation. The referral is made over the telephone to the Clinic's clerical staff; the probation officer follows up this telephone call by sending a copy of the preliminary probation report, typically containing a social/medical history, an outline of the offense, and the reason for the referral (i.e., to assess mental orientation pursuant to a presentence investigation or to assess mental health treatment needs of an offender on probation).

"Court assessment" referrals are made informally over the telephone by judges who have reason to suspect the mental or emotional stability of defendants in their courts. Typically, the information sought is intended to assist judges in sentencing defendants for whom no presentence report was prepared or in making pretrial or presentence release determinations (to assess bail risk). Ordinarily, the only information the Clinic receives upon referral is that supplied by the judge or his clerk over the telephone, including the defendant's name and location and a brief summary of the basis for the judge's concern and the reason for the referral (e.g., "he says his name is Adolph Hitler and he's discovered some Jews he missed; is he safe for bail?")

Acquisition Of Mental Health Information

Staff

The staff of the Clinic is multi-disciplinary and works as a team. The staff consists of a director, who is a psychiatrist, a director of administrative services, with a masters degree in public administration, seven part-time psychiatrists, one Ph.D. psychologist, one master's degree psychologist, three paraprofessionals with high school education, and ten administrative/clerical staff.

Procedures and Techniques

Fitness to Proceed. Upon receipt of a referral, the clerical staff prepares a case file containing identifying information and enters the case into a docket book. The clerical staff then conducts a search of old Clinic records to determine whether the defendant has been evaluated by the Clinic previously. If old records are located, they are incorporated into the new file and the old case file folder is retained with appropriate notation. The clerical staff then schedules an appointment for the defendant to be interviewed by two Clinic psychiatrists. Interviews ordinarily are scheduled within five days of the referral. If a court order is not accompanied by a copy of the charges against the defendant and a copy of his criminal record, the clerical staff will arrange to have these materials sent by calling the court clerk or checking court records.

If a defendant is not incarcerated (i.e., on bail) and fails to meet his appointment, the clerical staff will notify the court of his nonappearance. If the defendant is incarcerated and does not appear because of failure of release, transportation, custody problems, etc., the staff will schedule a new appointment; if this happens a second and third time, the court is notified.

When the defendant arrives for his appointment, the Clinic's security guards notify the clerical staff of his arrival, search him for weapons, and escort him to a waiting area. Defendants who are incarcerated pending trial are isolated from those on bail or otherwise released pending trial (waiting areas and interview rooms are separate). The clerical staff arranges for two available psychiatrists to interview the defendant. If two psychiatrists are not available simultaneously, the defendant will be interviewed by the one who is available and then will remain at the Clinic until a second becomes available. If a second psychiatrist does not become available on the day of the appointment, a new appointment will be scheduled for the second interview.

When a psychiatrist becomes available, the clerical staff gives him the defendant's file and arranges for a Clinic security guard to escort the defendant to an interview room. At the outset of the interview, the psychiatrist(s) warns the defendant that the information he acquires may not be held confidential (although the information is not admissible on the question of guilt or innocence). During the course of the interview, the following information typically is sought:

- psychiatric history (treatment, hospitalizations, nature of illness, diagnosis, if available);
- medical history (surgery, head or birth injuries, convulsive disorders, blackouts, headaches, other neurological disorders, venereal disease, and major medical illnesses);
- alcohol use (duration, amount, frequency);

- drug use (addiction or habituation, substances used, duration, amount, frequency);
- arrest record (including time served);
- military service (including type of discharge);
- family history (current living conditions; early living conditions; family history of mental illness, alcoholism, drug use, violent and aggressive behavior);
- educational history (academic performance, disciplinary record);
- work history (employment record, future goals);
- sexual history (longitudinal sketch of psychosexual development); and
- social history (friends, hobbies, interests, cruelty to animals, running away from home, inferiority feelings).

Additionally the psychiatrist(s) conducts mental status examinations, noting the following:

- appearance and behavior during interview;
- characteristics of speech and thought;
- emotional state;
- mental trends (anxiety, depression, suicidal tendencies, hallucinations, mistrustfulness, ideas of reference, delusions, sleeping difficulties, loss of appetite, obsessive compulsive symptoms, phobias, ability to deal with impulses); and
- sensorium (orientation, memory, recall, calculating ability, reading ability, fund of general information, estimated intelligence, insight and judgment, ability to understand proverbs).

Finally the psychiatrist(s) inquires specifically as to the defendant's knowledge of the charges against him and of the court process in general. The defendant's responses to the following questions are noted:

- What is the charge against you?
- Have you entered a plea? What plea have you entered?
- What is the name of your attorney?

- What is the function of a defense attorney?
- What is the function of a district attorney?
- What is the function of a judge?
- What is the function of a jury?
- What are the consequences of being found guilty?

Psychiatric interviews typically last 45 minutes to one hour if the defendant is cooperative. Either psychiatrist may refer the defendant for psychological testing by a Clinic psychologist. The referral is accomplished by completing a "Request for Psychological Testing" form (Appendix C) and delivering it to the clerical staff, who arrange for the testing. If a psychologist is available, tests will be administered the same day as the psychiatric interview; however, it may be necessary to schedule an appointment for psychological testing on another day. The psychiatrist indicates what information he desires, but the psychologist determines which tests to administer. The following tests commonly are administered:

- Wechsler Adult Intelligence Scale (WAIS)
- Bender Visual-Motor Gestalt Test
- Figure Drawings
- Thematic Apperception Tests (TAT)
- Rorschach
- Incomplete Sentences

Upon the completion of psychological testing, the psychologist provides the psychiatrist with a written report of his findings and the psychiatrist incorporates this into his report for the court.

On relatively rare occasions, the psychiatrist will feel it necessary to obtain particular information (i.e., hospital or employment records) by subpoena before preparing his evaluation report. The Clinic's paraprofessionals acquire this additional information at the request of the psychiatrist. The subpoena process may be time-consuming and require a continuance of the court date in order to allow the psychiatrist to receive the subpoenaed information and prepare his report for the court.

Probation Assessments. Upon receipt of a referral from a probation officer for a probation assessment, the clerical staff establishes a case file and enters the case into the docket book. After making a referral, the probation officer ordinarily sends the Clinic a copy of a preliminary probation report. If the report is not received within two to three days of the referral, the clerical staff will arrange

for a copy to be sent. The psychiatrists and psychologists will not initiate probation evaluations without receipt of a preliminary probation report.

Only one psychiatrist (or psychologist) evaluates cases referred for probation assessments. As a matter of Clinic policy, all offenders 21 years of age or younger who are referred for probation assessments automatically are scheduled for psychological testing. Additionally, a psychiatrist conducting an evaluation of someone over 21 may request psychological testing by completing a "Request for Psychological Testing" form and delivering it the clerical staff. The clinical staff will schedule the interview and the psychological testing. If the offender fails to keep his appointment, the clerical staff notifies his probation officer. When the offender arrives for his appointment, the clerical staff arrange for him to be interviewed by a paraprofessional (if indicated by the Chief Psychologist), evaluated by a psychiatrist or psychologist, and tested by a psychologist (if he is 21 years old or younger).

The interview by the paraprofessional results in a limited social history. The paraprofessional summarizes the information collected in a report for the psychiatrist or psychologist assigned to conduct the clinical interview. The interview conducted by the psychiatrist or psychologist closely resembles that conducted to assess fitness to proceed, as described above. Only the questions related to the person's knowledge of the charges against him and knowledge of court proceedings are omitted. Similarly, psychological testing is conducted in the manner described above, and the results are provided to the psychiatrist or psychologist primarily responsible for the probation assessment.

Court Assessment Cases. Upon receipt of a judicial request for a "clinical work-up," the clerical staff notify the Clinic's Chief Psychologist, who arranges for a paraprofessional to secure background information on the person referred. The paraprofessional ordinarily will contact the court for any background information it might have on the person and also may schedule an initial interview with the person to obtain a medical and social history.

Provision and Use of Mental Health Information

Upon completion of an evaluation to assess fitness to proceed to trial, each psychiatrist submits two reports to the court, one on a state Department of Mental Health form resembling an order (Appendix D) and one on a Clinic form (Appendix E). On the state form, the psychiatrist indicates his opinion regarding the defendant's fitness to proceed; if the psychiatrist's opinion is that the defendant is not fit, he also presents a clinical summary (including mental status), a diagnosis, a prognosis, and reasons for his opinion (specifying those aspects of the proceedings wherein the defendant lacks capacity to understand or assist in his own defense). The Clinic form also indicates the psychiatrist's opinion with regard to the defendant's fitness to proceed; for defendants believed to be not fit, the psychiatrist presents a diagnosis, a

prognosis, therapeutic recommendations, a one-page summary of psychiatric findings, and the defendant's responses to the questions relating to his knowledge of the charges against him and his knowledge of court proceedings generally. The court relies to a large extent on the reports submitted in making its determination of whether the defendant is fit to proceed to trial. Any one or all psychiatrists may be called to testify with regard to the fitness question.

Evaluations conducted upon referral from probation officers and judges result in clincial reports containing a social history, a mental status assessment, a diagnosis, a prognosis, and a discussion of particular treatment needs that might be addressed by appropriate probation plans. Community programs or other resources for which the offender is thought to be peculiarly suited often are indicated by name. Reports prepared for probation cases are submitted to probation officers, who use the information contained in the reports to construct their own reports to the court containing recommendations with respect to probation. Reports prepared for court assessment cases are submitted to the judges requesting them. The judge may use the information to determine matters of pretrial or presentence release or to fashion an appropriate disposition of a case (possibly entailing probation with mental health treatment conditions). The judge may telephone the Clinic psychologist or psychiatrist whose name appears on the report for more information or a clarification of the information presented; but Clinic staff rarely are called to testify in these cases.

At any time during the evaluation process, the primary evaluator (either psychiatrist conducting a fitness evaluation) may refer the person evaluated for a more extensive evaluation at Bellevue Hospital. If such a referral is made, a one-page referral form is completed, which indicates reasons for the referral. Copies are sent to Bellevue Hospital, the Department of Corrections, and the court. Additionally, copies of any preliminary reports on the offender or alleged offender prepared by or otherwise in the possession of Clinic staff are sent to Bellevue with the referral.

Feedback, Monitoring, And Evaluation

There is no formal, ongoing program evaluation mechanism operating in the Forensic Psychiatry Clinic. However, a number of the Clinic's functions serve to monitor operations and provide a measure of quality assurance.

The Clinic conducts an interdisciplinary weekly training seminar on issues pertinent to the field of psychiatry and law. Sessions are attended by Clinic staff, New York University law and medical students, New York City psychiatrists, and persons from the court, the Department of Probation, the district attorney's office, and the New York City police department. While such seminars do not directly entail program evaluation, participants routinely discuss topics that are directly related to the Clinic's operation.

The administrative structure of the Clinic provides for a degree of internal program monitoring. The Director of the Clinic is responsible to the Commissioner of the Department of Health and Mental Retardation; the professional staff of the Clinic is responsible to the Director; the administrative staff is responsible to the Director of Administrative Services; and the paraprofessional staff is responsible to the Social Services Supervisor. Annual personnel evaluations are conducted.

The close proximity of the Clinic to the judges and the probation officers it serves (all in one building) also provides for a measure of informal program monitoring. On a number of occasions in the past, judges have telephoned the Clinic's Director and requested that a person previously evaluated by Clinic staff be reevaluated by different psychiatrists. Further, the Clinic's close working relationship with the staff of Bellevue Hospital serves to expose its work to external scrutiny.

On several occasions, the Director of the Clinic has engaged in research drawing upon the work of the clinic. In one study, entitled "An Analysis of Demographic Variables in Adolescent Defendants Evaluated in a Forensic Psychiatry Clinic" (Rosner, Wiederlight, Horner-Rosner, and Wieczorek, 1977), specific demographic characteristics of 16-, 17-, and 18-year-old offenders examined at the Clinic in 1974 were analyzed. Another study, entitled "Sex Offenders: A Descriptive Analysis of Cases Studied at a Forensic Psychiatry Clinic" (Bonhem and Rosner, 1980), is based on forensic evaluations conducted at the Forensic Psychiatric Clinic in 1974 of defendants charged with at least one count of sexual assault.

Finally, the following statistics routinely are collected by the Clinic: number of fitness cases referred; number of probation cases referred; number of fitness interviews; number of probation interviews; and number of fitness cases recommended as fit, not fit, or referred to Bellevue. The statistics are used by the Director and the Director of Administrative Services to forecast caseload, maintain effective staff distribution, and demonstrate the accomplishments of the Clinic to the Commissioner of the Department of Mental Health and Mental Retardation.

COURTS DIAGNOSTIC CLINIC, HARTFORD, CONNECTICUT

The Courts Diagnostic Clinic was established in July, 1975, to accommodate changes in Connecticut law decentralizing the forensic evaluation process. (Prior to 1975, all evaluations to assess competency to stand trial, for example, were performed on an in-patient basis at a state hospital.) The Connecticut State Departments of the Judiciary, Probation, and Corrections collaborated to develop the Courts Diagnostic Clinic, which began operation as a three-year demonstration project funded by the Law Enforcement Assistance Administration (LEAA). Upon the expiration of LEAA funding in 1978, the Connecticut Department of Mental Health assumed fiscal responsibility for the Clinic's operation. In addition, the Department appropriated funds for the creation of courts diagnostic clinics in New Haven and Bridgeport. The New Haven Clinic

functions independently of the Hartford clinic, while the Bridgeport clinic is operated temporarily by Hartford Clinic staff. Long-range plans provide for the establishment of two additional courts diagnostic clinics in Connecticut, to result in a network of five clinics throughout the state providing forensic services to all Connecticut trial (Superior) courts.

The Hartford Courts Diagnostic Clinic functions as an agency of the Department of Mental Health. It performs forensic evaluations at the request of judges, public defenders, probation officers, and staff of a drug diversion program. Services are provided in 15 of Connecticut's 32 Superior Courts. In addition, the Clinic receives orders for competency-to-stand-trial evaluations from other courts in the state; however, the Clinic refers these cases to state hospitals for evaluation. (Because it entails no screening or evaluation, this referral function will not be addressed in this report.) Cases received from courts and probation officers are processed at no cost to the referring party, while all other referrals are processed on a fee-for-services basis.

The Courts Diagnostic Clinic performs two general types of evaluations: evaluations to assess competency to stand trial and psychosocial evaluations to assess drug dependency, mental health treatment needs, and general mental status. (Evaluations to assess criminal responsibility are arranged by the defendant or his attorney with private psychiatrists.) Evaluations are performed either at the Clinic's private office suite in downtown Hartford (if the person evaluated is not incarcerated) or at the Hartford Correctional Center (if the person is detained). Competency evaluations are conducted by a mental health team consisting of a psychiatric social worker, a psychiatrist, and a psychologist. Psychosocial assessments are performed either by a psychiatrist or a psychiatric social worker.

During 1978-79, the Clinic performed 310 psychosocial assessments and 219 competency-to-stand-trial evaluations. Of those cases received for psychosocial assessments, 167 were referred by the Public Defender's Office, 90 by the Probation Department, 43 by judges, and 10 by the drug diversion program. All cases received for competency- to-stand-trial evaluations were referred by court order. Of the defendants evaluated for competency to stand trial, 71.5 percent were found by Clinic staff to be competent, and 28.5 percent were found to be incompetent.

A Function Model

The caseflow of client-offenders into, through, and out of the Courts Diagnostic Clinic is depicted in Figures 9 and 10.

Competency-to-Stand-Trial Evaluations

Figure 9 illustrates the process by which the question of a defendant's competency to stand trial is raised, referred to the Clinic, addressed and responded to by Clinic staff, and resolved.

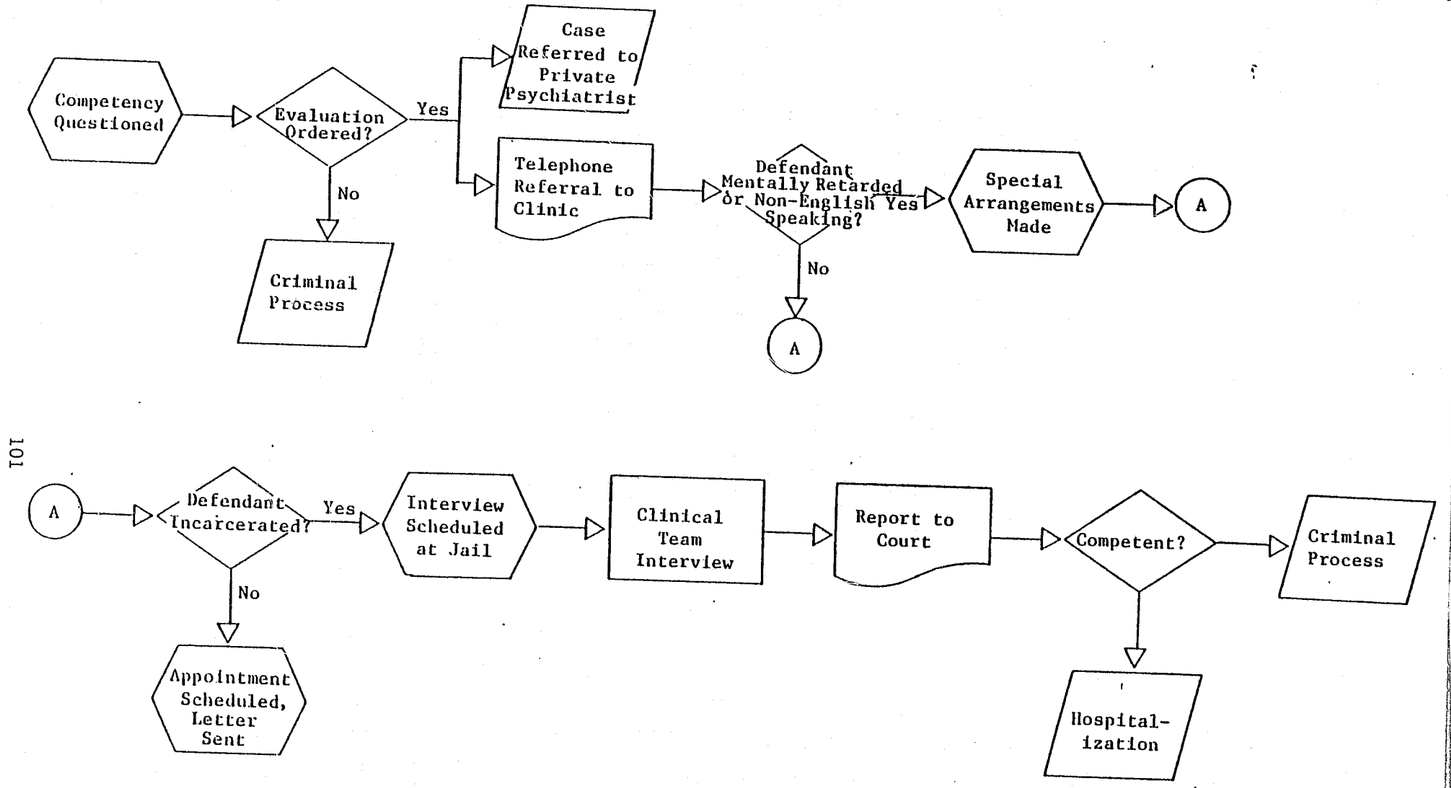


Figure 9. Process Flow of Evaluations to Assess Competency to Stand Trial at Hartford's Courts Diagnostic Clinic.

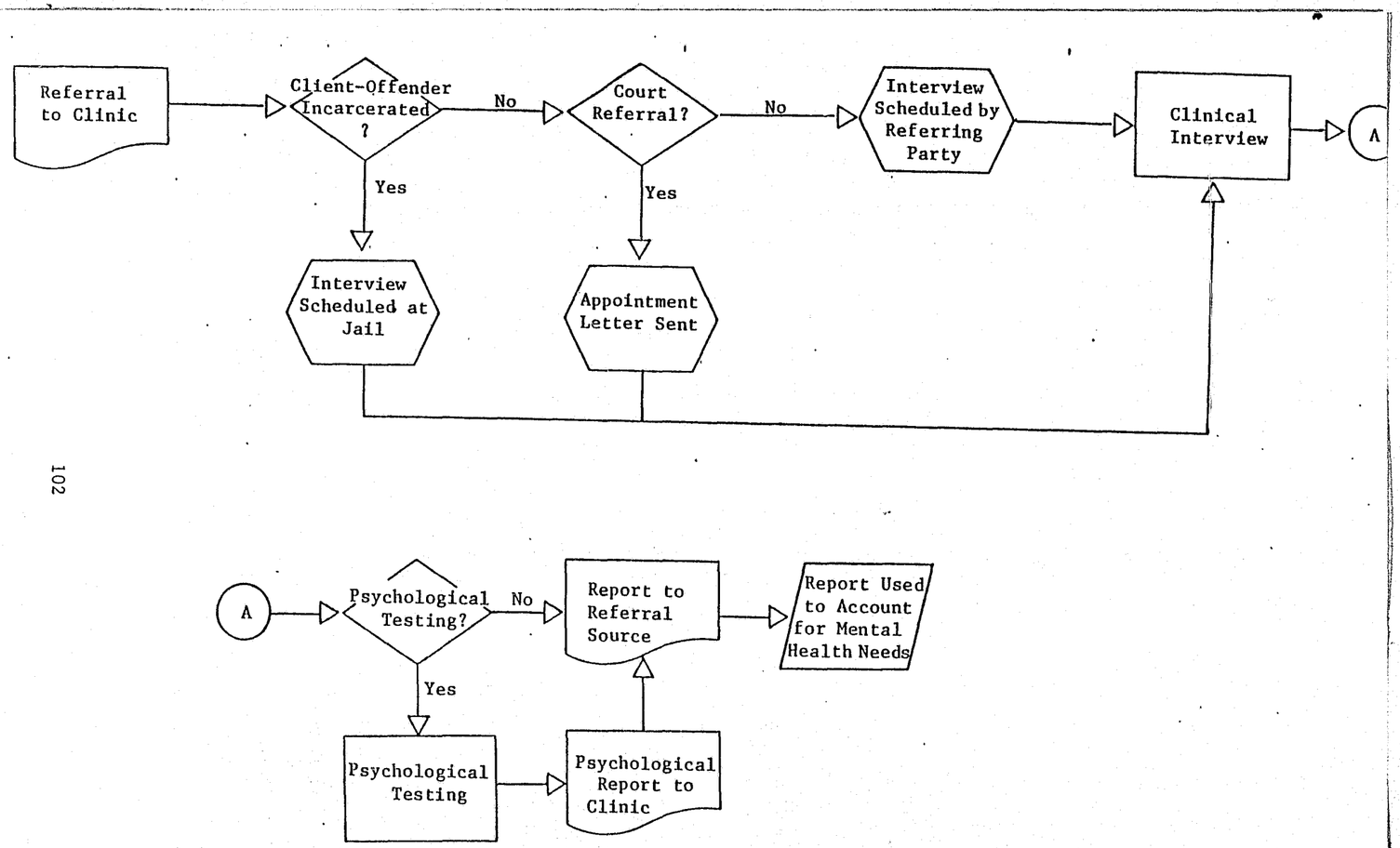


Figure 10. Process Flow of Psychosocial Assessments at Hartford's Courts Diagnostic Clinic.

The issue of competency to stand trial may be raised by the defense, the prosecution, or the court. The issue most often arises at arraignment, although it may be raised at any time prior to disposition. If the court is of the opinion that a defendant may be incompetent to stand trial, it will order that he be evaluated. Upon the issuance of a competency evaluation order, the court may either hire a private psychiatrist to conduct the evaluation (paid for out of court funds) or direct the case to the Court Diagnostic Clinic, as agent for the Department of Mental Health. (Of the competency evaluations ordered by Connecticut courts to which the services of the Courts Diagnostic Clinic are available, 95 percent are referred to the Clinic.)

On the day that the court issues the order, the court clerk telephones the Clinic with the referral. The Clinic's secretary/administrative assistant receives the call, completes a telephone referral form (Appendix F) and makes an entry in the competency referral log book (Appendix G). The court clerk follows up the telephone call with a mailing to the Clinic containing a copy of the order, a biographical data sheet ("face sheet") on the person referred, and a copy of the police report. Once per week, the Clinic Director reviews new referrals and schedules them for evaluations. An evaluation team consisting of a psychiatric social worker, a psychologist, and a psychiatrist is assigned to conduct the evaluation. If the defendant is not incarcerated, he is sent a letter specifying a date and time for an interview appointment at the Clinic's offices. If he is incarcerated, the Clinic's secretary/administrative assistant notifies the head nurse of the Hartford Correctional Center that the evaluation team will be visiting on a particular day to interview the defendant. If the information supplied by the court at referral suggests that the defendant is mentally retarded, arrangements are made for a psychologist from the Department of Mental Retardation to participate in the evaluation. Finally, if it is suspected that the defendant's primary language is not English, arrangements are made for the employment of an interpreter.

The interview is conducted, and the evaluation team formulates its opinion regarding the defendant's competency to stand trial. The psychiatric social worker prepares the team's report, arranges for obtaining signatures of team members, and submits the report to the court.

If the court determines that the defendant is competent to stand trial, a trial date is set. If the defendant is found incompetent to stand trial, he is admitted to a state hospital for treatment designed to restore competency. Subject to periodic review, the defendant may remain hospitalized, without being civilly committed, for as long as the maximum sentence he could receive were he convicted of the crime with which he was charged, or 18 months, whichever is less.

Psychosocial Assessments

Figure 10 illustrates the process by which cases referred for psychosocial assessments are directed to and processed by the Courts Diagnostic Clinic.

Referrals for psychosocial assessments are made in much the same manner as are referrals for competency-to-stand-trial evaluations. Referrals may be made at the pretrial or posttrial stage of criminal proceedings. They may be made by judges, public defenders, probation officers, or staff of the "Treatment Alternative to Street Crime" (TASC) program, a diversion program operated by the Probation Department for drug-dependent offenders. Referrals are made by telephone to the Clinic's secretary/administrative assistant, who completes a telephone referral form (Appendix F), makes an entry in the psychosocial assessment referral log book (Appendix H), and schedules a time for the client-offender to be interviewed. If the referral is from a probation officer, a public defender, or a TASC staff member, the referring person also completes a referral form (Appendices J, K, L) and mails it to the Clinic.

Probation officers and public defenders are responsible for arranging for their clients to keep their interview appointments. Incarcerated client-offenders are interviewed in the Hartford Correctional Center at times arranged with the Correctional Center's head nurse. Court-referred client-offenders who are not in custody are sent letters notifying them of their appointments.

The psychiatric social worker or psychiatrist assigned the case conducts a clinical interview and prepares a report for the person or agency responsible for the referral. The psychiatric social worker or psychiatrist may request that psychological testing be conducted by one of the Clinic's consulting psychologists. The results of such testing are incorporated into the report by the staff primarily responsible for the evaluation.

Delineation Of Mental Health Information Requirements

The Courts Diagnostic Clinic provides its services upon order or request of Superior Court judges, probation officers, public defenders, and TASC. The Superior Court is Connecticut's sole court of original jurisdiction and has family, civil, and criminal divisions. There are 32 Superior Courts in Connecticut, 15 of which are served by the Courts Diagnostic Clinic.

The standard for incompetency to stand trial in Connecticut is whether the defendant "is so insane or so mentally defective that he is unable to understand the proceedings against him, or to assist in his own defense." (Connecticut Criminal Procedure Statutes, §54-40(a)) Should the question of the defendant's competency to stand trial be raised, the judge may either order an evaluation by "one or more physicians specializing in psychiatry" or "may order the commissioner of mental health to effect an examination of the accused . . . either by a clinical team consisting of a psychiatrist, a clinical psychologist and a social worker or by one or more psychiatrists." (Connecticut Criminal Procedure Statutes, §54-40(b)) The Courts Diagnostic Clinic, as designee of the Commissioner of Mental Health, conducts all evaluations referred to the commissioner by courts to which the Clinic's services are available. Reports must be submitted to the court within 15 days of the date on

which the evaluation was ordered. (Connecticut Criminal Procedure Statues, §54-40[b])

Pretrial psychosocial assessments may be ordered by the court to generate information helpful to the judge in making pretrial release determinations and diverting appropriate cases to community drug, alcohol, or mental health programs. In cases for which no presentence report is prepared by the Probation Department, the judge may order a presentence psychosocial assessment to assist him in arriving at a sentencing decision and fashioning a suitable probation plan. Probation officers request presentence psychosocial assessments to help them prepare presentence reports for the court. They also may request psychosocial assessments of offenders on supervised probation for the purpose of identifying changes in mental health needs. According to Connecticut's Chief Public Defender, public defenders typically request pretrial (and, less often, posttrial) psychosocial assessments to "gain a better understanding of their clients" and to lay the groundwork for plea bargaining or raising the insanity defense. (As indicated previously, evaluations to assess criminal responsiblity are conducted by private psychiatrists.) The budget of the public defender's office allows for the referral of a maximum of 15 cases per month. TASC requests pretrial psychosocial assessments to identify drug-dependent offenders eligible for diversion into the TASC program.

Referrals are initiated by a telephone call to the Clinic. The Clinic's secretary/administrative assistant receives the call, completes a telephone referral form (Appendix F) and makes a log book entry (Appendices G and H). The telephone referral form records type of referral (i.e., competency or psychosocial); referral source; name, age, address, and telephone number of person referred; name of court and judge with jurisdiction over the case; bond amount; name of referred person's attorney; next court date; charges filed and pleas entered; reports being sent to the Clinic; and date and location of interview appointment. The completed form is the first item placed in the client-offender's case file. Log book entries record the progress of the evaluation. They document the name of the person referred, the Clinic file number, the court with jurisdiction, the referral source, the date the referral was received, the date the evaluation was ordered (if court-ordered), the court hearing date, the person's current address, the interview appointment date, the names of clinicians conducting evaluations, the date the evaluation was conducted, the clinical finding (for competency cases), the date the report was prepared, whether or not the clinician was called to testify (for competency cases), and any special information. Separate log books are maintained for competency referrals and psychosocial referrals.

After making a telephone referral for an evaluation to assess competency to stand trial, the judge or court clerk mails the Clinic a copy of the court order (which officially directs that an evaluation to assess competency to stand trial be performed but which presents no information not already communicated by telephone), a "face sheet" containing biographical information about the defendant, and a copy of

the police report indicating the particulars of the offense(s) charged. Probation officers making referrals for psychosocial assessments complete and mail the Clinic probation referral forms (Appendix J) containing information supplementing that provided in the telephone referral, including a summary of the incident(s) leading to arrest, the reason(s) for the referral, and available medical or psychiatric history. Public defender referrals include the mailing of a public defender referral form (Appendix K) indicating the charges pending, the reason for the referral, and other pertinent information. Public defender referral forms are completed by a social worker in the state public defender's office who is responsible for screening evaluation requests from the public defender staff and limiting the number of clinic referrals to 15 per month. TASC staff follow up their telephone referrals by completing and mailing TASC referral forms (Appendix L) indicating whether the reason for the referral is to assess "drug dependence," "rule out mental illness," or collect "general psychosocial" information.

Acquisition Of Mental Health Information

Staff

The staff of the Courts Diagnostics Clinic consists of four full-time psychiatric social workers, two full-time secretaries, five part-time, consulting psychologists, and four part-time, consulting psychiatrists. Evaluations to assess competency to stand trial are conducted by three-person evaluation teams composed of a psychiatric social worker, a psychologist, and a psychiatrist. The teams are assembled by the Clinic director. Psychosocial assessments are performed by a social worker or a psychiatrist, as assigned by the director.

Procedures and Techniques, Competency to Stand Trial

Upon receipt of a referral, the Clinic's secretary/administrative assistant prepares a file containing the referral materials and delivers it to the Clinic director. The director arranges for the psychiatric social worker on the evaluation team assigned the case to carry the file to the interview and share its contents with the other members of the team prior to commencement of the interview. If the director or secretary/administrative assistant has reason to believe that the defendant is non-English-speaking, arrangements are made for an interpreter to attend the interview. If the Clinic has reason to believe that the defendant is mentally retarded, arrangements are made for a psychologist from the Department of Mental Retardation to attend.

Competency interviews are performed one day per week. Four to six interviews are conducted on each interview day. Most interviews are conducted at the Hartford Correctional Center; however, defendants released prior to trial are interviewed in the Clinic's offices. If the defendant is incarcerated, the Clinic secretary/administrative assistant telephones the Hartford Correctional Center the afternoon before and the morning of the day scheduled for competency interviews and notifies the head nurse which inmates are to be interviewed that day. If the

defendant is female, the Connecticut Correctional Institute in Niantic, Connecticut, the state's only prison for women, is notified, and the defendant is transported to the Hartford Center to be interviewed. Since most interviews are conducted at the Hartford Correctional Center, the team scheduled to consider cases that day meets at the Correctional Center in the morning unless they are notified in advance that an interview is scheduled in the Clinic's office. Interviews in the Correctional Center are conducted in interview rooms in the infirmary.

Competency interviews generally last approximately 40 minutes. Before each interview, the team reviews the referral materials in the defendant's file. There is an "initial interviewer" who directs the questioning. The team members rotate serving as initial interviewer. The questioning addresses the defendant's understanding of

- current legal situation;
- the charges;
- the relevant facts;
- the legal issues and procedures;
- the function of court personnel;
- the mechanics of pleading and plea bargaining; and
- the possible dispositions and penalties;

and ability to

- identify and locate witnesses;
- comprehend instructions and advice;
- make decisions after receiving advice;
- maintain a collaborative relationship with his attorney;
- follow testimony for accuracy;
- testify and be cross-examined;
- tolerate stress; and
- refrain from irrational behavior.

Each team member completes a competency evaluation form (Appendix M), on which he rates the defendant as excellent, good, fair, or poor with respect to each of the items of inquiry listed above.

Following the interview, the evaluation team members discuss their impressions and arrive at an opinion regarding the defendant's competency to stand trial. Psychological testing is never conducted.

Procedures and Techniques for Psychosocial Assessments

Upon receipt of a referral, the Clinic's secretary/ administrative assistant prepares a file containing the referral materials and delivers it to the Clinic director. The director assigns the case for evaluation. The evaluation typically is conducted at the Clinic's Hartford offices and consists of a one- to two-hour clinical interview. Inquiry is made in the following areas:

- family and marital history;
- school history;
- work history;
- drug and alcohol history;
- psychiatric and medical history;
- arrest history; and
- mental status.

Some psychosocial referrals (notably TASC referrals) specifically request that the evaluation assess the person's drug dependency. In such cases, the interviewer additionally questions the person in the following areas:

- type of drugs used;
- amount used and duration of use;
- extent of detoxification;
- prior addiction;
- prior treatment; and
- arrest history related to drug charges.

If the psychiatric social worker or psychiatrist conducting the interview believes that psychological testing is necessary before an accurate description of a client-offender's psychosocial state can be produced, he may request that one of the Clinic's consulting psychologists administer a battery of tests to the client-offender. The psychologist conducting the testing completes a "psychological testing summary" (Appendix N), which describes psychological functioning in the areas of intelligence, achievement, personality, neurological functioning, and vocational aptitudes.

Provision and Use Of Mental Health Information

Competency to Stand Trial

The opinion reached by the clinical team following its evaluation of a defendant is summarized in a report for the court prepared by the psychiatric social worker. Signatures of each team member are attached. The report is submitted typically within ten to fourteen days of the evaluation order. The clerk of the court arranges for copies to be sent to the defense attorney and the prosecutor.

The report contains two standard paragraphs describing the manner in which the interview was conducted (Appendix O) and one page assessing the defendant's responses and reactions to the questioning and presenting the team's opinion regarding competency. If a member of the evaluation team disagrees with the majority opinion regarding competency to stand trial, his views are expressed in terms of possible qualifications of the clinical finding agreed to by the team; minority opinions are not expressed. The Clinic's policy is that competency to stand trial is a narrow legal question not to be confused with mental illness generally. Accordingly, the evaluation team may be of the opinion that a particular defendant is competent to stand trial (understands the nature of the charges against him and is able to assist in his own defense) but at the same time is mentally ill. As a result, competency reports occasionally

suggest follow-up medical, neurological, or other mental health examinations.

The courts receiving competency evaluation reports determine the question of competency to stand trial primarily on the basis of the information presented in the reports. Not infrequently, clinical testimony is requested. In such cases, the psychiatric social worker ordinarily is the team member who testifies, as permitted by Connecticut Criminal Procedure Statutes, §54-40(b).

Psychosocial Assessments

At the conclusion of his evaluation of an individual's psychosocial condition, the psychiatric social worker or psychiatrist prepares a report summarizing his findings. The report incorporates the results of any psychological tests administered. If the test results are especially revealing, the clinician attaches a copy of the testing summary. If the psychosocial assessment was court ordered, the report is sent to the court. If the assessment was requested by a public defender, a probation officer, or TASC, the report is sent only to the requesting person or agency and confidentiality is maintained. The evaluation is completed and the report is sent ordinarily within two to three weeks of the date on which the evaluation was ordered or requested.

The report summarizes the manner in which the interview was conducted and provides information in the following areas:

- family and marital history;
- school history;
- work history;
- drug and alcohol history;
- psychiatric and medical history;
- arrest history;
- mental status;
- diagnostic impressions; and
- recommendations (i.e., treatment).

If the referral specifically requests a drug dependency assessment, the report also indicates:

- type of drugs used;
- amount and duration of use;
- whether detoxification has been accomplished;
- prior addiction;
- prior treatment;
- arrest history related to drug charges; and
- medication currently in use to detoxify.

Judges may use the information provided to determine pretrial or presentence conditions of release, to divert a case out of the criminal justice system and into a community drug, alcohol, or mental health treatment program, to order mental health treatment as a condition of probation, or otherwise to dispose of a case taking into account the

client-offender's mental health requirements. Probation officers use the information provided either in preparing presentence reports for the court or in modifying (or requesting the court to modify) the conditions of probation for persons whose probation they are supervising. Public defenders use the information provided to lay the groundwork for plea bargaining and to determine whether the insanity defense should be raised. TASC uses the information provided to determine whether a person is drug dependent and therefore qualified for diversion into its program.

Quality Control and Program Evaluation

Quality Control and overall program evaluation of the Courts Diagnostic Clinic takes three basic forms: 1) management, monitoring, and informal feedback to Clinic staff; 2) routine statistical reporting; and 3) special studies and reports.

Management, Monitoring, and Feedback

The primary concerns of the Courts Diagnostic Clinic are that evaluations be focused, consistent, and thorough, and that reports be responsive and timely. To facilitate this, each new clinic staff member is given an orientation to the evaluation process. The staff members work together closely and regularly discuss cases on an informal basis. Lunch time typically finds the staff assembled in the conference room discussing issues ranging from mental health to religion and politics. In addition, the Clinic sometimes receives feedback on an informal basis from judges, public defenders, and probation officers using the services of the Clinic. Finally, the Clinic provides the Connecticut Department of Mental Health with annual reports summarizing its work during the previous year.

Statistical Reporting

The Courts Diagnostic Clinic collects the following statistics:

- number of referrals from each source;
- number of cases referred for psychosocial assessments;
- number of evaluations performed to assess competency to stand stand trial;
- number of women evaluated for competency to stand trial;
- number of competency-to-stand trial assessments performed at the Clinic and at the Hartford Correctional Center; and
- number of defendants evaluated for competency to stand trial recommended as competent or incompetent.

The Clinic's director uses this information to monitor demand for the Clinic's services and to prepare annual reports for the Connecticut Department of Mental Health. In addition, the Clinic provides the Department with extensive biographical and diagnostic information on persons evaluated. This information is entered into the state's computerized mental health information system, which tracks all cases receiving Department of Mental Health services.

Special Studies and Reports

In 1977, the Connecticut Department of Mental Health sponsored a study (Note 9) that described the work of the Clinic, analyzed the costs of the Clinic's operation (and compared the cost of evaluations performed by the Clinic with that of evaluations performed by private, court-appointed psychiatrists and psychologists), and surveyed judges and probation officers regarding their satisfaction with the Clinic's services.

Among the study's findings were the following:

- Approximately two-thirds (62 percent) of those examined for competency were found competent to stand trial, a percentage consistent with the findings of other groups (psychiatrists of the Department of Mental Health and private psychiatrists) who examine accused for competency. Competency findings evaluated in the light of demographic factors suggest that accused are more likely to be found competent if they are white, male, young, and accused of relatively serious crimes, i.e., crimes against people.

- The competency examination reports of the Clinic were returned to the court significantly faster (11.6 days) than were those of the other examining groups (19.0 days).

- The cost of each competency examination performed by the three-member Clinical Team was $76. This amount was lower than that estimated for the private psychiatrist ($83) but higher than that for the examinations performed by psychiatrists of the Department of Mental Health ($60). The last figure, however, does not take into consideration the loss of patient care services to the Department of Mental Health.

- In general, both judges and probation officers indicated favorable response to the Clinic's procedure and favored its expansion so that all members of their respective groups can avail themselves of the Clinic's services. 76 percent of the judges and 92 percent of the probation officers who responded so indicated. Some additional findings were that 72 percent of the judges who used the Clinic service agreed that the clinical team was expert in its ability to render competency opinions and 67 percent agreed that the clinical team members demonstrated professional expertise in their testimony at competency hearings. Of the probation officers who responded, 92 percent agreed that the reports of the Clinic are an aid in the disposition of cases and that the Clinic's interpretation contributes to a better understanding of the potential probationer.

In 1979, the Chief Public Defender's Office conducted a survey of public defenders in Connecticut who had used the services of the Clinic. The survey was designed to ascertain the reasons for public defenders' referrals and to assess the way in which the information provided by the Clinic affected the outcomes of cases. According to the Chief Public Defender, the most common reason given for referring a case was to "gain a better understanding of my client." Additionally, respondents indicated generally that the evaluations increased the likelihood of "probation with treatment" where incarceration might otherwise have resulted.

In addition to these evaluations, the Clinic's work has formed the basis for a number of studies and articles relating to mental health evaluations for the courts. The benefits and problems (actual and potential) of performing competency evaluations in a courts clinic setting are assessed in an article by Fitzgerald, Peszke, & Goodwin (1978) that focuses on the work of the Courts Diagnostic Clinic. Demographic profiles of persons referred to the Courts Diagnostic Clinic and outcomes of cases for which the Clinic performed public-defender-referred evaluations are discussed in a recent volume by Fitzgerald (1979).

CAMBRIDGE (MASSACHUSETTS) COURT CLINIC

The court clinic system in Massachusetts traces its roots to a Massachusetts Department of Mental Health "pilot project" established in 1948. The project, "brainchild" of Norfolk County juvenile court probation officer Jim Devlin and child psychiatrist Don Russell, entailed the establishment of a clinic operating out of existing Department of Mental Health facilities to provide mental health services to delinquent or alleged delinquent juveniles in the Boston area. As a result of the project's success, the clinic concept in Massachusetts was expanded in 1954 with the establishment of the Cambridge Court Clinic as a district court "demonstration project" to serve adult cases as well as juvenile cases. In 1956, a Division of Legal Medicine was established within the Massachusetts Department of Mental Health for the purpose of facilitating the growth and operation of the court clinic system in the state. To date, 26 clinics have been established. All but two, the Norfolk County Probate Court Clinic and the Suffolk County Superior Court Clinic, are located in and serve district courts. The Cambridge Court Clinic has operated continuously since 1954.

The Cambridge Court Clinic provides its services primarily for the Third District Court of Eastern Middlesex (Cambridge District Court), which has original criminal jurisdiction of misdemeanors and felonies carrying sentences of less than two and one-half years imprisonment; unlimited non-jury, civil jurisdiction; and exclusive juvenile jurisdiction. Additionally, the District Court conducts preliminary hearings in felony cases within the Superior Court's jurisdiction. The Clinic occasionally provides services on an informal basis for the Middlesex County Superior Court, which is Massachusetts' highest court of general trial jurisdiction, having general jurisdiction of all criminal

offenses and unlimited civil jurisdiction. Superior Court services are provided on a fee basis. Finally, the Clinic is administratively responsible for the Family Services Clinic, which is located in and provides services for the Middlesex County Probate Court, the jurisdiction of which includes probate matters and divorce and child custody contests.

The Cambridge Court Clinic provides the following services:

(1) screenings to assess competency to stand trial and criminal responsibility (the clinic recommends whether or not further evaluation is warranted);

(2) evaluations of persons claiming drug dependency (for deferred prosecution or treatment during sentencing), to assess drug dependency and treatment suitability;

(3) post-conviction, presentence evaluations of criminal offenders, to assess mental health treatment needs;

(4) evaluations of persons on supervised probation, to assess mental health treatment needs;

(5) evaluations of parties or potential witnesses, to assess competency to testify;

(6) screenings of applications for "warrants of apprehension" (warrants to detain persons for civil commitment hearings); evaluations of persons detained on warrants of apprehension, to assess civil commitability;

(7) screenings of requests and preparation of applications for temporary hospitalization of persons believed to constitute a "likelihood of serious harm" (to self or others) by reason of mental illness;

(8) evaluations of persons with respect to whom petitions for the involuntary commitment of an alleged alcoholic have been filed, to assess committability to a public health facility;

(9) pre-disposition evaluations of juvenile offenders to assess mental health treatment needs;

(10) evaluations of "CHINS" (children in need of service), to assess mental health treatment needs, as well as "care and protection" evaluations of abused and/or neglected children;

(11) supervision of the Family Service Clinic and evaluations of that clinic's overflow cases (primarily evaluations of children and their parents involved in custody/visitation contests);

(12) treatment of offenders or alleged offenders on probation or pretrial release with stipulations for treatment;

(13) education and training of graduate psychology and social work students and psychriatric residents; and

(14) research.

Only those services entailing screening and evaluation of criminal or alleged criminal offenders (1-5 above) will be described in detail in this report.

The core of the Cambridge Court Clinic's operation is funded by the Massachusetts Department of Mental Health. State-funded positions include one full-time psychiatrist (the Clinic Director), two half-time psychiatrists, one half-time psychiatrist permanently loaned to another court clinic, one half-time psychologist, two full-time social workers (one of whom is the Chief Social Worker), one part-time consultant psychologist ("forensic clinician"), and two secretaries/administrative assistants. In addition, there are a varying number of staff funded by federal and foundation grants. Among these are a masters-level drug counselor, a masters-level psychologist, and several graduate students in psychology and social work. With the exception of secretaries/administrative assistants, all of the staff participate in the evaluation and treatment of offenders and alleged offenders and may be referred to as "clinicians" in this report. Students serve as clinicians under the close supervision of staff.

The Director of the Cambridge Court Clinic estimates that the Clinic receives 800-900 new referrals per year, of which 200-300 are "court calls" (generally to assess competency to stand trial or criminal responsibility or to assist in psychiatric emergencies). In all, the Clinic averages 400 visits per month for evaluation and treatment.

Process Flow

The flow of mental health evaluation cases into, through, and out of the Cambridge Court Clinic is depicted in Figures 11-15.

Competency to Stand Trial and Criminal Responsibility

Figure 11 indicates the typical process by which the questions of competency to stand trial and criminal responsibility are raised in a particular case, referred to the Clinic, addressed and responded to by Clinic staff, and resolved.

Questions of competency to stand trial and criminal responsibility typically arise at arraignment, although they may be raised at any time prior to or during a trial. (Competency may be raised at any time prior to disposition.) Each day, prior to arraignment, a probation officer interviews all defendants to be arraigned. If the probation officer observes behavior that indicates that a particular defendant may be

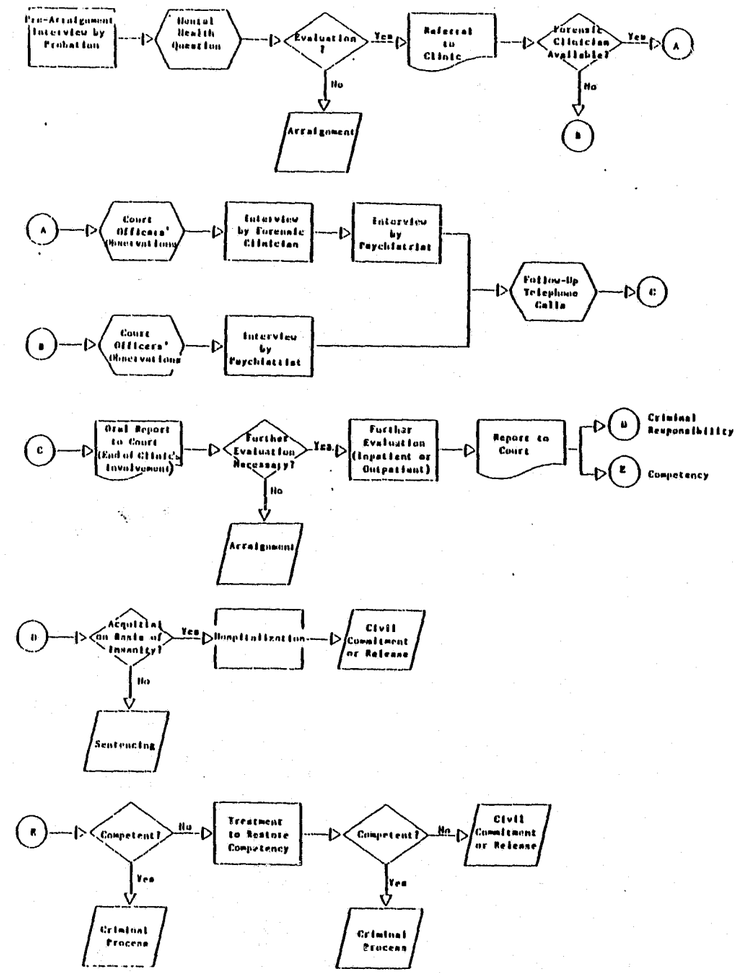


Figure 11. Process Flow of Screenings to Assess Competency to Stand Trial and Criminal Responsibility at the Cambridge Court Clinic.

mentally disordered, he brings this to the attention of the judge at the opening of court. The judge appoints an attorney for the defendant and usually orders the Cambridge Court Clinic to screen her or him. The probation officer calls the Clinic secretary, who makes a note of the names of the defendant and attorney and the crime(s) charged. The secretary then checks the Clinic files to determine whether the defendant has been screened or evaluated at the Clinic before. The secretary delivers this information to either the "forensic clinician," if he is available, or to a psychiatrist, if the forensic clinician is not available. (The forensic clinician is an MA-level psychologist who works three days per week and screens "court calls" prior to the psychiatric screening.)

Upon receiving the referral, the clinician (forensic clinician or psychiatrist) immediately visits the courtroom and speaks with the probation officer, the defense attorney, and the court officer regarding their impressions of the defendant's behavior. The clinician then interviews the defendant. When the forensic clinician has performed these services, he then telephones the Clinic's secretary and requests that a psychiatrist be dispatched also to interview the defendant. (Massachusetts law requires that competency and criminal responsibility evaluations be performed by a qualified physician.) The psychiatrist reports to the courtroom immediately and speaks with the forensic clinician before interviewing the defendant. After the interview, the psychiatrist and the forensic clinician discuss their impressions and, in order to verify or supplement what the defendant has said, may telephone doctors, hospitals, relatives, or others mentioned by the defendant during the interview. They also ask for the defense attorney's opinion about his client's ability to carry on a reasonable conversation regarding his case. The clinicians determine whether inpatient evaluation is required and then formulate an opinion regarding the defendant's competency to stand trial and/or criminal responsibility. This information is presented verbally to the court. (If a psychiatrist was assigned the case from the beginning, he alone conducts the evaluation and reports to the court.)

With regard to competency to stand trial, the court either finds the defendant competent and proceeds with arraignment or orders that he be evaluated further for competency. With regard to criminal responsibility, the court either orders the defendant evaluated further for criminal responsibility or proceeds with arraignment. (The court ordinarily may not, at this stage and on the basis of this screening, rule that the defendant was criminally responsible at the time that he is alleged to have committed an offense, since criminal responsibility is a defense that may be determined only at trial.) If the defendant, though not requiring further evaluation for competency or responsibility, is believed to have other mental health problems, the judge may recommend that he receive treatment at the jail or as a condition of release in the care of a probation officer. If the judge orders further evaluation, he will ask the clinician(s) to recommend whether the evaluation should be performed on an inpatient or an outpatient basis and, if on an inpatient basis, whether the defendant should be admitted to a regular Department

of Mental Health hospital or to the maximum security facility at Bridgewater State Hospital. (Only males may be admitted to Bridgewater.) With this recommendation, the Clinic contacts staff of the facility in which the defendant is to be hospitalized and advises them of the impending transfer and of the clinical condition and legal status of the defendant. The defendant may be hospitalized for a period not to exceed twenty days, at the end of which time the hospital either reports its findings regarding competency and/or responsibility or requests a twenty-day extension for further observation and evaluation. The hospitalization may not exceed forty days from the date of the initial court order of hospitalization unless the defendant requests continued care and treatment during the pendency of the criminal proceedings against him.

The hospital or other clinical facility performing the evaluation reports its findings to the court, and the court determines the question of the defendant's competency to stand trial. If the defendant is found competent, the criminal process resumes. If he is found incompetent, he may be admitted to a hospital for a period of forty days for observation and examination (maximum of fifty days including all previous hospitalization for evaluation). According to the Director of the Clinic, at the end of this period the defendant is either committed by the criminal court under civil commitment standards (until such time as his competency to stand trial is restored), or held under criminal standards for the maximum period for which he might have been sentenced if convicted of the most serious offense charged (and then committed civilly, or released if not found committable). The question of criminal responsibility is determined at trial if the insanity defense is raised. If the defendant is found not guilty by reason of insanity, he may be admitted to a hospital for observation and examination for a period of forty days (maximum of fifty days including all previous hospitalization for evaluation), at the end of which time he is either committed or by civil standards released. Incompetency and insanity commitments are initially for six months and may be renewed annually thereafter at formal commitment hearings.

Party or Witness Competency

Figure 12 illustrates the process by which the Cambridge Court Clinic receives referrals, conducts evaluations, and reports its findings regarding the competency of a party or a potential witness to testify as a witness. The question of witness competency may arise prior to any court hearing and may be raised by the prosecutor, the probation officer, the defense attorney, or the court. If the judge believes there may be some question as to the mental capacity of the party or witness to understand and participate in the proceedings, he will order the defendant evaluated by a Clinic psychiatrist. A written order is issued and routed by inter-office mail to the Clinic's Director, who assigns a qualified physician to conduct the evaluation and schedules an appointment for the party or witness to be evaluated. The evaluation is conducted, and the physician either testifies or submits his findings in writing to the court. The court uses the information provided in

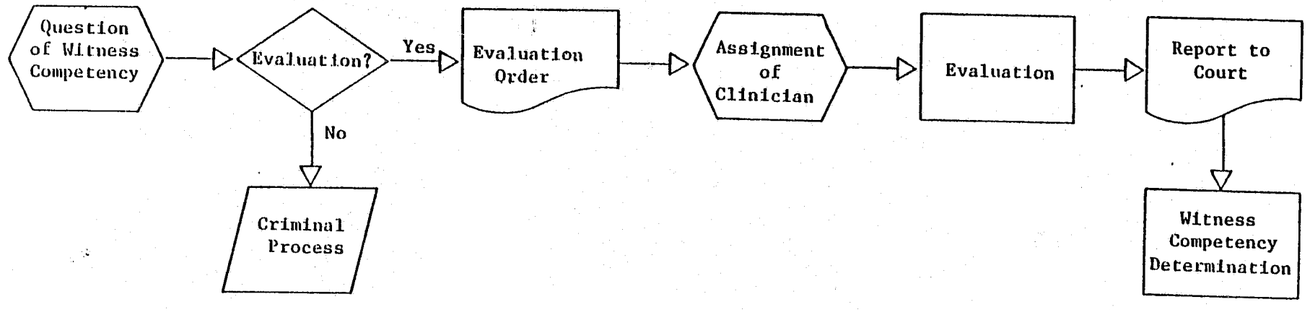


Figure 12. Process Flow of Witness Competency Assessments in the Cambridge Court Clinic.

determining whether or not to declare a potential witness incompetent to testify.

Presentence Evaluations

Figure 13 illustrates the process by which the Cambridge Court Clinic receives referrals, conducts evaluations, and reports its findings regarding the mental condition of a criminal offender prior to sentencing.

After a finding of guilty and prior to sentencing, if the court believes that an offender's mental condition may warrant special consideration in sentencing, it may order the offender evaluated at the Clinic. The evaluation may be requested by the defense attorney, the prosecutor, or the probation officer, or it may be ordered sua sponte. If the court believes an inpatient evaluation is necessary, a written order is issued and the offender is hospitalized for a period not to exceed forty days. If an outpatient evaluation is specified, a verbal order is issued, and the court probation officer sends a clinic referral form to the Clinic through the inter-office mail along with a copy of a "face sheet" and any other pertinent material on the offender. The Clinic's Director receives the referral, assigns a clinician to evaluate the offender, and schedules an appointment for the offender to be evaluated in the Clinic's offices. The evaluation is conducted and the clinician submits his findings in writing to the court within forty days of the date of the evaluation order. The court uses the information provided to fashion an appropriate sentence.

Probation Referrals

Figure 14 indicates the process by which the Cambridge Court Clinic receives referrals, conducts evaluations, and reports its findings regarding the mental condition of a criminal offender on supervised probation.

If a probation officer believes that an offender whose probation he is supervising may be in need of mental health services, he sends a referral form to the Clinic through the inter-office mail along with a copy of a "face sheet" and any other pertinent material on the defendant. Probation referrals ordinarily are directed to the Chief Social Worker, who meets with the Clinic Director weekly to assign cases to particular clinicians. The evaluation is conducted, the case is discussed, and the clinician submits his findings and any treatment recommendations to the referring probation officer. If treatment is indicated, the probation officer ordinarily attempts to persuade the offender to enter into treatment on a voluntary basis, either at the Clinic or elsewhere. If the offender resists treatment, the probation officer may notify the court and request that the conditions of probation be amended to include treatment. Before making such an order, the court appoints counsel for the offender and hears the matter. Once treatment has begun, confidentiality is maintained under the patient-psychotherapist privilege.

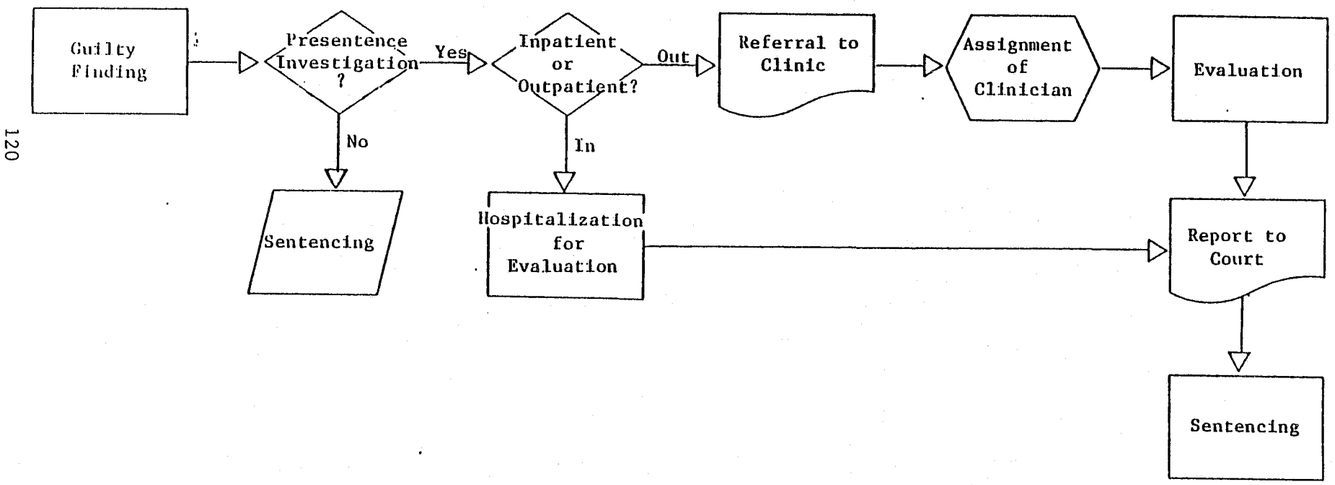
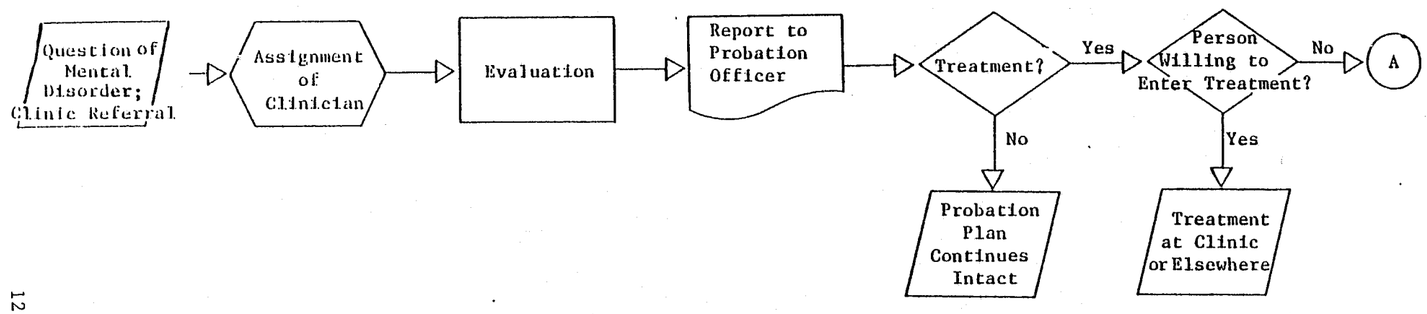


Figure 13. Process Flow of Presentence Evaluations at the Cambridge Court Clinic.



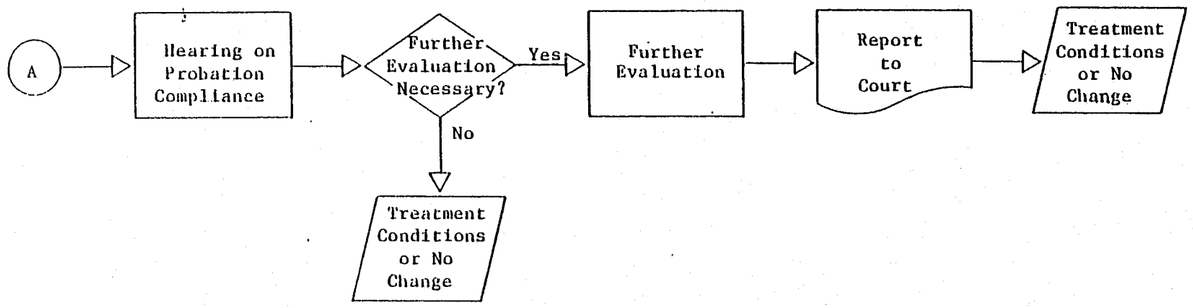


Figure 14. Process Flow of Evaluations of Probationers in the Cambridge Court Clinic.

Drug Dependency

Figure 15 indicates the process by which the Cambridge Court Clinic receives referrals, conducts evaluations, and reports its findings regarding the drug dependency and treatment suitability of offenders or alleged offenders.

Every person charged with a drug offense is advised of his right to request in writing an evaluation to assess whether or not he is drug dependent and would benefit by treatment. Further, persons convicted of offenses other than drug offenses may request a drug dependency evaluation prior to sentencing. Upon receipt of a request for evaluation, the court may find the person drug dependent without ordering an evaluation or may order the person evaluated by a psychiatrist at the Clinic. Evaluation orders are issued in writing and are routed through the inter-office mail to the Clinic's Director, who assigns a clinician to conduct the evaluation. The evaluation is conducted and a written report is submitted to the court.

If the court finds that a person charged with a drug offense is drug dependent and would benefit by treatment, it may, with the person's consent, assign him to a drug facility for treatment on an inpatient or an outpatient basis for a period not to exceed eighteen months or the maximum sentence he could receive were he convicted of the offense with which he is charged, whichever period is shorter. Criminal proceedings are stayed during the period of the treatment. If the person completes the treatment program successfully, the court as a matter of practice dismisses the charges against him. If the person fails to complete the treatment program successfully, the court revokes the stay of proceedings and tries the person on the charges pending.

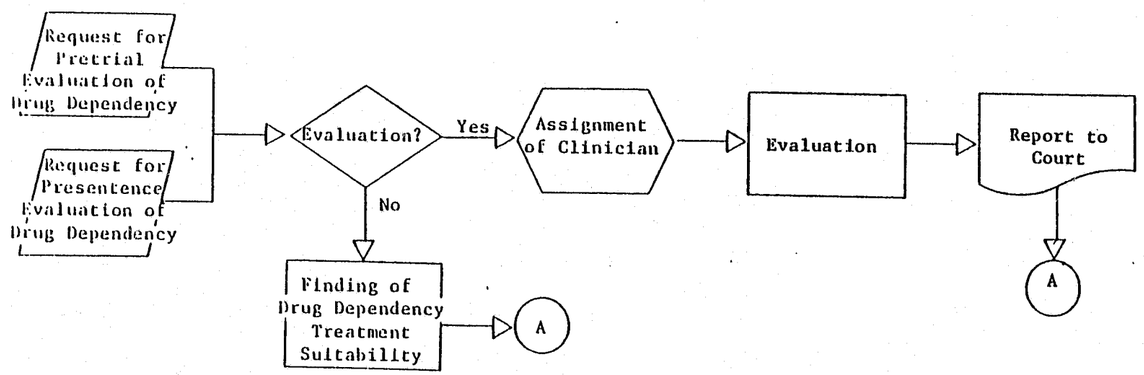
If the court finds that a person convicted of an offense other than a drug offense is drug dependent and would benefit by treatment, it may, with the consent of the person, order that the person be either treated while incarcerated or admitted to an in-patient or an out-patient treatment program as a condition of probation.

Delineation of Mental Health Information Requirements

The Cambridge Court Clinic receives referrals for evaluation by telephone, by written court order, and by clinic referral form.

Competency to Stand Trial and Criminal Responsibility

Screenings to assess competency to stand trial or criminal responsibility are ordered verbally by the court upon request of the court probation officer, the defense attorney, the prosecutor, or sua sponte. The probation officer relays the order by telephone to the Clinic's secretary, delineating for the secretary the defendant's name, the crime(s) charged, the judge before whom the case is pending, and the fact that a mental health examination was ordered. At this stage of the proceedings, the defendant's suspected mental disorder typically will not



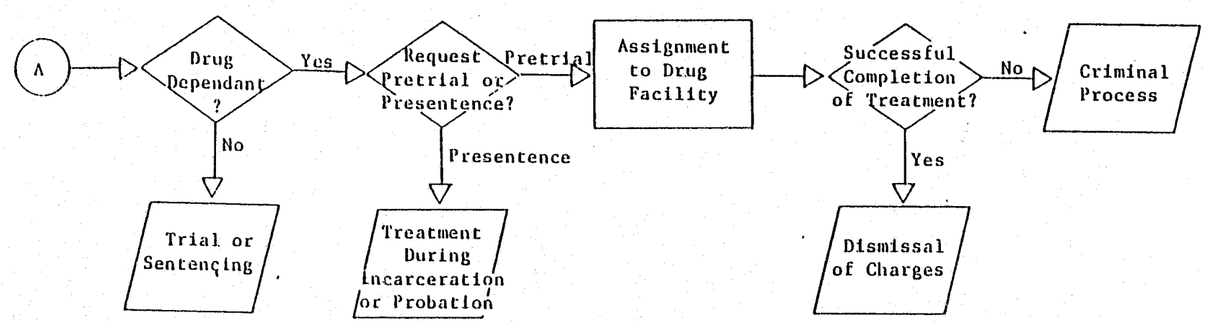


Figure 15. Process Flow of Drug Dependency Evaluations in the Cambridge Court Clinic.

have been classified as incompetency to stand trial or lack of criminal responsibility.

The test for competency to stand trial is whether the defendant has "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as a factual understanding of the proceedings against him." Commonwealth v. Hill, 375 N.E. 2d 1168 (1978). The test for criminal responsibility is whether the defendant, "as a result of mental disease or defect, . . . lacked substantial capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law." Commonwealth v. O'Conner 387 N.E. 2d 190 (1979). Outpatient screenings to assess competency to stand trial and criminal responsibility are authorized by Massachusetts General Laws, Chapter 123, §15(a).

Party or Witness Competency

Referrals for evaluations to assess the competency of a party or a potential witness come by written court order issued at the request of the defense attorney, the prosecutor, the probation officer, or sua sponte. The order is routed to the Clinic Director through the inter-office mail. The order indicates the name of the person to be evaluated, the caption of the case in which he is expected to testify, and the date of the next court hearing, and directs that a "§19 examination" be performed by a qualified physician to ascertain the person's competency to testify as a witness. Evaluations to assess a person's competency to testify as a witness are authorized by Massachusetts General Laws, Chapter 123, §19. According to the Director of the Clinic, the evaluation is designed to assess the person's mental capacity to understand the proceedings, realize the consequences of his testimony, and participate meaningfully in the proceedings.

Presentence and Probation Evaluations

Presentence evaluations are ordered verbally by the court at the request of the defense attorney, the prosecutor, the probation officer, or sua sponte. The probation officer completes a referral form and routes it, along with a copy of a "face sheet" and any other pertinent material on the defendant, through the inter-office mail to the Director of the Clinic. Referrals for evaluation of offenders on supervised probation also come by referral form with a face sheet attached, but are directed to the Clinic's Chief Social Worker. The referral form indicates the offender's name, age, address and telephone number; offense; reason for the referral (i.e., "presentence evaluation upon court order"); urgency of the referral; sentencing data; and a statement of the problem (examples of disordered behavior, as perceived). Face sheets are prepared by the court probation officer during the prearraignment interview and indicate identifying information, marital history, family history, employment history, school history, financial condition, mental and physical health problems, drug and alcohol use, military history and prior criminal record. Presentence evaluations are

authorized by Massachusetts General Laws, Chapter 123, §15(e). According to the Clinic Director, the presentence evaluation process is designed to assess 1) whether or not the person is mentally ill, 2) the extent to which such mental illness would hinder his ability to serve a sentence in a penal environment, and 3) whether or not another rehabilitative approach would better serve the needs of the offender and society. Evaluations of offenders on probation are intended to assess the offender's treatment needs generally.

Drug Dependency

Referrals for drug dependency evaluations come by written court order, issued at the request of the defendant or offender. The order typically indicates the name of the person to be evaluated, the offense(s) charged or committed, and the date of the next court hearing, and directs that a "§47 examination" be performed by a qualified psychiatrist to ascertain whether the defendant or offender is drug dependent and would benefit by treatment. Drug dependency evaluations are authorized by Massachusetts General Laws, Chapter 123, §§47-49. According to the Director of the Clinic, drug dependency evaluations are intended to assess the extent to which drug use affects the person's behavior and life style and whether the person might benefit by participation in a drug treatment program. According to the Clinic's drug treatment specialist, a primary implicit purpose of the evaluation relates to job placement and the extent to which treatment might promote employment stability.

Acquisition Of Mental Health Information

Competency to Stand Trial and Criminal Responsibility

Upon receipt of a referral, the clinician (forensic clinician, if available, or the psychiatrist on "court call") reports immediately to the courtroom in which the defendant is being held pending continuation of arraignment. The clinician questions the probation officer regarding the nature of the problem and examines the face sheet and any other reports in the probation file. He then asks the defense attorney for his observations and requests that the attorney sit with his client during the clinical interview.

The interview usually is conducted in an interview room adjacent to the courtroom; however, if the defendant is "out of control" and violent, the interview is conducted through the bars of the defendant's cell elsewhere in the building. The clinician begins the interview by explaining the purpose of the examination and warning the defendant that his statements may not be held confidential. During the course of the interview, the clinician typically inquires as to defendant's family background, school history, marital status, medical history (with emphasis on recent injuries or illness), mental health history (noting psychiatrists seen or hospitalizations in the past, particularly if related to suicidal or homicidal behavior), military history, employment history, drug and alcohol use, and previous criminal history (noting

charges and dates of offenses). The clinician always screens for incompetency to stand trial, inquiring with regard to the defendant's understanding of the charges against him (nature, seriousness, consequences) and of the court process (roles of participants, concept of pleading, etc.). If the clinician suspects that criminal responsibility may become an issue, he inquires into the circumstances surrounding the incident leading to the defendant's arrest. All evaluations include a mental status examination entailing assessments of physical appearance and behavior, speech, affect, mood, suicidal/homicidal ideation, thought processes (evidence of hallucinations, looseness of associations, paranoia, ideas of reference, flight of ideas etc.), thought content, cognitive and intellectual functions (memory, orientation), judgment, and insight. The clinical interview typically lasts 45-50 minutes.

If the forensic clinician has conducted the initial interview, he telephones the psychiatrist on "court call" to arrange for him also to interview the defendant. This second interview (by the psychiatrist) focuses on the forensic clinician's particular concerns regarding psychopathology in the defendant's mental status. Upon the completion of the psychiatric interview, be it the second interview or the only interview, the clinician(s) may telephone persons mentioned by the defendant during the interview or other significent persons to verify or supplement the defendant's statements.

Other Evaluations (Presentence, Probation, Witness Competency, Drug Dependency)

Presentence. Upon receipt of a presentence evaluation referral, the Clinic Director assigns a clinician to the case. Before the interview commences, the clinician reviews the items in the offender's file, including the probation referral form and the arraignment face sheet. The clinician begins the interview by explaining the purpose of the examination and warning the offender that his statements may not be held confidential. The clinician then collects information to complete a psychiatric evaluation face sheet (Appendix P), indicating general personal information, including a relatively detailed social history. The balance of the interview is similar to interviews to assess competency to stand trial and criminal responsibility. This interview typically lasts one hour.

The clinician frequently telephones persons mentioned by the defendant during the interview, to verify or supplement the defendant's statements. Occasionally, the clinician will request that family members or others visit the clinic and speak personally with the clinician.

Arrangements sometimes are made for a staff psychologist to administer a battery of psychological tests to the offender. The clinician indicates to the psychologist on a referral form what general question(s) he would like addressed, and the psychologist selects the tests to be administered, conducts the testing, and reports the results to the clinician. The clinician usually conducts additional interviews with the offender prior to preparing his report for the court.

Probation Referrals. The Chief Social Worker receives probation referrals and meets with the Clinic Director weekly to assign clinicians to cases. The clinicians schedule initial interview appointments, and the secretary notifies the defendants of their appointments. The evaluation process essentially is the same as that described above with respect to presentence evaluations. According to the Director of the Clinic, the evaluation ordinarily entails two to six one-hour interviews.

Witness Competency. The Clinic Director receives orders for witness competency evaluations and assigns clinicians to conduct the evaluations. The clinicians schedule appointments, and the secretary notifies to-be-evaluated persons of their appointments. The statute requires that witness competency examinations be performed by "qualified physicians." Witness competency evaluations ordinarily entail one or two one-hour interviews. The evaluation process essentially is the same as that described above with respect to presentence and probation evaluations.

Drug Dependency. The Clinic Director receives referrals for drug dependency evaluations and assigns clinicians to cases. The clinicians schedule appointments, and the secretary notifies to-be-evaluated persons of their appointments. Although the statute requires that drug dependency evaluations be performed by psychiatrists or other "qualified physicians," the Clinic's grant-funded drug treatment specialist (M.A. psychologist) ordinarily is assigned to serve as primary evaluator, consulting with psychiatrists prior to submitting reports to the court. The evaluation process typically entails two to four one-hour visits and essentially is the same as that described above with respect to presentence, probation, and witness competency evaluations. However, questioning with regard to drug usage is more detailed and focuses on types of drugs used, amount used and duration of use, prior addiction, prior treatment, and arrest history related to drug use.

Provision and use of Mental Health Information

Emergency Court Calls (Competency to Stand Trial, Criminal Reponsibility)

At the conclusion of the psychiatric interview to assess competency to stand trial or criminal responsibility, the clinician (usually the psychiatrist, although often joined by the forensic clinician) notifies the probation officer and the court officer that he is prepared to report to the court. The case is called, and the clinician verbally reports his findings, indicating specifically:

- the defendant's prior psychiatric history, if any;
- evidence of the defendant's present mental illness, if any (i.e., examples of the defendant's disordered behavior or impaired judgment);

- opinion, supported by facts, regarding the defendant's competency to stand trial or criminal responsibility;
- clinical findings regarding the defendant's present need for treatment;
- if recommended incompetent to stand trial or otherwise in need of treatment, opinion regarding appropriate location for treatment (i.e., outpatient, inpatient at a Department of Mental Health Hospital, inpatient at Bridgewater State Hospital); and
- whether there is any substantial mental illness that would affect his ability to await trial in a penal facility.

The court then makes any of the following rulings:

- If the defendant is competent, not mentally ill, presents no substantial likelihood of serious harm (LSH), and is able to be maintained in a penal facility, arraignment continues.
- If the defendant is competent, mentally ill, presents no substantial LSH, but requires psychiatric treatment, the court may order that he receive treatment at the jail or as a condition of pretrial release.
- If the defendant is competent, mentally ill, and presents a substantial LSH, the court may recommend that the charges be dismissed and the defendant be committed civilly, or retained in custody, with charges, and transferred to a psychiatric facility.
- If the defendant is mentally retarded, the same standards and procedures apply in assessing his competency to stand trial and criminal commitment for evaluation (however, it should be noted that civil commitment cannot be instituted on the basis of mental retardation alone).
- If the defendant is believed to require further evaluation to assess competency or criminal responsibility, he is ordered evaluated further, either on an outpatient basis or on an inpatient basis (at a Department of Mental Health Hospital or at Bridgewater State Hospital).

After testifying, the clinician(s) returns to the Clinic and prepares a two- to three-page report documenting his findings, places the report in the defendant's file and sends a copy to the judge. If the judge orders the defendant committed to a hospital, the psychiatrist completes the commitment paperwork for the judge's signature, informs the facility, and forwards copies of the evaluation report to the hospital and to the judge.

Other Evaluations (Presentence, Probation, Witness Competency, Drug Dependency)

At the conclusion of an evaluation to assess witness competency, drug dependency, or treatment needs for presentence or probation considerations, the clinician primary responsible for the evaluation prepares a two-three page report containing the following information:

- identifying data (name, age, address, referral source, court status, charges, date of alleged incident, stage of proceedings);
- structure of the evaluation (dates of interviews, who was interviewed, others present; other sources of information [e.g., police reports, probation records, consultation with former therapists, hospital records, etc.]; informed consent given to person with explanation of procedure);
- present situation regarding competency to be a witness, drug dependency, treatment needs, ability to serve a sentence in a penal facility;
- significant past history (developmental; school; family; medical; psychiatric treatment; drug and alcohol use; work; sexual-marital; military; recent accidents, illnesses, or injuries; previous legal problems);
- observations during interview(s) (mental status examination, cooperation with evaluation, punctuality);
- formulation and assessment (a "dynamic" statement about the person's history and how it relates to current presentation, conflicts, and defenses; strengths, weaknesses, attitude to treatment);
- diagnostic impression keyed to the Diagnostic and Statistical Manual of Mental Disorders III (DSM III); and
- recommendations regarding need for treatment and whether treatment should be administered on an outpatient basis, on an inpatient basis at a Department of Mental Health Hospital, or at Bridgewater State Hospital.

Presentence evaluation reports, witness competency evaluation reports, and drug dependency reports are submitted to the court. Probation evaluation reports are submitted to the referring probation officer. Reports generally are submitted within thirty days of the referral. Drug dependency evaluation reports are submitted within five days of the date of the evaluation.

Feedback, Monitoring, And Evaluation

The primary formal mechanism for program feedback, monitoring, and evaluation operating with respect to the Cambridge Court Clinic is an annual evaluation conducted by the Office of Quality Assurance, Massachusetts Department of Mental Health. The Office evaluates all programs operated, financed, or regulated by the Department of Mental Health. The evaluation consists of a 25-page questionnaire and a 10-page rating form (see Note 10). Measurements are made of the Clinic's compliance with ten "principles of care":

- o minimization of barriers to access (free from cultural, geographic, economic, linguistic, physical, or temporal barriers to delivery of service);
- o staffing (appropriate composition; explicit delineation of roles, functions, qualifications);
- o training (integrated orientation and training plan);
- o community orientation (documentation of efforts to establish relationships with other community agencies);
- o clinical recordkeeping (adequate, confidential record);
- o physical setting (comfortable and aesthetically pleasing);
- o client goals (individual service plan for each client);
- o client rights (enforcing of rights to refuse treatment, to have access to records, to collaborate in defining treatment);
- o continuity of care (uninterrupted and congruent care for clients transferred between programs or agencies);
- o management and administration (governed by explicit policies and practices).

In addition to the formal evaluation system outlined above, the Clinic is subject to ongoing monitoring by the judges and probation officers of the Cambridge District Court. Because the Clinic staff, the judges, and the probation officers all are located in the same building, there is frequent informal feedback to the Clinic staff. Within the Clinic itself, the management structure provides for a degree of internal monitoring. The Clinic's administrative assistant maintains the Clinic's records, and the Director is responsible for general office management and staff quality control. The Chief Social Worker supervises graduate social work students and the chief psychologist supervises the graduate psychology students placed at the Clinic.

The training and research functions of the Clinic serve to some extent to focus attention on the operations of the program. In addition to the ongoing training of students working at the Clinic, the Clinic sponsors weekly lectures by noted mental health professional in the Boston area. Lectures frequently are presented by Clinic staff and presentations often are based upon the work of the Clinic. The Clinic staff also have engaged in research studies based upon the work of the Clinic. For example, a study presently being conducted is using the results of Clinic-conducted evaluations of delinquent juveniles to assess the link, if any, between learning disabilities and juvenile delinquency.

THE PIMA COUNTY (ARIZONA) COURT CLINIC

The Pima County Court Clinic (PCCC), which is under the jurisdiction of the Superior Court of Pima County, Arizona, was established in 1972 with a $52,230 grant from the Law Enforcement Assistance Administration (LEAA) "to test the feasibility of having court-appointed professionals do impartial mental health evaluations of convicted felons" (Ginnetti, Note 11). Federal support of PCCC lasted for three years; from 1975, PCCC has been supported by Pima County monies.

The major function of PCCC is to provide forensic mental health evaluations, crisis intervention, and outpatient treatment for convicted felons at the request of the courts and allied agencies. Some pretrial services are rendered also.

Approximately 80 percent of the evaluation requests are made by Pima County Superior Court, the court of general jurisdiction; 10 percent come from Tucson city courts (Justice of Peace Court and Police Court), courts of limited jurisdiction. The remaining referrals are made by a variety of sources discussed later in this section. Among the services provided by PCCC (see Ginnetti, Note 11) are the following.

(a) Psychological, psychiatric, and psychosocial evaluations, usually performed at the presentence and/or post-conviction stage of the criminal proceedings. All individuals with a prior history of emotional disturbance are evaluated at PCCC, as are all violent offenders, sex offenders, and the majority of substance abusers.

(b) Diagnostic and treatment programs to assist the counselor or probation officer dealing with the case.

(c) Referral of clients within the criminal justice system with emotional difficulties to appropriate treatment agencies or hospitals for short- or long-term therapy, hospitalizations, or neurological testing.

(d) Emergency consultation and evaluation for clients who are exhibiting bizarre or aggressive behavior currently—in a courtroom, for example.

(e) Individual psychotherapy for selected offenders in the County Jail or on probation.

(f) Prescription and psycho-chemical treatment when warranted.

(g) In-service training provided to legal departments when requested, as well as community consultation and education on mental health topics.

Under the Arizona Rules of Criminal Procedure (Arizona Revised Statutes Annotated, Section 26.5), the Court may request, at any time before sentencing, that the defendant undergo mental health evaluation. Before the existence of PCCC the courts paid for contract services provided by private psychiatrists and psychologists to obtain these evaluations. Requests for these services were typically made by probation officers during their presentence investigations if they felt a defendant showed signs of a mental disorder. Mental health evaluation referrals were also made by prosecuting attorneys or defense counsel whenever they wanted testimony during "aggravating" or "mitigating" hearings before sentencing.

The prevalence of psychological, behavioral, and sexual disorders, as well as drug and alcohol abuse, in the population of offenders seen by the criminal justice system created difficulties for Court departments required to handle and complete presentence investigations for these individuals. At least partly because the number of these presentence evaluation requests increased rapidly in the early 1970's, the court drafted the 1972 LEAA grant proposal to assess the feasibility of having court-appointed professionals do impartial mental health evaluations of convicted felons. An evaluation of the PCCC performance under the federal grants at the conclusion of funding showed that evaluation services, when provided by a Court department, were much more cost-effective than contracting with private mental health professionals. Consequently, funding for the Court Clinic operation was assumed by Pima County under the authority of the Superior Court in 1975.

PCCC seldom performs evaluations to determine competency to stand trial or sanity at the time of the offense. These pretrial evaluations requested by the Pima County Superior Court are referred to psychiatrists and clinical psychologists in the private sector on a fee basis. This difference in court referrals during the pretrial and posttrial stages of a case holds only for the Superior Court, the major referral source of PCCC. Referrals from Tucson's municipal courts, representing approximately ten percent of PCCC's caseload, include requests to determine competency to stand trial and sanity at the time of the alleged offense, personality assessments, and treatment recommendations.

To date, the Court Clinic has evaluated approximately 5,000 felons. About 1,500 of these have been provided extended evaluation or therapeutic intervention. In 1979, PCCC provided 895 presentence evaluations for the Adult Probation Department (representing 43 percent of this department's caseload); these evaluations were of felons who were

sexual or violent offenders, had a history of mental illness, or were alcohol or drug abusers. This compares with 729 in 1978 and represents a 23 percent increase in services. PCCC personnel provided 432 other mental health contacts to convicted felons in 1979, as compared to 154 in 1978 (see Ginnetti, Note 11). These contacts included intellectual and neurological assessments, crisis intervention, and extended outpatient psychotherapy for probationers. Many of the individuals evaluated by PCCC had been convicted of crimes of sex and violence. The examination by PCCC is often the only mental health evaluation available to the sentencing judge.

Since 1972, the number of full-time clinical staff of PCCC has remained at two--one Ph.D. psychologist and one M.S.W. social worker. They are assisted by a part-time consulting psychiatrists, students in psychology and social work, and a clerical/administrative staff of three.

A Function Model Of Delineation, Acquisition, And Provision Of Evaluation Information

Figures 16-18 describe the "flow" of cases into, through, and out of PCCC. Figure 16 shows the delineation process, which occurs before the appearance of a defendant in the PCCC: i.e., the activities and procedures, beginning with the initial referral of a case to PCCC and ending with the actual assignment of the case to a primary examiner, which serve to define the psycho-legal question. Figure 17 shows the process of information acquisition from the defendant's first appearance at the clinic to the time when a clinical impression is formed regarding the defendant. Finally, Figure 18 depicts the process of provision of information to the referral agent that requested the evaluation. Obviously, this function model of PCCC operations is an abstraction and simplification. It represents a convenient conceptualization, hopefully simple enough to facilitate comparisons with other court clinics and similar agencies, yet sufficiently complex to be a close approximation of reality.

Delineation: Defining the Psycholegal Questions

As depicted in Figure 16, the mental health examination process is initiated when PCCC receives a telephone call from one of its referral agents--judges, probation officers, or others. At the time of the initial telephone referral, the defendant identification information is recorded by PCCC administrative or clerical staff, a time and date for the defendant's appearance for evaluation by PCCC is scheduled, and a case file is created for the individual client. Defense and prosecution attorneys are notified of the referral and scheduled examination. In cases referred to PCCC by the Adult Probation Department, Correctional Volunteer Center, the County Attorney's Office, and other agencies, a formal referral form is completed and submitted to PCCC. When the referrals are made by judges of the Pima County Superior Court or the city courts, the PCCC practice is to complete the referral form on the basis of the telephone referral only.

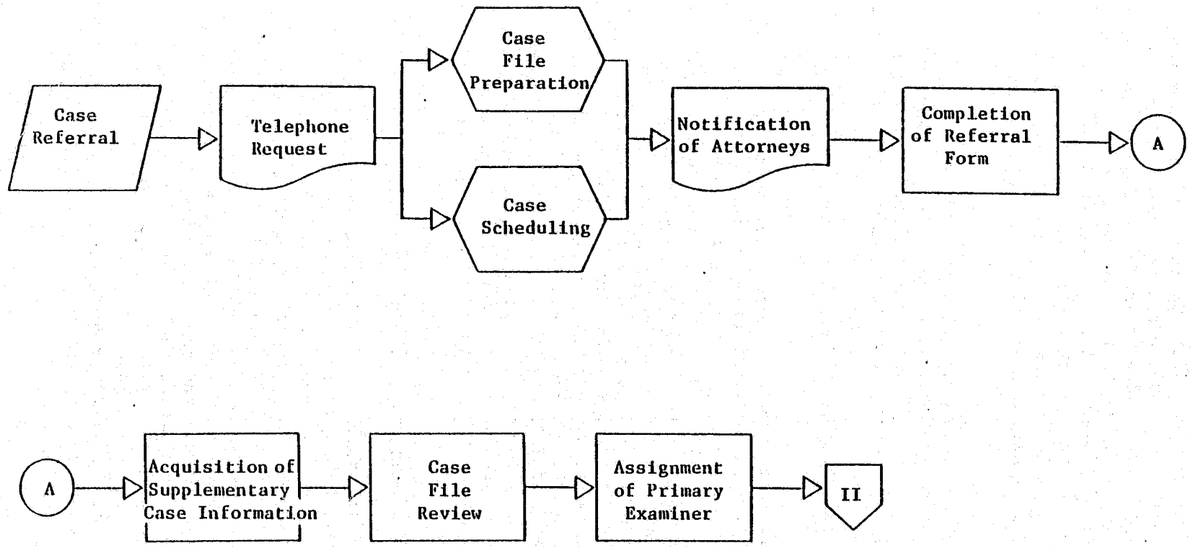


Figure 16. Case Processing Model of the Delineation of the Forensic Evaluation Information in the Pima County Court Clinic.

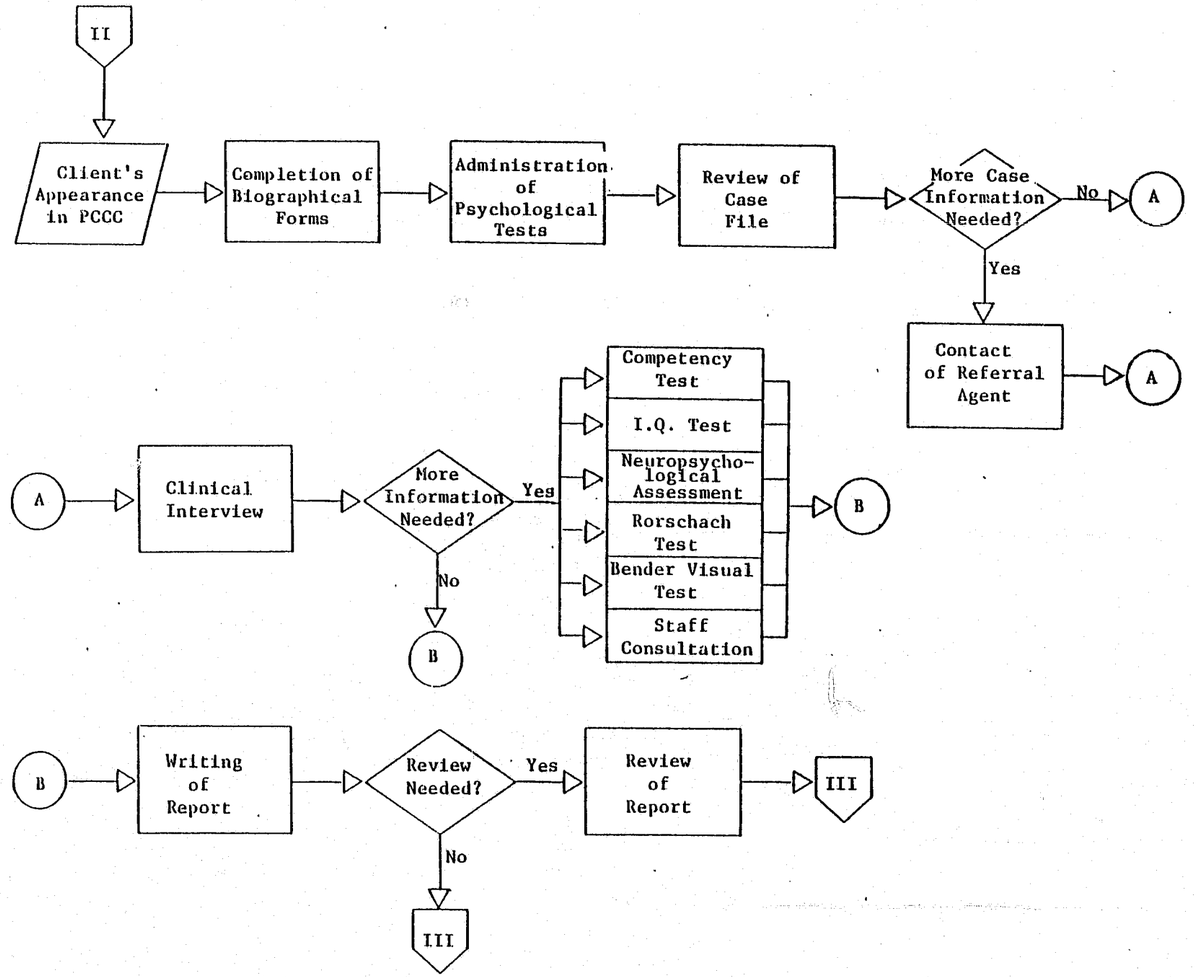


Figure 17. Case Processing Model of the Acquisition of Forensic Evaluation Information in the Pima County Court Clinic.

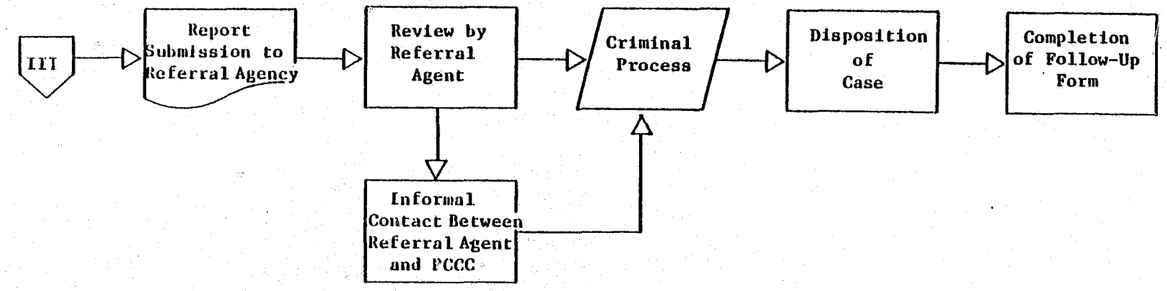


Figure 18. Case Processing Model of the Provision of Forensic Evaluation Information to Referral Sources in the Pima County Court Clinic.

At the time of the telephone referral, PCCC requests standard supporting information (e.g., police reports, available mental health records, and a brief social history). In approximately 90 percent of the cases this information is provided with the referral form prior to the defendant's first appearance for evaluation at PCCC. The referral form and supporting documents are typically sent to PCCC via courier.

The complete case file, including the reasons for referral, is then reviewed by the Director or Assistant Director, who makes case assignments to a primary examiner based upon professional strengths, personal preferences, case needs, individual caseloads and schedules.

Acquisition

Figure 17 depicts the essential operations occurring to acquire direct evaluative information about the defendant, beginning with his or her first appearance at PCCC and ending with a clinical decision.

Deputies of the Sheriff's Department escort defendants in custody to PCCC. Defendants not in custody typically arrive unescorted for their appointment. Approximately 60 percent of the PCCC clients are "walk-in" clients, i.e., those not in custody at the time of the scheduled evaluation. Upon arrival, clients are administered a standard battery of tests (i.e., the Minnesota Multiphasic Personality Inventory (MMPI) and the Rotter Sentence Completion Blank) and are asked to complete a biographical information form. Test results and the completed form are included in the case file, which is reviewed by the examiner assigned to the case prior to the clinical interview. In some cases, the examiner may contact the referral agent to request clarification or additional information following review of the case file and prior to the clinical interview.

After reviewing the case file, the primary examiner begins the clinical evaluation, which consists of a face-to-face interview with the defendant in which the defendant's mental status is assessed, the referral questions are addressed, and a clinical decision is reached. Evaluations vary in duration, but rarely are they shorter than 45 minutes or longer than two hours. The style and format of the clinical evaluation are dictated largely by background, experience, and preference of the examiner, as well as the nature of the case and the defendant's particular reactions to the evaluation. When the referral question is one of competency to stand trial, a clinician sometimes administers portions of a competency screening instrument as part of the clinical interview.

In the majority of the cases, conclusions and a clinical decision are reached as a result of the clinical interview. In cases where a clinical decision is not reached, further evaluation and testing procedures are arranged, typically for a later time. Procedures and tests instituted to provide supplementary information include intelligence and cognitive functioning assessments utilizing standard tests; neuropsychological assessments; and the administration of other

objective or projective standard instruments. Further, informal consultation with other PCCC staff is initiated if a decision cannot be reached at the conclusion of a clinical interview.

The clinical decision about the defendant becomes the basis for the preparation of a written report. Reports by senior clinicians are submitted to the referral source without review. Reports by interns, externs, and other examiners under the direct supervision of senior staff are reviewed by a senior supervisor prior to submission to the referral agency.

Provision

Within five working days of a client's initial appearance at the PCCC for evaluation, a formal written evaluation report is submitted to the referral agency. This provision process is depicted in Figure 18. Reports are typically hand delivered to the referral agency by a courier. Reports meet several objectives: (1) they address the specific issues and questions posed in the referral (e.g., competency and criminal responsibility, risk in community, or probability of completing a diversion program); (2) they present diagnostic impressions (e.g., "defendant suffers from chronic undifferentiated schizophrenia"); (3) reports provide the bases of the clinical impressions, recommendations, and conclusions, as well as relevant facts of the case, including social, medical, and legal history, and charge; and (4) they provide a brief summary and specific recommendations (e.g., "defendant should be maintained on medication").

Attached to every completed written evaluation report is a "Follow-up Report," which the referral agents are requested to complete upon disposition of the case. In approximately 20 percent of the cases, the formal submission of a written evaluation report is supplemented with informal telephone contact between PCCC staff and the referral agent. Follow-up reports returned to PCCC (the response rate is, according to PCCC staff, over 90 percent) are reviewed by the Clinic Director and examiner and are filed for future use.

The following three sections describe in greater detail the delineation, acquisition, and provision of evaluation information of PCCC.

The Delineation of Evaluation Requirements

Statutory Delineation

Legal authority for the conduct of post-conviction, presentence mental health evaluations, the major work of PCCC, is found in 17 A.R.S. Rules of Criminal Procedure, Rule 26.5 (Supp. 1975), which gives the sentencing court a tool for obtaining information needed to supplement the presentence investigation report. Rule 26.5 reads in part:

> At any time before sentence is pronounced, the court may order the defendant to undergo mental health examination or diagnostic evaluation.

A.R.S. §13-605 (1978), corollary to Rule 26.5 states:

> If after presentence investigation, the court desires more detailed informtion about the defendant's mental condition, it may commit or refer the defendant to the custody of any diagnostic facility for the performance of psychiatric evaluation. The commitment or referral shall be for a period not to exceed ninety days. Within that period the facility shall return the prisoner to court and transmit to the court a diagnostic report, including whatever recommendations the facility may wish to make.

Statutory authority for an inquiry into competency to stand trial is found in 17 A.R.S. Rules of Criminal Procedure, Rule 11.1 (1973), which reads,

> A person shall not be tried, convicted, sentenced or punished for a public offense while, as a result of a mental illness or defect, he is unable to understand the proceedings against him or to assist in his own defense.

Statutory authority for a plea of insanity is found in §13-502, Ariz. Rev. Stat. (1978), which reads,

> A person is not responsible for criminal conduct if at the time of such conduct the person was suffering from such a mental disease or defect as not to know the nature and quality of the act or, if such person did know, that such person did not know that what he was doing was wrong.

Although not currently specifically expressed in any statute, this section reflects the rule from the M'Naughten case establishing criminal responsibility. Rule 11.1 and §13-502 are implemented by Rule 11.2, Ariz. Rules Cr. Proc. (Supp. 1975) which reads, in pertinent part,

> [A]t any time after an information is filed or indictment returned, any party may move for an examination to determine whether a defendant is competent to stand trial, or to investigate his mental condition at the time of the offense, or both.

Referral Courts and Agencies

Table 8 summarizes PCCC referral agencies, primary referral agents, and the percent of the PCCC caseload represented by each of the referral sources. The great majority of the PCCC's referrals for evaluation are made by the Adult Probation Department, primarily by its Investigative Unit, as part of their preparation of the presentence report. Occasionally, the Supervision Unit of the Adult Probation Department refers cases to establish a treatment program for an offender on probation.

The client's permission is required for evaluation when requested by the Adult Diversion Project and the Correctional Volunteer Center,

Table 8

Summary of Referrals for Evaluation to the Pima County Court Clinic

Source	Percent of Caseload	Authority	Agent
Adult Probation Department	80	Rule 26.5	Probation Officer
City Courts	10	Rule 11.2 or 26.5	Judge Probation Officer
Adult Diversion Project	3	Voluntary	Staff Attorney
Juvenile Court	3	Rule 26.5	Probation Officer
Public Defender	*	Rule 11.2	Public Defender
Correctional Volunteer Center	*	Voluntary	Staff
Department of Corrections	*	Inter-Agency Agreement	Probation Officer
Superior Court Judges	*	Rule 11.2 or Rule 26.5	Secretary
Court-Appointed Attorneys	*	Rule 11.2	Private Attorney
Other	*	Voluntary	Various

*Less than one percent of PCCC caseload

which are special programs aimed at, respectively, removing first offenders from the criminal system and securing pretrial release for arrestees with few community ties who are nevertheless reasonably certain to appear for trial. Similarly, staff of other special programs geared to particular problems (i.e., drug or alcohol abuse) occasionally refer offenders who appear willing to accept treatment if given probation.

Juvenile Court referrals are primarily for the purpose of establishing treatment programs and are typically made when the client is due to be released from a juvenile facility. Referrals from the Department of Corrections are accepted on an informal basis in order to provide information for post-release supervision of parolees.

PCCC seldom conducts competency and sanity examinations for the Superior Court (but see Postscript in this chapter). Instead, the court maintains a list of private psychiatrists and clinical psychologists (not PCCC staff) available to perform such evaluations on a fee basis of $50 for the first hour, $40 for each subsequent hour for each case, and $35 for appointments not met by clients. When such evaluations are requested by the Superior Court, the party who makes a motion requesting such examination "may include in his motion a list of 3 qualified mental health experts; the other party may include such a list in a response to the motion; one expert shall be appointed from each list" (Rule 11.3[b]). On some occasions, PCCC is called upon by the Superior Court, before it requests the services of a private psychiatrist or psychologist, to determine whether reasonable grounds for an examination exist. Also, although rarely, PCCC is called upon to resolve the divergent opinions of psychiatrists or psychologists appointed by the Superior Court to conduct competency and insanity examinations.

The Tucson city courts, however, make all requests for evaluations, including sanity and competency determinations directly to PCCC. There is no explicity stated reasons why the city courts make all requests for evaluations directly to PCCC instead of court-approved private psychiatrists or clinical psychologists, as is the practice in the Superior Court. The practice may have been prompted by economics and limited resources, or by the limited number of requests for evaluations emanating from the city court and the particular relationship that court has with PCCC (i.e., PCCC's evolution from its primary function in aiding the postconviction, presentence investigation of the Adult Probation Department).

Referral Reasons and Questions

The psycholegal questions and reasons for referral direct the conduct of the evaluation. For example, review of the reasons for evaluation referral cited by the Investigation Unit of the Adult Probation Department in referral forms (see Appendix S) completed in the period May 1-21, 1980, revealed that the most common referral reason concerned the probable psychological aspects of the offense. Common "reasons" include:

- Defendant feels he or she has a mental problem; and
- there has been previous psychiatric hospitalization.

Common reasons for referral cited by the Supervision Unit of the Adult Probation Department include a perceived "need for probation supervision"; and the detection of an "extensive" criminal record or drug abuse in cases where no prior evaluations had been made.

The most common reasons for referrals by the city courts, during the same period of review, indicated a direct concern with competency and sanity. The following "reasons" recorded in the referral forms are representative:

- Whether the defendant suffers from a mental illness or defect;
- Whether the defendant is able to understand the proceedings against him or assist in his own defense;
- What the defendant's mental status was at the time of the incident and whether or not he can understand the difference between right or wrong or the nature and quality of his acts;
- What treatment is appropriate, particularly an opinion as to whether or not a petition under Title 36 [civil commitment] is appropriate.

Specific information requested in the referrals, in addition to the stated reasons for the referrals, shows a greater expansiveness and variety than the stated reasons for referral. This may be due to the subtle suggestion provided by the small amount of space provided on the referral form for "Information Requested" and relative to "Reason for Referral," that is, the reasons should be succint and tersely stated, whereas further questions can be broad and open ended (see Appendix S).

Typical questions raised by the Investigation Unit of the Adult Probation Department, again as reflected in completed referral forms from the period of May 1-21, 1980, include:

- Does the defendant's personality manifest some characteristics of an anti-social personality?
- Evaluation of defendant's violence potential, impulsivity, degree of drug addiction--personality traits and prognosis for treatment.
- Is the defendant dangerous to the community? Does the defendant demonstrate significant depression or suicidal indication?

- General psychological evaluation on the defendant--personality traits and prognosis for treatment.
- General psychological evaluation with emphasis on defendant's potential for violence, amenability to treatment, and a treatment recommendation.
- Are there any sexual problems?
- General psychological evaluation; mental illness, diagnosis; sexual deviancy; risk; treatment program while imprisoned.
- Any idea why he committed such a serious offense in view of what appears to be a stable background? Is he dangerous? Any appropriate therapy?
- Diagnosis? Mental illness? Risk? Suggested treatment?
- General psychological evaluation---identify any problems---is treatment recommended?
- Diagnosis? Mental illness? Potential for violence? Sexual deviancy? Treatment while in prison?
- Any evidence of psychosis presently or in past? Assess reasons for committing the offense. Assess treatment potential. Assess rehabilitative potential.
- Reasons for assaultive behavior. Presence of problems in thought processes or aptitude or learning disabilities--WAIS if necessary.
- Degree of dangerousness he presents to community. Evaluate drug or alcohol problems. Rehabilitative potential.

Questions raised by the Supervision Unit of the Adult Probation Department include:

- Feasibility of continued placement in a residential treatment center as well as an assessment of his current mental and emotional well-being.
- Recommendations for supervision purposes.

Referral Procedures

Referral for evaluation by PCCC is always initiated when a referral agent telephones PCCC. Preliminary referral information is recorded on a referral data form (see Appendix Q) that is completed by PCCC clerical staff. The following information on the referral data form is typically collected and recorded during the initial telephone referral:

- Date of referral;
- name of prosecuting attorney;
- name of defense attorney;
- telephone number and address of attorney (if private);
- client's name;
- case number;
- appointment information;
- jail (yes/no);
- request for IQ assessment;
- request for specific member of PCCC staff to conduct evaluation;
- name of referral agent;
- name of referral agency; and
- sentencing date.

Immediately following telephone referral, clerical staff create a case file and schedule the defendant's appearance for evaluation, and notify the defense and prosecuting attorneys of the referral to PCCC and the time of the evaluation (see standard PCCC memorandum for this purpose in Appendix R).

In cases referred by the Adult Probation Department, the Correctional Volunteer Center, or the County Attorney's Office, the referral agents complete a Court Clinic Referral Form (see Appendix S) following the initial telephone request; a courier takes the completed forms to PCCC. The referral form is accompanied by the police report(s) available on the case, mental health information, social histories compiled by the referral agent, school records, and any other pertinent information. When referrals originate from judges of the Superior Court or the City Courts, the PCCC practice is to complete the Court Clinic Referral Form from information gleaned from the initial telephone request.

The PCCC will not proceed with the assignment of an examiner to the case and the subsequent acquisition of information in the clinical interview until pertinent information and supporting documents have been submitted by the referral agent. According to PCCC staff, supplementary information requested by PCCC is submitted at least one day prior to the date a defendent is scheduled for an evaluation in 92 to 95 percent of the cases.

Once pertinent information has been gathered, the case file is reviewed by the Director or Assistant Director of PCCC, who then makes staff assignments to the case. If a particular examiner is requested by the referral agent, the request is usually honored. Otherwise, routine cases are assigned to students under the supervision of a senior staff member; more difficult or complex cases are assigned to senior staff members on the bases of staff availability, strength or expertise (e.g., success with minority clients, alcohol problems, or experience in test interpretation), and personal preference.

Acquisition Of Mental Health Information

Staff

Since the inception of the PCCC in 1972, the number of full-time clinical staff has remained at two, although it has been supplemented consistently by consultants, psychiatric residents, interns in clinical psychology, and other students affiliated with various schools, colleges, and universities in the Tucson area. At this writing, the staff of PCCC includes a full-time director, who is an Arizona-certified Ph.D. clinical psychologist; a full-time assistant director, who is an MSW., ACSW psychiatric social worker; a consulting psychiatrist working approximately 20 hours per week; a volunteer psychiatric resident affiliated with the University of Arizona Hospital; two student "externs," Ph.D. candidates in clinical psychology at the University of Arizona, supervised by the PCCC Director; social work students at Arizona State University; one administrative aide; and two secretaries.

The Director has both administrative and clinical responsibilities. She establishes policies and procedures and performs administrative duties of the PCCC, and appoints and supervises all clinical, consulting, and clerical staff. She assigns referrals for evaluation to appropriate staff members and determines what psychological and neurological assessment devices should be administered in each case; interprets, for other clinical staff, data from psychological tests administered to criminal defendants; performs short-term crisis intervention therapy; and initiates liaison, consultation, and training for all Tucson agencies providing outpatient and inpatient mental health services. She also conducts and prepares psychological examinations of criminal defendants and provides written and oral testimony to the Court and other criminal justice system departments; evaluates and provides treatment for probationers who are in crisis or facing revocation; provides consultation services to referring judges, attorneys, and probation and other department officers regarding individual defendants; provides training in interview techniques, evaluation, and supervision of various kinds of criminal defendants; and assists referring agents in the development of plans for probationers under treatment and supervision (see Ginnetti, Note 11).

The Assistant Director has administrative responsibilities in the absence of the Director. She supervises a graduate-level social work intern and aids in supervising the clerical staff. She also conducts mental health evaluations of criminal defendants for the Superior Court, assesses information and prepares formal written reports to the court and occasionally testifies in court, in addition to consulting with Court personnel and other criminal justice agencies concerning defendants.

In March 1980, PCCC employed two psychiatrists, one a full-time faculty member at the Arizona Health Sciences Center, who consulted with the PCCC approximately 20 hours per week; the second was a third-year psychiatric resident at the Arizona Health Sciences Center, who worked under the supervision of one of the psychiatrists and provided four hours

of services weekly to the Clinic (Ginnetti, Note 11). They conducted presentence psychiatric evaluations, performed cursory physical and neurological examinations, prescribed psychotropic medication, and provided testimony to the Court.

The PCCC also employed two psychology interns as of March 1980, both of whom were students in the University of Arizona doctoral program in clinical psychology. They performed mental health evaluations and psychological, intellectual, and neurological assessments. They also provided outpatient individual psychotherapy. Further, PCCC had a graduate-level social work intern, who conducted psychosocial evaluations, personal history interviews, and psychotherapy under the direct supervision of the Assistant Director, a certified MSW, ACSW Psychiatric Social Worker.

An administrative aide and two secretaries comprise the clerical support staff of PCCC. The administrative aide administers paper and pencil psychological tests to defendants and scores psychological test data, notes clients' behavior in the waiting room and during testing, answers questions, and maintains a professional atmosphere in the office, i.e., encourages cooperation from prisoners and other clients and discourages inappropriate behavior. The aide supervises all clerical personnel; assists in preparing annual budgets, applications for grants, and all related records; compiles information and calculates statistical data; aids in organizing methods of data collection for ongoing research projects and performs most of the data collection tasks; implements and maintains record-keeping and filing systems (incorporating some 5,000 files); attends meetings for professional staff and takes minutes of meetings; generally, aids the Director in many administrative matters; composes and types letters and memoranda; and types and edits psychiatric and psychological evaluations. The two secretaries type psychiatric and psychological evaluations from rough drafts, shorthand notes, or from electronic dictating equipment; handle all incoming phone calls, which includes responding to requests for information and scheduling clients referred from the Pima County criminal justice system; collate referral information for professional staff members; file; and assist the Administrative Aide in administering and scoring psychological tests.

Procedures and Techniques

The mental health examination of a defendant begins with his or her arrival at PCCC, located on the second floor of an office building one block from the Pima County Superior Court. Deputies of the Sheriff's Department escort defendants in custody and remain with them throughout the examinations, except during the clinical diagnostic interviews. About 60 percent of the clients are not in custody and, therefore, arrive unescorted. Upon arrival, the defendant is greeted by the administrative aide, or one of the secretaries, who briefly explains the reasons for the referral to PCCC and then asks the defendant to complete several forms and psychological instruments, as well as to answer any questions that may arise. The defendant, except when he or she refuses, completes a 40-question form requesting biographical information (see Appendix F), the

Minnesota Multiphasic Personality Inventory (MMPI), and the Rotter Sentence Completion Blank. Any unusual behaviors exhibited by the defendant during the administration of the forms and tests are noted by the administrative aide. The Mooney Problem Check List (Gordon & Mooney, 1950) is sometimes administered to "difficult" clients. The administrative aide or one of the clerical staff administers the tests orally and completes the biographical forms for clients who may have difficulty with reading.

Standardized tests and the biographical form are administered in a large waiting area with two large tables, and in a smaller room with a large window out to the waiting area. Clients typically remain at the PCCC for about 3 hours, including the clinical interview. The tests are scored by the administrative aide and placed into the case file, which is given to the examiner responsible for the case just prior to the clinical interview.

Clinical Diagnostic Interview. The clinical diagnostic interview, the centerpiece of the PCCC forensic mental health evaluation, is variously referred to as the "psychiatric evaluation," "psychological evaluation," or "psycho-social evaluation" depending on the professional discipline and preference of the examiner. As mentioned above, case assignment depends on the nature and complexity of the case (typically, the complex or controversial cases are assigned to the senior staff), staff expertise, and staff availability. The clinical interview, conducted by the examiner in a private office, is generally 45 to 90 minutes long. The interview usually begins immediately after the administration of the standardized tests and biographical information form.

The style and format of the clinical interview are dictated by the reasons for referral, specific referral questions, the nature of the case, the background, experience, and preference of the examiner, as well as the client's behavior during the interview. The interview may begin with several inquiries designed to build rapport, followed by a brief statement explaining, in effect, that the examiner is assisting the Court to assess mental problems. This may be followed by a number of pointed questions (Why are you here? What happened in the past? When? Are you on medication?), which prompt responses, discussion, and more questions, such as the following posed in one presentence psychiatric evaluation:

- You know, of course, that you will be sent to prison or placed on probation? What will you do while on probation?
- Are you having problems in jail? Sleeping? Are you hearing voices?
- How is your health?
- Did you have trouble in court?
- Do you know today's date? Time?

- What does "No use crying over spilled milk" mean?
- Where are your folks now?
- How far did you go in school?
- Have you been able to work? What do you like to do?

Critical questions from the MMPI (i.e., those framing problem areas such as depression, suicide, persecution, family discord, and alcohol problems) are sometimes used in the clinical interview. When the referral question concerns competency to stand trial, the clinical interview may include the administration of checklists, tests, or sections of competency-to-stand-trial instruments (e.g., the Georgia Court Competency Test, see Note 12).

In 70 to 90 percent of the cases, again depending on the examiner, nature of case, and referral questions, the clinical interview results in the examiner's reaching decisions regarding diagnosis, prognosis, and possible treatment recommendations. In such cases, the examiner prepares a report based on the clinical decisions.

In the minority of the cases, where clinical decisions are not reached at the conclusion of the interview, further information typically is sought by means of additional psychological testing, neurological examination, and consultation with other PCCC staff. Also, further information may be sought from the referral agency and mental health professionals in other agencies who have had contact with the individual.

Testing. Instruments to assess intellectual ability (e.g., the Wechsler Adult Intelligence Scale [WAIS]) are administered in approximately ten percent of the cases, as are the Bender Visual Motor Gestalt Test and the Rorschach Test. Neuropsychological assessments, used as gross screening measures, typically involve the administration of portions of the Halstead-Reitan Neuropsychological Test Battery (Reitan and Davison, 1974), probably the best standardized and comprehensive test for assessing organic (i.e., neurological) brain impairment. Selected portions of this battery are utilized to determine the presence or absence of organicity, following the identification of signs of the same in the Bender-Gestalt and the Memory for Designs. This test usually requires the administration of the WAIS. Need for electroencephalography (EEG) may be noted and communicated to the defense attorney. (A medical fund, now depleted, in the past was used to pay the cost of EEG, allowing the results to be incorporated in PCCC evaluations.) Case consultation with other PCCC staff may include an additional clinical interview by a second examiner, test interpretation by other staff members, and informal discussion about the case.

Following the acquisition of all necessary supplemental information, a formal report is prepared by the examiner assigned to the case and typed by the clerical staff. A senior staff member (the Director, Assistant Director, or Consulting Psychiatrist) reviews reports prepared by a junior staff member.

Provision of Evaluation Information

Case information acquired in PCCC evaluations is provided to referral agents by means of formal written reports, informal communications between the PCCC staff and referral agents, and by means of court testimony by PCCC staff. Testimony by examiners is rare and is given in controversial cases when written reports are insufficient or when legal tactics call for such testimony. Informal communication about cases between referral agents and PCCC staff occur frequently, both before and after reports are sent. Such communication may be initiated by PCCC staff seeking clarification or further information about a case, or by a referral agent who, for example, wants information about a case before a formal written report is received. These informal communications, it appears, are an important communications component.

Format of Written Reports

A typical PCCC evaluation report is two to three pages long (single spaced) and gives the defendant's name, case number, and the date(s) the evaluation was conducted. Subsections of the report describe tests administered and interviews conducted, information identifying the defendant, and the referral source and questions. The greatest amount of text describes the result of the examiner's evaluation of the defendant's mental status. Finally, a paragraph or two summarizes the examiner's diagnosis, prognosis, and recommendation. It is typed on letterhead bearing the name "Superior Court, Pima County Court Clinic" and it is signed by the examiner.

Dissemination of Reports

The schedule for submission of the written report to the referral source is controlled by two dates. In the case of presentence reports requested by the Department of Probation, the deadline for submission of reports is set by the sentencing date. (Reports submitted after that date, obviously, would be untimely and disruptive to the criminal proceedings.) The second controlling date is the fifth day after the appearance and examination of the defendant by the PCCC. This five-day time limit was established by PCCC, and approved by the Superior Court, to manage its internal operation and to be responsive to the needs of its major referral agents, probation officers, allowing sufficient time to include the content of evaluation reports in presentence reports prior to the day of sentencing.

A single copy of the evaluation report is submitted to the referral agent by means of courier. The Probation Department transmits copies of the PCCC evaluations, within 72 hours of receipt and at least 24 hours before sentencing, to the judge and attorneys in the case.

Conclusions and Recommendations Provided

Listed below are typical conclusions and recommendations to the Investigation Unit of the Adult Probation Department in evaluation reports dated May 1-21, 1980:

- This man represents a reasonable risk to the community as a probationer.... He should be referred to an agency such as the Southern Arizona Mental Health Center for brief to intermediate term psychotherapy to help him resolve some of the psychodynamic issues previously mentioned.

- This man is likely to go on pursuing an irresponsible lifestyle and using drugs when they are available.... In the future, this man should be on a low dose of a moderate potency anti-psychotic drug.

- If [defendant] is placed on probation, he should be required to give a strict account of his behavior and to prove his words with actions.

  Although he is a risk for recidivism, he does not give evidence of being violent or dangerous to the community.

- Based on the client's past poor adjustment and particularly his substance abuse history and subsequent violence, this client has a high recidivism risk for violence. Since the client does not consider this a particular problem, nor does he have particular guilt about his actions, it would be difficult for this client to benefit from treatment.... Based on the lack of psychotic thinking, it would appear the client would probably not be a high risk for becoming psychotic should he be incarcerated.

- It is imperative that [defendant] receive intensive psychotherapy directed toward helping him realize the function of his aggressive impulses and gaining internal controls for his behavior.

- [Defendant] is a poor candidate for psychotherapy and an extremely high recidivism risk.... I see his prospects for rehabilitation as extremely poor. I recommend against probation. I see prison for him as only effective in keeping him segregated from society.

- In my opinion, [defendant] has an excellent potential for rehabilitation and a low potential for violent acting-out if he can maintain his job and become involved in an alcoholism treatment program which includes both long-term psychotherapy and a monitored Antabuse program.

- This client does not feel that he is in need of therapy, but the development of insight into cultural, familial, environmental, and racial factors related to his personality style could be helpful.

- I could diagnose no mental disorder in this man. He should have no real difficulty adjusting to prison life.

- I see no indication for treatment necessary at the present time. [Defendant] would probably present a reasonable risk to the community as a probationer. If she is offered probation, it would be worthwhile to supervise her very closely in terms of her acquaintances, possible drug use, and her following through on her restitution to the victims in these cases.

Representative conclusions and recommendations made in response to referrals from the Supervision Unit of the Adult Probation Department during the period May 1-21, 1980, include the following:

- This examiner is not aware of another treatment program which might assure a high degree of success for [defendant] since he presents little motivation for any type of change other than to be free of restraints, responsibilities and expectations.

- Should [defendant] fail to comply with any of his conditions of probation, I do not think there should be any hesitation about revoking him.

The following are typical conclusions and recommendations in written reports requested by the Court pursuant to "Rule 11", authorizing determination of competency and sanity:

- It is my opinion that [defendant] is incompetent to be tried.... It is my opinion that his ability to understand the nature, quality, and consequences of his actions was severely impaired, probably sufficiently to meet the M'Naghten Test for criminal responsibility. He appears to understand the difference between right and wrong in the legalistic sense but appears unable at this time, and probably was unable, to appreciate that his specific actions were criminal in nature.

- [Defendant] is not at this time in sufficient control to participate in his own defense.... At the time of the most recent instant offense ... he was probably not able to appreciate the nature and quality of his acts.

- [Defendant] is currently suffering from a mental illness of a schizophrenic nature--most probably paranoid schizophrenia. His paranoid delusional system is preventing him from understanding the proceedings against him or [assisting] in his own defense. I am unable to assess his mental status at the time of the offenses.

- Individual is currently suffering from a mental illness of a schizophrenic nature, most probably chronic paranoid schizophrenia (DSM IV 295.32).

- Defendant seemed to understand the difference between right and wrong (i.e., knew that shoplifting was wrong) but seemed to have little sense of the quality of his own behavior.

- Defendant is not petitionable under Title 36. He does, however, need treatment. I recommend a short trial in-patient treatment and appropriate chemotherapy. I consulted with the Court Clinic psychiatric consultant, and it is his as well as my opinion that if the chemotherapy is going to work to stabilize the defendant to the point of being able to stand trial, it will do so within three to four weeks.

- Defendant suffers from manic-depressive psychosis (bi-polar affective disorder). Schizo-affective schizophrenia deserves consideration as a diagnostic possibility.

- Defendant understands the nature of the proceedings against him, and at the present time can assist in his defense.

- The defendant is hypo-manic at present but not floridly psychotic. Although his mental state has been somewhat labile, his current treatment will hopefully maintain or improve his present mental state.

- Defendant understood the nature, quality, and consequences of his actions at the time of the incident offense and knew the difference between right and wrong.

- Defendant is not a danger to self or others as defined by Title 36 ARS.

- Defendant's paranoid delusional system is preventing him from understanding the proceedings against him or to assist in his own defense.

- Defendant is currently suffering from chronic schizophrenia, residual type (DSM III, Code No. 295.62).

- The defendant is able to understand the proceedings against him and to assist in his own defense.

- At the time of the instant offense, he was probably not able to appreciate the nature and quality of his acts. It was unclear, however, whether that was because of his intoxication or an episodic disorganization stimulated by the intoxication.

- Defendant probably would benefit from a day treatment program such as the ones run by St. Mary's Hospital for the Southern Arizona Mental Health Center.

- Defendant is petitionable under Title 36.

- Defendant is suffering from a mental illness. I would diagnose him as: DSM III, AXIS I:V71.09-- no diagnosis on AXIS I. AXIS II: 301.83--border line personality disorder (principal diagnosis) AXIS II: 301.00--paranoid personality disorder.

- Defendant at this time is not in sufficient control to participate in his own defense, primarily because of his paranoia.

- Because of defendant's history of assaultiveness, his intense paranoia, anger, and his tenuous control he is currently a danger to others, as defined by title 36.

- A period of confinement at Kino Community Hospital and appropriate chemotherapy is recommended with treatment, defendant's chance of gaining competency to stand trial in a relatively short period of time is fairly good.

Program Monitoring, Quality Control, and Program Evaluation

Program evaluation of PCCC, overall quality control, and program monitoring arise in four types of activities: (1) management and routine administrative monitoring; (2) routine statistical reporting; (3) case disposition follow-up; and (4) special studies.

Monitoring and Management

In response to needs of referral agents requesting (usually by a telephone call) evaluation information on a defendant prior to the PCCC's five-day schedule for evaluations, the status of a PCCC evaluation case is noted on a form entitled "How to Track Down an Evaluation." This form indicates information such as the client's name, case number, date the referral was received by PCCC, date of examination, date of typing and name of typist, and signature and date of report duplication. The form also indicates whether collateral information submitted with the referral form was returned to the referral source. Finally, the report indicates the time and date a report was sent to the referral source and the referral mechanism (i.e., courier or hand delivery by PCCC staff).

Routine Statistical Reporting

Monthly statistics are compiled in the following categories: a) number of clients scheduled, b) number of clients seen, c) number of "no shows," d) number of clients rescheduled, e) number of intelligence evaluations, f) number of neuropsychological assessments performed, g) number of medication checks performed, h) number of referrals by various sources, and i) number of follow-up clients seen at PCCC.

Once a report is written, a record of the following case information is made on another standard form entitled "Typing and Research Chrono": a) name of client, b) offense, c) alcohol or drug abuse (yes or no), d) sex of client, e) race, f) age, g) marital status, h) education, i) referral source, j) prior visits to clinic (yes or no), k) primary examiner, l) evaluation extended over time (yes or no), m) tests administered, n) diagnostic impression, and o) date examined. An identical yet separate record of cases handled pursuant to comptency or sanity questions is also maintained.

Case Disposition Follow-Up

Case follow-up information is sought by PCCC from its referral agencies by requesting that a "Court Clinic Follow-Up Report" (see Appendix U), attached to every written evaluation report, be completed by the referral agent. Information identifying the client is completed by the PCCC staff. Offense, statutory range, sentencing disposition, and other conditions are noted by the referral agent. Further, a rating of the "helpfulness" of the report is requested. The respondent is asked to indicate whether the report was very, moderately, minimally, or not at all helpful. Respondents are asked to indicate, in a sentence or two, what was the most helpful aspect of the report, if indeed it was helpful. If the report was only minimally helpful, respondents are asked to indicate reasons why. Finally respondents are asked to indicate if recommended treatment is being followed and under whose responsibility such treatment is being administered. According to PCCC personnel, compliance with requests for follow-up information, i.e., submission of completed follow-up reports, has been above 90 percent.

A cursory review of follow-up forms received by PCCC in the period April 14-25, 1980, indicated that referral agents found reports either very or moderately helpful. Respondents indicated that most helpful were the reports' summaries and recommendations, which typically described the examiners' assessments of the clients' mental statuses or personalities and amenabilities to one or more kinds of treatment. Other comments on aspects of the reports deemed most helpful included these:

- o confirmatory information in presentence reports;
- o educational/vocational prognoses; and
- o documentation of behavior by other than probation officers--recommendations of observation and examination.

Only one of the completed follow-up reports in the period April 14-25, 1980, from the Adult Probation Department, commented that the PCCC report was of minimal help, stating that "it didn't offer much information which helped at sentencing."

An arbitrary check of follow-up reports from other periods of time revealed only two in which the PCCC evaluation reports were considered as "not at all helpful." The reasons noted were that (1) the report was

late and the offender was sentenced prior to its receipt by the probation officer; and (2) the client refused to particpate in the testing and interview and, consequently, the examiner lacked sufficient information to provide a reliable evaluation.

Once a completed follow-up report is received, it is reviewed by the Director and necessary actions with PCCC staff or referral sources and agents are taken. Completed follow-up reports are used for informal quality control management and for inclusion in a follow-up database for subsequent research or special studies.

Special Studies

A recent study by Caravello (1980) examined PCCC's treatment recommendations, whether they were followed by the probationer's supervising officer, and whether treatment was related to probationary compliance or short-term recidivism of felony offenders. The study also compiled demographic information regarding the population served by PCCC.

A 12-item questionnaire was completed by the supervising probation officers of a sample of 67 defendants, randomly selected from PCCC files, for whom treatment was recommended between 1975 and 1977. The probation officers were asked to indicate to what degree they followed each recommendation, selecting from: 1--not followed; 2--followed to a minimum degree; 3--followed with major change; 4--followed with minor change; 5--followed completely (i.e., probationer entered the exact type of treatment specified). Whether or not a petition was filed to revoke an individual's probation was taken as a measure of recidivism. The probation officers were also asked to assess the subject's compliance in treatment.

The results of the study indicated that the more probation officers followed PCCC's recommendations, (a) the more compliant the clients were with the treatment, (b) the more stable they were in their employment, residence, and family, and (c) the less likely they were to have future contact with the criminal justice system, according to the assessment of their probation officers. The majority of treatment recommendations were completely followed by the supervising probation officers. Increased compliance in treatment by the individual was related to lower recidivism and greater stability in employment, education, training, residence, and family situations.

The Pima County Court Clinic: A Postscript

The foregoing describes the PCCC as it operated at the time of the visit of one of the authors in June 1980. By March 1981 the clinic had added a major function and significantly modified its delineation and provision procedures.

Since its inception, PCCC's major function had been to provide psychological, psychiatric, and psychosocial evaluations performed at the presentence or post-conviction stage of the criminal proceedings. The

Clinic staff seldom performed pretrial evaluations to determine competency to stand trial or sanity at the time of the offense—dubbed "Rule 11 evaluations" according to the applicable section of the Arizona Rules of Criminal Procedure--except at the request of the municipal courts or, on rare occasions, at the request of the Superior Court to determine whether reasonable grounds for Rule 11 evaluations exist. As described earlier, Rule 11 evaluations were almost exclusively performed for the Superior Court by psychiatrists in the private sector on a fee basis.

At the writing of this postscript, the PCCC conducts "screening" of all client-offenders for whom a motion for a Rule 11 evaluation has been entered in Superior Court. Formally, the screening assists the court in determining whether reasonable grounds exist for another (presumably more thorough and costly) examination of competency and criminal responsibility by private psychiatrists retained by the court for such purposes. The Rule 11 "screening" report is the basis upon which the court grants or rejects the motion for a "full" Rule 11 evaluation. The length of the typical Rule 11 screening report, one-half page, compared to over two pages of text provided by PCCC to the municipal court for "full" Rule 11 examinations, is consistent with the distinction between the screening performed by PCCC and the full Rule 11 evaluations conducted by private psychiatrists (and clinical psychologists). In practice, however, aside from the abbreviated report provided to the court, the conduct of Rule 11 screenings conducted by PCCC and that of the full evaluations performed by private psychiatrists are quite similar.

Before the institution of the PCCC Rule 11 screening procedure, Superior Court judges typically granted motions for Rule 11 examinations and, in accord with Arizona statute, provided both the defense and the prosecution with an examination of the client-offender by psychiatrists drawn from the private sector. In approximately 90 percent of the cases, according to Superior Court Judge William E. Druke (see Note 13), the examining psychiatrists agreed in their opinions that the client-offenders were competent to proceed with trial and sane at the time of the offense.

The intent of the Rule 11 screenings performed by PCCC, prompted largely by monetary considerations, was to deny motions for "full-scale" Rule 11 examinations when the PCCC "screening" revealed competency and criminal responsibility--presumably, the case in the great majority of client-offenders. Without additional costs to the court (excluding the allocation of existing resources of PCCC, court time in examining screening reports, etc.), the screening would eliminate the bulk of "full" Rule 11 examinations performed by private psychiatrists and paid for by the courts. In practice, the court may, however, grant a motion for a full Rule 11 even after the PCCC screening has indicated competency and sanity--but in these instances, the court will not foot the bill for the examination, and the costs would be shouldered by the defense (Note 13).

Interestingly, the Rule 11 "screenings" now performed by the PCCC, and full evaluations performed as always by private sector psychiatrists and clinical psychologists, maintain the historical precedence of PCCC and the theory of some Arizona psychiatrists (cf. Beigel, 1976), insofar as they still allow, strictly speaking, post-conviction mental health system involvement but not pretrial examination. The latter, as argued by Beigel (1976) and others (e.g., Miller, 1980), should not be organizationally affiliated with the courts at all, but be part of the adversary process, i.e., connected with prosecution or defense. The PCCC Rule 11 screening, conceived in this narrow sense, is used only to assist the court to determine reasonable grounds for granting a motion for a Rule 11 examination; and, strictly speaking, PCCC still does not conduct pretrial examinations for the Superior Court.

Another change instituted by PCCC since the writing of the earlier sections, is a detailed specification of the referral procedures performed by PCCC and its referring agencies. Owing in large part to the addition of the Rule 11 screening function and a dramatic increase in other referrals, PCCC developed and documented detailed instructions describing referral contacts and procedures for each of its referral agencies. For example, the draft document describing procedures for Superior Court referrals for Rule 11 examinations specifies:

- the name and location of the nominal agent (judge) and actual agent (the judge's secretary) making the referral;
- the name and location of the agent from whom additional referral information can be obtained by telephone;
- the procedures for acquiring referral information;
- the form and content of the information;
- how to schedule appointment times for examinations;
- transportation arrangements for the client-offender and support personnel (e.g., court interpreter);
- obtaining of confidential collateral information;
- procedures upon arrival of the client-offender at PCCC;
- rescheduling of a client-offender upon a "no show";
- typing of the report; and
- provision and dissemination of the report.

The documents describing the delineation and provision procedures for each of PCCC's referring agencies serve as instructions to referral agents and the PCCC staff receiving referrals. Also, the documents aid in the communications with referral agencies and in the training of new staff.

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APPENDIX A

REQUEST FOR EVALUATION

TO THE MEDICAL SERVICE OF THE
SUPREME BENCH OF BALTIMORE

NAME: _____ DATE ORDERED: _____

ADDRESS: _____ DATE REPORT NEEDED: _____

_____PHONE:_____ COURT: _____ JUDGE:_____

RACE:_____ SEX:_____ INDICTMENT NO: _____

DATE OF BIRTH: _____ OFFENSE(S): _____

SPOUSE OR NEXT OF KIN: _____ _____

STATE'S ATTORNEY: _____

ADDRESS: _____

DEFENSE ATTORNEY: _____

_____PHONE:_____

DEFENDANT'S STATUS: INSTITUTION: _____ BAIL/RECOG. _____
(Fill in) (Check)

TYPE OF EVALUATION:

PRE-TRIAL _____ PRESENTENCE _____ POST SENTENCE_____

REASON(S) FOR REFERRAL:

In order to assist our office in furnishing an appropriate report to the Court, please review this section and check one or more categories which relate to your reason(s) for referral. If desired, add a statement concerning your referral in the space below.

1) NATURE OF OFFENSE _____

2) UNUSUAL OR DANGEROUS BEHAVIOR SEEN IN COURT OR ELSEWHERE _____

3) PRIOR MENTAL/EMOTIONAL HISTORY. If yes, where treated? _____

4) DIAGNOSIS OF SPECIFIC PROBLEM, e.g. alcoholism _____

5) NEED FOR TREATMENT _____

6) DISPOSITION, e.g. incarceration vs. probation _____

7) OTHER, explain below _____

_____

_____

_____

WAS THIS REFERRAL REQUESTED BY THE DEFENDANT'S ATTORNEY? YES_____ NO_____

ADDITIONAL STATEMENTS: (If desired, attach additional note.)

110-92391

APPENDIX B

PSYCHOLOGICAL EVALUATION REFERRAL SHEET

Patient:_____ Date referred to Psychology:_____

Patient No._____ Psychology Appointment Date:_____

Psychiatrist:_____ Date Report Needed:_____

Pre-trial_____ Pre-sentence_____ Other_____

Present Offense(s):_____

Previous Offense(s):_____

_____

REASON(S) FOR REFERRAL:

_____Differential assessment of intellectual functioning

_____I.Q. only.

_____Assessment of organic brain damage.

_____Aggressive acting out potential.

_____Sexual preoccupation and/or acting out potential.

_____General personality assessment.

Is there a specific diagnostic question involved?_____

_____

_____

Is there a question regarding disposition?_____

_____

_____

COMMENTS:_____

_____

_____

RACE:_____ AGE:_____

APPENDIX C

REQUEST FOR PSYCHOLOGICAL TESTING

APP'T DATE _____

_____ _____ _____
Defendant's name Clinic No. Date

Psychological Testing - Please specify possible problem area (s):

Organicity _____

Psychosis _____

Controls _____

Reality testing _____

Dangerousness: a) To self _____

b) To others _____

Personality structure _____

Malingering _____

Intelligence _____

Other comments _____

_____

_____

_____

The following records:

Return Appointment:

Full P.O. report, if available

Dr. _____

APPENDIX D

FORM DMH 704 (4-72) JC

EXAMINATION REPORT

(Psychiatric examination, C.P.L. Article 730)

STATE OF NEW YORK

SUPREME COURT

COUNTY OF NEW YORK

JUSTICE

THE PEOPLE OF THE STATE OF NEW YORK VS DEFENDANT	EXAMINATION REPORT Clinic # _____ Indictment No. _____ Information No. _____ Charge _____ _____, in violation of _____.

I, the undersigned, duly certified pursuant to law as a qualified psychiatrist or a certified psychologist, having been designated by The Commissioner of the Dept. of Mental Health and Mental Retardation of the City of New York, pursuant to an order signed by Hon. _____, _____ (Justice) of the SUPREME court, NEW YORK county, dated _____, to examine the above-named defendant, pursuant to Article 730 of the Criminal Procedure Law, to determine if the defendant is an incapacitated defendant, have conducted such examination with due care and diligence.

The nature and extent of the examination was as follows: _____

I have come to the following opinion as a result of such examination:

(NOTE TO EXAMINER: If the following paragraph sets forth the opinion of the examiner, sign the report where indicated below and do not complete Page 2. Otherwise, strike out the following paragraph, complete fully the remainder of this report and sign on Page 2.)

It is my opinion that the above-named defendant does not as a result of mental disease or defect lack capacity to understand the proceedings against him or to assist in his defense.

SIGNATURE: _____, DATED: _____ 19____
(Print name _____)
Qualified Psychiatrist

(Continued)

RE: _____ IND # _____

It is my opinion that the above-named defendant is an incapacitated person in that the said defendant as a result of mental disease or defect lacks capacity to understand the proceeding against him or to assist in his own defense. My opinion is based on the following:

1. History and Clinical Summary, including Mental Status. (Attach additional sheets, if necessary):

SEE ATTACHED REPORT

2. Diagnosis:

3. Prognosis:

4. Reasons for my opinion, specifying those aspects of the proceedings wherein the defendant lacks capacity to understand or to assist in his own defense: (Attach additional sheets, if necessary):

SEE ATTACHED REPORT

SIGNATURE: _____ DATED _____ 19___
(Print name _____)

(Qualified Psychiatrist) (Certified Psychologist)
(STRIKE OUT ONE)

APPENDIX E

PSYCHIATRIC EXAMINATION REPORT

Name_____ Clinic #_____ Date:_____

Doctor's Name_____ Ind. or Docket #_____

Identification: Date of Birth:_____ Age:_____ _____

Birth Place:_____ Marital Status:_____ _____

Status: (Incarcerated or In-the-Community):_____

Educational Level Attained:

Current Alleged Offense:

KNOWLEDGE OF CHARGES:

What is the charge against you?

KNOWLEDGE OF COURT PROCEEDINGS:

a) Have you entered a Plea? What Plea have you entered?

b) What is the name of the Defendant's Attorney?

c) What is the function of a Defense Attorney?

d) What is the function of a District Attorney?

e) What is the function of a Judge?

f) What is the function of a Jury?

g) What are the consequences of being found Guilty?

Name:_____ Clinic #_____

Summary of Psychiatric Findings:

Re: _____ Clinic # _____

Medical-Legal Opinion: A) _____ The defendant is NOT INCAPACITATED* (i.e. is fit to proceed).

B) _____ The defendant IS INCAPACITATED* (i.e. is not fit to proceed).

If Incapacitated (Not Fit) and/or for Probation Dept. reports:

Diagnosis:

Prognosis:

Therapeutic Recommendations:

* The term INCAPACITATED is defined in article 730 of the NYS-CPL.

APPENDIX J

TELEPHONE REFERRAL

Type of Referral: Competency___ Psychosocial___ Date of Call_____

From: Court___ Pub Def___ Probat___ Caller_____

Other Info_____

Name of Defendant_____ Age (if psychosocial)_____

Residence_____ Phone_____

_____

Court Information

C.A._____ Part A_____ Where_____ Date Ordered_____

Judge_____

Bond Amount $_____ Date of Hearing_____

Attorney: Public Defender___ Private___

Name_____

Charges	Pleas Entered
1.	
2.	
3.	
4.	
5.	

Will report be sent? Yes___ No___.

If no, write out brief narrative on reverse side.

Examination Data

Date of Exam_____ Time (for Psychosocials)_____

Place of Exam: Courts Diagnostic Clinic___ Hartford Correctional___

Competency Referral Log Book

(19)

NAME	FILE #	COURT	DATE NOTIFIED	DATE ORDERED	HEARING DATE	CURRENT RESIDENCE	EXAM DATE	CLINICAL TEAM	EXAM DONE	FIND-ING	TEST-IFY?

Psychosocial Assessment Referral Log Book

(10)

NAME	FILE #	COURT	COURT	JFFS	TASC	PROB	DATE NOTIFIED	DATE ORDERED	HEARING DATE	CURRENT RESIDENCE	EXAM DATE	SEEN BY	EXAM DONE	REPT DONE	SPECIAL INFORMATION

PSYCHOSOCIAL ASSESSMENT

APPENDIX J

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH

COURTS DIAGNOSTIC CLINIC

84 WADSWORTH STREET · HARTFORD, CONNECTICUT 06106

566-2186
566-2696

PROBATION REFERRAL FORM

Date_____

SPOKE TO
(CLINIC STAFF MEMBER)_____

DEFENDANT_____ AGE____ SEX____ MARR_____

ADDRESS_____ PHONE_____

_____

PROBATION
OFFICER_____ PHONE_____

OFFICE ADDRESS_____

SENTENCING
DATE_____ (IF NOW ON
PROBATION: DATE_____ PERIOD_____

SP. CONDITIONS_____)

CHARGES_____

SUMMARY OF INCIDENTS_____

_____

_____

REASON FOR
REFERRAL_____

_____

_____

_____

_____

MED/PSYCH
HISTORY_____

EXAM
DATE_____ TIME_____ PLACE_____

APPENDIX K

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH

COURTS DIAGNOSTIC CLINIC

84 WADSWORTH STREET · HARTFORD, CONNECTICUT 06106

566-2186 566-2606

PUBLIC DEFENDER REFERRAL FORM

DATE_____

SPOKE TO (CLINIC STAFF MEMBER)_____

PUBLIC DEFENDER_____ PHONE_____

G.A.#_____ ADDRESS_____

*DEFENDANT_____ AGE_____ SEX_____

CURRENT ADDRESS_____ PHONE_____

CHARGES_____

_____

_____

BRIEF NARRATIVE_____

_____

_____

_____

_____

UPCOMING COURT DATE_____

REASON FOR REFERRAL_____

_____

_____

_____

DATE OF EXAM_____ TIME_____

PLACE OF EXAM_____

APPENDIX L

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH

COURTS DIAGNOSTIC CLINIC

84 WADSWORTH STREET · HARTFORD, CONNECTICUT 06106

566-2186
566-2696

T.A.S.C. REFERRAL FORM

Name of Defendant_____ Date of Call_____

Address_____ D.O.B._____ Age____

_____ Phone_____

Reason for Referral: Drug Dependence____ General Psychosocial____ Rule Out Mental Illness____

Other Reason_____

Referred by_____ Clinic Staff_____

Court Information

G.A._____ or Part A_____ Location_____

Judge_____ Hearing Date_____

Attorney: Public Defender_____ or Private_____ Name_____

Charge_____ Any Plea?_____

Charge_____ Any Plea?_____

Charge_____ Any Plea?_____

Charge_____ Any Plea?_____

Examination Data

Date of Evaluation_____ Time_____ Place: Clinic____ H.C.C.____

Other Info_____

Additional Notes_____

_____

_____

_____

COMPETENCY EVALUATION

Client _____ Date _____

Team: Psychiatrist _____ Psychologist _____ Social Worker _____

Factual Items				
Understand current legal situation:	E	G	F	P
Understand the charges:	E	G	F	P
Understand the relevant facts:	E	G	F	P
Understand legal issues and procedures:	E	G	F	P
Understand function of court personnel:	E	G	F	P
Understand pleading and plea-bargaining:	E	G	F	P
Understand possible dispositions/penalties:	E	G	F	P
Identify and locate witnesses:	E	G	F	P
Inferential Items				
Comprehend instructions and advice:	E	G	F	P
Make decisions after advice:	E	G	F	P
Maintain collaborative relationship w/atty:	E	G	F	P
Follow testimony for accuracy:	E	G	F	P
Testify and be cross-examined:	E	G	F	P
Tolerate stress:	E	G	F	P
Refrain from irrational behavior:	E	G	F	P

MEDICATIONS:

APPENDIX N

PSYCHOLOGICAL TESTING SUMMARY

Psychologist_____

Client_____ Testing Date_____

Tests Administered:

___	Intellectual Evaluation	(23.50)	$_____
___	Scholastic Achievement	(10.00)	_____
___	Personality Diagnosis	(60.00)	_____
___	Organicity Evaluation	(22.00)	_____
___	Voc. Aptitudes/Interests	(52.00)	_____
___	Diagnostic Interview	(22.00)	_____
___	Staff Consultation	(11.00)	_____
		Total	$_____

List Specific Tests: _____

_____

_____

_____

_____

_____

_____

_____

_____

Signature_____

APPENDIX O

DESCRIPTION OF EXAMINATION: In our examination of the accused we utilized a structured interview which is designed to elicit information pertinent to the issues surrounding competency to stand trial. The interview is divided into two main areas of inquiry. In the first of these areas we attempt to elicit factual information relating to the accused's understanding of his current legal situation. For example, his understanding of the charges against him; his perception of legal issues and procedures; his understanding of facts relevant to his case,etc.

The other major area of inquiry is more predictive in that we attempt to appreciate the accused's capacity to deal with situations that have in fact not yet occurred. That is, by evaluating his ability to communicate with us during our exam, we attempt to predict his ability to work cooperatively with his lawyer in their upcoming contacts. Areas of concern here would be, for example, the extent to which he would be able to comprehend instructions and advice from his attorney; his ability to be cross-examined; and his ability to tolerate stress at or while awaiting trial.

APPENDIX P

CAMBRIDGE COURT CLINIC — PSYCHIATRIC EVALUATION

NAME _____ NUMBER _____ DATE _____

ADDRESS _____ D.O.B. _____ AGE _____ SEX _____

_____

PHONE _____ SOC SEC # _____ RACE _____ RELIGION _____

INSURANCE: MEDICAID # _____ MARITAL STATUS _____

OTHER: NAME OF INSURER _____ EDUCATION _____

POLICY # _____ SUBSCRIBER (RELATION TO PT.) _____

INCOME (ALL SOURCES) _____

OCCUPATION _____ HOW LONG THERE? _____ CITIZENSHIP _____

EMPLOYER _____ FULL TIME _____ PART TIME _____

ADDRESS AND PHONE _____ MEDICATIONS _____

OTHERS WORKING AT HOME, YES _____ NO _____ MILITARY SERVICE _____

ON WELFARE, YES _____ NO _____

PREVIOUS THERAPY, YES _____ NO _____ DATES _____ WHERE? _____

REFERRAL SOURCE _____ _____

CURRENT CHARGE AND STATUS _____ COURT ____ SUP.
____ CAM. DIST.
____ PROBATION
____ SOM. DIST.
____ JUVENILE

INITIAL DX AND DISPOSITION (INCLUDING MEDICATION)

_____

_____

DIAGNOSIS AT COMPLETION OF EVALUATION

_____

DISPOSITION AT COMPLETION OF EVALUATION

_____

_____

SIGNATURE AND DISCIPLINE

APPENDIX P (Continued)

Name	Age	Residence	Marriage Date	Divorced Date	Health	Occupation
YOUR MOTHER						
FATHER						

PRIOR OR SUBSEQUENT MARRIAGE (S) — MARRIAGE DATE — ENDING DATE — INDICATE ONE by SEP. DIV. DEATH

OF MOTHER TO: _____

OF FATHER TO: _____

YOUR BROTHERS AND SISTERS in order of birth, including miscarriages, deaths; list step and half separately (use back of this sheet if more space is needed):

NAME:	AGE:	SEX:	MARITAL STATUS:	RESIDENCE:

YOUR SPOUSE	AGE	RACE	RELIG	OCCUPATION	MARRIAGE DATE	SEP. DIV. DATE	HEALTH IF DEAD, AGE DATE CAUSE

OTHER MARRIAGES OF: — MARRIAGE DATE: — ENDING DATE: — INDICATE ONE BY SEP. DIV. DEATH

YOURSELF TO: _____

YOUR SPOUSE TO: _____

YOUR CHILDREN in order of birth, including abortions, miscarriages, death:

NAME: AGE: BIRTH DATE

_____

DESCRIBE YOUR LIVING ARRANGEMENTS, WHO LIVES WITH YOU AT HOME:

YOUR SIGNATURE _____

APPENDIX Q

REFERRAL DATA DATE REFERRAL MADE

PROS. ATTY: _____
DEFENSE ATTY: _____
PHONE NO: _____
ADDRESS: _____

CLIENT'S NAME: _____
CASE NOS: _____
APPT. INFO: DAY:_____ TIME:_____ DATE:_____
FROM JAIL? YES:_____ NO:_____
POSSIBLE IQ? YES:_____ NO:_____
IF REFERENT IS REQUESTING SPECIFIC STAFF MEMBER, NAME: _____

REFERRED BY: _____
REFERRING AGENCY: _____
WHEN REFERRAL INFO RECEIVED: DATE:_____ TIME:_____

SEEN BY: _____
NO SHOW: CHECK:_____ DATE:_____
RESCHEDULED? YES:_____ NO:_____
TO WHAT DATE?_____ TIME?_____
SEEN BY: _____
NO SHOW AGAIN? CHECK:_____ DATE:_____
RESCHED. AGAIN? YES:_____ NO:_____
TO WHAT DATE?_____ TIME?_____
SEEN BY: _____

DATE REC'D FOR TYPING: _____
***SENTENCING DATE: _____

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APPENDIX R

Superior Court
Pima County
COURT CLINIC
45 WEST PENNINGTON
TUCSON, ARIZONA 85701
TELEPHONE: 792-8137

Date: _____
Case No: _____

CYNTHIA J. GINNETTI, PH.D.
CAROLYN M. FORD, ACSW
JOHN LAWALL, M.D.

HARRY GIN
PRESIDING JUDGE

MEMORANDUM

TO: Defense Attorney: _____

Prosecuting Attorney: _____

FROM: Pima County Court Clinic

_____ has been referred to the Pima County Court Clinic by _____

_____.

An appointment is scheduled for _____

_____. Any information that you may wish to contribute to this evaluation will be helpful.

APPENDIX S

COURT CLINIC REFERRAL FORM Referral Date_____

REFERRING AGENCY_____

PERSON MAKING REFERRAL_____

SUBJECT_____ CASE NO._____

DATE OF BIRTH_____ AGE____ JUDGE_____

SENTENCING DATE_____ IN JAIL: YES____ NO_____

INSTANT OFFENSE_____

_____

PRIOR OFFENSES_____

_____

_____

POSSIBLE SENTENCE_____

SOCIAL HISTORY (Personal, marital, family history, substance abuse, etc. Write brief note and/or attach available information.)

_____

_____

_____

_____

(use reverse side if needed)

REASON FOR REFERRAL_____

INFORMATION REQUESTED_____

_____

_____

_____

_____

_____

SCHEDULED APPOINTMENT (Date/Time)_____

AGENCY NEEDS REPORT BY (Date)_____

APPENDIX T

Biographical Information Form

1. Name: _____ Date: _____
2. Age: _____ Birthdate: _____
3. Sex: _____
4. Present reason for arrest: _____
5. Previous arrests:

   Adult: _____

   _____

   Juvenile: _____

   _____
6. Are your parents still living? _____ Age of mother: _____ Age of father: _____
7. Are your parents married? _____ Divorced? _____

   How many times were your mother _____ and father _____ married? How old were you when your parents were first divorced? _____
8. Did either of your parents have a drinking problem?

   Mother: _____ Father: _____
9. Ages of brothers and sisters: _____

   _____
10. Have any other members of your family had any problems with the law? _____ Who? _____

    Reason? _____

    Result? _____
11. Were you subjected to physical abuse as a child? _____

    If so, by whom? _____
12. Did you wet the bed after age 5? _____
13. As a child, did you have problems with reading, spelling, writing, or arithmetic? _____ Which? _____

    _____

PCCC #6

14. As a child, did you have any behavior problems in school? _____ If so, what kind? _____

_____

15. Did you frequently set fires as a child? _____

16. Have you ever had a pet? _____

17. Have you ever injured or excessively teased your own pet or someone else's, or any other animal? _____ Describe: _____

_____

18. Education (highest grade of school completed): _____ When? _____ If you quit school, what was the reason? _____

_____

19. Have you ever served in the military? _____ Branch: _____ Dates: _____ Type of discharge: Honorable? _____ General? _____ Dishonorable? _____ Other? _____

20. How often do you use alcohol? _____ When did you start? _____

21. Do you, or have you, used any drugs other than those prescribed by a doctor? _____ If yes, what drugs and when did you start? _____

_____

22. Have you ever owned a knife or a gun? _____ Do you own one now? _____ If yes, what type? _____

_____ _____

23. Have you ever had a car accident? _____ How many? _____ When? _____

24. Have you ever had any traffic tickets? _____ When? _____ How many? _____

25. Have you ever tried to kill yourself? _____

26. Do you suffer from headaches? _____

27. Have you ever had a convulsion (fit)? _____

28. Have you ever had a head injury that made you unconscious? _____

29. Have you lost or gained an unusual amount of weight in your life? _____ How old were you? _____

30. Do you have blackout spells? _____

31. Do you have any difficulty sleeping? _____ Eating? _____

32. Do you belong to any organizations or clubs? _____

33. How many close friends do you have? _____

34. Are you married? _____ If yes, how many times? _____ Living common-law? _____ Have a special girlfriend? _____ Boyfriend? _____

35. Do you have children? _____ If you have children, state ages and sex: _____

_____

36. Have you ever intentionally or unintentionally hurt your children? _____ Describe: _____

_____

37. List hobbies that you engage in at least two to three times per month: _____

_____

38. Are you working now? _____ Doing what? _____ _____ For how long? _____ If unemployed, when did you work last? _____ Doing what? _____ For how long? _____ How long did you work at the longest job you have held? _____ When? _____

39. Describe yourself as a person: _____

_____

_____

_____

_____

_____

_____

40. Have you ever had any psychiatric treatment or hospitalizations?

_____ If so, when? _____

_____

Where? _____

_____

_____

APPENDIX U

COURT CLINIC
FOLLOWUP REPORT

TO: Pima County Court Clinic

FROM: _____, Probation Officer

EXAMINER: _____

SUBJECT: _____ DATE REPORT RELEASED: _____

AGE: _____ EDUCATION: _____

ETHNIC ORIGIN: _____ MARITAL STATUS: _____

OFFENSE: _____

STATUTORY RANGE: _____

SENTENCING DISPOSITION: _____

_____

OTHER CONDITIONS: _____

_____

HELPFULNESS OF COURT CLINIC REPORT: Very, Moderate, Minimum, Not At All (Circle One)

WHAT WAS MOST HELPFUL? _____

_____

_____

IF MINIMALLY HELPFUL, WHY? _____

_____

_____

IF TREATMENT WAS RECOMMENDED, IS THIS TREATMENT BEING FOLLOWED? _____ IF SO, AT WHAT AGENCY? _____

_____

_____

PCCC #7

Chapter 5

JAILS

In the last chapter, we described one type of alliance--the court clinic--between the mental health and criminal justice systems to evaluate the mental condition of client-offenders. This chapter describes another type of arrangement, the jail-mental health relationship. Four jail mental health services are described in detail: the Psychiatric Services of the Cook County Correctional Complex in Chicago, Illinois; the Mental Health Diagnostic Services for Jail Inmates, Nashville (Tennessee) Sheriff's Office; the Pierce County Jail Social Services and Central Intake Unit in Tacoma, Washington; and the Wyandotte County Pretrial Services Project in Kansas City, Kansas.

The United States has some 4,000 jails--detention facilities, administered by local law enforcement agencies, that hold individuals pending adjudication or individuals confined after sentencing, usually for a year or less. From 20 to 60 percent of the approximately 142,000 persons in jails on any given day have mental health problems, yet most jails do not screen and evaluate all inmates needing mental health care intervention (Comptroller General of the United States, 1980).

Jails in most larger metropolitan areas throughout the country provide mental health services for inmates, including identification, screening, evaluation, treatment, training, consultation, and any combination of these. Some jails maintain medical and mental health departments, clinics, or infirmaries that screen and classify inmates upon intake and provide counseling and treatment during incarceration. Other jails operate social services departments that attend to the general social problems of inmates and arrange for inmates in need of mental health services to receive evaluation and treatment on a referral basis The primary concern of most jail services is the "maintenance" of the inmates during the period of incarceration; extensive psychotherapy rarely is provided. Close working relationships are usually maintained with jail medical staff and local hospitals.

A number of organizations and agencies have promulgated standards for mental health screening and evaluation of inmates. This includes the American Correctional Association, the Commission on Accreditation for Corrections, the American Medical Association, the American Bar Association, the American Public Health Association, the National Sheriff's Association, and the Department of Justice (U.S. Department of Justice, 1981). The American Association of Correctional Psychologists has enunciated 57 standards for psychological services in adult jails and prisons (American Association of Correctional Psychologists, 1980), including the following five standards for screening and evaluation:

> Receiving screening is performed on all inmates upon admission to facility before being placed in the general population or housing area. The findings are recorded on a printed screening form.

Inmates identified as having mental problems are referred for a more comprehensive psychological evaluation. Screening includes inquiry into: (1) past and present history of mental disturbance, and (2) current mental state, including behavioral observations. (Standard 23)

In a prison setting, all newly committed inmates with sentences over one year shall be given a psychological evaluation within one month of admission. Such routine evaluations are brief and include (but are not necessarily limited to) behavioral observation, a records review, group testing to screen for emotional and intellectual abnormalities, and a written report of initial findings. Referral for more intensive individual assessment is made when appropriate. (Standard 24)

Collection of psychological evaluation data is performed only by psychological services staff personnel or facility staff trained by them. Review of written reports based on the results of the examination, testing, and developing a plan of treatment are done by, or under the supervision of, a qualified psychologist. All such information is recorded on data forms approved by the chief psychologist and in accordance with headquarters policy in multifacility systems. At no time is the responsibility for test administration, scoring, or the filing of psychological data given to inmate workers. (Standard 25)

The individual assessment of all inmates referred for a special comprehensive psychological appraisal is completed within 14 days after the date of the referral as applied in a jail. This includes the following:
(A) Reviewing earlier screening information,
(B) Contacting prior psychotherapists or the individual's family physician regarding any history of mental symptomology,
(C) Conducting an extensive diagnostic interview,
(D) Writing and filing a brief report,
(E) If evidence of mental disturbance is found, placing the individual in a separate area where closer supervision is possible, and either
(F) Referring the individual to an appropriate mental health resource or to his or her family physician (if indicated and when release is imminent), or
(G) Beginning appropriate care in the jail by staff members of the psychological and/or psychiatric services.

This standard as applied in a prison setting includes the following:
(A) Reviewing earlier screening information and psychological evaluation data,
(B) Collecting and reviewing any additional data to complete the individual's mental health history,
(C) Collecting behavior data from observations by correctional staff,

(D) Administering tests which assess levels of cognitive and emotional functioning and the adequacy of coping mechanisms,
(E) Writing a report describing the results of the assessment procedures, including an outline of a recommended plan of treatment which mentions any indication by the inmate of a desire for help,
(F) Communicating results to referral source, and
(G) Writing and filing a report of findings and recommendations. (Standard 26)

Crisis evaluations should be conducted as soon as possible, but not later than 24 hours after the staff member has been notified. Subsequently, a report of the session(s) is written and appropriately filed. (Standard 27)

Although jail-mental health relationships have remained relatively unexamined until very recently (see Steadman and Morrissey, Note 1), Morgan (1978, p. 42) has suggested a promising format (Morgan called it a "typological model") for understanding various jail-mental health programs. This format, reproduced in Table 9, describes four types of jail mental health services:

(a) internal - mental health services are provided exclusively by jail staff;

(b) intersection - services are provided in a separate jail unit in alliance with another agency outside the jail;

(c) adjunct - services are provided by arrangement with external service contractors but are located within the jail; and

(d) combination - services are provided by various types of service arrangement in combination.

Morgan's typological distinctions, which were adapted from the National Jail Resources Study, Pennsylvania State University, capture the four jail mental health service programs profiled in this paper.

PSYCHIATRIC SERVICES OF THE COOK COUNTY CORRECTIONAL COMPLEX

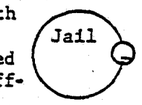
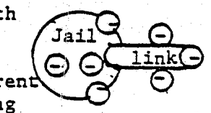
A Brief History

A jail facility was opened in 1929 to house approximately 1,300 inmates at the site of Cook County's present Correctional Complex around 26th Street and California on Chicago's near-southwest side. This facility has grown and changed, a process that continues to this date, resulting in the present complex of buildings covering over 50 acres of land, and administering almost 60,000 pretrial detainees and short-term misdemeanants each year, an average daily census of around 5000 people (see Note 2).

Table 9

A Typological Model

for Mental Health--Jail Service Delivery[a]

System	Primary Focus of Service Delivery System	Description	Schema
INTERNAL	Treatment while incarcerated, brokerage arrangements and referral post-release.	Jail autonomous. Service is administered and provided by sheriff's personnel.	
INTERSECTION	Treatment while incarcerated, brokerage arrangements and follow-up post-release.	Jail interacts with outside agencies. Service is provided by a separate staff-organization and integrated into jail operations.	
ADJUNCT	Treatment while incarcerated, brokerage arrangements and referral post-release.	Jail interacts with adjunct unit. Service is contracted exclusively for jail and integrated into operations.	
COMBINATION	Type varies depending on systems.	Jail interacts with several providers concurrently. Two or more different conduits, including jail staff, outside resources, and brokerage arrangements provide services to inmates.	

⊖ Service component

[a]From Morgan, 1978, p. 42.

A neuropsychiatric clinic was opened in 1933, in conjunction with a local hospital, to provide psychiatric services to jail inmates. Services were initiated at the request of a family member or by staff who observed inmates with obvious conditions of psychosis or psychological impairment. Inmates who had serious mental disorders were removed to a state hospital.

In 1964, the Diagnostic and Classification Center was created at the complex. All prisoners who were to remain in the jail on misdemeanor charges for more than 90 days were screened by a clinical psychologist. Inmates having difficulty adjusting to the jail and those with narcotic addictions also received this screening. The purpose of this screening was to detect inmates who would need special psychological services during their incarceration. The Diagnostic and Classification Center has continued as a recognizable unit within the Correctional Complex. Since 1978, it has functioned with approximately five profes- sional mental health staff providing psychological screening and some treatment services for inmates.

The only other mental health services available to detainees until 1974 were provided by two psychiatrists, who worked at the Cermak Memorial Hospital, a medical and psychiatric facility located on the grounds of the Correctional Complex.

In June 1973, following a series of newspaper articles that were critical of jail health services, the Health and Hospitals Governing Commission of Cook County assumed responsibility for providing medical care, including mental health services, to detainees. In August of that year, the Commission solicited assistance from the Illinois Department of Mental Health in exploring ways to improve jail mental health services.

The impetus behind swift and continuing change within the last several years was a condition-of-confinement suit filed by the American Civil Liberties Union in 1974. Harrington v. DeVito (Note 3) raised the issue of whether detainees in the Cook County Correctional Complex were entitled to mental health treatment from the Illinois Department of Mental Health. Even before the case was settled, additional staff were hired for the complex in 1975 and a special facility was established, originally with 52 beds as a residential treatment unit. The resulting new mental health services laid the foundation for the Psychiatric Services unit that is the main topic of this section of the chapter.

A court-appointed panel of three medical doctors filed an evaluation report of the Cook County Department of Corrections mental health program in October 1977 (Note 4). The report noted that many improvements had been made in mental health services since 1975, but that more improvement was needed. Space and staff were judged to be far from adequate. It further noted that individual psychological screenings were not provided for every prisoner, a process that the report's authors deemed essential, and that the screening process that did occur was frequently done by jail guards or other inmates who had no specialized training. The report also noted a shortage of physicians, a high

incidence of mental health problems, the need to provide services for night-hour admissions, and a high potential for suicidal and assaultive behavior among inmates.

Harrington v. DeVito was resolved by a consent decree in 1978 (Note 5). As part of the settlement, the Department of Corrections agreed to provide all necessary space, buildings, renovation, and security; the Department of Mental Health agreed to provide mental health staff; and the Health and Hospitals Governing Commission agreed to provide matching funds and to develop and implement the needed program. This basic multi-agency arrangement continues today. The present Psychiatric Services is funded jointly by the Illinois Department of Mental Health and Developmental Disabilities and by the Cook County government. The program is operated by the Prison Health Services, an independent organizational structure within the correctional complex, of which Psychiatric Services is one part.

By 1979, all detainees in or entering the Correctional Complex were receiving a psychiatric screening. The professional mental health staff of the Psychiatric Services team numbered about 20 and were complemented by twice as many specially trained corrections officers. Although Cermak Memorial Hospital was closed in March 1979, its wing on "3-North" continues to function as an acute psychiatric care unit, providing specialized intensive care and total physical restraints (if needed) for detainees with critical or potentially destructive psychiatric problems.

The Psychiatric Services unit apparently is providing increasingly better mental health care for inmates. Its continuing progress is affirmed by staff and documented in a recent report to the court, filed in June 1980 (Note 6). While describing some difficulties at the jail, both new and continuing, the report generally concedes that significant progress has been made. It attributes to the Harrington consent decree a clearly improved environment of services. The mental health professional staff is given high ratings. The report affirms that all inmates in the Correctional Complex are now given medical and psychological screenings within a day of their admission.

Objectives of the Psychiatric Services

Psychiatric Services is unique among mental health screening and evaluation programs studied as a part of the National Center's evaluability assessment because it is designed specifically to meet the needs of inmates, instead of those of justice system officials. It is a special case of the "internal" type of mental health--jail service delivery described by Morgan (1978) and depicted in Table 9. The Harrington consent decree was a major factor shaping the present system of services provided by the Cook County Correctional Complex for its detainees. Other forensic mental health programs in court clinics, community mental health centers, and centralized hospitals have been developed to provide information about client-offenders to judges, attorneys, and probation officers, with benefits to the client-offenders as a fortuitous side effect. This program evolved in response to

inmates' needs; it was not intended to provide information to serve legal decisions. (It should be noted that the mental health screening and evaluation provided by Psychiatric Services do not comply neatly with the operational definition presented in Chapter 2.)

Psychiatric Services provides both screening and treatment of psychological problems of all detainees, i.e., all individuals awaiting trial or sentencing as well as sentenced offenders serving up to one year. Its two major goals are 1) to relieve debilitating behaviors and prepare detainees for the general population of jail inmates, and 2) to provide followup care to maintain adjustment in the general jail inmate population. As future resources permit, staff would like to add a third goal of helping facilitate inmate re-entry to the society outside of corrections through liaison with community mental health facilities.

To reach these goals, Psychiatric Services engage in six major functions. They provide staff and training for the Receiving, Classification, and Diagnostic Center (hereafter RCDC), a recently established intake unit for the jail. Acute psychiatric inpatient services are provided in 3-North, a wing of the building that was formerly the Cermak Memorial Hospital. The most visible function is that of the Residential Treatment Unit (hereafter RTU), currently a 200-bed facility, for inmates who are treatable, not in acute states, but not able to function among the other jail inmates. Working through the Correctional Complex's organization in six physical-functional divisions, followup services are given to inmates who are incorporated within the general inmate population, yet who need some special help as "outpatients." Another rapidly developing function is research and staff training. Finally, although only embryonic at this time, the function of providing "linkage" to the outside society is currently foreseen.

To describe the Psychiatric Services mental health screening and evaluation program, in contrast with others that have been studied, it may be useful to explicate more fully what is included in the program and what is not. To emphasize the point made earlier, the program does not provide information about the inmates to criminal justice system decisionmakers; rather, the program is designed for the benefit of the inmate. Only the staff of Psychiatric Services have access to information about inmates; they use it to diagnose inmate problems, to place inmates appropriately within the institution, and to design and implement treatment plans. Information about detainees is considered strictly confidential. It is not normally shared with corrections officers or officials, let alone with attorneys, judges, or probation officers.

Inmate information is released to others only under certain circumstances. On rare occasions, it may be subpoenaed by a court. Sometimes, a detainee may sign a release form and request release of his records to be used in court. Because Psychiatric Services frequently does psychological screenings within one day of a person's arrest, this information may be of considerable value in assessing questions of criminal responsibility. It should be stressed, however, that Psychiatric

Services records are used this way quite infrequently. It is less frequent still that their records are used for determinations of competency to stand trial or as input to presentence reports.

Clientele

The Cook County Correctional Complex serves nearly 60,000 admissions each year, holding around 5,000 detainees at any particular time. Men and women arrested throughout the City of Chicago are arraigned in court and gathered at various stations until they are transported in groups to the jail several times each day. The corrections facility is used entirely for pretrial detainees and for inmates sentenced on misdemeanor charges for periods of less than one year.

Division I, housed in the building which used to be the Cook County Jail, consists of about 500 to 600 maximum security and "management problem" inmates. Because of the nature of their charges, these men may remain as long as two to three years until they are brought to trial (Note 7). Men in Division II, the main men's units, typically stay eight to twelve months awaiting trial; they usually number approximately 1,200. Division III is the women's division, housed in a separate building, with a population of between 250 and 300. Division IV is a minimum security facility, housing work release prisoners, and including the gym and kitchen facilities. RCDC and the administrative offices are parts of Division V, which also includes "high-bond" inmates. Division VI comprises youth and, occasionally, other prisoners needing protective separation from the rest of the general inmate population. Divisions IV, V, and VI may have between 1,000 and 1,200 inmates each.

In a typical month, between 4,000 and 4,500 people enter (and an equivalent number leave) the Correctional Complex. All incoming detainees are screened, whether or not they are "recidivists" to the jail, i.e., people who have been detained in the facility previously (the vast majority are). Most are screened in RCDC (over 95 percent, or an average of 125 to 150 people each day of the year). Roughly 2 percent are women who are screened in Division II, the women's dorm; and 2 percent are emergency cases brought in at times other than the normal RCDC hours, who are given special screenings in the Residential Treatment Unit (RTU).

All incoming detainees are screened, but only a fraction of these, of course, receive mental health services. During a month, RTU typically will receive from 100 to 200 new detainees for services, maintaining an average daily count of between 85 and 150 men. The 3-North population is typically 10 to 20 inmates (occasionally including women in acute crisis) and Psychiatric Services typically "consults" with 100 to 125 inmates in all the divisions on an outpatient basis each month.

Staff

The inpatient acute care unit, 3-North, is staffed by a part- time psychiatrist, a part-time psychologist, one social worker, and three

specially trained corrections officers. Nursing care is provided on a 24-hour basis; although the nurses are not members of Psychiatric Services staff, they are made available by Prison Health Services of which the Psychiatric Services is a part.

RTU, designed with a client capacity of 200, is staffed by a part-time psychiatrist, an internist, four psychologists, one consulting psychiatrist, one social worker, five mental health specialists, a paramedic, and 75 specially trained corrections officers. Nursing care is also available on a 16-hour basis, provided by Prison Health Services.

The outpatient treatment program is staffed primarily by a part-time psychiatrist. Regular RTU and 3-North staff can be called upon to provide "consults" as required.

RTU and 3-North staff include corrections officers who were described above as being "specially trained." These officers are selected from the general population of officers in the complex. All corrections officers who work within the complex receive 20 hours of training in psychological and social mental health treatment topics from the Psychiatric Services staff. Officers learn basics of psychopathology, chemotherapy, and psychiatric interviewing. The Psychiatric Services program is fully explained to them. The purposes of the training are to facilitate referrals of inmates from the general inmate population and to prepare corrections officers with interviewing skills in case they encounter inmates who are in psychological crisis.

Following the initial training for all corrections officers, those who seem to have an aptitude for such services, who are interested in the program, and who have good interviewing skills are recruited by Psychiatric Services. They are given the special training, which includes an additional 10 weeks of full-time instruction. These officers then become part of the RTU or 3-North staff; they also can perform psychological screenings at RCDC. Approximately 80 officers currently have been so trained at this time.

In-service training sessions are provided for all the Psychiatric Services staff. Speakers provide workshops covering specialized topics at least once per month.

It should be noted that this staff information pertains only to Psychiatric Services, which is the focus of this section. No information will be reported for the general Corrections Complex or other related institutions.

Process Flow

Diagrammatic Overview

A series of figures, presented on the pages to follow, represents the flow of detainees through the Cook County Correctional Complex and associated institutions. Appendix A provides a key to abbreviations and

geometric shapes used in the figures in this section. Figure 19 presents an overview of the system. Various components shown in Figure 19 are broken down into finer detail in the five figures (Figures 19 to 24) that follow it.

As shown in Figure 19, the process begins with a person's arraignment in criminal court. If the defendant displays psychologically aberrant behavior, the court can divert the case for further study either to the state mental hospital at Chester, Illinois, or to the Psychiatric Institute, an independent facility of the Circuit Courts of Cook County. Either because of such diversions, or at times without them, the criminal proceedings can be suspended and the case diverted to a civil court for a civil commitment hearing. Normally, however, detainees proceed from court directly to the Correctional Complex.

Detainees sent to the Correctional Complex typically enter through RCDC. If psychological problems are apparent, the inmate is referred to Psychiatric Services; otherwise he or she is placed into the general population of inmates. Psychiatric Services tries to return all detainees to the general inmate population within a period of 10 to 15 days. It also has the option of referring inmates to the Psychiatric Institute in certain circumstances. Inmates in the general inmate population who develop psychological problems can be referred by corrections officers, by a chaplain, or by self-referral to Psychiatric Services.

Eventually, all pretrial detainees leave the complex. Many are released by posting a bond. Most return to criminal court for trial. Some pretrial detainees, of course, are ultimately sentenced to serve one year or less on a misdemeanor charge. They are returned to the jail's general inmate population, to be released after serving their time.

Initial Placement

Figure 20 details the detainee's entrance to and initial placement within the system. Most defendants are arraigned in criminal court shortly after their arrests and then are sent to RCDC, the Correctional Complex intake unit. At times, a person may be brought directly to the jail without arraignment; this may occur if the person is apparently severely disturbed and in need of immediate psychiatric care. If a defendant enters the jail without an arraignment, he or she is returned to court for arraignment at the earliest opportunity, usually within 24 hours.

During court proceedings, questions may be raised about a defendant's need for mental health treatment (NMT) or incompetence to stand trial (IST). If either occurs in a felony case, the defendant is sent to the Illinois Department of Mental Health and Developmental Disabilities maximum security hospital at Chester. The hospital staff evaluates the defendant and reports back to the court.

If the Chester staff determine neither NMT nor IST to be of concern, the court usually sends the defendant to the Correctional

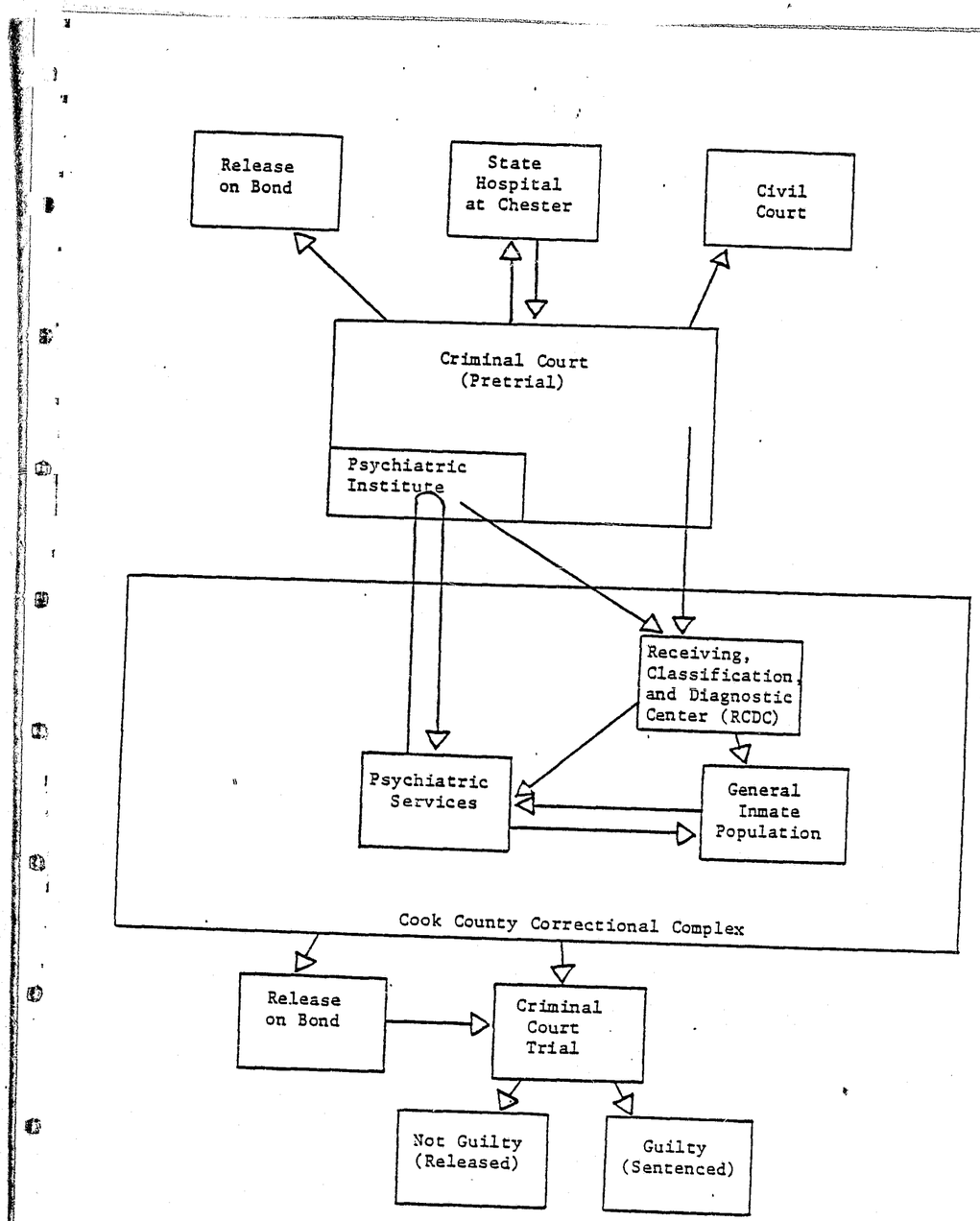


Figure 19. Overview of Flow of Detainees through the Cook County Correctional Complex.

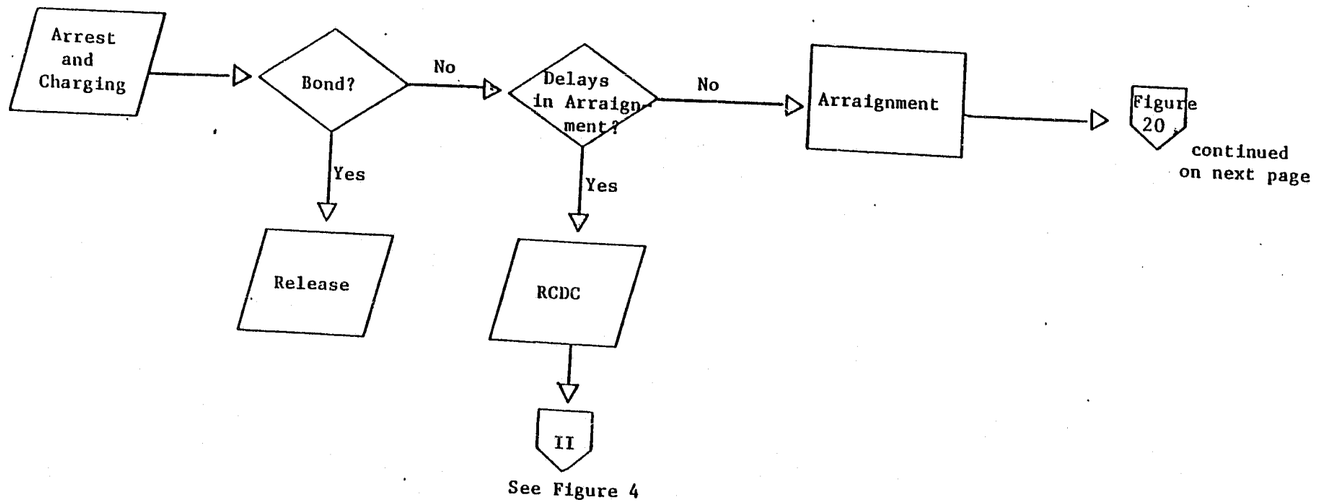


Figure 20. Initial arrest, charging, and determination of placement in the Cook County Correctional Complex.

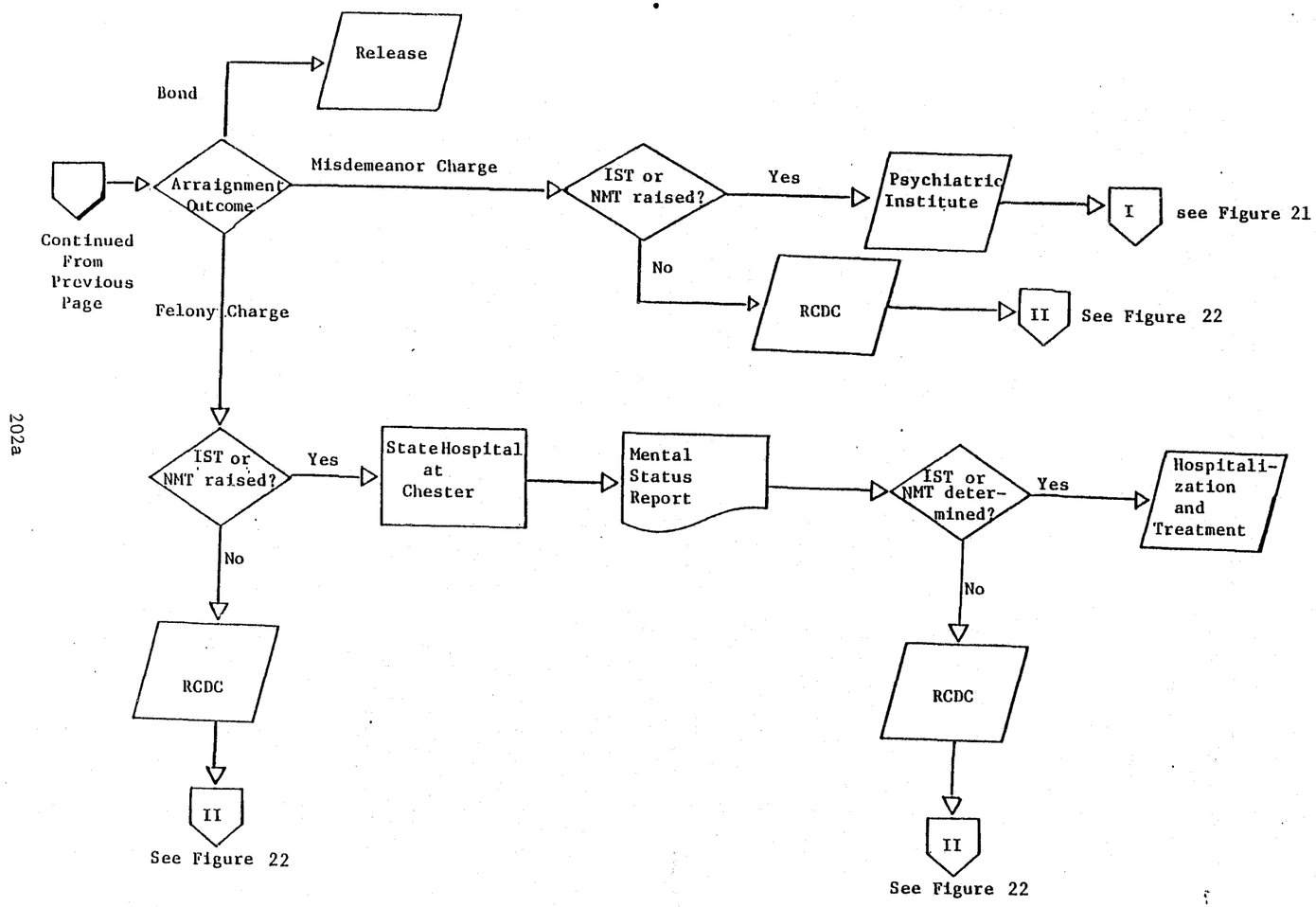


Figure 20. (continued) Initial arrest, charging, and determination of placement in the Cook County Correctional Complex.

Complex. If the court determines that the defendant is not fit to stand trial, the person is held and is treated at Chester until competency is restored. If and when competency is restored, the court sends the defendant to the Correctional Complex to await trial. Before the establishment of Psychiatric Services, those referred from Chester were a major source of difficulty; defendants who had been restored to competency at Chester frequently became unfit to proceed with trial while in the Cook County Jail. The Psychiatric Services unit now is able to provide ongoing treatment to maintain competency, enabling detainees to proceed to trial.

In misdemeanor cases, defendants with psychological problems are not sent to Chester. Rather, they are sent to the Psychiatric Institute.

The Psychiatric Institute

The process of referral to the Psychiatric Institute is shown in Figure 21. The Psychiatric Institute is entirely independent of and unrelated to Psychiatric Services. The former is a part of, and located in the same building as, the Circuit Courts of Cook County, whereas the latter is located within the Correctional Complex. The jail complex, the court building, and several other public institutions all are physically proximate on the same 50-acre site.

The Psychiatric Institute receives referrals directly from the courts and also from staff of Psychiatric Services. The Institute assesses defendants for fitness to stand trial and for criminal responsibility; it makes recommendations to the courts for sentencing options; and it assesses defendants for possible referrals for treatment in psychiatric wards of state hospitals. On the basis of the Psychiatric Institute's recommendations, the court may drop criminal charges and divert a case to a civil commitment hearing, or it may, for example, impose probation with special conditions relating to treatment. Defendants sent by the court directly to Psychiatric Institute for assessment, if not diverted immediately to a civil hearing or sent to a state hospital, will be sent to RCDC to await their day in court. At that time, RCDC examiners will learn of Psychiatric Institute's involvement (a copy of the court order to the Psychiatric Institute is sent to the Correctional Complex along with the detainee's other legal documents) and will be alert to a possible referral to Psychiatric Services. Detainees who were sent for assessment in the Psychiatric Institute by Psychiatric Services are returned to Psychiatric Services pending the court's determinations.

Receiving, Classification, and Diagnostic Center (RCDC)

Over 95 percent of those entering the Correctional Complex come through RCDC. The exceptions are women, who are screened in Division III, the women's dorm, and those in crisis situations who may be brought directly to Psychiatric Services for screening. RCDC case processing is shown in Figure 22.

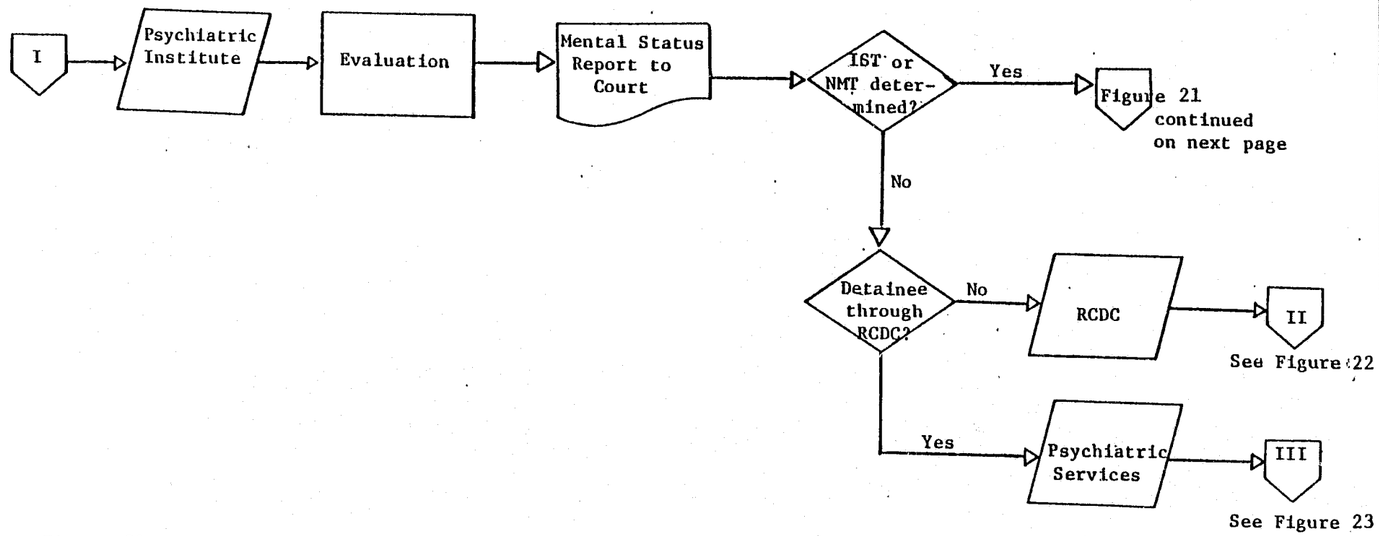


Figure 21. Referral to Psychiatric Institute for questions of competency to stand trial and need for mental treatment.

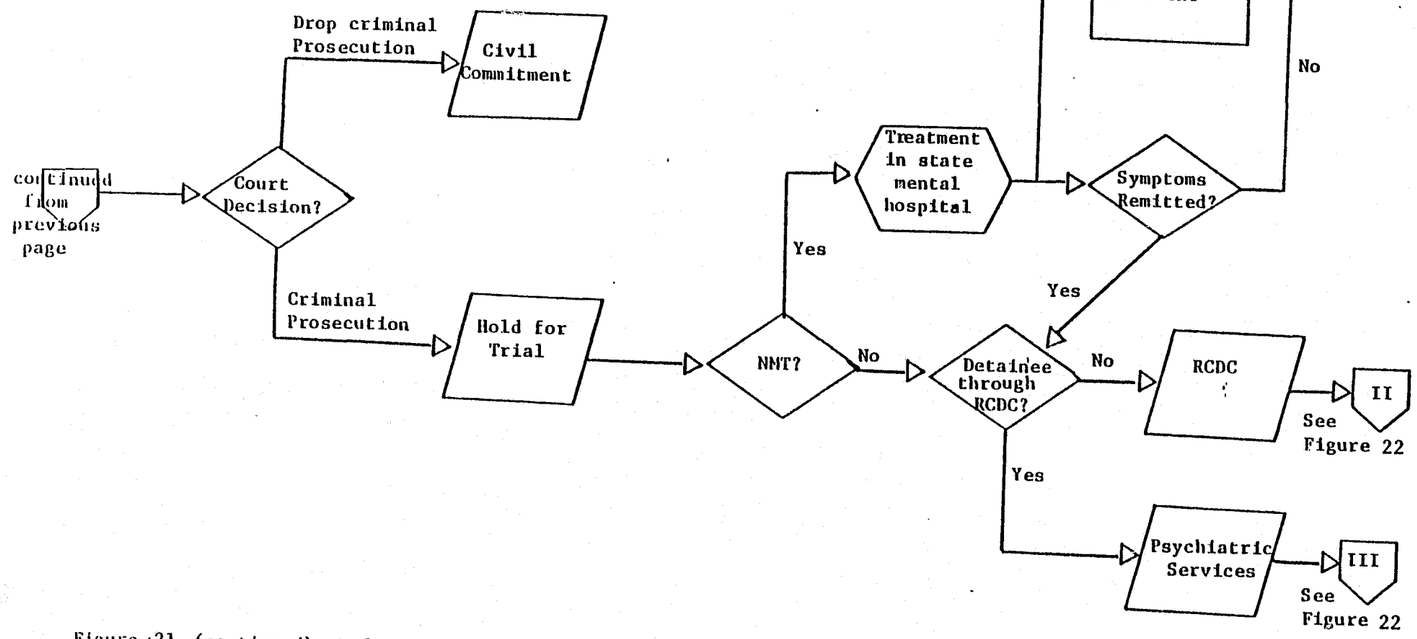


Figure 21. (continued) Referral to Psychiatric Institute for questions of competency to stand trial and need for mental treatment.

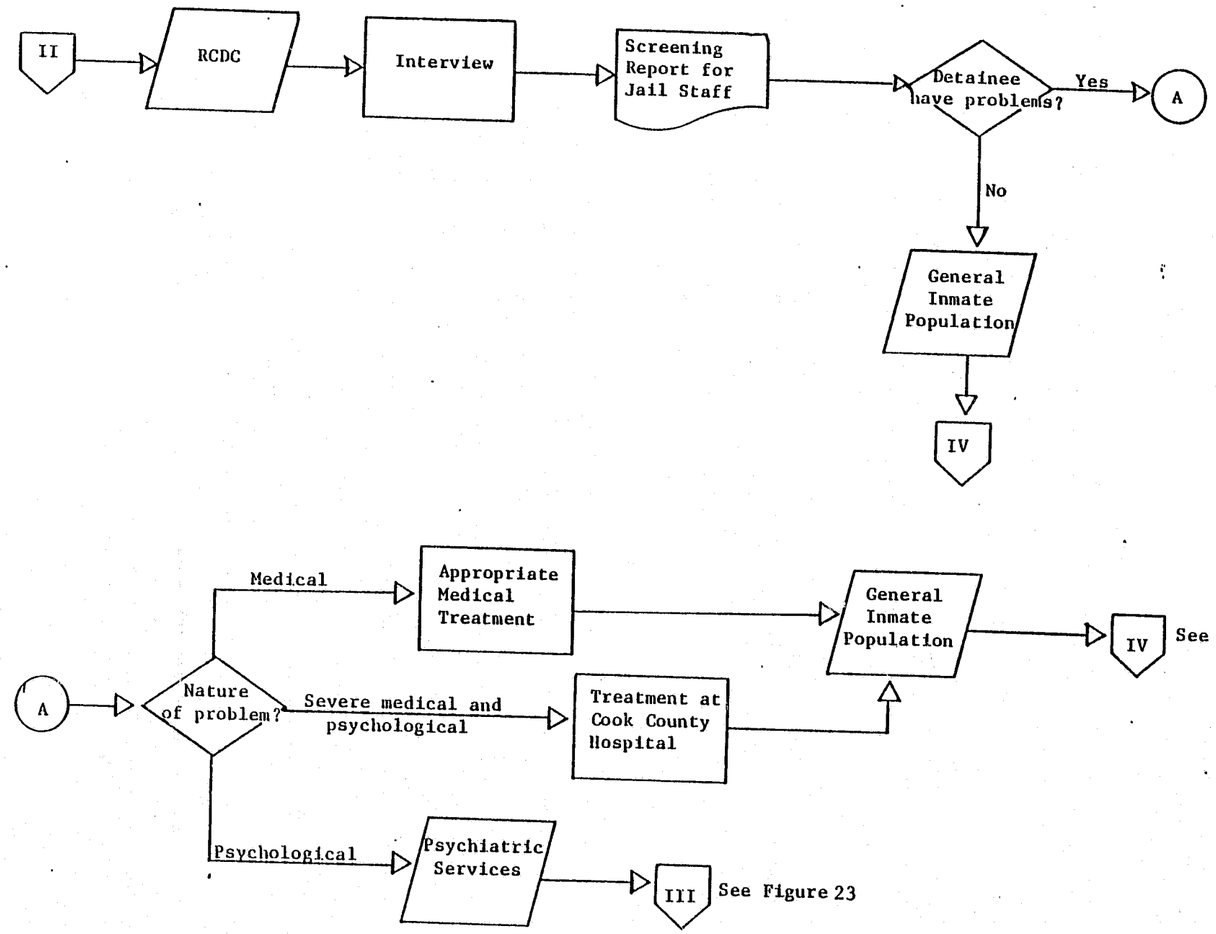


Figure 22. Processing in the Cook County Correctional Complex through the Receiving, Classification, and Diagnostic Center (RCDC).

Newly arrested detainees arrive in groups. They are stripped of clothing, searched, reclothed with jail uniforms, fingerprinted, and photographed. They wait in "bullpen" cells until they are fully processed and ready for dispersement to the jail complex's six divisions.

The intake process includes a series of interviews to detect any potential medical or psychological problems. Psychiatric Services professional staff and specially trained officers give each entering man a short interview (form attached as Appendix B). In emergency situations, the man can be removed immediately to 3-North or RTU; normally, he will be retained in the bullpens with other detainees until they are dispersed as a group. Those with medical problems will receive needed medical care and then enter the general jail population. Those with serious medical and psychiatric problems may be transported from the Correctional Complex to the secure facility at the Cook County Hospital. Most detainees, about 95 percent of those going through RCDC, are sent from RCDC directly to the general inmate population.

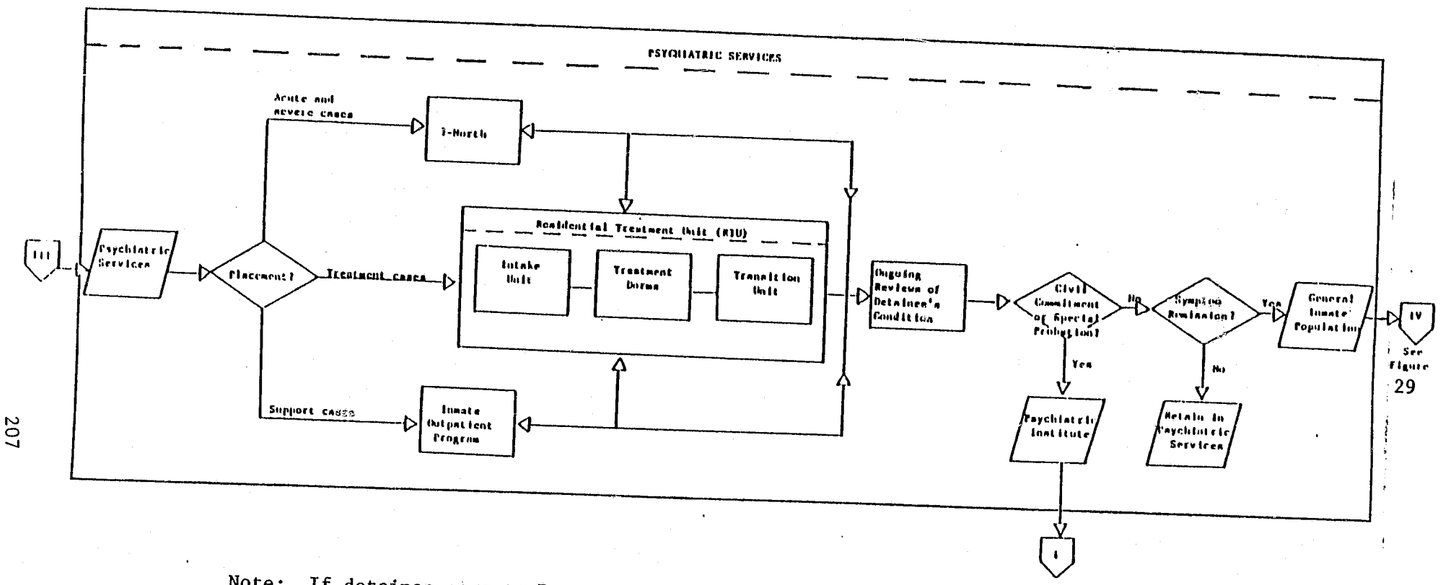
Other types of screening also are done at RCDC. Information is acquired for possible referral to the jail's drug treat- ment program. Detainees also are considered for admission to Treatment Alternatives to Street Crime (TASC), a federally funded demonstration program to reduce drug- and alcohol-related crimes and recidivism by identifying substance abusing offenders and referring them to community- based treatment programs.

Psychiatric Services

The Psychiatric Services unit, the major topic of this report, is shown schematically in Figure 23. It has three major correc- tions components: 3-North, RTU, and the inmate "outpatient" program. According to its policy manual, Psychiatric Services accepts detainees who have psychotic symptoms; are suicidal; are in serious manic, depressive, or toxic states; or present serious adjustment problems. The 3-North unit is for acute cases--those who are considered to be potentially dangerous to themselves or to others. RTU is for patients who need residential care, but who are not dangerous. Outpatient services are given to detainees who need supportive care, but who can function among the general inmate population. Detainees are transferred among the three treatment modalities as needed.

RTU was designed to administer up to 200 detainees. The inmates are housed both in dorms and in individual cells.

All RTU detainees undergo an intake procedure. During a one-day period, the inmate is given a psychiatric screening to supplement the screening conducted in RCDC, and he is observed closely by the professional staff and the trained corrections officers. After a staff consultation, a treatment program is designed including individual therapy, group therapy, and chemotherapy.



Note: If detainee came to Psychiatric Services without arraignment, he or she is returned for arraignment at the earliest opportunity. If detainee is then returned to jail, he or she returns directly to Psychiatric Services without going through RCDC again. At any time while in Psychiatric Services, detainee may be released on bond or may be returned to court for a scheduled appearance.

Figure 23. Referral to Psychiatric Services, Cook County Correctional Complex.

The RTU is composed of several treatment dorms. For example, the second floor of the unit currently houses two drug treatment dorms. Staff try to move detainees out of treatment within 10 to 15 days, and most detainees are transferred, in fact, within a month. Inmates go from their treatment dorm to a transition unit that helps prepare them to join the general inmate population. A detainee who leaves the transition unit usually is considered on outpatient status and provided followup services.

As mentioned earlier, staff may refer detainees for assessments at the Psychiatric Institute. This occurs when staff believe that a case would be handled better as a civil commitment, when they would recommend special conditions of probation, or when they feel a detainee needs special psychiatric treatment in a state hospital. In these cases, inmates are referred for evaluation at the Psychiatric Institute and then are returned to Psychiatric Services to await further progress of their cases through the courts. The Psychiatric Institute's, but not Psychiatric Services' records on the detainee will be considered by the court at a detainee's hearing.

The General Jail Inmate Population

The last figure, Figure 24, shows the process flow for the general population of jail inmates. For the most part, inmates remain in the general population until they are released after posting bond or, more often, until they are brought to trial. The general population also includes misdemeanants sentenced to less than one year, who remain at the jail until their time is served.

While in the general inmate population, a detainee may begin to experience psychological problems. If the problems are relatively major or involve the need for medication, the inmate is referred to the Psychiatric Services. This is known as a "back-door referral," both because the patient is not referred via the usual RCDC route, and because the patient will be sent for an emergency screening literally through the back door of the building that houses 3-North.

If a detainee in the general inmate population is having minor personal problems, he or she will receive counseling from staff of the Diagnostic and Classification Center. This is another unit within the Correctional Complex that provides some psychological assessments and treatment. The Diagnostic and Classification Center, with five professional staff, is a carryover from the jail's program begun in 1964 before the Harrington case and its impact on the development of the Psychiatric Services. The distinction between Psychiatric Services and the Diagnostic and Classification Center is largely organizational rather than functional; they are funded through different sources. The units coordinate their work, however, and probably will continue to merge their activities (if not their funding sources) within the years to come. The jail's drug treatment program, for example, is administered by one of the Diagnostic and Classification Center's staff, although it is housed physically as one of the treatment dorms in RTU. Finally, if a detainee receiving help from the Diagnostic and Classification Center begins to deteriorate

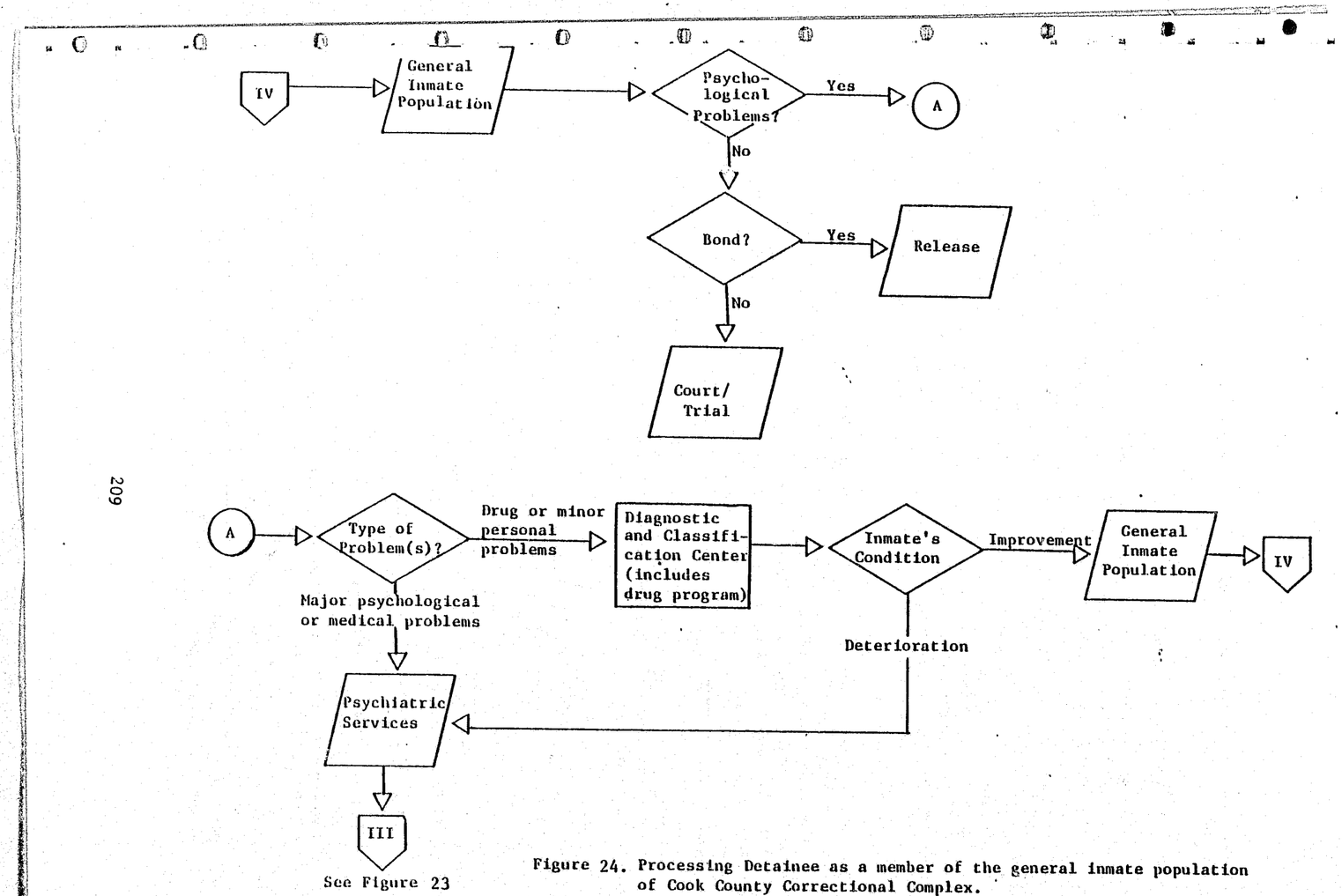


Figure 24. Processing Detainee as a member of the general inmate population of Cook County Correctional Complex.

psychologically, he or she is referred to Psychiatric Services as a "back-door" referral.

Delineation of Mental Health Information Requirements

This section will review briefly the manner by which the psychological question about a detainee is defined: the mechanisms by which information needs are delineated for the Psychiatric Services unit. Although detainees may be referred to Psychiatric Services directly upon their entrance to the Correctional Unit, after screening in RCDC, or through a "back-door" referral from the general inmate population, the delineation of needed information is not differentiated by or related to referral source, as is usually the case in other forensic mental health screening and evaluation programs. Because the Psychiatric Services are primarily for the detainee's benefit, the needed information is always the same regardless of the referral source: information about the psychological well being of the detainee, as delineated by Psychiatric Services policy.

The program's policy manual and its screening form reveal the types of information that are typically sought. Overt behavioral symptoms are checked for evidence of psychosis, manic or depressive states, or chemical dependency. Questions are asked and the detainee's social history is discussed to determine potential suicidal or other destructive tendencies and to assess potential social difficulties with other prisoners. If a complete and accurate diagnosis is difficult and important to the determination of a treatment plan, Psychiatric Services staff will arrange for psychological testing to provide additional information about the detainee. Testing, when done, usually includes parts of the Rorschach and Bender tests, but there is no designated standard test battery.

Mechanisms of referral from RCDC to Psychiatric Services are routine and straightforward. All incoming detainees are screened, and all detainees who are recommended for Psychiatric Services by the screeners are sent either to 3-North or to the intake unit at RTU. "Back-door" referrals usually are facilitated by a corrections officer who arranges for an inmate to enter the emergency intake unit at the rear of the building that houses 3-North, where the detainee is seen almost immediately by a Psychiatric Services staff member.

Acquisition of Mental Health Information

For most detainees in Psychiatric Services, information is acquired at two points. First, all detainees are screened in a structured interview using a standard interview form (see Appendix B) in RCDC. All detainees sent to the RTU intake unit or to 3-North then are given a more complete interview by a Psychiatric Services staff member. The second interview session differs from the first more in extent than in kind. The screening interview in RCDC is done rapidly (five to ten minutes) and in an impersonal setting (within sight and hearing of many other incoming detainees, at a long, semi-partitioned counter). The second screening

interview is done in greater detail over a longer time (perhaps 15 to 30 minutes, or more if necessary) and in relative privacy (usually in a setting in which the conversation cannot be overheard).

Each day, Psychiatric Services professional staff meet as a group to discuss all the detainees who have been referred to them during the previous 24 hours. The person who performed the RTU or 3-North intake screening discusses the interview with the staff. The detainee is assigned a primary therapist, a diagnosis and treatment plan is fashioned and agreed upon, and decisions are made regarding the need for further interviews, testing, and medication.

Once each week staff members review their entire caseload as a group. Information is shared about detainees in Psychiatric Services and recommendations are made to maintain or to alter treatments, or to transfer the detainee to the general inmate population.

Provision and Use of Mental Health Information

In the Psychiatric Services program few problems are encountered in providing information to those who need it or in making use of it. Those who collect the information are those who use it; the information is not gathered by a specialized forensic mental health screening and evaluation facility and then provided to a separate treatment unit.

Psychiatric Services uses a team approach for providing therapy. Many different types of therapy are employed, depending upon the psychological strengths of the individuals involved. The initial placement and the treatment plan depend strongly upon the information acquired in the first screening and in subsequent staff conferences. Changes in therapy depend more strongly, however, on the observations of staff as they work with the detainee and discuss the person's behavior and progress at staff meetings.

Information about each detainee is considered confidential. It is not released or shared with any others. If it is in the detainee's best interest, and only with written consent, an inmate's records may be transferred to a community mental health facility, to the Psychiatric Institute, or to a court; but this happens infrequently.

Information Feedback, Monitoring, and Program Evaluation

The purpose of this section is to review activities, procedures, and mechanisms of the Psychiatric Services that provide information about the program to the program staff. Evaluative information is useful to ensure quality control and to help initiate and assess program change.

The Psychiatric Services program has a written procedures manual to guide its operations. The document contains policies and descriptions covering topics such as the procedures for screening new inmates, criteria for admissions to RTU or to 3-North, the team approach to treatment planning and therapy, and the use of staff meetings.

Observations made during our visit to the Psychiatric Services lead to the conclusion that the policy manual contains accurate and pertinent information that can be used in conducting day-to-day operational activities (Note 8).

The Harrington consent decree established certain standards for the mental health services to be provided at the Correctional Complex. As examples, it specified that every incoming detainee shall be screened for psychological problems, that the mental health dormitories shall maintain a ratio of at least one corrections officer for every ten inmates, and that all corrections officers shall receive specialized training in mental health care. The decree also specified that six reports were to be filed to the court within a two-year period after the date of the settlement, providing a list of information to be reported with which the court could evaluate how well the correctional facility was meeting the court's mandate. It is presumed that this information has been reviewed as part of the process employed by the court-appointed panel.

Psychiatric Services staff have been keeping regular statistics and filing them as reports to the court on a monthly basis. As mentioned earlier, a special panel filed a report to the court in June 1980, regarding the Correctional Complex's response to the consent decree. All available statistics and the 1980 report indicate that the services specified in the decree are being provided, and that the Psychiatric Services unit is continuing to expand and deliver services even beyond those originally expected.

Finally, staff at Psychiatric Services are working with professors from Northwestern University and from the University of Chicago in a number of training and research projects connected to their program. Other reports about the program are being prepared for publication by the mental health staff at this writing. Psychiatric Services staff have participated in national conferences to share experiences with other mental health workers in corrections environments.

The only discernible major problem regarding information feedback stems from the insular position the program maintains regarding the provision of information to other agencies. Probably because no mechanism exists for providing information about detainees to the courts, no mechanism exists for transmitting information back to the Psychiatric Services from the courts. According to monthly statistics for 1979, between 60 and 90 percent of the Psychiatric Services cases are terminated because a detainee returns to court. When this happens, the Psychiatric Services unit loses all contact with the detainee; they receive no information about the disposition of the detainee's case. Clearly, Psychiatric Services records could be of value to other mental health workers who may come into contact with the detainee, whether the detainee is imprisoned, placed on probation, or released.

Feedback and long-term followup are recognized by the Psychiatric Services staff as desirable functions, but they have not yet been

implemented in a substantial manner, primarily because of limited staff resources. Also, many individuals return to the Correctional Complex on new charges; it would be useful for Psychiatric Services to have access to the court's records of the dispositions of the detainees' previous cases. The absence of this information is a source of frustra- tion for the Psychiatric Services staff, for which no immediate relief is in sight.

MENTAL HEALTH DIAGNOSTIC SERVICES FOR JAIL INMATES, NASHVILLE (TENNESSEE) SHERIFF'S OFFICE

The Diagnostic Services for Jail Inmates Project (hereafter DSJI) is in the Correctional Rehabilitation Division of the Nashville Sheriff's Department. It provides intake mental health screening of male defendants awaiting trial for felony charges in the Nashville jails, as well as limited treatment to mentally ill defendants. The basic purposes of DSJI are a) to inform jail wardens and counselors about potential problems that individual inmates may present and to suggest special handling, and b) to identify and treat inmates with major mental health problems, especially suicidal or psychotic problems. The inmates screened generally are in the early stages of the pretrial process and DSJI reports and treatment usually are aimed at the pretrial detention stage, rather than the post-sentencing stage. DSJI, however, also evaluates a few inmates being considered for parole or work-release and, on occasion, for pretrial release.

DSJI is currently funded by the Tennessee Law Enforcement Planning Agency under a formula (block) grant administered by the Tennessee Department of Justice. The project began on October 1, 1979; the early stages of the project were devoted to hiring staff and planning project operations. Inmate evaluations did not begin until November 1, 1979. The Sheriff's Department hired two masters-level psychometricians for the project and it retained two consultants, a psychiatrist to work 10 hours per month and a doctorate-level clinical psychologist to work 40 hours per month. The project staff also includes a secretary and a program coordinator, who is also a jail counselor.

Nashville, a city of some 800,000, has a metropolitan government that combines the former city and county governments. All local jails are within the authority of the Sheriff's Department. The department has four facilities: the Metropolitan Jail, the Detention Center, the Metropolitan Workhouse, and the Pre-Release Center. The Metropolitan Jail is the most important facility for the purpose of this program. It houses only defendants awaiting trial for felonies and, of course, only defendants not out on bond or pretrial release. Defendants are not sentenced to serve prison terms in the Metropolitan Jail.

All booking (initial jailing after arrest) is done in the Detention Center. After booking, defendants charged with felonies are typically sent to the Metropolitan Jail; misdemeanor defendants remain in the Detention Center unless they are released on bond. The Detention Center also receives offenders sentenced to prison terms of six months or less. The Pre-Release Center is a minimum security facility that

receives inmates referred from other prisons for several months prior to their release. Inmates are typically on work-release and are absent from jail during working hours.

The Metropolitan Workhouse is the location of all DSJI offices and screening operations. Most Workhouse inmates are employed in various work details during the day and spend the nights in six-man cells. The several categories of inmates in the Workhouse are (1) men serving prison terms of six months to a year (between the maximum term for the Detention Center and the minimum term for the state penitentiary); (2) men with sentences of one to five years specifically sentenced to the Workhouse by a judge; and (3) "contract" inmates sent to the Workhouse under a contract between the sheriff and the Tennessee Department of Corrections permitting the latter to relieve prison overcrowding by transferring up to 100 prisoners to the Workhouse. The Workhouse also holds some inmates awaiting trial for felonies who would ordinarily go to the Metropolitan Jail. These include prisoners needing medical attention available in the Workhouse, defendants awaiting trial in the local federal court, juveniles bound over to the adult courts, inmates separated from others who may threaten them, and prisoners with suicidal tendencies. All Workhouse inmates are male.

The number of referrals to the project, and hence the demands on the project staff, has varied greatly. At the beginning, DSJI received about a dozen referrals per week, too many for the single psychometrician originally hired. Then, after a second psychometrician was hired, inmate referrals decreased. There was not enough DSJI work to keep the psychometricians fully occupied, and they performed other tasks in the Correctional Rehabilitation Division of the Sheriff's Department such as screening inmates to be transferred from the state prison to the Workhouse, counseling jail inmates, and screening prospective jail guards. In June 1980, the DSJI greatly changed its procedures, as described in this section of the chapter. These changes subsequently increased the number of referrals, such that DSJI screening now fully occupies the staff's time.

Process Flow

The flow diagram in Figure 25 gives a simplified outline of the case processing and information flow in DSJI. The steps will be described fully in the following three sections; only an overview is provided here.

The selection of inmates for screening and evaluation by DSJI is automatic. There is no referral source as such. Each inmate on the "bound-over docket" (defendants newly entering the jails, prior to indictment) is sent to DSJI in the Workhouse unless he (a) is out on bond, (b) was screened earlier by DSJI, or (c) is being screened (e.g., for competency to stand trial) by the local community mental health center. The DSJI screening ends and the inmate is returned to the jail if the DSJI staff discovers that he was recently screened for mental health services, either at DSJI or elsewhere, or whenever the inmate does

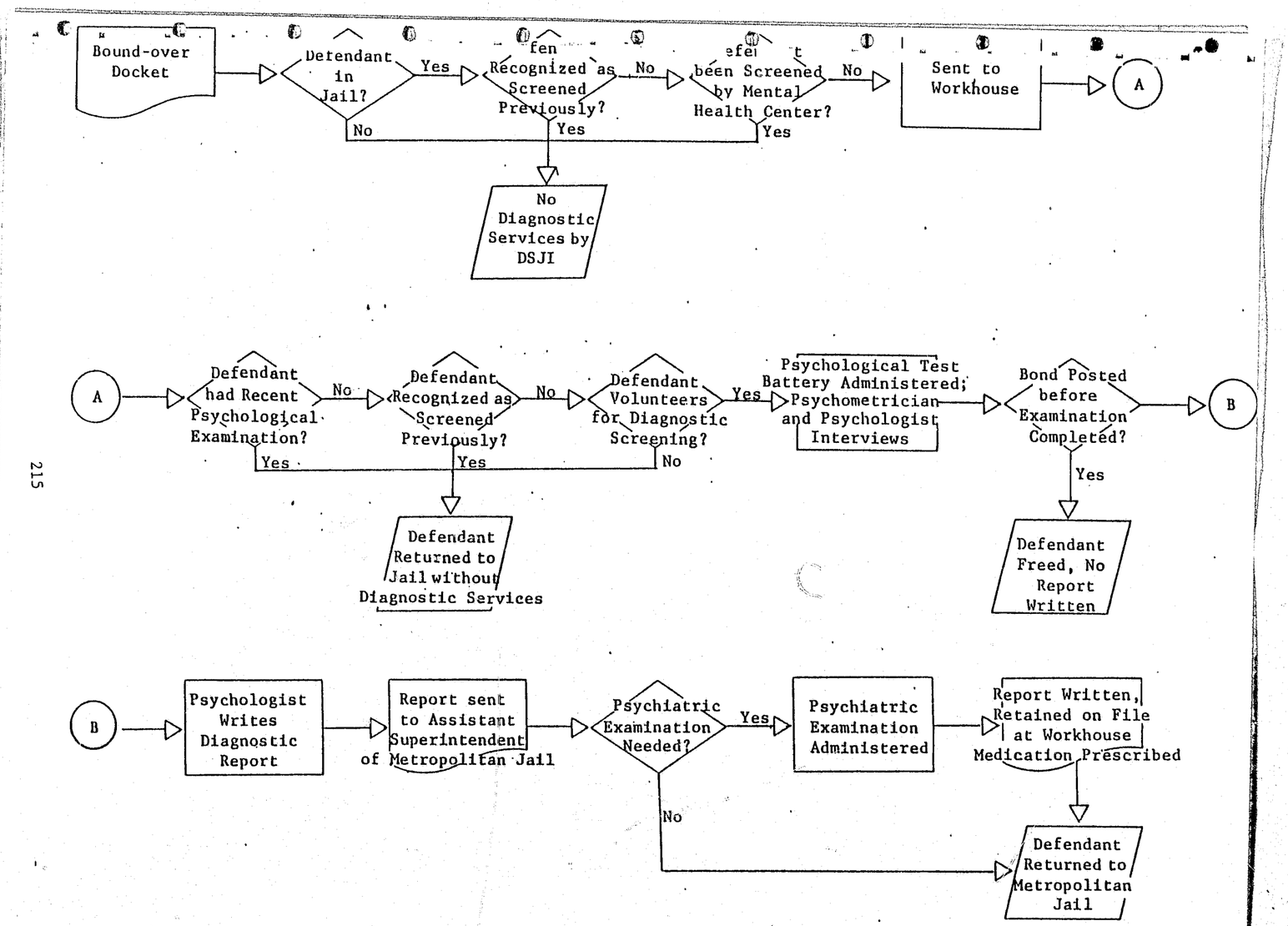


Figure 25. Screening and Evaluation Case Flow in the Diagnostic Services for Jail Inmates (DSJI) Project in Nashville.

not give permission for the screening. In addition, at any time during the examination process, an inmate may be released on bond, in which case the screening process terminates.

The first stage of DSJI evaluation, conducted by psychometricians, comprises interviewing the inmate and administering a standard battery of psychological tests. The results then are transmitted to a psychologist, who interviews the inmate and writes a psychological report. The report, which contains recommendations to the jail wardens for treatment and handling of the prisoner, is sent to the assistant superintendent of the Metropolitan Jail. In a small percentage of the cases, the inmate is referred to a consulting psychiatrist for an interview, also held in the Workhouse, and for possible treatment through administration of medicine or psychological counseling. The psychiatrist's report, however, is not transmitted to the Jail officials, but is retained in DSJI for the purpose of administering medicine. The inmate is usually sent back to the Metropolitan Jail as soon as the screening and treatment, if any, is completed.

Delineation of Mental Health Information Requirements

By far the most important source of DSJI clients is the Metropolitan Jail, which houses inmates awaiting trial for felony charges. DSJI provides mental health screening for almost all such defendants. (It does not screen defendants out on bond or pretrial release pending trial because, of course, jail personnel would not use mental health evaluations if the defendant is not in jail.) Those screened tend to be defendants who are charged with the most violent crimes or who are not natives of the Nashville area, because these defendants are less likely to be given pretrial release.

The Metropolitan Jail transmits defendants who have been placed on the "bound-over docket," which contains mainly defendants who are about to be considered by the grand jury for possible indictment; but some are defendants arrested a few weeks earlier and, for some reason, not promptly placed on the bound-over docket. The number of defendants sent to DSJI from the Metropolitan Jail varies from week to week; according to DSJI records, there are typically some seven or eight inmates, although there may be as few as two and as many as a dozen.

Each week DSJI screens one or two other inmates in addition to those referred from the Metropolitan Jail. Some are felony defendants awaiting trial in the Workhouse or the Detention Center (only a small minority of felony defendants await trial in these two jails). Also, there are some referrals of sentenced prisoners being considered for parole or work release. DSJI screens only a very small portion of parole and work release candidates, however, and typically those convicted of sex crimes or unusually violent crimes. These few cases come from the prisons at an irregular and unpredictable rate. They will not be discussed further in this report because they occur infrequently and because they are not screened for prison intake, the main function of DSJI.

Prior to screening, defendants are transferred to the Workhouse, where the project staff is located. Each Friday the Project Coordinator of DSJI receives a copy of the "bound-over docket" for each day of the current week from the Criminal Court, the local court with jurisdiction over felony cases. The names of defendants who are still in jail are recorded (most defendants are on bond, as indicated on the docket by the name of the bonding firm); cards for these defendants are pulled from the jail registry; and the warden is asked to have identified inmates prepared for transport to the Workhouse on the following Monday morning.

The Project Coordinator and other project staff remove defendants' names from the "bound-over" list, even though still in the Metropolitan Jail, under two circumstances. First, if DSJI has already screened a defendant, when the defendant was arrested earlier on other charges, it will not evaluate a second time. The Project Coordinator sometimes recognizes a defendant previously screened by DSJI when first reviewing the bound-over docket, or DSJI staff recognize the defendant when the bound-over docket is taken back to DSJI offices on Friday. The names of prospective defendants are usually checked against the file list of previously evaluated defendants. The second circumstance in which defendants are eliminated from DSJI services occurs when defendants are being assessed for competence to stand trial or criminal responsibility by the local community mental health center, the Dede Wallace Mental Health Center. Dede Wallace staff inform DSJI of such defendants, and the Project Coordinator removes their names from the list of inmates transferred to the Workhouse for screening. There have been very few such defendants, however.

The next step is transporting the defendant from the Metropolitan Jail to the Workhouse, a distance of about two miles through downtown Nashville. A deputy sheriff performs this task, usually within one week of the defendant's admission to the jail. However, because of court scheduling conflicts, medical difficulties, or disciplinary problems, this move may be delayed for up to four weeks. Upon arriving at the Workhouse, the inmate is placed in a secure area; unlike regular Workhouse inmates, he cannot leave the building. According to DSJI staff, the inmates often complain that the Workhouse facilities are worse than those of the jail, because they are not permitted to participate in recreation, commissary, or visiting privileges in the Workhouse. These activities are prohibited for security considerations and because of the staff's position that pretrial defendants should not be mixed with inmates serving sentences.

DSJI receives no information or formal instructions from the Metropolitan Jail. The only referral information is contained in the bound-over docket list, which gives only the inmate's jail number, court docket number, and pretrial release status. (The Metropolitan Jail gives the Project Coordinator a card with information about the defendant, including the charge; but the card is used only for planning security arrangements and is not given to the remaining DSJI staff.)

Acquisition of Mental Health Information

The first stages of the screening procedures are conducted by the two DSJI psychometricians. After the jail guards escort the defendants to a classroom in the Workhouse, a psychometrician explains the purpose of the examinations, i.e., to help the inmates, mainly by treating those with mental problems. The inmates are told that the screening is voluntary and that they may refuse and return immediately to the Metropolitan Jail. Few inmates refuse. At this initial meeting, also, a defendant may mention to DSJI staff that he was recently given psychological screening, either at DSJI or elsewhere, such as a community mental health center or state forensic mental hospital. A psychometrician then asks the defendant when and where the screening took place. If it appears that the DSJI screening would largely duplicate recent screening elsewhere, the psychometrician terminates screening and returns the defendant to the Metropolitan Jail. The staff estimates, however, that only about 1 in 20 inmates leaves because he declines to volunteer or because previous psychological evaluation is discovered after arriving at the Workhouse.

A more common cause of attrition from the DSJI potential case load occurs when defendants post a bond. Inmates are released, of course, the moment they receive bond, even in the midst of a psychological evaluation. Hence, in about 20 percent of the cases, the staff conducts at least some testing and interviewing, but does not prepare a report because the inmate is released.

The information used in the screening is developed from interviews, psychological tests, and, in a few cases, records obtained from other institutions. There are three stages in the screening process: testing and initial interview conducted by two psychometricians, a psychologist's interview, and a psychiatric interview. The last stage occurs in only a minority of cases, when the DSJI psychologist refers the defendant to the consulting psychiatrist.

Testing and Initial Interview

The week's group of inmates is assembled in a classroom in the Workhouse, usually on Monday afternoon, and psychological testing and interviews begin. The procedure varies little from case to case. The psychometricians first administer the Minnesota Multiphasic Personality Inventory (MMPI), giving a copy to each client and instructing him how to fill out the answer sheet. Each inmate's work on the MMPI is temporarily interrupted while he is taken into another room for an interview with one of the two psychometricians. The psychometrician also administers the Wechsler Adult Intelligence Scale (WAIS) test and then completes the "Jail or Workhouse Interview Form." Each of these two steps takes approximately 30 minutes. The "Jail or Workhouse Interview Form," which is used for every person coming into the Workhouse or Metropolitan Jail, requests considerable information about the inmate's social history. The only part directly relevant to mental health problems, however, is a question regarding past psychiatric treatment; this question is usually

asked early in the interview, and an affirmative answer leads to close questioning about the past mental health services given the inmate.

The psychometricians do not prepare written reports as such. The written information given the psychiatrist is the testing results and the material in the interview form, supplemented occasionally by a short note. The psychometricians closely observe the inmate while administering the WAIS and completing the interview form, and they tell the consulting psychologist about any indications of mental health problems.

The psychometricians and the psychologist believe that the MMPI and the WAIS are the major sources of test information. The psychometricians also routinely administer the Rotter Incomplete Sentence Blank and the House-Tree-Person Drawing Technique tests. If the inmate is illiterate, the psychometrician administers a Mini-MULT, a short version of the MMPI given orally. The psychometricians also administer the Bender Motor Gestalt tests to some inmates, generally when the previous tests indicate that there may be organic brain damage. DSJI also maintains materials for administering the Thematic Apperception Test (TAT) and the Rorschach Ink Blot Test, but the psychometricians have not used these tests, mainly because they take considerable time to administer. The consulting psychologist, as will be discussed below, sometimes administers the TAT during his interview, which follows the psychometricians' screening.

DSJI plans to add the General Aptitude Test Battery (GATB). The GATB, which takes over two hours to administer, has 12 tests that yield 9 aptitude scores in the area of verbal aptitude, numerical aptitude, spacial perception, form perception, clerical perception, motor coordination, finger dexterity, and manual dexterity. The battery is intended primarily for use in counseling individuals who are looking for occupations or vocational choices (Freeman, 1950). The stated reason for adding this test was to make DSJI evaluations compatible with the prison intake screening evaluations performed by the Tennessee Department of Corrections for state penal institutions. The aim is to relieve the Department of Corrections of the need to conduct intake evaluations of inmates who have already been screened by DSJI.

The psychometricians' tests and interviews generally take about five hours during Monday afternoons and, typically, Tuesday mornings. The psychometricians obtain further information in only a few cases. Although they do not routinely interview the clients' relatives, some information may be obtained when relatives telephone DSJI to inquire about the inmate's status. Also, if the defendant indicates that he was treated at a mental health facility, the project staff tries to acquire relevant earlier records. A release from the inmate, however, is necessary to obtain this information, except that the staff may receive, without release, any information from an institution that is part of the state or local government.

Psychologists' Interviews

The next stage in the DSJI screening is an interview conducted by the consulting psychologist. The diagnostic interview is generally half an hour to an hour in length, and takes place on Wednesday, after the psychometricians' screenings are completed. Prior to the interview, the psychologist studies the test results and the social history information on the interview form. The only other information he is likely to have before his interview are verbal reports from the psychometrician about possible mental health problems that were observed during testing. On rare occasions the psychologist may also have reports from mental health centers or institutions where the inmate was treated earlier.

The psychologist conducts a loosely structured diagnostic interview without the use of standard forms or lists of written questions. He especially looks for the existence of recurrent patterns in the inmate's life (e.g., a long history of violent actions), evidence of organic brain damage such as psychomotor epilepsy, mental deficiencies, and evidence of psychosis, depression, suicidal tendencies, or other mental health problems. The psychologist also administers the TAT in a few cases. And on rare occasions, especially in cases of family violence, he interviews the inmate's wife or other family members.

Immediately following each interview, the psychologist dictates his report, to be typed later by the DSJI secretary. (The contents of the report will be described in the following section.) He then informally discusses each case with the psychometricians, outlining his opinion of the problems. He also decides whether the inmate should be referred to the consulting psychiatrist. Such referrals for psychiatric examination, made in about 15 or 20 percent of the cases, are usually done because the inmate seems psychotic, depressed, or otherwise mentally ill. The major stated purpose of the referrals is to obtain medication that requires the psychiatrist's prescription. The psychologist also refers inmates to the psychiatrist if he suspects organic brain damage; the purpose of the referral is to determine the need for further referral to a neurologist. (In a few emergency cases, when the psychometrician believes that the inmate needs immediate medication, the psychiatrist will be requested to make an emergency visit. The psychiatrist then will come without the intermediate step of a referral by the psychologist.)

The inmate usually returns to the Metropolitan Jail after the psychologist's interview. He remains at the Workhouse, of course, if scheduled for a psychiatric interview; typically the psychiatric interview takes place on Thursday, and the inmate returns to the Metropolitan Jail immediately after the interview. A very few inmates, especially suicidal inmates, remain in the Workhouse after screening so the DSJI staff can watch them closely.

Provision and Use of Mental Health Information

The Report and Recommendations

The major result of the DSJI screening and evaluation is a report about each inmate screened. The report is typically a single page to a page and a half in length, letter-sized, and single spaced. The typical report first lists the psychological tests given. It then describes the inmate's criminal history, his personal appearance, the crime charged as described by the inmate, and his social history. The latter emphasizes mental health, alcohol, and drug problems and treatments. The next section of the report gives the psychological testing results and interpretations of the results.

The final section of the report contains the psychologist's recommendations concerning how the inmate should be handled by the jail personnel and what types of treatment should be given the inmate. About three quarters of the reports advise the jail to maintain standard procedures in handling the inmate. In the others the psychiatrist recommends that the inmate be given special treatment or subjected to special precautions in the institution. The latter includes recommendations that the inmate have limited segregation (separation from jailmates), that he be watched especially as an escape or suicide risk, or that he be given medication while in custody (this requires review by the psychiatrist). A common recommendation is that the inmate be referred to a substance abuse program for alcohol or drug treatment. A few inmates are referred to the local community mental health center for treatment.

Uses of the Report

The report is sent to the assistant superintendent of the Metropolitan Jail, who in turn shows it to rehabilitation counselors. It is used when handling the inmate while he awaits trial. The report is not given to the courts and is not used directly for incompetency or responsibility issues. There are, however, other uses of the report and the information obtained from the DSJI screening:

- —In a few cases DSJI ascertains that the inmate might be incompetent to stand trial or not guilty by reason of insanity. DSJI then telephones the inmate's counsel and the District Attorney to inform them of this possibility, and they generally will initiate examinations for these purposes in the community mental health center. DSJI does not send the report to the attorneys.
- —The psychologist holds treatment sessions with a few inmates found to have suicidal tendencies.
- —Inmates might later be sentenced to the Workhouse, and the report is available to the counselors as an aid in their counseling.
- —If the inmate is sentenced to a state penal institution, the report is sent to the intake screening and classification unit there. At present, the report supplies only part of the infor-

mation needed by the state department of corrections; with the DSJI's expansion of testing, however, it will probably provide all the information needed.
--The report is also sent to any other state or local govern- ment agency requesting it or to a private agency if the inmate permits, principally to the community mental health center when inmates are referred there for treatment by the project.

In addition, of course, the report forms the basis of the psychologist's referral of the inmate for psychiatric information. The psychologist either gives the psychiatrist a copy of the report or communicates verbally his concerns and reason for referral. In rare cases, the psychiatrist will refer the inmate to the Workhouse physician if a medical examination or care seems necessary. Drugs prescribed by the psychiatrist in DSJI are mild drugs, usually tranquilizers, that do not require physical examinations before prescription.

When cases are referred to the psychiatrist, the psychiatrist prepares a short report presenting a diagnosis and prescribing medicine. A typical psychiatric report is shown in Appendix C. This report is not sent to the Metropolitan Jail; rather, it remains in the inmate's file in the Workhouse and a copy is given to the jail nurse.

Feedback, Monitoring, and Program Evaluation

Management, Monitoring, and Feedback to Staff

In general, the project is managed by the psychologist and the project director through informal conversation and meetings with the staff, mainly the two psychometricians. The psychologist talks with them once a week after he conducts his interviews. DSJI does not have the formal administration envisioned by the Standards for Psychological Services in Adult Jails and Prisons (American Association of Correctional Psychologists, 1980); specifically, there are no formal organization charts showing detailed lines of authority and no formal monthly administrative meetings as recommended by Standards 4 and 7. DSJI staff, however, often informally discuss current problems and often adjust operations in response.

There has been very little feedback from the Metropolitan Jail to the DSJI staff about the quality of reports sent or about what has happened to the inmates once screened. The psychologist who makes the major decisions and prepares the report seldom sees inmates after screening. The major exceptions are informal feedback when inmates are later sentenced to the Workhouse and treated there and when the psychologist holds treatment sessions with the few pretrial inmates retained in the Workhouse after screening because they have apparent suicidal tendencies. One reason for the limited feedback to the psychologist is that DSJI is only a diagnostic team; treatment generally is administered by others. Another reason is that the psychologist believes conflict-of-interest restrictions prevent him from recommending treatment by him as a private practitioner.

Routine Statistical Reporting

The routine statistical reporting in the DSJI's internal reports contains standard summary demographic information, including the race, age, crimes, and intelligence range of the inmates screened, the number of inmates for whom alcohol and drug treatment was recommended, and the number found to be psychotic or to require suicidal precautions. The internal reports show that about 60 percent have been found to need drug or alcohol treatment, about 10 percent have been found to be psychotic, and about 5 percent have been found to have suicidal tendencies.

Special Studies and Reports

To date there have been no special studies or reports. However, one of the psychometricians is presently conducting a followup study using several methods. The Metropolitan Police Department computer, which contains arrest and incarceration records for all local inmates and which is connected with the FBI's centeralized computer, is used to identify inmates screened by the project who are still in the local jails. Plans have been made to determine whether the recommendations and conclusions in the DSJI reports were followed for these inmates. Preliminary results indicated that 7 of the first 21 inmates screened (in November and December 1979) are still in the Metropolitan Jail; six are still awaiting trial. The computer search has also located screened inmates who are in the Tennessee State Prison and who, thus, have been subjected to psychological screening and examination by the prison intake classification unit. The psychometrician has begun to obtain the unit's files to compare those test results and psychological findings with those of DSJI. No definite evaluation criteria have been developed, but he generally has noted the similarity of MMPI scores and treatment recommendations resulting from DSJI screening and the prison intake screening.

DSJI maintains a file on each inmate screened. These files, which may be a valuable source of evaluation information, contain the completed interview form, the test results, the psychologist's report, and the psychiatrist's report, if any. The files are available to internal researchers and probably would be available to external researchers if sufficient precautions were taken to preserve confidentiality.

Recent Changes

Soon after the site visit to the DSJI in May 1980, several changes were made to increase the number of screenings, to enhance efficiency, and to provide greater feedback. In mid-June, one psychometrician began screening inmates in the Metropolitan Jail, while the other continues to screen them in the Workhouse. The consulting psychologist and psychiatrist now both go to the Jail and the Workhouse one day each week. The Jail Superintendent determines which inmates are sent to the Workhouse for screening and which remain in the Metropolitan Jail; the basic criteria are that inmates who seem to be security risks or to be psychotic remain in the Metropolitan Jail for screening. The original

grant application for the DSJI project stated that the screening was to be done in the Metropolitan Jail, but the DSJI staff decided that the Jail, which is very old, does not have sufficient facilities for screenings. After a half-year's experience with screening in the Workhouse, however, the DSJI decided to move much of the screening to the Jail despite the poor facilities. There are several reasons for this decision: the security problems and logistic difficulties of transferring prisoners to the Workhouse, the lack of feedback about the prisoners and their treatment after the screening (this was discussed above), and the inability of the psychiatrist to monitor medication of inmates. Hence, the move to the Metropolitan Jail may well increase the ability of the DSJI staff to improve their services through information about the impact of the screening.

DSJI also changed the procedure for selecting inmates to be screened to increase the number of clients, which had declined during the program's first six months. DSJI no longer relies on the bound-over docket as the source of inmates. It screens all inmates entering the Metropolitan Jail. DSJI is also screening inmates who were not screened earlier because, for a variety of reasons, they were not on the bound-over docket. In addition, woman inmates are now being screened; they could not be screened before because the Workhouse does not have female inmates (while the Metropolitan Jail does). Finally, DSJI is rescreening inmates who are still in the Jail six months after the original screening; in the rescreening, however, the only psychological test given is the MMPI.

The problems of transportation to, and housing in, the Workhouse have been alleviated. Also, most inmates now are screened within two days after they arrive in the Metropolitan Jail, less than half the time for inmates screened in the Workhouse. It should be noted, however, that Standard 23 of the Standards for Psychological Services in Adult Jails and Prisons (see page 5 in this paper) implies that screening should be performed immediately after admission.

The new procedures have important implications for the project's monitoring and feedback operations. The continual access to the Metropolitan Jail inmates now permits the DSJI staff to follow inmates after screening and, therefore, to determine whether the recommendations made in the original report were followed by the Jail and whether they were accurate in view of later developments. The second screening given to inmates after six months serves much the same purpose and it also provides information about possible effects of incarceration on inmates.

PIERCE COUNTY (WASHINGTON) JAIL SOCIAL SERVICES AND CENTRAL INTAKE UNIT

Brief History and Overview

In early 1978, William Regan, Superintendent of the Pierce County Jail, in an effort to modernize his jail's operation, enlisted the assistance of Pacific Lutheran University Social Welfare Professor Kathy Briar to develop a program to facilitate the provision of social services

to jail inmates. The Social Services Unit was created as a result of this collaboration. The Unit began operating in March 1978 as a two-month experimental program. Initial staffing consisted of two social workers serving on a volunteer basis during the experimental period. In June 1978, the jail received private donations to provide for the continued operation of the Social Services Unit. Since 1978, Unit staff have secured Law Enforcement Assistance Administration (LEAA) and Comprehensive Employment and Training Act (CETA) grants permitting an expansion of the unit and of the scope of the services it provides.

The Social Services Unit currently consists of two operations: a Central Intake Screening Unit (CIU), which screens persons upon admission to the jail and provides crisis intervention for inmates requiring immediate attention at any time during incarceration, and a Social Service Coordination Unit (CU), which provides case management for inmates in need of services. CIU screenings are conducted from 7:00 a.m. until 12:00 midnight, seven days per week. An attempt is made to screen all pretrial admissions except those held for charges pending in other jurisdictions. (Offenders sentenced to jail by the court are not screened.) The CIU screening identifies inmates with drug, alcohol, mental health, or other problems and may result in referrals to the CU for social needs assessments and special services. The screening also generates information useful to the arraignment judge in determining questions of pretrial release. The CU receives referrals of jail inmates from attorneys, jail guards or other jail personnel, family members, and other inmates, as well as from the CIU. All jail inmates are eligible for the CU's services, including sentenced offenders and inmates held for charges pending in other jurisdictions. CU staff assess the nature of inmates' problems, provide counseling, and make arrangements for inmates to become involved with community social service programs upon release. Although in some respects the services they provide overlap, the CIU and the CU are basically distinct, complementary operations. In essence, the CIU functions to identify problem cases in the jail, and the CU functions to bring to these cases the appropriate social services.

The Social Services Unit staff consists of ten social workers: a CIU director and three CIU "screeners" funded by a Law Enforcement Assistance Administration (LEAA) Pretrial and Overcrowding grant, a CU "coordinator" funded out of the jail superintendent's budget, and five CU case managers (a drug counselor and an alcohol counselor funded by an LEAA Intensive Drug and Alcohol Jail Services grant and three employment/education counselors funded by a CETA grant).

The Pierce County Jail serves Pierce County and the city of Tacoma, Washington. The jail has an average daily inmate population of approximately 250. During the period October 15, 1979, through March, 1980, 5,835 persons were processed with criminal charges at the jail; 2,643 were eligible for central intake screening; and 1,698 of these were screened by CIU staff.

Process Flow

The flow of cases into, through, and out of the Social Services Unit is depicted in Figures 26 and 27.

Central Intake Screening

Figure 26 indicates the manner in which cases are received and processed by the CIU of the Social Services Unit. When a person is arrested in Tacoma or Pierce County, the arresting officer transports the person to the Pierce County Jail, where an officer charges ("books") the person with a particular crime. The charging ("booking") officer completes a "booking sheet" and posts a copy at the main desk for inspection by the director of the CIU. The CIU director periodically reviews new booking sheets and assigns CIU screeners to interview qualifying inmates. If the arresting or charging officer believes that a person entering the jail may be experiencing an emotional or other crisis or otherwise is in need of emergency services, the officer may contact a CIU screener directly and request that he immediately interview the arrestee. Similarly, if an inmate experiences a crisis at any time during his incarceration, any jail personnel may request that a CIU screener interview the inmate.

The CIU screener interviews the inmate, verifies the inmate's statements (by telephoning his family, doctors, etc.), and prepares a report of the interview results. If the screener believes an inmate charged with or convicted of a misdemeanor clearly is disordered mentally, he may, with the approval of the jail supervising officer on duty, the jail superintendent, or the CIU director, request a mental health professional from the Office of Involuntary Commitment to visit the jail and assess the civil committability of the inmate. (The Office of Involuntary Commitment is a state department with powers of civil commitment.) If the CIU screener is uncertain about the mental condition of a misdemeanant or alleged misdemeanant, he may contact a "crisis intervention worker" from the area Comprehensive Mental Health Center (a private, nonprofit organization in Tacoma), who will interview the inmate and consult with the screener regarding the advisability of pursuing civil commitment (i.e., arranging for an assessment by a mental health professional from the Office of Involuntary Commitment). Inmates charged with or convicted of felonies ordinarily are evaluated for civil commitment only upon court order. A CIU screener believing such an evaluation appropriate typically contacts the defense attorney and the prosecutor and urges them to arrange for a court-ordered evaluation. If the inmate is in "acute crisis" (defined by a Social Services Unit policy statement as "so out of control or suicidal that immediate action [need] be taken to assure appropriate care and safety for the detainee"), the screener may directly telephone a psychiatrist at Western State Hospital's Mentally Ill Offender Unit and request an emergency evaluation at the jail. If the screener suspects that an inmate may be in withdrawal from drugs or alcohol, he must notify the jail supervisor on duty and an appropriate social service case manager. If a screener believes an inmate charged with a misdemeanor is qualified to be released on his personal

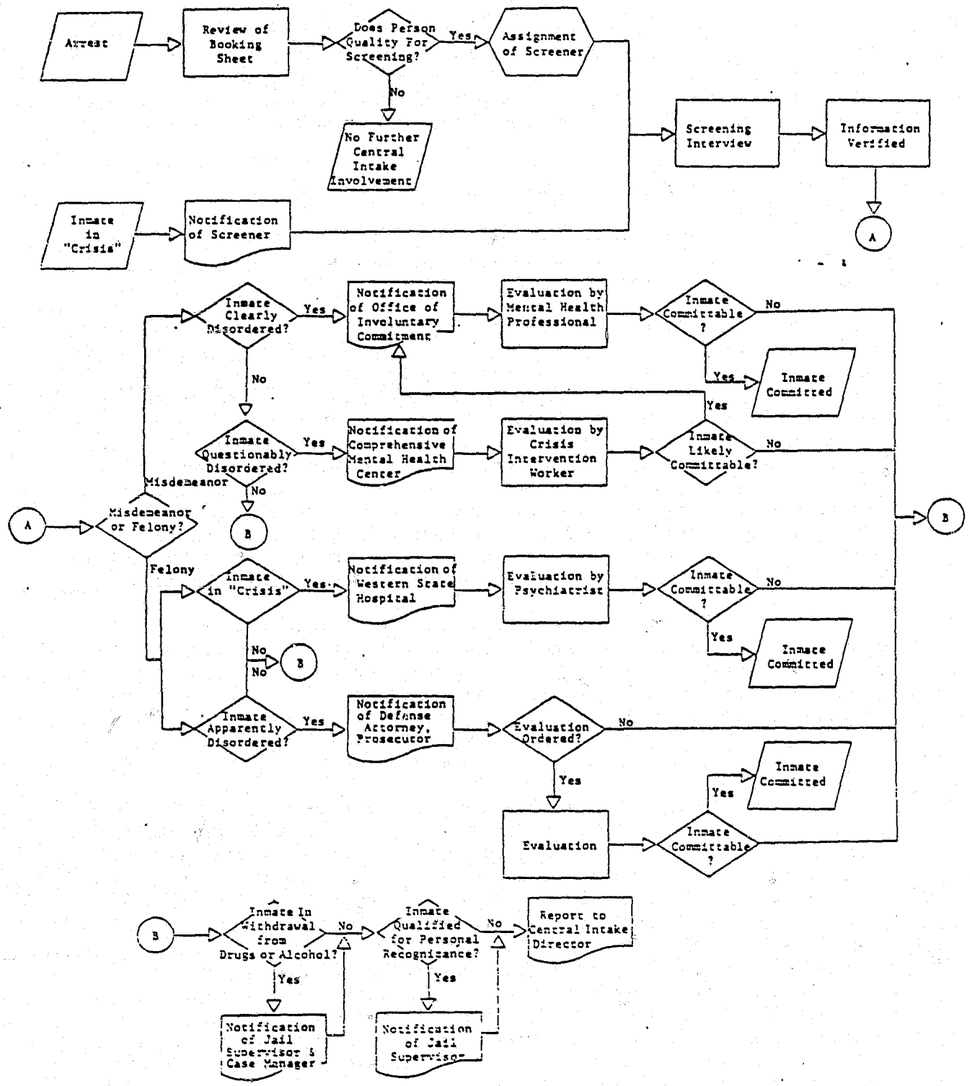


Figure 26. Case Process Flow of the Central Intake Screening at the Pierce County Jail Social Services and Central Intake Unit.

recognizance, he may so advise the jail supervisor on duty, who has authority to order such release.

The CIU screener's report is reviewed by the CIU director, who may assign appropriate cases to CU case managers for counseling and coordination of services. Particular parts of the report may be forwarded to various jail or court personnel. The balance of the report is deemed confidential and is maintained in the Social Services Unit's files.

Coordination Unit Case Management

Figure 27 illustrates the manner in which cases are received and processed by the CU. Only the evaluative and referral aspects of case management will be described.

The CU receives referrals from the CIU, defense attorneys, jail personnel, family members, employers, and other inmates. Additionally, inmates may request services on their own behalf. The referral process is generally informal. The CIU director assigns CU case managers cases that appeared to require services during the CIU screening. The case manager is provided with a copy of the CIU screening report. Referrals from defense attorneys, jail personnel, family members, and employers typically are made in person or by telephone and are directed to the CU coordinator, who assigns cases to case managers. Referrals and assistance requests from jail inmates come in the form of "kites," handwritten requests for service, which are passed to jail personnel and forwarded to the CU coordinator for assignment to a case manager.

The case manager assigned to a particular case reviews any referral materials received and conducts an initial interview with the inmate to assess his needs. The case manager may contact Community Alcohol Services or Methadone Maintenance, units of the public health department, for advice or to discuss possible diversion of inmates with apparent alcohol or drug problems. Mental health evaluations may be arranged as described above.

For inmates in need of services who are likely to be released from jail within two weeks of admission, the case manager will recommend community programs for the inmate to contact upon release. The case manager may arrange for a representative of a particular program to visit the jail and to meet the inmate before he is released. For inmates in need of services who appear likely to remain in jail for more than two weeks (i.e., are not released at arraignment), the case manager will arrange to provide counseling on a periodic basis in the jail and may develop a plan for alternate placement of the inmate in an appropriate community social services program. The placement plan usually is constructed in cooperation with the defense attorney (and sometimes the prosecutor) and typically is used by the attorney(s) to persuade the judge to dispose of the case by diversion.

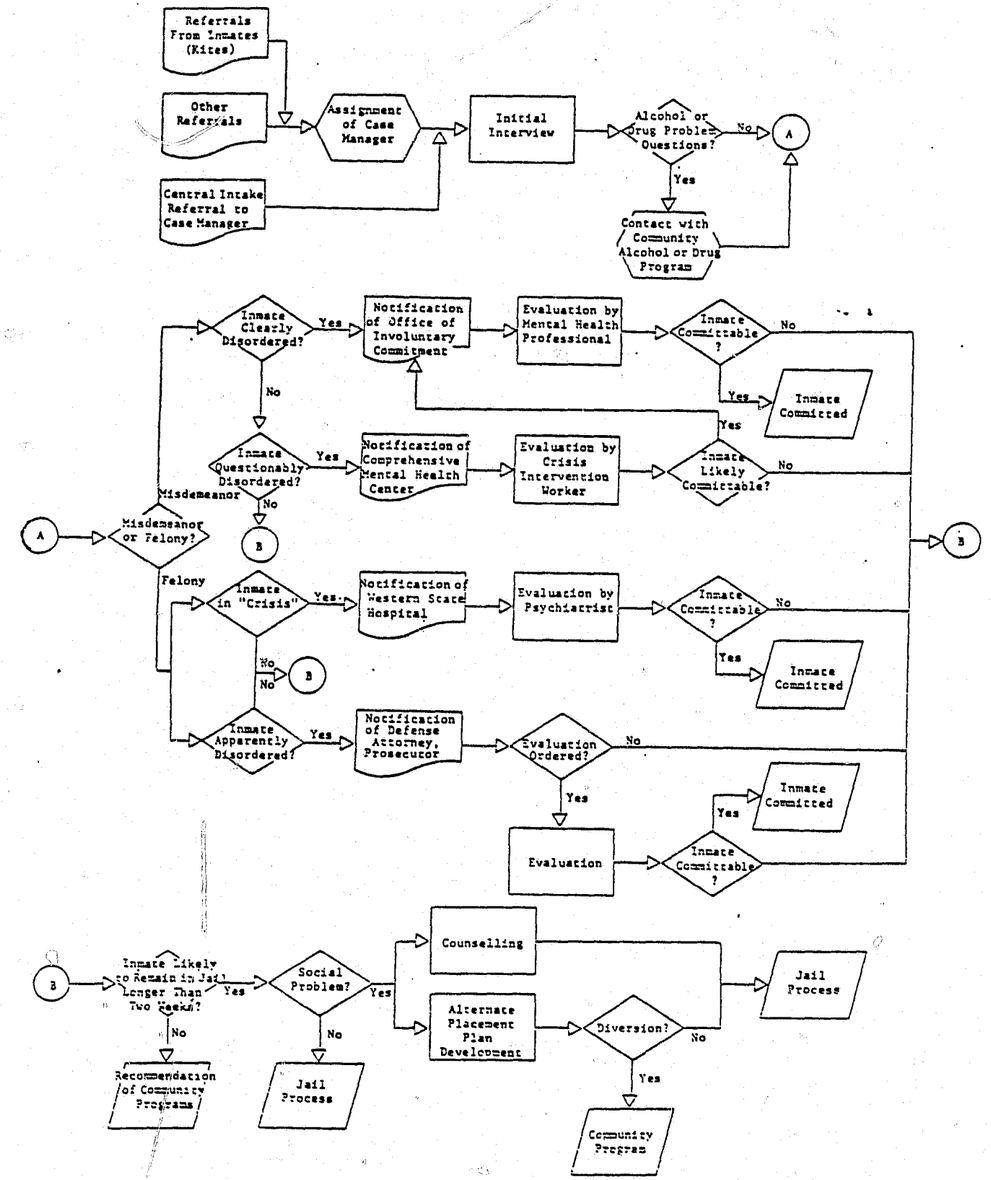


Figure 27. Case Process Flow in the Case Coordination Unit at the Pierce County Jail Social Services and Central Intake Unit.

CONTINUED

3 OF 8

Delineation of Mental Health Requirements

The CIU may become involved in the assessment of the social needs of an inmate either as a result of the CIU director's review of the jail's booking sheets (all eligible inmates receive CIU screening) or upon referral from the arresting or charging officer or other jail personnel if the inmate is experiencing a "crisis." The booking sheet ordinarily indicates only limited biographical data (name, address, aliases), limited medical information (medications used, physical disabilities), and the offense(s) charged. Referrals for crisis intervention typically are made in person and consist of the name and location of the inmate in crisis and a brief description of his behavior.

The CU receives referrals from the CIU, defense attorneys, jail personnel, family members, employers, and inmates requesting service for themselves and other inmates. CIU referrals are made by the CIU director, who assigns cases to particular case managers based on the results of the CIU screening (e.g., inmates with drinking problems are assigned to the alcohol counselor). The case manager is provided with a copy of the CIU screening report, the general contents of which are described below. Referrals from defense attorneys, jail personnel, family members, and employers typically are made in person or by telephone to the CU coordinator. In the course of a referral, a defense attorney may relate his client's drug, alcohol, or mental health history and describe any current behavior indicating the advisability of the Unit's involvement. Additionally, he may note his intention to raise questions of competency to stand trial or criminal responsibility or to ask the court for diversion into a community social service program. Jail personnel make referrals of inmates whom they perceive to be in need of social services. Referrals typically communicate no more information than the name and location of the inmate referred and a description of the behavior that motivated the referral. Referrals from family members and employers often specify social, medical, and mental health background information and generally are made for the purpose of promoting pretrial release or diversion. Referrals from inmates requesting service for themselves or other inmates are received in the form of "kites," hand-written messages passed to jail personnel for delivery to the CU coordinator. Kites typically indicate the name and location of the person requiring attention and a brief description of the reason for the referral.

Acquisition of Mental Health Information

Central Intake Screening

The CIU screening is conducted by an interview with the inmate. The interview is guided by several interview forms, which are attached as Appendix D. The screener reviews the booking sheet prior to meeting with the inmate. At the beginning of the interview, the screener explains the purpose of the screening and informs the inmate of his right to refuse to be interviewed. If the inmate appears to be intoxicated or is uncooperative, the screener will not continue with the interview.

The interview begins with inquiry in the following areas:

- o prior record (adult and juvenile);
- o personal information (including present and previous addresses, family and community references);
- o employment history;
- o educational background;
- o military background; and
- o medical history.

The inmate then is questioned with regard to his use of drugs and alcohol, his mental health history, and any family problems he may have experienced as a result of his incarceration. The inmate is notified that the confidentiality of this information is guaranteed by law, and he is asked to sign a "consent for disclosure" of the information to other social service personnel (see Appendix D). Finally, the inmate is questioned thoroughly with regard to his financial condition, including income, assets, and liabilities. (This information is collected for the arraignment judge to use in determining pretrial release.) An effort is made to avoid questions pertaining to the guilt or innocence of the inmate.

Coordination Unit Case Management Assessment

Inmates with various sorts of problems (e.g., mental health, substance abuse, jail adjustment, management of personal affairs in the community) may be referred for case management. The case manager assigned to an inmate conducts an initial interview with the inmate to assess his problems. Prior to the interview, the case manager reviews any referral materials (e.g., CIU screening report) he might have received. If the referral is from someone other than the CIU director, the case manager secures and reviews a copy of the CIU screening report, if available. If the referral indicates that the inmate is particularly agitated or violent, arrangements will be made for at least two security guards to join the case manager in the interview.

As with CIU interviews, interviews conducted by CU case managers begin with an explanation of the purpose of the interview and a notification of the right to refuse to be interviewed. The case manager advises the inmate that the information collected will be held confidential unless the inmate consents in writing to the release of such information. The inmate usually is asked to sign a form consenting to release of certain information for specified purposes. If no CIU screening report is available, the case manager's initial questioning is directed toward collection of certain demographic information, including:

- o personal information;
- o information relating to the status of the inmate's court case;
- o employment history and job skills;
- o educational background;
- o military background; and
- o medical history.

If the case manager has a copy of the central intake screening report, the above information may be taken from that report. Following this preliminary questioning, the case manager explores in detail any incidents, events, or precipitating factors related to the inmate's present difficulty. The inmate's social background is explored, and all prior arrests, hospitalizations, and treatment are reviewed. Finally, the inmate is questioned concerning his adjustment to incarceration. The case manager exercises discretion in the manner in which he conducts the interview. He may allow the inmate to speak freely about matters of his own choosing or may carefully direct the questionning. During the course of the interview the case manager may conduct a mental status examination, assessing the inmate's orientation to time and place, verbal level, mood, attention span, thinking process, and level of control.

The initial interview typically completes the CU case manage- ment assessment process and may result in periodic counseling or referral for other services as described above.

Provision and Use of Mental Health Information

Following a CIU screening, the screener prepares a report containing several parts (see Appendix D):

- a demographic information sheet that accompanies referrals to case managers and other social service providers and is sent to the court for use at arraignment (contains limited personal information, prior record, employment history, educational background, military background, medical history, qualification for misdemeanor personal recognizance);
- a financial statement that is sent to the court's depart- ment of assigned counsel for use in determining the inmate's eligibility for assigned counsel (indicates all sources of income, assets, and liabilities);
- a confidential information sheet that, with consent of the inmate, may accompany referrals to other Social Services Unit staff (indicates drug and alcohol usage, mental health history, and family problems experienced as a result of incarceration);
- a personal recognizance/custody level recommendation sheet that is delivered to the jail supervisor on duty for use in making misdemeanor personal recognizance release decisions and classifying inmates (contains recommendations and comments); and
- a medical information sheet that is delivered to the jail supervisor on duty for use in establishing medication schedules (indicates medical problems, medication used, when last seen by a physician, and the screener's observations).

In addition, central intake screeners frequently send memoranda to the CIU director indicating informal, off-the-record opinions.

The information collected during the CU case manager's initial interview ordinarily is not reported in detail. Upon completion of the interview, the case manager makes a record for the inmate's file, indicating the name of the inmate interviewed, the referral source, the length of the interview conducted, the inmate's next court date, the names of the defense attorney and the judge in the case, and general comments regarding the interview. If the case manager makes a referral for a mental health evaluation or other services, he will informally report information necessary to effect the referral but generally will not submit a written report of his interview findings.

Feedback, Monitoring, and Evaluation

There is no formal, on-going program evaluation mechanism operating with respect to Pierce County Jail Social Services Unit. How- ever, a number of activities are conducted that informally provide a measure of quality assurance.

At this writing, the CIU director and the CU coordinator are developing a policy and procedures manual for the Social Services Unit that will contain specific guidelines for conducting intake interviews, arranging for mental health evaluations, making community referrals, and providing counseling and case management. When completed, the manual will be incorporated into a larger manual describing the various operations and services provided by the Pierce County jail.

In August, 1979, the Midwest Research Institute (Note 9), at the direction of the Law Enforcement Assistance Administration (LEAA), conducted an evaluation of the Pierce County Jail's Intensive Drug and Alcohol Jail Services Project, sponsored by LEAA, and reviewed the jail's compliance with the 1971 Amendment (Part E) to the Omnibus Crime Control and Safe Streets Act of 1968. (Part E specifies several requirements for jails, including the availability of alternatives to incarceration, special provisions for the treatment of alcohol and drug abusers, separation of juveniles from adults and males from females, willingness to accept federal prisoners, regionalization of facilities, and advanced practices in personnel, operations, training, programs, and services.) The evaluation resulted in a report (see Note 9) that makes recommendations concerning a number of the functions of the Social Services Unit, including

- the promotion of alternatives to incarceration;
- the treatment of alcohol and drug abusers;
- the provision of medical and health care;
- the facilitation of visitation, mail, and telephone com- munication; and
- the provision of recreation and library services.

Finally, the jail Social Services Unit receives feedback on an informal basis from the jail superintendent, the county sheriff, corrections officers in the jail, defense attorneys, judges, probation officers, and others. Because of the location of the Unit in the halls of the jail (which, in turn, is located in the county courthouse), a close working relationship is maintained, and problems with Unit procedures or particular cases are freely discussed.

THE WYANDOTTE COUNTY (KANSAS) PRETRIAL SERVICES PROJECT

The Wyandotte County Pretrial Services Project (hereinafter PSP) was created in July, 1977, for the purpose of ameliorating deficiencies in the operation of the County Jail discovered during an inspection of the facility by the State Department of Corrections in 1976 (Note 10). Severe jail overcrowding, discriminatory bail practices, and inadequate service provision to inmates were identified by the Corrections Department as major problems. The initial goal of PSP included a substantial reduction of both the jail population and the size of the criminal court docket; cost reduction was an incentive in this goal (see Note 11).

The Wyandotte County Jail, which takes up the entire fourth floor and a part of the fifth floor of the Wyandotte County Courthouse, serves a population of 186,000 and houses between 75 and 91 inmates at any given time. On March 12, 1981, for example, the total population of the jail was 85. Approximately 75 to 85 percent of the incarcerated individuals are black.

PSP serves the Kansas District Court of the Twenty-ninth Judicial District (Note 12). The District includes Wyandotte County and the court sits at Kansas City. The court has original jurisdiction in all criminal and civil matters and has appellate jurisdiction over cases originating in municipal courts. The Kansas Supreme Court provides money for all personnel, except for one Court Services Officer whose salary is provided for by Wyandotte County. The County provides office space, equipment, and supplies for the entire Project.

In addition to assisting the District Court in criminal matters, PSP also provides advice to the civil division of the Court in civil commitment issues and to the family court in child custody and incest cases, and juvenile cases. This latter function is facilitated by the location of the PSP's suite of offices adjacent to the family court on the first floor of Wyandotte County courthouse.

PSP's primary function is to serve as a clearinghouse that identifies the various alternatives to and additions to jail detention. Activities include (Note 10) the following:

- Pretrial Screening - All incarcerated client-offenders (and client-offenders who may be referred by police, the hospital emergency room, or the mental health clinic) are interviewed within twenty-four hours of arrest, unless incarcerated on a

Saturday or Sunday. This interview is used to inform client-offenders of their rights under the law and to determine their eligibility for court-appointed counsel. It also enables the PSP to initially assess a client offender's potential for release or need for further mental health evaluation and treatment.

- Release on Recognizance (ROR) - The Vera-Manhattan Scale, an objective community stability measurement device, is administered to all client-offenders incarcerated at Wyandotte County Jail and to other referred individuals. If release is indicated, an Order of Discharge is submitted for judicial approval. Release conditions then are discussed with each client-offender.

- Release With Services (RWS) - Although a candidate for ROR, a client-offender may present social disabilities such as substance abuse, employment handicaps, or medical needs. Restrictions are placed upon freedom of movement, and remedial conditions such as participation in counseling or educational programs may also be imposed as prerequisites to release.

- Pretrial Diversion - As an alternative to criminal processing, pretrial diversion serves as a mechanism for referring client-offenders to more appropriate services and resources outside the criminal justice system. After a determination of eligibility by PSP staff, a contractual agreement as to appropriate services is negotiated. The average length of a diversion program is one year.

- Mental Evaluations - The PSP performs pretrial mental health evaluations upon court order. The request may originate from the prosecutor, the defense attorney, or the PSP staff who have conducted pretrial screening.

- Domestic Relations - Upon the request of the court, PSP staff investigate domestic relations cases involving custody questions. In addition, PSP staff may provide divorce counseling and divorce workshops.

- Referral Services - Community organizations and resources are utilized extensively by PSP staff for various services on a referral basis.

Although categorized in discrete fashion for the purposes of this section, these activities are not clearly separate in practice. The following report of PSP will focus only on those PSP activities that involve mental health screening and evaluation: Pretrial Screening, Pretrial Diversion and Mental Evaluations.

Process Flow

Figure 28 represents a case processing function model of the Pretrial Services Project. Every client-offender who is arrested and incarcerated at the Wyandotte County Jail receives a pretrial screening interview. PSP also accepts referrals for screening from police, hospital emergency rooms, and mental health clinics. If mental health problems are discovered in the screening, a psychological evaluation is conducted. If competency to stand trial remains an issue after the psychological evaluation, the client-offender is sent to an appropriate state institution for further evaluation and treatment for up to sixty days. Civil commitment may be indicated for client-offenders who are not expected to regain competency within a reasonable period of time.

A client-offender without mental health problems and without needs for the pretrial services of PSP is either incarcerated until the trial or released on bail, if eligible. Other client-offenders may be eligible for such pretrial services programs as Diversion, Release on Recognizance, or Release with Services. A Vera-Manhattan Scale assesses community stability is used to determine eligibility for the release programs while awaiting trial. The degree of correspondence between the client-offender's characteristics and those of a successful diversion candidate determines whether a diversion agreement may be negotiated. If an agreement is made and fully implemented, charges against the client-offender are dropped; otherwise, the client-offender faces trial.

Delineation of Mental Health Information Requirements

Statute

The mental health evaluation conducted by PSP is formally concerned only with the client-offender's competency to stand trial. The statutory standard for competency is whether the client-offender is able "to understand the nature and purpose of the proceedings against him; or to make or assist in making his defense" [Kan. Stat. §22-3301(1)]. The PSP Director views competency as involving the following questions. Does the client-offender know right from wrong? Is the client-offender able to assist in his or her defense? Does the client-offender understand the nature of the crime? There are no other formal provisions in Kansas statutes delineating the work performed by PSP.

Pretrial Screening

Persons arrested in Wyandotte County are transported to the county jail where they may be "booked" on particular criminal charges and detained. A booking sheet is prepared on each person arrested; this sheet details information such as the person's name, race, sex, age, charge, and tank (jail location). All inmates are screened by a Court Services Officer within 24 hours of arrest. Pretrial screening interviews also may be arranged at the request of defense attorneys, the district attorney, or other interested individuals for client-offenders

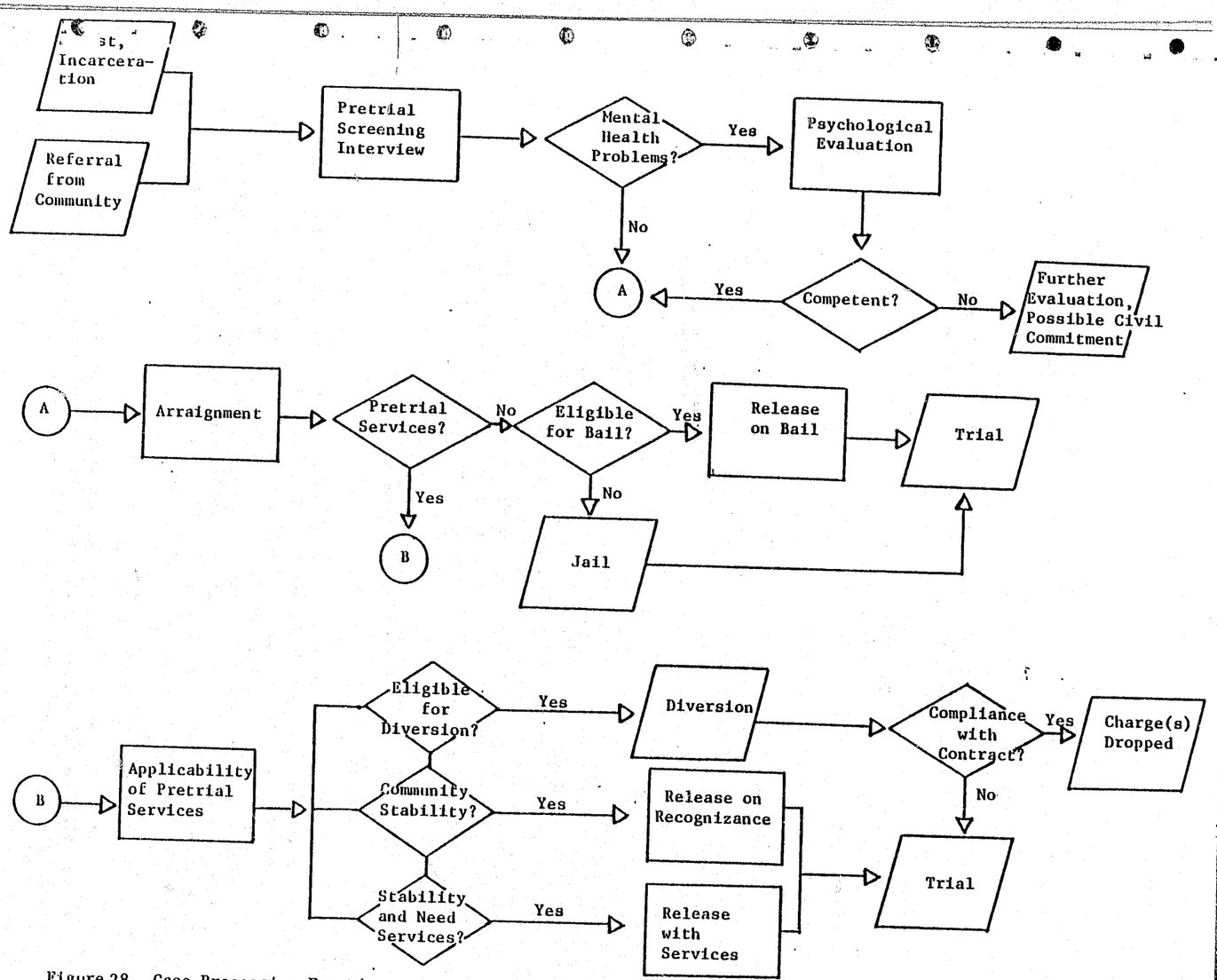


Figure 28. Case Processing Function Model, Pretrial Services Project, Wyandotte County, Kansas.

who are not incarcerated. About 20 percent of the referrals to PSP come from the police, the city jail, or other community organizations such as public health, social service, or community mental health agencies.

Pretrial Diversion

Client-offenders may be identified as potential candidates for diversion as a result of ROR or RWS investigations, pretrial screening, court referral, referral by defense attorneys, or referral by other interested parties. According to the director, attorneys have become familiar with the type of individual that might be identified as a candidate for pretrial diversion and, hence, make few inappropriate referrals.

Mental Evaluations

The vast majority of client-offenders receiving in-depth mental evaluations are referred as a result of the pretrial screening interview conducted by PSP. About five to ten percent of those evaluated are referred from the District Court. Evaluations may also be requested by prosecuting and defense attorneys.

The request for a mental health evaluation is directed to the District Court of Wyandotte County in the form of a "Motion for Pre-Trial Evaluation." (Appendix E) The request is for permission to "test, evaluate, interview, and gather criminal records or any other pertinent information necessary to determine the mental and physical capacity of the defendant." In response, the judge of the District Court may issue an order (Appendix F) providing for a pretrial evaluation by PSP and a confidential report of findings to be made to the court. The court, at its discretion, may appoint an independent examiner or designate another mental health agency to evaluate the client-offender [Kan. Stat. §22-3302(3)].

Acquisition of Mental Health Information

Staff

The PSP staff includes a state-certified clinical psychologist who serves as Director, four Court Services Officers (CSO), and a clerk. Two CSOs conduct the bulk of the interviewing; one formerly was a priest in a state prison, and the other was an offender. The Director devotes approximately one-half of his time to mental health evaluations and the other half to administrative duties. The Director of PSP is the only psychologist on the official payrolls of the Kansas Supreme Court, which controls the budgets of the District Courts.

Pretrial Screening

At the beginning of the pretrial screening interview, the client-offender is informed by the interviewer (usually a CSO) of the court process. In addition, PSP staff inquire if the client-offender is

indigent and requires court-appointed counsel. Client-offenders are usually taken at their word that they cannot afford to hire their own attorney.

The screening, which takes approximately 30 minutes, is designed to identify client-offenders in need of immediate medical or mental health treatment or further evaluation. The interview serves to generate biographical information for use by personnel of the release programs. Also, information about the client-offender's background and community ties may be presented to a judge during the client-offender's initial court appearance.

The interview (see form in Appendix G) is designed to elicit information from the client-offender in several areas: identifying information, arrest data, residence history, medical and psychiatric history, education, military service, references, client-offender's version of the crime, family history, employment history, prior criminal record, needs assessment, and interviewer's observations.

Pretrial Diversion

A "diversion interview" is conducted in an effort to identify client-offenders who would be better served outside the traditional criminal justice process. At this time, the client-offender is given the Vera-Manhattan Scale, a community stability measurement device. Following the interview, PSP staff verify the criminal history by a check of the individual's available records, and verify the family history with a person identified by the client-offender. Family members, friends, police, and jailers are particularly helpful in this verification.

In order to identify client-offenders who are likely to be successfully diverted from the criminal justice system, PSP staff assess the extent to which various factors are present in each client-offender's case. As recommended for use in the National Advisory Commission on Criminal Justice Standards and Goals Report on Courts (see Kansas Governor's Committee on Criminal Administration, Note 10, p. 8), these factors are:

- youthfulness of client-offender;
- willingness of victim to forgo a conviction;
- likelihood that client-offender is suffering from a medical or mental disability that is amenable to treatment;
- likelihood that crime was induced by employment or family problems capable of being addressed through a diversion program; and
- a positive motivational attitude on the part of the client-offender.

Following the interview and verification process, a conference is held with all interested parties, including the defense attorney, prosecutor, and project staff. PSP recommendations concerning diversion are made to the District Attorney. If approved, recommendations are

implemented by a negotiated contract involving all parties, and prosecution is deferred.

Mental Evaluations

Client-offenders referred for mental evaluations are examined by the PSP psychologist. The Minnesota Multiphasic Personality Inventory (MMPI) serves as a screening instrument for the psychologist to determine the form of further testing. If either IQ or a personality disorder is an issue, a Wechsler Adult Intelligence Scale may be administered; a Beta Intelligence Test is administered if the client-offender cannot read. In addition, projective tests such as the Rorschach Test or the Bender Motor Gestalt Test may be administered. Also, the psychologist will usually conduct an interview.

If the client-offender has been referred as the result of a pretrial screening, the psychologist, before conducting his evaluation, typically confers with the court services officer who conducted the screening.

Provision and Use of Mental Health Information

Pretrial Screening

The information collected during the pretrial screening interview generally is used by PSP staff both for identifying jail detainees and other client-offenders eligible for services and for determining whether a client-offender is a candidate for ROR or RWS.

Pretrial Diversion

Client-offenders found suited for diversion by PSP staff and approved by the District Attorney and a judge, enter into a "Deferred Prosecution Agreement" with the Wyandotte County District Court. The agreement specifies the conditions of the diversion arrangement and governs the client-offender's conduct during the diversionary period. Diversion programs usually last for one year. Conditions for the client-offender's participation in a diversion program typically include several stipulations:

- seeking and obtaining appropriate services on the advice and consent of the client-offender's attorney;
- waiver of the right to a speedy trial; and
- a release of information to the Wyandotte County Court Services Department of the Wyandotte County District Court.

During the course of the diversionary period, criminal proceedings against the client-offender are postponed. PSP does limited monitoring and counseling of diverted offenders and reports to the court every three weeks. Upon the completion of the program, PSP staff review the client-offender's compliance with the conditions set forth in the Deferred Prosecution Agreement. Charges against the client-offender are dismissed upon successful completion of the program.

Mental Evaluations

When a court-ordered mental evaluation is completed, the PSP psychologist prepares a report for the court. The report typically contains the following information:

- identifying information (i.e., name, age, address);
- tests administered;
- background information, including referral data and the client-offender's testing behavior;
- psychological findings; and
- recommendations, if any.

The judge, prosecutor, or defense attorney may request the psychologist to testify at the trial following arraignment. Typically, this occurs if further evaluation is needed or if commitment to regain competency is indicated.

If a client-offender is found to be incompetent to stand trial or to require further evaluation, the Wyandotte County District Court may commit the client-offender to the State Hospital at Osawatomie, Kansas, for a psychiatric examination and treatment. Within sixty days, the state institution is required to report to the court regarding the client-offender's competency to stand trial (Kan. Stat. §22-3302).

The court may issue an "Order for Continued Hospitalization and Treatment for Competency to Stand Trial" (Appendix H). This order permits the state institution to extend the sixty-day confinement period so that the client-offender may receive treatment designed to restore competency. If the staff finds that competency will not be regained within a reasonable time period, the client-offender may be civilly committed (Kan. Stat. §22-3303).

Quality Assurance and Program Evaluation

Internal program evaluation, activities not part of the service part of the project, includes the following activities and procedures by PSP to ensure the quality and effectiveness of their services.

- Monthly statistics are maintained on the number of cases received, interviews conducted, and client contacts made in the program areas of diversion, pretrial screening, and mental health evaluations (Note 13).
- The progress of restitution payments is monitored.
- Treatment programs are monitored on a quarterly and monthly basis.
- Follow-up counseling is provided once a month for diverted client-offenders.
- One-half of the Director's time is devoted to project management.

At least one external evaluation of PSP has been conducted. In 1978, PSP was evaluated by the Research and Evaluation Unit of the Kansas Governor's Committee on Criminal Administration (see Note 10). In addition to a quantitative analysis of the types and amounts of services rendered by PSP staff, the evaluation method included questionnaires addressed to criminal justice personnel closely involved with the project. The report contains an explanation of PSP's objectives, a description of the types of services rendered, examples of forms used by both criminal justice and mental health personnel, a flow chart detailing the relation of the Wyandotte County District Court to PSP, and the findings of the Committee's investigations. The report's findings were generally favorable, but highlighted communication and coordination problems between the staff of the variously involved agencies. The report seems primarily useful for descriptive and historical purposes, an opinion shared with the Director of PSP.

REFERENCE NOTES

1. Steadman, N.J., and Morrissey, J.P. Interfacing Local Jails with the Mental Health System. Grant application submitted to the National Institute for Mental Health, Public Health Services, by the Research Foundation for Mental Hygiene, Inc. (44 Holland Avenue, Albany, New York, 12229), 1980.

2. This history was prepared by assembling materials from several sources. A major source, gratefully acknowledged, was a manuscript about the Cook County Correctional Complex Psychiatric Services prepared by Dr. Ronald Simmons and other staff. Another document from which historical information was drawn was an internal memorandum of September 19, 1979, from Simmons to Mr. Robert Dean, entitled "Synopsis of Psychiatric Programming within the Cook County Correctional Complex."

3. Harrington v. DeVito, No. 74-C-3290 (N.D. Ill. Oct. 19, 1978) (unpublished consent order).

4. Mental Health Survey: Cook County Department of Corrections. By an Appointed Expert Panel, Harrington v. DeVito, No. 74-C-3290 (N.D. Ill. Oct. 19, 1978).

5. Consent Order, Harrington v. DeVito, No. 74-C-3290 (N.D. Ill. Oct. 19, 1978).

6. First Report by Court-Appointed Panel of Experts Pursuant to Agreed Order of October 19, 1978, Harrington v. DeVito, No. 74-C-3290 (N.D. Ill. Oct. 19, 1978).

7. Information about typical lengths of incarceration at the Correctional Complex is based upon information in Consent Order, supra note 5, at 6, and informed opinions of Dr. Simmons. We are not in possession of authoritative data in this regard.

8. The authors reviewed relevant portions of the policy manual, including Policy and Procedure Standard Forms, numbers:

   4101 Procedure for Screening New Inmates
   4104 Team Approach
   4105 Staff Meetings
   6001 Admission to Hospital
   9001 Admission to Residential Treatment Unit.

9. Midwest Research Institute. LEAA technical assistance for advanced practices and secure juvenile and adult facilities and programs, monitoring and compliance report, Pierce County, Washington. Milwaukee, Wisconsin: Author, August, 1979.

10. Much of the information embodied in this report is drawn from a report of the Research and Evaluation Unit of the Kansas Governor's Committee on Criminal Administration: An Evaluation of: The Wyandotte County Pre-Trial Services Project, Grant Number 77-A-3197-1-A, December, 1978.

11. Ironically, on March 15, 1981, two days after one of the authors' visits to PSP, five Wyandotte County Jail inmates, in what was described by the press (Kansas City Times, March 15, 1981) as a well-planned early morning jailbreak, escaped from their fourth-floor cell by "sawing through two sets of iron bars and climbing down a 50-foot homemade rope of sheets and blankets." According to the newspaper account, the "escape was just the latest in a history of escapes, deaths, state investigations and complaints of abuse at the 54-year-old jail. State corrections authorities once tried to close the facility because of its inadequacies."

12. The information on jurisdiction is extracted from Reincke, M. and Lichterman, N. (eds.), The American bench: judges of the nation (2nd annual ed.). Minneapolis, Minnesota: Reginald Bishop Forster and Associates, Inc., 1979.

13. In February 1981, for example, the PSP handled 27 individual cases involving first-time interviews with client-offenders and made 94 subsequent contacts with client-offenders or third parties involved with the cases.

REFERENCES

American Association of Correctional Psychologists. Standards for psychology services in adult jails and prisons. Criminal Justice and Behavior, 1980, 7(1), 81-127.

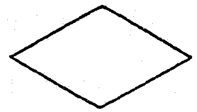
Comptroller General of the United States. Jail inmates mental health care neglected; state and federal attention needed. Washington, D.C.: U.S. General Accounting Office, 1980.

Freeman, F.S. Theory and practice of psychological testing. New York: Holt, Rinehart, and Winston, 1950.

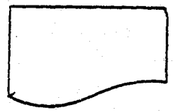
Morgan, C.H. The special national workshop on mental health services in jails--service delivery models. Washington, D.C.: U.S. Department of Justice, 1978.

U.S. Department of Justice. DOJ issues prison standards. Justice Assistance News, 1981, 2(1), 1.

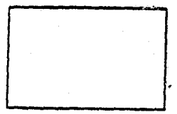
Operations, events, and decision points are portrayed in figures by geometric shapes, viz:



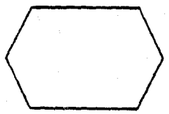
= Decision to make regarding the client-offender.



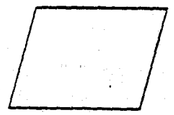
= Information received or transmitted, usually in document form.



= Implementation of a process involving the client-offender.



= Preparation for a process or decision involving the client-offender.



= Exit or entry of the client-offender into the criminal justice system or the mental health system.

= Connector with corresponding part of the flow chart on the same page.

= Connector with corresponding part of the flow chart on another page.

The following abbreviations are used in the figures:

RCDC	=	Reception, Classification, and Diagnostic Center
IST	=	Incompetent to stand trial
NMT	=	In need of mental treatment
NGRI	=	Not guilty by reason of insanity
3-North	=	Inpatient acute care unit

CERMAK MENTAL HEALTH INSTITUTE

INTAKE SCREENING AND EVALUATION FORM

Date:_____

_____ _____ _____ DOB:_____
Last Name First Name Middle Init.

Inmate No._____ Charge:_____ Bond:_____ Ct. Date:_____

_____ _____ _____ AC _____
Home Street Address City State Telephone Number

Race: White_____ Black_____ Spanish Speaking_____ Other___

Psychiatric History:_____

_____

_____

MENTAL STATUS EXAMINATION: Circle positive responses;

Underline negative responses;

Leave unaltered if data is not available; and

Elaborate where appropriate.

GENERAL APPEARANCE: Neat, well-groomed, meticulous, unkempt, sloppy, bizarre, eccentric, incontinent, unusual breath odor.

POSTURE AND PSYCHOMOTOR ACTIVITY: Moist palms, tense, rigid, overactive, agitated, pacing, wringing hands, dejected, underactive, retarded, apathetic, lethargic, stuporous, relaxed, playful, alert, seductive, stereotyped, echopraxic, ritualistic, waxy flexibility.

COOPERATION AND INTERACTION: Cooperative, uncooperative, submissive, assertive, negativistic, distrustful, resentful, fearful, hostile, threatening.

FACIAL EXPRESSION: Happy, sad, dull, bored, flat, sleepy, tearful, masklike, anxious, fearful, grimaces, tics, suspicious, flirtacelous.

MOOD: Anxious (mild, moderate, panic), agitated, irritable, hyperventillating, happy, optimistic, elated, euphoric, hypomanic, manic, depressed (mild, moderate, severe), pessimistic, hopeless, helpless, worthless, self-deprecatory, self-accusatory, guilty, suspicious, pananoid, histrionic, silly, indifferent, bland.

AFFECT: Constricted, blunted, shallow, flat, stable, labile, appropriate, inappropriate.

SENSORIUM: Clear, Cloudy, confused (mild, moderate, severe).

DISORIENTATION: Time, place, situation, person.

MEMORY IMPAIRMENT: None, immediate recall, recent memory, remote memory, confabulation, perseveration.

10. ATTENTION: Easily distractable, difficulty concentrating, impairment, short span.

11. FLOW OF THOUGHT: Normal, retarded, blocking, rapid, pressured, multiple thoughts.

12. ASSOCIATIONS: Tight, goal-directed, circumstantial, tangential, loose, flight of ideas, clang, rhyming, punning, word salad, impoverished.

13. THOUGHT CONTENT: (Elaborate below). Obsessions, delusions (persecutory, grandiose, religious), ideas of reference, ideas of influence, depersonalization, derealization, hypochondria, somatizations, phobias, suicidal ruminations, suicidal intent, suicidal plans, homicidal ruminations, homicidal intent, homicidal plans.

14. PERCEPTION: Illusions, hallucinations (auditory, visual, tactile, olfactory).

15. INTELLIGENCE: Estimated as superior, above average, average, borderline impaired, moderately impaired, profoundly impaired.

16. ABSTRACTING ABILITY: Add here ways of testing - descriptive, functional, concrete.

17. FUND OF KNOWLEDGE: Knowledge of current events (superior, above average, average, below average, poor) for amount of education. Common knowledge (superior, above average, average, below average, poor) for amount of education.

18. CALCULATIONS: Serial 3's (satisfactory, occasional mistake, many mistakes) serial 7's (satisfactory, occasional mistake, many mistakes), mathematical ability (superior, above average, average, below average, poor) for educational level.

19. JUDGMENT: Subjective impairment, objective impairment.

20. INSIGHT: Aware of illness, grasps nature of illness, understands operative dynamics, aware of severity of illness, aware of limitations, limited insight, no insight.

IMPRESSION:

DISPOSITION:

CONSENT

I the undersigned, do hereby request, authorize and consent to the above and foregoing psychiatric examination administered by the Department of Psychiatry, Cermak Memorial Hospital in order to help diagnose, aid or assist the psychiatric caseworkers in determining the causes of my complaints and/or symptoms and to provide such treatment as may be required.

_____ _____
Signature of Psychiatric Caseworker Signature of Patient

DATED:_____

APPENDIX C

PSYCHIATRIC CONSULTATION

The patient is a 21 year old white male who is quite thin and appears to be perhaps younger than his stated age. He states that he is in jail on a charge of armed robbery, he gives a history of having taken various things in the past. He expresses somewhat of a hopelessness about the future, indicated that he does not know how long he will have to serve in jail.

Clinically the patient is seen to be rather depressed, his face reflects and well as his affect. During the interview he begins to cry and states he frequently wants to cry but can not when he is around the other prisoners. In my opinion, this patient would benefit from a anti-depressant and I am therefore recommending Amitriptyline 100 miligrams at bedtime daily.

PSYCHIATRIST

APPENDIX D

PIERCE COUNTY JAIL CENTRAL INTAKE

Name _____ Interview Date/Time _____

AKA: _____ Booking Date/Time _____

Booking Charges	Cause No.	Booking No.	Bail

Probation _____ Parole _____ P/P Officer _____ Notified _____

PRIOR RECORD

	Charge	Date	Place	Disposition	Verified	Defendant Info
1.					☐	☐
2.					☐	☐
3.					☐	☐
Juvenile:						
1.					☐	☐
2.					☐	☐
3.					☐	☐

PERSONAL INFORMATION Verified ☐

Sex _____ Age _____ Ethnic _____ DOB _____ S.S. No. _____
Address _____ How Long? _____
Lives with/Relationship _____ Phone _____
Previous Address _____ How Long? _____
How Long in Pierce County? _____ Marital Status _____ Children? _____ Residing With _____

Family References

Name	Address	Phone	Relationship

Community References

EMPLOYMENT Verified ☐

Employer _____ Address _____
Phone _____ Job Title _____ How Long? _____
Previous Employer _____ Address _____
Phone _____ Job Title _____ How Long? _____

EDUCATION Verified ☐

Currently Enrolled? _____ How Long? _____
Contact Person _____ Highest Grade Completed _____ Trade School? _____

MILITARY Verified ☐

Active _____ Contact Person _____ Phone _____
Branch _____ Type of Discharge _____ Dates _____ to _____

MEDICAL Verified ☐

Current Medical Problems _____ Medication _____
Physician _____ Phone _____

MISD. PR Met Criteria? Yes☐ No☐ Released Yes☐ No☐ Court Date/Time _____

FINAL COMMENTS

Disposition Information (For Central Intake Use Only)

Screener _____ Reviewed By _____
Phone: 593-4903

Z-1397

APPENDIX D (Continued)

PIERCE COUNTY JAIL CENTRAL INTAKE

FINANCIAL STATEMENT

Name _____ Sex _____ Age _____

Marital Status _____ No. of dependents _____

Monthly Income		Assets		Monthly Liabilities	
Salary	$ _____	Cash	$ _____	Alimony & Child Support	$ _____
Spouse's Salary	$ _____	Vehicles Worth (Type)			
Other:		1. _____		Bank Loans	_____
_____	_____	2. _____	_____	Vehicle Payment	_____
_____	_____	Property Owned (Where)	_____	House or Rent	_____
		_____		Other	
		Insurance Cash Value	_____	_____	_____
				_____	_____
Total Income	$ _____	Total Assets	$ _____	Total Payments	$ _____

Comments:

I certify the foregoing is true to the best of my knowledge and belief.

Date _____ Signed _____

Witness _____

Z-1232

APPENDIX D (Continued)

PIERCE COUNTY JAIL CENTRAL INTAKE

MISDEMEANANT PR

Recommendation _____ Yes

_____ No

Comments:

	YES	NO
I.D.	____	____
Employment/Residence	____	____
Community Ties	____	____
Record of FTA's	____	____
Detention Necessary	____	____

Booking No. _____ Date _____ Time _____

LESA Employee No. _____ Screener _____

CLASSIFICATION

Custody Level Recommendation	Comments
____ Minimum	_____
____ Medium	_____
____ Maximum	_____

Housing Assignment: _____

Name _____ Screener _____ Z-1466

APPENDIX D (Continued)

PIERCE COUNTY JAIL CENTRAL INTAKE

Name _____ Booking No. _____ Date _____

Physician _____

MEDICAL

	Medical Problem	Medication	How Often	Problem Onset	When last seen by Physician
1.					
2.					
3.					
4.					
5.					

SCREENER COMMENTS:

_____

_____

_____

Signature _____ Witness _____

Z-1423

APPENDIX E

MOTION FOR PRETRIAL EVALUATION

FORM 12

IN THE DISTRICT COURT OF WYANDOTTE COUNTY, KANSAS

STATE OF KANSAS, Plaintiff

vs.

Case:

_____, Defendant

MOTION FOR PRE-TRIAL EVALUATION

Comes now the District Attorney/Defense Attorney and moves the Court for an order for a pretrial investigation to be conducted by the Court Services Program. This program may test, evaluate, interview and gather criminal records or any other pertinent information necessary to determine the mental and physical capacity of the defendant.

_____ Defendant's Attorney

_____ Assistant District Attorney

Dated this _____ day of _____, 19____.

APPENDIX F.

ORDER FOR PRE-TRIAL EVALUATION

IT IS THEREFORE ORDERED:

That the defendant _____ should be evaluated by the Court Services Program and that a confidential report of this evaluation should be made of the findings to the Court.

_____
Judge of the District Court
Wyandotte County, Kansas

_____
Defendant's Attorney

_____
Assistant District Attorney

Dated this _____ day of _____, 19____.

APPENDIX G

PRETRIAL SERVICES INTERVIEW/EVALUATION FORM

INTERVIEW/EVALUATION

Disposition
ACCEPTED:
___ ROR
___ RWS
___ DIVERSION
MENTAL:
_____
DENIED:
_____
_____

NAME _____ DATE _____
Last First Middle
OTHER NAMES USED _____ INTERVIEWER _____
RACE _____ SEX _____ DOB _____ SS # _____
CHARGE _____ CASE # _____ BOND _____
ATTORNEY _____ ARREST DATE _____
Co-Defendants _____ Days in Jail _____

RESIDENCE
PRESENT ADDRESS _____
PREVIOUS ADDRESS _____
PREVIOUS ADDRESS _____
PHONE _____ Planning to Change Address _____

Point Scale
1yr.+ = 3
6 mos. + = 2
4 mos. + = 1
Ver. ___ Total_

FAMILY/COMMUNITY TIES
LIVE WITH _____ RELATIONSHIP _____
Single ___ Married ___ Divorced ___ Separated ___
Widow ___ Common Law (2yrs. +) ___
Wife's Maiden Name _____ Marriage/Divorce Date _____
Children _____
Child Support Amount _____

Point Scale
Spouse/Family=
Spouse/Parents=
Family Ref. =
Ver. ___ Total_

LENGTH OF RESIDENCE IN K.C. AREA _____
PLACE OF BIRTH _____

Point Scale
5yrs + = 2
Ver. __ Total__

HEALTH
Health Problems _____
Medication _____ Doctor _____
TREATMENT RECEIVED FOR:
Alcohol Abuse _____ Drug Abuse _____ Mental Illness _____
Date _____ Where _____

EDUCATION
Highest Grade Completed _____ Where _____
When _____ Read _____ Write _____

MILITARY SERVICE
Branch _____ Dates _____
Type of Discharge _____

REFERENCES

NAME	RELATION	ADDRESS	PHONE	FREQUENCY	Verified

DEFENDANT'S STORY
_____
_____
_____

FAMILY HISTORY
_____
_____
_____

APPENDIX G (Continued)

EMPLOYMENT

PRESENT _____ ADDRESS _____

Phone _____ Title _____ Salary _____

How Long _____ Can you return to job _____

TOTAL JOBS IN LAST TWELVE MONTHS _____

TOTAL YEARS EMPLOYED _____

JOB EXPERIENCE _____

_____

JOB TRAINING _____

Employment Point Scale

4* = Present job one year or more
3* = Present job four months..OR..present & prior 6 months
2* = Present job one month
1* = Current job.... OR unemployed 3 months or less with 6 months more on prior job
OR receiving unemployment compensation or welfare
OR supported by family

(* Deduct 1 point from first three categories if job is not steady or if not salaried, if defendant has no investment in it)

Verified _____ Total Points _____

PRIOR RECORD

JUVENILE CONVICTIONS _____ (List Charge, Disposition, Where & When, Probation Officer)

_____

_____

ADULT CONVICTIONS _____ (List Charge, Disposition, Where & When, Probation Officer)

_____

_____

OTHER PENDING COURT CASES _____

Prior Criminal Record Scale

3 = No convictions
2 = No convictions in last year
1 = Misdemeanor convictions in last year
0 = One felony conviction
-1 = Two or more felony convictions
-3 = Convictions of crimes against persons
-5 = Convictions of crimes against persons within last year

Verified _____ Total Points _____

TOTAL POINTS _____ (Includes Residence, Family/Community Ties, Employment & Record)

NEEDS ASSESSMENT:

_____

_____

_____

_____

_____

OBSERVATIONS:

_____

_____

_____

_____

APPENDIX H

ORDER FOR CONTINUED HOSPITALIZATION AND TREATMENT

FOR COMPETENCY TO STAND TRIAL

IN THE DISTRICT COURT OF WYANDOTTE COUNTY, KANSAS

STATE OF KANSAS)
)
vs.) Case No.
)
)
)

ORDER FOR TREATMENT

Now on this ____ day of this matter comes for hearing on the motion of defendant for an order of treatment at Osawatomie State Hospital. The defendant appears by and through his attorney, . The State appears by , Assistant Wyandotte County District Attorney. , Director of Wyandotte County Court Services also appears.

And the Court, being well and fully advised in the premises, and after examining the papers and pleadings filed herein, and hearing the statements of Dr. , finds:

1) That defendant is a mentally ill person;

2) That the order entered on committing the defendant to the Osawatomie State Hospital for evaluation and report to the Court within 60 days should be modified to permit treatment of the defendant until the treatment prescribed by the staff of said hospital shall be completed;

3) That upon completion of the treatment by the staff of said hospital, a report of such treatment shall be submitted to . Director of Court Services, together with any recommendations for further or continued outpatient treatment.

4) That upon completion of the treatment by the Osawatomie State Hospital, the defendant shall be turned over to the custody of the Sheriff of Wyandotte County, Kansas, or at such earlier time, if the defendant refuses treatment or leaves the hospital without authority.

IT IS SO ORDERED.

Chapter 6

COMMUNITY AND REGIONAL FORENSIC MENTAL HEALTH PROGRAMS

As almost any historical review of the criminal justice and mental health systems would indicate, both systems relied almost exclusively on "total" institutions for many decades but have recently developed less restrictive environments and implemented programs where evaluation and treatment of the "mad and the bad" will occur, at least initially, in the community (cf. Beran and Toomey, 1979; Monahan, 1976).

This chapter describes forensic mental health screening and evaluation conducted by community and regional forensic mental health centers. Collaboration with the criminal justice system is one of the most rapidly growing areas of community mental health work (Monahan, 1976). The great bulk of the chapter is the description of the operations of six community and regional forensic mental health centers:

(1) Dayton Area Forensic Psychiatry Services
Dayton, Ohio

(2) San Mateo County Mental Health Courts and Corrections Unit
Redwood City, California

(3) Forensic Unit of the Barren River Mental Health-
Mental Retardation Board
Bowling Green, Kentucky

(4) Forensic Services of the Malcolm Bliss Mental Health Center
St. Louis, Missouri

(5) Forensic Unit of the Peace River Center
for Personal Development
Bartow, Florida

(6) Riverside Hospital Community Mental Health Center Forensic
Screening and Evaluation
Newport News, Virginia

There are strong national trends toward community-based services as an alternative to institutionalization for most human service needs. Forensic mental health screening and evaluation is no exception to this trend. For example, in 1971 Ohio established its first community forensic center; by early 1974, six state-supported centers were in operation; and, as of August 1978, there were 16 community forensic centers across the state (Roth, 1979). State legislation in Ohio designates the community centers, rather than a central facility, as the setting for court-ordered mental health evaluations for competency and criminal responsibility. Some states plan to phase out central institutional facilities entirely and develop smaller forensic centers on

the grounds of existing state civil hospitals and training schools for the retarded (Roth, 1979; Petrila, 1981).

The signing into law of the Mental Health Systems Act (P.L. 94-63) by President Jimmy Carter in October 1980 marked (at the time) a national commitment to deal with the mental health problems of a wide range of populations with community resources. Collaboration between the mental health and the criminal justice systems is clearly mandated in the definitions of a community mental health center in the general provisions of the Act:

> A community mental health center is a legal entity which provides comprehensive mental health services to individuals in a particular catchment area regardless of their ability to pay and agrees to give "special attention to those who are chronically mentally ill." The center must provide inpatient, emergency, and outpatient services, assistance to the courts and other public agencies in screening residents who are referred for evaluations, follow-up care, consultation and educational services. (P.L. 94-63, Section 101, emphasis added)

The six community and regional forensic mental health centers described in this chapter represent operating systems of varying sizes, collaborations with other agencies, resources, philosophies, management policies and procedures--yet, they are as a group distinguishable from the other elements of a forensic mental health delivery system: centralized institutions, state and local corrections agencies and court clinics (see the discussion in "Conclusions," Chapter 3, and the introductions to the previous chapters).

In a number of jurisdictions throughout the country, mental health questions of immediate concern to the criminal justice system are referred to outpatient mental health clinics located in or near courthouses designed to serve exclusively the courts and their agencies. Exclusive service to the courts and their allied agencies most clearly distinguishes court clinics from community-based forensic units serving a particular catchment area. Insofar as community or regional forensic units are aligned with other community mental health services, their connection with the courts may be less clearly perceived, even if individual forensic staff members view themselves as agents of the court. Aside from the actual and perceived distance between them and the courts, there are few differences between court clinics and community or regional community forensic mental health centers.

The following sketch could well describe both court clinics and community or regional forensic mental health centers. They differ in their organization and operation. Some receive their operating funds from the court system which they serve; some operate within community mental health centers; others are allied with courts but receive only a portion of their funds from the courts; still others are agencies of local or state departments of mental health. Some provide relatively extensive evaluative services, and a few provide limited treatment for

criminal defendants, witnesses, and their families; others are designed merely to provide advisory opinions on specific mental health questions for judges and other court personnel. They can be differentiated on the basis of caseload, sources of referral (e.g., courts, probation departments, and police), time of referral (e.g., pretrial, at sentencing, or post-conviction), staff, budget, type of reporting mechanisms (testimony and written reports), treatment options, data collection methods, and many other factors.

The primary function of most community forensic mental health centers is to examine criminal defendants and render opinions regarding competency to stand trial, suitability for pretrial release, and psychosocial condition (bearing on sentencing and probation decisions). With regard to certain forensic questions (e.g., competency to stand trial), some clinics perform a threshold screening function, advising the court whether the question merits further evaluation (perhaps more prolonged evaluation in a hospital setting); other clinics are authorized to conduct thorough evaluations and address ultimate mental health-legal questions. Virtually every court clinic works closely with area psychiatric hospitals, and most recommend inpatient evaluation of difficult cases.

The staff of a typical community or regional forensic mental health unit consists of a core group of full-time mental health professionals (including psychiatrists, psychologists, and social workers) and support personnel and any number of part-time consulting psychiatrists and psychologists. Some centers have large, full-time staffs well coordinated as a team, while others rely heavily on consultants who function relatively independently.

Although the process by which mental health information is acquired varies from center to center, most clinics rely upon the clinical interview as the primary means for assessing the mental state of client-offenders. Most centers compile background information about the defendant, conduct clinical interviews, and perform psychological testing, including objective tests of intelligence and subjective personality inventories. Neurological testing and other more extensive procedures generally are performed on a referral basis in area hospitals.

The interest in working with the criminal justice system varies among community mental health centers. In a study of 26 community mental health centers in Kansas, Modlin, Porter, and Benson (1976) it was found that most centers were reactive rather than proactive. The creation of community forensic mental health units was likely the result of strong interests of specific individuals in each system.

> Many mental health personnel are skeptical of the legal offender's treatability. They point out that he often, with no personal motivation toward treatment, is coercively referred by a judge or probation officer. One psychiatrist stated wryly: "They are all alcoholics, drug users, or psychopaths, three of the categories we have least success in helping." Such bias may be

justified if traditional psychiatric treatment is all a center offers.

> This clinical stance concerning offenders contaminates attitudes toward personnel in the criminal justice system. It is felt that the referring agency frequently does not understand the difficulties and the requirements for adequate psychiatric practice; that referring agencies are looking for legal rather than medical decisions and solutions; that the legal system *in toto* offers a restrictive, or even antithetical, climate for psychiatric treatment; and that punishment and treatment are incompatible. (Modlin, Porter, and Benson, 1976, pp. 717-718)

The study by Modlin *et al*. revealed three conditions correlated with the success of a reciprocal program between community mental health centers and the criminal justice system: the location of the program *within* the criminal justice system, an urban setting, and individual initiative by staff from each system.

THE DAYTON (OHIO) AREA FORENSIC PSYCHIATRY SERVICES

The Dayton Center was opened in October 1972 and received the first client-offender case a few months later (see Program for the Study of Crime and Delinquency, Note 2). It is a component and an identifiable operation of Eastway Community Mental Health Center in Dayton, Ohio, and provides the criminal courts outpatient psychiatric and psychological evaluations of accused offenders. Outpatient treatment, crisis intervention, case consultation, and mental health intervention services to the Montgomery County Jail are provided as time and resources permit. The primary clients of the Dayton Center are the criminal courts in seven counties (Montgomery, Champaign, Darke, Greene, Logan, Miami, and Shelby) with a population close to one million. The Dayton Center is currently funded by the Division of Forensic Psychiatry, Ohio Department of Mental Health and Mental Retardation, though monies were made available from federal sources in the past.

The Dayton Center is one of 18 outpatient community forensic mental health centers in Ohio. The Division of Forensic Psychiatry of the Ohio Department of Mental Health and Mental Retardation began developing community forensic mental health centers in 1972 to reduce inpatient evaluation referrals to Lima State Hospital, a maximum security facility located in Lima, Ohio. There are four basic types of community forensic centers approved by the Division of Forensic Psychiatry of the Ohio Department of Mental Health and Mental Retardation: (1) a branch of a community mental health center; the Dayton Center is of this type; (2) a free-standing entity with its own Board of Directors; (3) a division of a general outpatient mental health facility of a university; and (4) an agency of a court or probation department (see Beran and Toomey, 1979; and Note 9, Association of Ohio Forensic Psychiatric Centers, for a discussion of the development of the Ohio community forensic center network).

The Dayton Center provides comprehensive forensic mental health evaluation services. Court-requested evaluations are conducted at various points in the adjudication process: pretrial, post conviction but before sentencing, and during probation or parole. Referral questions include competency to stand trial; insanity; identification of persons as mentally ill, mentally retarded, or "psychopathic"; dangerousness; probability of repeating offense (recidivism); amenability to treatment; and probation risk. In 1979, the Dayton Center performed approximately 600 evaluations at the request of the common pleas courts in the seven counties served by the Center, two county municipal courts in Montgomery County, the probate courts, the Probation Department, the Adult Parole Authority, and the juvenile courts; more than 75 percent of the referrals came from the Court of Common Pleas.

Psychiatrists, clinical psychologists, social workers, counselors, and secretaries serve as staff of the Dayton Center.

A Function Model

Figures 29-31 depict how a defendant comes to be evaluated at the Dayton Center, how a case is referred and delineated, how case information is acquired, and, finally, how the acquired information is provided to the referral agent.

The initial decision to involve the Dayton Center in a case occurs in the referral courts and allied referral agencies. Referral reasons and the stages in the criminal process at which referrals for evaluation are made vary considerably. In a felony case, following preliminary arraignment in the lower courts (municipal or county), the issue of competency may first be raised by the court, prosecution, or defense attorney at a preliminary hearing during which the state must show "probable cause" that a crime was committed and that the accused person committed the crime. The preliminary hearing is conducted before grand jury indictment, before entry of a plea and before appearance in common pleas court arraignment. The issue of competency can be raised and an evaluation may be ordered by the court at arraignment, at a pretrial conference, or during trial. The defense must raise the issue of insanity and enter a not-guilty-by-reason-of-insanity plea at the time of arraignment.

If a defendant is found guilty, or has pled guilty through a negotiated plea, the court may refer the case to the probation department for a presentence investigation. At this stage in the criminal proceedings, the evaluation referral question may focus on the presence or absence of mitigating circumstances, advisability of treatment, or factors favoring probation.

Figure 29 captures the "flow" of a case *before* the actual appearance of the accused individual at the Dayton Center, the specific activities and events that delineate the mental health information to be sought about the individual case. Cases come to the attention of the

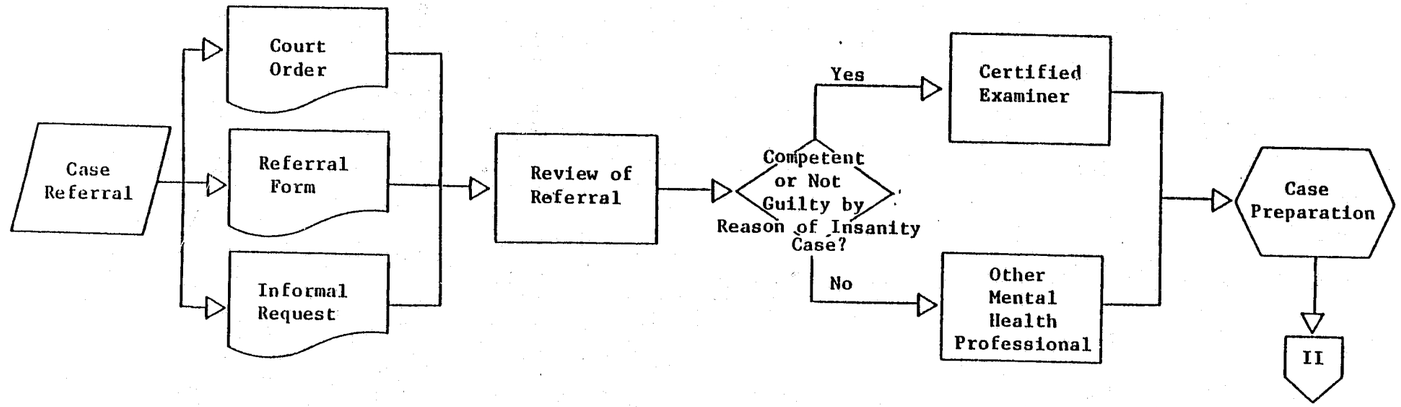


Figure 29. Case Processing Model of the Dayton Center, Delineation of Evaluation Information.

Dayton Center by means of referrals from judges of the Municipal Court, the Court of Common Pleas, probation officers, parole officers, or County Jail personnel. All referrals, with the exception of requests from the Adult Parole Authority and the County Jail, are made by formal court order. The order specifies the type of evaluation requested (i.e., competency, insanity, etc.), and the statute section authorizing the evaluation. A court order is accompanied by a referral form further detailing case information and referral questions. Referrals from the Adult Parole Authority and the County Jail are made by referral form or a brief checklist only (no court order), and are often preceded by informal contact with the Dayton Center. The Dayton Center Director reviews all referrals and assigns the case to a staff member as primary examiner. Evaluations for competency to stand trial and criminal responsibility are assigned only to "board eligible," certified psychiatrists or clinical psychologists licensed in Ohio. Other types of evaluations typically are assigned to other staff members.

Once a referral (i.e., court order, referral form, informal contact with referral agent) has been received, the administrative staff and the primary examiner (after assignment) begin the preparation of the case: i.e., checking and acquiring information supporting the case (e.g., reports from hospitals or mental health centers, copy of indictment, report of arrest, and copy of most recent presentence investigation report); asking the referral agent to further delineate the referral question(s); arranging for defendant to come to the Dayton Center for evaluation; and, scheduling the evaluation process to accommodate a 30-day time limit.

Figure 30 depicts the essential operations and events occurring to acquire evaluative information about the defendant. Once the defendant comes to the Dayton Center, the direct acquisition of information begins by obtaining the defendant's informed consent and authorization for release of information (if not already obtained by the referral agent before the defendant appears in the Dayton Center for evaluation). This is followed by a clinical interview conducted by the assigned examiner. Except in evaluations of the insanity issue, which often last longer than a single session, most clinical interviews seldom exceed two hours and a single session. The conduct of the actual interview varies depending on the referral question, the nature of the case, the amount of prior information, the mental status of the defendant at the time of the interview, and the professional style of the examiner.

If a clinical decision is not reached at the conclusion of the clinical interview, as is most often the case when the referral question is insanity, preparations are made to secure additional information such as the social history of the defendant, performance on intelligence tests and other standard psychological instruments, professional opinions of other staff members, and neurological or medical examination results. Once the examiner has reached a clinical decision, he or she prepares a formal report that is reviewed by the Supervisor of Psychological Services or the Supervisor of Social Services (if the responsible examiner is a psychologist or a social worker under its supervision) and, ultimately, by the Director of the Dayton Center.

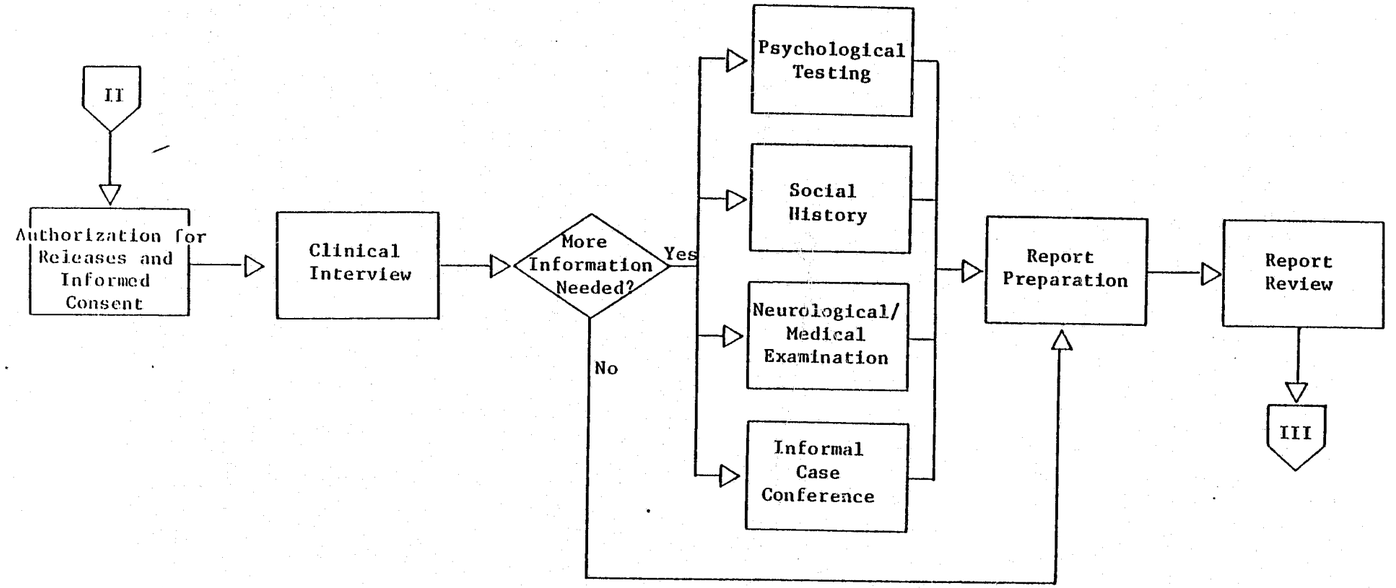


Figure 30. Case Processing Model of the Dayton Center, Acquisition of Case Information.

The final stage, the provision of the evaluative information to the referral agents, is depicted in Figure 31. Ordinarily, written evaluations are submitted to the referral agent within 30 days of the receipt of the referral. Copies are sent to the referring court by courier or U.S. mail, depending on the distance of the court from the Dayton Center, with copies for the initial referral agents (attorneys, probation officers and parole officers). Distribution of copies is the responsibility of the courts except in cases involving the Adult Parole Authority and the County Jail, where the issues may be advisability of treatment or case consultation, in which case reports are submitted directly to those agencies. Informal communication about a case between Dayton Center staff and the referring agent before, during, and after the preparation of a formal written report is a frequent occurrence. The examiner may testify as an expert witness during a trial or presentence hearing, albeit infrequently. The following three sections describe in greater detail the delineation, acquisition, and provision of forensic evaluation information in the Dayton Center.

The Delineation of Evaluation Requirements

Statutory Delineation

The Dayton Center places strong reliance on specific sections of the Ohio Revised Code to guide its referrals and outline the information acquisition requirements. Specific legal guidelines outline the referral questions, qualifications of examiners, the format of requested reports, and the time requirements for filing the report. All referrals specify not only the type of evaluation requested by name (i.e., competency, drug dependency, etc.) but also the Ohio Revised Code (O.R.C.) Section number authorizing the evaluation. The referral form used by the Dayton Center specifies eight types of evaluations, according to authorizing statute:

(1) Competency to Stand Trial (2945.371 O.R.C.);

(2) Not Guilty by Reason of Insanity (2945.39 O.R.C.);

(3) Mitigating Circumstances in Capital Offenses (2929.03 O.R.C.);

(4) Medication to Maintain Competency (2945.38 O.R.C.);

(5) Mitigating Circumstances (2947.06 O.R.C.);

(6) Advisability of Treatment (2967.22 O.R.C.);

(7) Presentence Evaluation (2951.03 (O.R.C.); and

(8) Drug Dependency (2951.04[D] and 2951.041 (O.R.C.).

Although the referral form also lists an "other" category, and the Dayton Center responds regularly to informal evaluation requests by the courts which are not necessarily reflected in completed referral forms, the checklist of statute authorities invariably shapes the referral

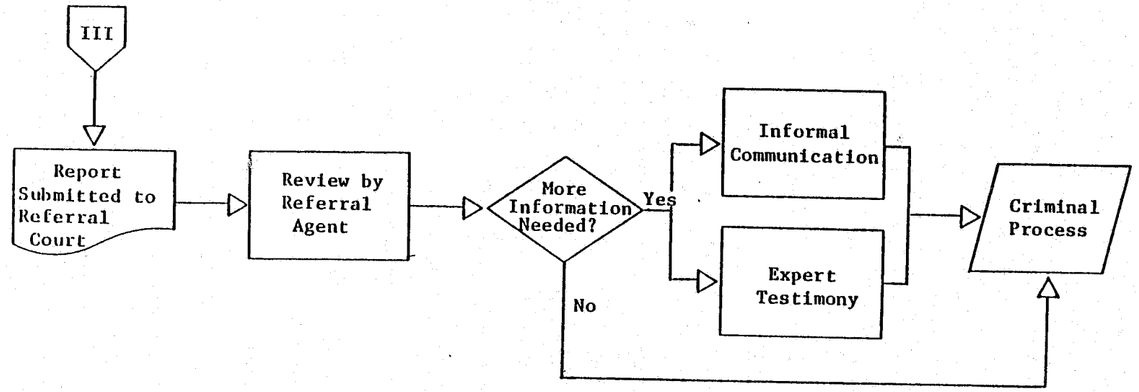


Figure 31. Case Processing Model of the Dayton Center, Provision of Evaluation Information.

process. Delineation of the evaluation process by the Dayton Center is also evident in procedural memoranda outlining the purpose, referral procedures, and reporting requirements of various types of evaluation. Statute citation and language are prominent in the memoranda. Further, the Manual of Forensic Psychiatric Centers, prepared by the Association of Ohio Forensic Psychiatric Center Directors (see Note 9) emphasizes the statutory base of the evaluations performed by the forensic community centers. Finally, the Dayton Center categorizes its year-end reporting of evaluation caseload according to Ohio statutes authorizing the evaluation.

The applicable Ohio statutes and case law for the evaluations conducted by the Dayton Center are as follows:

Competency to Stand Trial. The Code specifies the time and manner in which the issue of competency may be raised, criterion required to prove incompetency, the number of separate evaluations authorized, who shall conduct evaluations, where they should be conducted, and the provision of evaluation results.

> In a criminal action in a court of common pleas or municipal court, the court, prosecution, or defense may raise the issue of the defendant's competence to stand trial. If the issue is raised before trial, the court shall hold a hearing on the issue as provided in this section. If the issue is raised after trial has begun, the court shall hold a hearing on the issue only for good cause shown.
>
> A defendant is presumed competent to stand trial unless it is proved by a preponderance of the evidence in a hearing under this section that because of his present mental condition he is incapable of understanding the nature and objective of the proceedings against him or of presently assisting in his defense. (Ohio Revised Code 2945.37.)
>
> If the issue of a defendant's competence to stand trial is raised under Section 2945.37 of the Revised Code, the court may order one or more, but not more than three evaluations of the defendant's mental condition. An evaluation shall be conducted through examination of the defendant by a certified forensic center designated by the Department of Mental Health and Mental Retardation to conduct such examinations and make such evaluations in an area in which the court is located or by any other program or facility that is certified or operated by the Department to diagnose or treat mental illness or mental retardation and is designated by the Department to diagnose or treat mental illness or mental retardation and is designated by the Department to conduct such examinations and make such evaluations, or the court may designate a center, program, or facility other than one designated by the Department to conduct the examination, and in any case the court may designate examiners other than the personnel of the center, program, facility, or department to make the examination.

If an evaluation is ordered, the defendant shall be available at the times and places established by the center, program, facility, or examiners. The court may order a defendant who has been released on bail or recognizance to submit to an examination under this section. If a defendant who has been released on bail or recognizance refuses to submit to a complete examination, the court may amend the conditions of bail or recognizance and order the sheriff to take the defendant into custody and deliver him to a center, program, or facility operated or certified by the Department where he may be held for examination for a reasonable period of time not to exceed twenty days.

A defendant who has not been released on bail or recognizance may be examined at his place of detention, or the court at the request of the examiner may order the sheriff to transport the defendant to a program or facility operated by the Department, where he may be held for examination for a reasonable period of time not to exceed twenty days, and to return the defendant to the place of detention after the examination.

The examiner shall file a written report with the court within thirty days after entry of an order for examination. The court shall provide copies of the report to the prosecutor and defense counsel. The report shall contain the findings of the examiner, the facts in reasonable detail on which the findings are based, and the opinion of the examiner as to the defendant's competence to stand trial. If the examiner reports that in his opinion the defendant is incompetent to stand trial, he shall also state his opinion on the likelihood of the defendant's becoming competent to stand trial within one year and if, in his opinion, the defendant is mentally ill or mentally retarded. (Ohio Revised Code 2945.371)

Insanity. Insanity was legally defined by the Ohio Supreme Court in the case of State of Ohio v. Staten as follows:

> In order to establish the defense of insanity, the accused must establish that disease or other defect of his mind so impaired his reason that, at the time of the criminal act with which he is charged, either he did not know that such an act was wrong or he did not have the ability to refrain from doing that act (cited by the Association of Ohio Forensic Psychiatric Center Directors, Note 9).

The Staten decision requires complete impairment, rather than partial impairment as implied in the words "lacks substantial capacity" of the American Law Institute's Model Penal Code definition of insanity. The Staten court felt that partial inability or impairment to control should be considered in sentencing, rather than at the trial stage (see Note 9, p. 24). Sections 2945.39 and 2945.40, of the Ohio Revised Code, which address the plea of insanity, do not define insanity or set standards for criminal responsibility, although they do describe the administration of the insanity plea, agencies authorized to receive

referrals, availability of the defendant for evaluation, notification of parties involved, time frame for evaluation, issuance of temporary detention orders, commitment procedures, and other procedural matters.

Conditional Probation for Drug Treatment and Drug Treatment in Lieu of Conviction. The purposes of these evaluations are to determine whether the defendant is drug dependent or in danger of becoming drug dependent and whether he or she can benefit from treatment. The evaluations of treatment in lieu of conviction are ordered by the court after the defendant is charged but before a plea is entered.

> If the court has reason to believe that an offender charged with a felony or a misdemeanor is a drug dependent person or is in danger of becoming a drug dependent person, the court shall, prior to the entry of a plea, accept that offender's request for treatment in lieu of conviction. If the offender requests treatment in lieu of conviction, the court shall stay all criminal proceedings pending the outcome of the hearing to determine whether the offender is a person eligible for treatment in lieu of conviction. At the conclusion of the hearing, the court shall enter its findings and accept the offender's plea.
>
> The offender is eligible for treatment in lieu of conviction if the court finds that:
>
> (1) The offender's drug dependence or danger of drug dependence was a factor leading to the criminal activity with which he is charged, and rehabilitation through treatment would substantially reduce the likelihood of additional criminal activity;
>
> (2) The offender has been accepted into an appropriate drug treatment facility or program.
>
> (3) If the offender were convicted he would be eligible for probation.
>
> (4) The offender is not a "repeat offender" or "dangerous offender" as defined in Section 2929.01 of the Revised Code.
>
> Upon such a finding and where the offender enters a plea of guilty or no contest, the court may stay all criminal proceedings and order the offender to a period of rehabilitation. Where a plea of not guilty is entered, a trial shall precede further consideration of the offender's request for treatment in lieu of conviction. (Ohio Revised Code Section 2951.041)

The evaluation for conditional probation for drug treatment can be ordered by any trial court after conviction but before sentencing. Again, the defendant must be eligible for probation.

If the court has reason to believe that an offender convicted of a felony or misdemeanor is a drug dependent person or is in danger of becoming a drug dependent person, the court may, and when the offender has been convicted, the court shall advise the offender that he has a right to request conditional probation for purposes of treatment and rehabilitation.

Within a reasonable time after receipt of the request for conditional probation, the court shall hold a hearing to determine if the offender is eligible for conditional probation. The offender is eligible for conditional probation if the court finds that:

(1) The offender is drug dependent or is in danger of becoming drug dependent and he may benefit from treatment;

(2) The offender has been accepted into an appropriate drug treatment facility or program;

(3) The offender has committed an offense for which probation may be granted.

If the court finds that an offender is eligible for conditional probation, the court may suspend execution of the sentence imposed after completion of any period of actual incarceration which may be required by Chapter 2925. of the Revised Code, and place the offender on probation subject to chapter 2951. of the Revised Code and under the control and supervision of the county probation department or the adult parole authority.

Probation under this section shall be conditioned upon the offender's voluntary entrance into an appropriate treatment program or facility and his faithful submission to the treatment prescribed for his drug dependence or danger of drug dependence and upon other conditions as the court orders.

The court shall not suspend execution of a sentence and place the offender on probation until the court affirmatively finds that the offender is not, or there is no substantial risk of his becoming, a dangerous offender as defined in Section 2929.01 of the Revised Code and such finding is entered into the record. (Ohio Revised Code Section 2951.04)

Mitigation of Penalty Presentence Evaluation. Under Ohio Revised Code Section 2947.06, after conviction and before sentencing of a defendant, the court may request the probation department to inquire into mitigating circumstances. The evaluation is mandatory in capital offenses. In non-capital offenses, the evaluation may be ordered by any trial court. The purpose of the evaluation report is to inform the sentencing judge about motives and other factors that may have contributed to the defendant's offense (see Note 9, pp. 29-30).

The trial court may hear testimony of mitigation of a sentence at the term of conviction or plea, or at the next term. The prosecuting attorney may offer testimony on behalf of the state, to give the court a true understanding of the case. The court shall determine whether sentence ought immediately to be imposed or the defendant placed on probation. The court of its own motion may direct the department of probation of the county wherein the defendant resides, or its own regular probation officer, to make such inquiries and reports as the court requires concerning the defendant, and such reports shall be confidential and need not be furnished to the defendant or his counsel or the prosecuting attorney unless the court, in its discretion, so orders.

The court may appoint not more than two psychologists or psychiatrists who shall make such reports concerning the defendant as the court requires for the purpose of determining the disposition of the case. Each such psychologist or psychiatrist shall receive a fee to be fixed by the court and taxed in the costs of the case. Such reports shall be made in writing, in open court, in the presence of the defendant, except in misdemeanor cases in which sentence may be pronounced in the absence of the defendant. A copy of each such report of a psychologist or psychiatrist may be furnished to the defendant, if present, who may examine the persons making the same, under oath, as to any matter or thing contained therein. (Ohio Revised Code Section 2947.06)

Benefit of Treatment Presentence Evaluation. Under Section 2951.03, a probation officer may request psychiatric or psychological examination of a defendant as part of the post-conviction, presentence investigation. The evaluation may be useful in deciding the questions of probation and probation rules, especially those involving mental health treatment.

No person who has pleaded guilty of or has been convicted of a felony shall be placed on probation until a written report of investigation by a probation officer has been considered by the court. The probation officer shall inquire into the circumstances of the offense, criminal record, social history, and present condition of the defendant. Such written report of investigation by the probation officer shall be confidential and need not be furnished to the defendant or his counsel or the prosecuting attorney unless the court, in its discretion, so orders. Whenever the probation officer considers it advisable, such investigation may include a physical and mental examination of the defendant. If a defendant is committed to any institution, the report of such investigation shall be sent to the institution with the entry of commitment. (Ohio Revised Code Section 2951.03)

Advisability of Treatment During Probation and Parole. Under O.R.C. Section 2967.22, a probation officer may request assessment of the probationer's or parolee's mental condition. This evaluation takes place

after the judge has placed the person on probation or parole, under the supervision of the Adult Parole Authority or the County Probation Department. Participation in the evaluation may be a condition of probation. Occasionally, behavior problems that occur during probation or parole may precipitate the evaluation; the results of the evaluation are then used to change the conditions of probation or parole (see Program for the Study of Crime and Delinquency Note 8, p.31).

Referral Courts and Agencies

The Dayton Center accepts referrals from the common pleas court in each of the seven counties within its area of jurisdiction, the two courts of limited jurisdiction within Montgomery County, the Montgomery County probation and parole departments, local detention facilities, and, infrequently, from the juvenile courts.

The Court of Common Pleas is Ohio's court of general jurisdiction. There is one court in each of the seven counties served by the Dayton Center. The court's jurisdiction includes all criminal cases, except some minor offenses. The court also exercises jurisdiction over probate, domestic relations, and juvenile matters. In some counties, separate divisions have been created within the court to handle these cases (Reincke & Lichterman, 1979). The twenty-six judges, including six probate judges and one juvenile judge, in the courts of common pleas in the seven county area served by the Dayton Center, are the principal referral agents.

The four-judge municipal court in Dayton, which refers cases to the Dayton Center, is a court of limited jurisdiction within municipal boundaries. This court has criminal jurisdiction over misdemeanors carrying a sentence of imprisonment of less than one year. The Montgomery County Court, with five judges, has countywide jurisdiction in criminal cases involving misdemeanors and motor vehicle violations. The court may bind over persons to the grand jury in felony cases, rule on matters of law, and issue arrest warrants.

In addition to referrals from the courts, the Dayton Center accepts referrals from probation officers of the Montgomery County Probation Department and the parole officers in the Adult Parole Authority. Finally, referrals are also received on occasion from the staff of the Montgomery County Jail.

Referral Procedures

All evaluation referrals to the Dayton Center, with the exception of requests from the Adult Parole Authority and consultation requests from the County Jail, require a formal court order issued by a judge. The order specifies the type of evaluation requested and the Ohio Revised Code section authorizing the evaluation. The Dayton Center requests that referral agents complete a referral form and submit this form with the court order. Over ninety percent of the referrals comply with this request.

Referral agents are also requested to include all relevant, available case information with their referrals. The following information, according to the type of evaluation authorized by statutes, is requested by the Dayton Center (Dayton Area Forensic Psychiatry Services, Note 11).

(a) Competency to stand trial and not guilty by reason of insanity.

- o Copy of indictment.
- o Report of arrest.
- o Arrest record.
- o Bond check if completed; name and telephone number of investigator, if available.
- o Copy of most recent presentence investigation, if available; name and phone number of probation officer.
- o Copy of arraignment information, (from lower court) if available.
- o Reports from Lima State Hospital, Dayton Mental Health Center, other state-operated hospitals, community mental health center or any other reports of psychiatric treatment.

(b) Medication to maintain competency treatment to attain competency.

- o All records of mental health treatment, including medication record.

(c) Advisability of treatment (treatment plan for probationer) and mitigating circumstances.

- o Copy of P.O.'s supplement to judge requesting evaluation.
- o Copy of most recent presentence investigation report.
- o Indication on referral sheet of specific reason for evaluation.
- o Reference to any past mental health treatment.

(d) Candidate for probation and drug dependency treatment.

- o Copy of arrest record.
- o Copy of most recent presentence investigation report.
- o Copy of bond check, if available.
- o Record of past involvement with Lima, Dayton Mental Health Center, community centers, drug treatment programs.
- o Record of previous offenses.
- o Name and telephone number of investigator.
- o Source of request for evaluation (judge, attorney, probation officer, defendant).
- o Indication on referral sheet of specific reason for evaluation.
- o Copy of supplement if request made by investigator.

The referral orders, completed forms, and the above supplementary data are delivered by courier to the Dayton Center approximately three times per week. Requests from outlying areas are sent by U.S. mail. Frequently, an informal telephone request from the referral agent precedes or accompanies the formal request. Once a case is assigned, the responsible examiner may contact the referral agent or agencies for additional information clarifying reasons for referral, and for information not submitted with the order or entry.

Arrangements are then made to schedule the actual evaluation of the defendant. Referral agents are alerted to the need for their assistance in transporting defendants or probationers to the Dayton Center, particularly if the person is incarcerated in a facility outside Montgomery County. Persons not in custody, i.e., defendants released on bail or their own recognizance, must be contacted directly for an appointment by the Dayton Center staff.

Acquisition of Mental Health Information

Staff

The staff of the Dayton Center consists of two consulting psychiatrists, a full-time clinical psychologist who also is Chief of Psychological Services, three consulting psychologists, two consulting psychiatric social workers, a full-time social worker as Supervisor of Social Services, a masters-level "therapist" working primarily in the Center's Jail Services, a psychology associate, and several other persons (a drug evaluator specialist, a juvenile diversion officer, and a court liaison officer) who perform work of the Dayton Center but receive funding from other sources. The Dayton Center is coordinated and administered by the director, who is a social worker, assisted by a clerical staff.

Procedures and Techniques

The major function of the Dayton Center is case information acquisition. The other two major functions--decisionmaking and treatment--have been discussed in detail elsewhere (cf. Beran & Toomey, 1979; Program for the Study of Crime and Delinquency, Notes 2 and 8) and will not be dealt with here. Information acquisition focuses on the types of examinations requested by the referral agents, including determinations of 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. As discussed above, the conduct of each of the examinations is largely determined by statutes governing its use, although in practice, statutory provisions are difficult to trace through the information acquisition process. In general, the process is influenced by applicable statutes, executive and administrative orders, formal and

informal policies of referral agencies, and the professional styles of the examiners.

Examinations of defendants typically begin with the clinical interviews conducted by the examiners assigned primary responsibility for the case by the Director. Evaluations of competency to stand trial and sanity at the time of the offense are always assigned to certified clinical psychologists or psychiatrists. Other types of examinations are assigned on the basis of staff availability, type of case, and examiner's expertise.

Before the clinial interview, the defendant is asked to read and sign a form (see Appendix A) indicating his or her informed consent. Also, if the authorization for release of written information has not been obtained before the defendant arrives at the Dayton Center, he or she is asked to sign a release form (see Appendix B).

Evaluative techniques employed at the Center include the individual clinical interviews, social case history, and psychological and psychiatric testing. The latter includes assessments of intellectual functioning (using the Wechsler Adult Intelligence Scale (WAIS), Stanford-Binet, and Wide Range Achievement Test), personality tests (Rorschach Test, Minnesota Multiphasic Personality Inventory (MMPI), Thematic Apperception Test (TAT), and the Rotter Incomplete Sentence Test) and measures of neurological dysfunctioning (Bender Visual-Motor Gestalt Test, and the Graham-Kendall Test). The type and number of psychological and psychiatric tests administered vary with the type of case, the completeness of the information acquired during the clinical interview, and the judgment of the primary examiner. With the exception of evaluations for sanity at the time of the offense, which usually take longer than a single session, examinations are conducted in a single session lasting less than two hours. Differences in the conduct of specific examinations are noted below.

Competency. Assessment of competency at the Dayton Center involves a clinical interview and an assessment of the defendant's cognitive and emotional functioning. In addition to information gained during the clinical interview, the examiner sometimes administers (or requests that other Dayton Center staff administer) the MMPI; in cases in which mental retardation is suspected and mentioned by the referral agent, the WAIS is administered. The examiner may interview relatives; request the compilation of social history by staff social workers; review the reasons for referral with the referral agent(s); and seek the advice of other staff members.

A Dayton Center memorandum (Dayton Area Forensic Psychiatry Services, Note 12) suggested that the following aspects and issues of competency be covered to guide examiners in competency evaluations:

a) Assessment of present mental condition

- Are there signs of mental disorder--psychosis, mental deficiency, organic cerebral disorder?
- Does the mental disorder cause defect in judgment?
- Does the defect in judgment result in specific incapacity with reference to matter in question?

b) Does the person understand the nature and objectives, including consequences, of the proceedings against him or her?

- Who is your lawyer now?
- Have you had any other lawyers in this case?
- How did you get them?
- What is your lawyer's job?
- What is the purpose of the judge?
- What does the jury do?
- What does the prosecutor do?
- Since arrest, have you spent time in jail? How long?
- Have you been questioned by the police? When? Where? Did they tell you what rights you have in this case?
- What are the charges against you?
- What do they mean to you?
- Why were they made against you?
- When is your trial going to take place?
- In which court?
- Can the judge or prosecutor make you take the witness stand in court and make you answer questions?
- Since your arrest have you gone before any court or court official? When? Where? What was reason? Who was the court official? What was decided? Did you have a lawyer? How did you get him or her?
- What is the difference between guilty and not guilty?
- If you are found guilty, what are the possible sentences?
- What do you think will happen? Why?
- What is a suspended sentence?
- What is probation?

c) Can the person assist his or her attorney in the defense?

- What is your plea at this time?
- What alibi or defense do you think you have at this time?
- Does your lawyer agree with this?
- Why are you going to use this alibi/defense?
- Have you and your lawyer discussed any other defense you might use? Why not using?
- What does incompetent to stand trial mean to you?
- Do you think there is any reason why you should be found incompetent to stand trial?
- Would you want to be found incompetent? Why?
- Will there be any witnesses against you?
- Do you think you know what they might say?
- If one of them lies or makes a mistake, what would you do?
- Will there be any witnesses for you?

- What have you done to contact them to make sure they'll be at your trial?
- Has your lawyer been helpful in letting you know about your rights (and other things to do) in this case?
- Has there been anything you thought your lawyer could do to help your case that you have been reluctant to ask him to do?
- Are you able to work with your lawyer?
- Have you ever testified before? Describe.
- Do you think you will have to testify at your trial?
- How do you feel about testifying?
- What will you do if you are asked a question you don't want to answer?

Sanity. The examiner in the evaluation of a defendant's sanity at the time of the alleged act utilizes all available sources of information, including reports of police and witnesses; records of past mental health care involvement; information acquired from family members and significant others; and, in some cases, autopsy reports. The defendant's own account of the circumstances of the alleged crime is the central focus.

Most sanity examinations require two or more clinical interviews. The initial session typically consists of a preliminary assessment of mental state at the time of the alleged offense, building of rapport, and gathering of some background information tracing the history that may have led up to the alleged offense. Psychological and psychiatric testing, typically including the MMPI, TAT, Rorschach and the WAIS, follow subsequent sessions. The examiner requests that a social history be prepared in most cases; less frequently, a neurological examination is requested by the examiner.

Drug Dependence Evaluations. The purpose of these evaluations is to determine whether the defendant is drug dependent or in danger of becoming drug dependent, and whether or not he or she can benefit from treatment. These evaluations are conducted by social workers or a "drug evaluator specialist," and rarely require the collaboration of psychologists and psychiatrists.

Drug dependency evaluations in the Dayton Center generally follow the guidelines outlined below.

The defendant's general psychological history should include assessment of early family environment, parental relationships, and educational experience. Scholastic and disciplinary problems should be reviewed in detail. Military service should also be noted, with emphasis on any time spent in Vietnam or other foreign countries.

The patient's past legal difficulties should be reviewed, with particular attention to drug-related offenses. Confinements to both juvenile and adult correctional facilities should be

explored. A careful history of alcohol use is important because of the close relationship between alcohol and drug abuse. An understanding of the instant offense is helpful to determine if it resulted from the defendant's need to support a drug habit.

A detailed chronological history of drug use will reveal any significant patterns. This should include defendant's age at first usage, specific drugs taken, method for obtaining drugs, and the effects upon the defendant. Periods of addiction should be delineated. Whether the drugs were taken orally, intramuscularly, or intravenously, is also important. Other questions to be answered are: How did the defendant support his habit? What treatment facilities or methods have been utilized? How long did the defendant stay in treatment? If a program was not successful, why did it fail?

Most persons will be "off drugs" at the time of the evaluation. It is useful to learn when their most recent drug use was terminated and whether there were withdrawal symptoms. Examination for tracks (needle scars) should be made in each case. This may help to corroborate the defendant's story. The absence of tracks, however, is not conclusive.

An attempt should be made to assess the defendant's current motivation for treatment and rehabilitation, as well as his preoccupation with drugs. The realism of the defendant's plans for a life without drugs should be evaluated.

The psychological/psychiatric evaluation should include a detailed mental status examination. Areas to be covered include assessment of intelligence and personality, and evidence of psychotic symptoms. An assessment of dependency, impulsivity, anti-social behavior, and immaturity is also relevant. (Association of Ohio Forensic Psychiatric Centers, Note 9, pp. 27-29)

Mitigating Circumstances and Other Presentence Evaluations. These evaluations assist the court in fashioning a disposition in a case by providing insight into the motives and other conditions that may have contributed to the criminal conduct of the defendant. The evaluation results may be useful in deciding among alternative conditions of probation. The court may decide on the basis of the content of an evaluation report that psychological intervention is a more promising rehabilitation plan than incarceration. Such disposition is particularly frequent in cases where the defendant is found to be mentally retarded. These evaluations may also assist probation or parole officers in deciding treatment plans as part of conditions of parole or probation.

The conduct of these evaluations differs little from that of the previously described evaluations. The major differences are the assignment of non-certified examiners, the referral questions posed, the focus of the examiner on factors that might bear directly on the "mitigation of the penalty" imposed (i.e., mental retardation, organic

brain disease, and other mental illness), and the emphasis on recommendations for possible alternatives to incarcerations.

Provision and Use of Evaluation Information

Case information acquired in Dayton Center Evaluations is conveyed to referral agents by means of court testimony by examiners, informal communications with the referral agent(s), and written reports. The latter are the virtual raison d'etre of the evaluation process. Examiners rarely testify in court, and do so only in cases where written reports are insufficient or legal tactics dictate such testimony.

Informal communication between referral agents and Dayton Center staff is frequent and is an important aspect of the provision and use of evaluation information. Such communication may occur before the appearance of the defendant at the Dayton Center, perhaps initiated by an examiner seeking clarification or more information; during the conduct of a lengthy examination of insanity, initiated for example by an impatient defense attorney; or after the completion of an examination but before the preparation of a formal report.

Written Reports

Reports prepared by the Dayton Center typically begin with a citation of the Ohio Revised Code authorizing the evaluation and a statement of charges against the defendant. General guidelines are suggested by the Association of Ohio Forensic Psychiatric Center Directors (Note 9):

- Give the length of time spent with client (this information may prove to be valuable for program monitoring and evaluation at some future time).
- State the factors adversely affecting the evaluation (e.g., lack of privacy, interruption, etc.).
- Describe how the purpose of evaluation and the limits of the evaluation's confidentiality were explained to the defendant.
- Limit the report's content to information directly relevant to the requested legal question necessary to substantiate conclusions and recommendations.
- Subdivide report--client's account of the crime, mental health history, and family history.
- Avoid technical mental health terms and/or jargon.
- Use objective statements instead of subjective or interpretative statements (e.g., "client stated he consumed 'no' alcohol" instead of "client denied using alcohol").

- It is important to include data which support the conclusion of the report. It is also vital to explain the reasoning behind the conclusion. This explanation is the single most important difference between the legal report and an ordinary mental health report (Note 9, p. 31, emphasis added).

Competency Evaluation Reports. Memoranda distributed to Dayton Center staff, and supported by statements made by staff during interviews, indicate the content of competency evaluation reports as outlined in this subsection, as well as the content of other types of evaluation reports described in subsequent sections.

Identifying Information

Name of person examined
Date of birth
Court case number

Opening statement

Ohio Revised Code number specifying type of evaluation
Date of interview
Place of interview
Length of interview
Information that was reviewed
Current charges

Background Information

Physical health
Marital status
Family relationship
Work history
Present or past mental health and/or mental retardation treatment
Present or past use of psychotropic medications

Mental Status (Present)

Appearance
Orientation
Memory
Perceptions
Mood
Thought
Intellectual Capacity

Knowledge of the Legal Proceedings

Understanding of the charges
Understanding of the trial process
Extent to which he or she can counsel with defense

Summary

Summary of the information concerning the person's mental condition and its effect upon understanding the proceedings or assisting attorney in defense, including the extent of mental illness and/or mental retardation which would interfere with the above.

Clear statement as to whether or not the person is so affected by a mental condition that he or she is not capable of understanding the nature of the proceedings or participating in the defense.

If the person is incompetent, statement of opinion as to whether or not the individual is mentally ill or mentally retarded, whether or not the individual may be restored to competency within one year, whether or not there is a risk that the individual might physically harm himself or others, and recommendations as to the appropriate treatment.

Sanity Evaluation Reports. Identifying information, content of the opening statement, and background information in sanity evaluation reports (except for statement of past criminal conduct) are similar to competency evaluation reports. Categories regarding mental status are also the same; in sanity reports, however, the orientation is toward the time the act was committed, not present mental status. Summary statements include findings, opinions, and facts supporting the opinion. If the defendant is found to be not sane, reports show a connection between the defendant's mental condition and behavior at the time of the crime.

Presentence Evaluation Reports. Presentence evaluation reports emphasize the defendant's current social functioning, information that may assist the judge in fashioning an appropriate disposition of the case and suggest specific management or treatment to the probation officer.

Identifying Information

Name of person examined
Date of birth
Court case number

Opening Statement to Include

Ohio Revised Code number specifying type of evaluation
Date of interview
Place of interview
Length of interview
Offense for which individual was convicted

Background Information

- Physical health
- Marital status
- Family relationship
- Work history
- Present or past mental health and/or mental retardation treatment
- Present or past use of psychotropic medications
- Prior offenses

Current Social Functioning

- Appearance
- Marital
- Family
- Occupational
- Pattern of use of alcohol
- Pattern of use of prescribed and non-prescribed drugs
- Motivation for changing behavior

Summary

- Summary of findings as they relate to the person's mental condition and need for treatment. Recommendation for possible treatment and suitable alternatives for the offender, considering the individual, special problems, support system, and possible problems that may occur if not placed on probation. Suggestions of how the probation officer may manage and assist the offender in following through on needed treatments.

Drug Dependency Evaluation Reports. Except for a statement of defendant's military record and any drug use in the service, the identifying information, opening statement, and background information in these reports follow the basic format of the aforementioned reports. The remainder of this type of report, emphasizing the referral issue, contains the following:

Drug History

- Age of first use
- Types of drugs abused
- Frequency of use
- Precipitating factors in drug use
- Individual's view of drug use
- History of alcohol abuse
- Overdoses
- Withdrawal syndrome
- Date of last use and drugs abused
- Prior treatment and success/failure of treatment
- Amount of money spent on drugs

- Verification of drug use from criminal record, treatment agency or significant others
- How individual supported drug use
- Prior offenses
- Relationship of criminality to drug abuse
- Presence of tracks
- Intoxication at time of interview

Clinical Observations

- Mental status
- Motivation for treatment
- Appropriate distress
- History of behavioral stability
- Precipitating factors
- Sincere request for treatment
- Personality factors
- Interpretation of psychological testing

Summary

- Summary of whether individual is physically or psychologically drug dependent or in danger of becoming drug dependent
- Primary drug abuse
- Recommendion for treatment setting, considering needs of individual, particularly the need for structure and the possible outcome of treatment

Presentence, Mitigating Circumstances Evaluation Report. The format and general content of these reports combine the features of the pretrial and presentence reports insofar as motives and conditions at the time of the crime, present mental condition, and amenability to treatment are addressed.

Identifying Information

- Name of person being examined
- Date of birth
- Court case number

Opening Statement to Include

- Ohio Revised Code Number Specifying Type of Evaluation
- Date of interview
- Charge of which convicted
- Place of interview
- Length of interview
- Information reviewed

Background Information

- Physical health
- Marital status
- Family relationship
- Work history
- Present or past mental health and/or mental retardation treatment
- Present or past use of psychotropic medications
- Prior criminal record

Mental Status

- Appearance
- Orientation
- Memory
- Mood
- Perceptions
- Thought
- Intellectual Capacity
- Mental status at the time of the alleged offense

Summary and Opinion

Dissemination of Reports

Written reports, with a transmittal letter from the Director of the Dayton Center, are submitted to the referral agency within 30 days from the date of the referral. The reports are forwarded only to the Court or Probation Department that referred the client, or to other court officials--prosecution and defense attorneys--when designated by the referring court. The court may, at its discretion, distribute the report but bears the responsibility for that distribution. No other agency receives records from the Dayton Center--except in emergency situations--without a signed release of information from the client or guardian.

Diagnoses and Recommendations

The Center seldom makes use of diagnoses in terms suggested in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM III). Nine out of ten evaluation reports make specific practical recommendations, including appropriate disposition, to the referral agent (see Program for the Study of Crime and Delinquency, Note 2, p. 29).

Program Monitoring, Quality Control, and Program Evaluation

Program evaluation of the Dayton Center, overall quality control and program monitoring is involved in three forms of activities: (1) management, routine administrative monitoring, and informal feedback to staff; (2) routine statistical reporting; and (3) special studies.

Management, Monitoring and Staff Feedback

Considerable direction and guidance for the overall operation of the Dayton Center is provided by administrative and operational standards. Administrative standards in such areas as the structure and design of community forensic centers, procedural aspects of mental health evaluations, and the appropriate stance of the Center with regard to its referral agencies have been established as an administrative rule (see Division of Forensic Psychiatry, Note 10) for implementing the requirements for Ohio's community forensic psychiatric centers. Procedural standards for the evaluation process of the Dayton Center are documented in a series of "procedural memoranda" to Dayton Center staff, and a procedural manual developed by the Association of Ohio Forensic Psychiatric Center Directors (see Note 9).

Procedural memoranda have been prepared in the areas of competency, not guilty by reason of insanity, presentence evaluation, factors involved in probation, definitions of terms such as "repeat offender" and "dangerous offender," conditional probation for drug treatment, treatment in lieu of conviction, mitigating circumstances, case and program consultation, advisability of treatment, and a number of treatment-related areas such as aftercare, the probate court, jail counseling, the outpatient treatment program, the Adult Parole Authority, and the Adult Probation Department. The procedural memoranda are typically no more than several pages in length, and discuss the purpose of the particular evaluation and treatment, who may order such services, and the reporting requirements. A Manual of the Ohio Forensic Psychiatric Centers (Note 9), developed by the association of Ohio Forensic Psychiatric Center Directors, is a 76-page document describing the historical development of forensic centers in Ohio, the goals of the centers, the court structure in Ohio, statutory referrals, guidelines for report writing, and other supplementary information.

The Ohio certification program, established by the Division of Forensic Psychiatry, set the minimum standards for the operation of Ohio's community forensic centers (see Appendix C, "Application for Certification). The certification process is established in administrative rule promulgated under the authority of the Ohio Revised Code. This rule (see Division of Forensic Psychiatry, Note 10) establishes policies regulating eligibility, allocation methods, payment schedules, accounting standards, financial report formats, and other accountability requirements for state funding to community agencies providing forensic mental health services to the courts of common pleas. This administrative rule defines certification as the approval given by the Division of Forensic Psychiatry to any agency meeting the criteria determined by the Division in order that that agency may provide the required forensic mental health services. "Forensic psychiatry services" are psychiatric and psychological evaluations, ordered by a common pleas criminal court, of either a defendant's present mental competence to stand trial or his sanity at the time of the offense. Other services, such as other types of evaluations, some outpatient mental health treatment, and emergency mental health intervention services to detention

centers, are also included in this definition of forensic psychiatry services and may be included if time and resources permit. Certification standards state that:

(a) A certified community forensic psychiatric center must be clearly identifiable as being either free-standing or a specifically designated subsection of a larger mental health facility.

(b) Services provided by a center must include at a minimum written evaluations by a qualified mental health professional for pretrial, presentence, and post-sentence clients referred by the court of common pleas, its probation department, and adult parole authority in the designated geographic area.

(c) Optimally, the community forensic centers should also provide services including treatment, diagnostic services to other court systems, training and liaison to both mental health and criminal justice agencies, research in forensic psychiatry issues, and public information.

(d) Staffing for community forensic psychiatric centers must include at least one full-time qualified mental health professional in an administrative and/or supervisory position; representation on staff of at least one qualified mental health professional; in accordance with the law, performance by a qualified mental health professional of all evaluations ordered by common pleas courts; performance of, or supervision and individual review by, a qualified mental health professional of all other evaluations.

(e) Each community forensic psychiatric center must perform and document at least 50 completed cases per year from adult criminal courts or probation or parole departments. Requests for evaluations from common pleas courts should take precedence in evaluation and reporting.

(f) Each community forensic center must prepare periodic reports.

Routine Statistical Reporting

In compliance with the rules and policies of the Ohio Department of Mental Health and Mental Retardation, Division of Forensic Psychiatry, the Dayton Center reports monthly statistics to the Bureau of Statistics on the following forms:

(a) Monthly Statistical Summary Report, Community Mental Health Facility;

(b) Forensic Psychiatry Admission Report (see Appendix D); and,

(c) Forensic Psychiatry Termination Report (see Appendix E).

Also, on a biennial basis, the Dayton Center reports routine statistics and responses relevant to certification standards on an application for certification (Appendix C).

The level of compliance with the administrative and operational standards set in the administrative rule, as well as the overall compliance with and reliance by the staff on the procedural memoranda, has not been formally assessed by the Dayton Center.

Special Studies

The only completed inquiry that may be described as "program evaluation" of the Dayton Center was conducted in 1974 as part of an evaluation research project conducted by Ohio State University Program for the Study of Crime and Deliquency. The purposes, methods, and results of this evaluation research project are documented in detail in a series of eight monographs (see Notes 1-8) and one book (Beran and Toomey, 1979).

One of the monographs prepared by the Ohio State group, entitled "An Evaluation of the Dayton Center for Forensic Psychiatry: An Experiment in Community-Based Services" (Note 2), presents the results of the Dayton Center evaluation. The stated purpose of the evaluation was to gather basic information on clients served at the Center along the following dimensions: demographic characteristics (sex, age, race, education, occupation, marital status, past criminal record, etc.); status within the criminal justice system (current charge, court status, prior juvenile and adult record); history of involvement in the mental health system; referral source and reason for referral; processing within the Dayton Center (type of evaluation, psychometric testing, psychiatric interviews, social case history); evaluation and recommendations of the center; and, court disposition. Data were gathered from files for 301 clients referred since the opening of the center, in October of 1972, whose cases were no longer active by June 15, 1974. For comparative purposes, similar data were gathered on a sample of first admission referrals to Lima State Hospital, a maximum security facility located in Lima, Ohio, from the same counties served by the Dayton Center from January 1, 1971, through June 30, 1974. Data were also gathered by means of extensive participant observation, interviews, and questionnaires administered to center staff, judges, and probation and parole officers. Although not explicitly stated, the aim of the evaluation was to compare and contrast the process and outcome of screening and evaluation conducted by Lima State Hospital and the Dayton Center.

Although the 1974 evaluation of the Dayton Center conducted by the Ohio State University Program for the Study of Crime and Delinquency may be flawed by some procedural problems (e.g., the evaluation may have been conducted by individuals who set out to prove that Lima State Hospital was inferior to the Dayton Center in its delivery of forensic mental health centers), it describes valuable measures, some of considerable comparative value for use in program evaluation strategies. The following is a partial listing of process and outcome measures utilized in the Ohio State evaluation of the Dayton Center:

- Perceptions of working relations among participants (judges, probation officers, Dayton Center staff, etc.) in the system.
- Perceptions of Dayton Center influence on criminal justice decisionmaking.
- Demographic characteristics of the Dayton Center sample, including sex, age, race, marital status, occupation, and education.
- Prior criminal record of defendants.
- Number of years incarcerated.
- Convictions by offense type and "currentness."
- History of mental health institutionalizations of clients, including civil residency and criminal residency.
- Reason for referral.
- Current court status of referred cases.
- Current offense.
- Type of psychometric testing conducted.
- Mean evaluation time in hours.
- Mean evalution time in hours for various types of evaluations.
- Types of diagnoses.
- Positive/negative evaluation results according to type of evaluation.
- Agreement between recommendations and court decisions according to type of evaluation.
- Recommendations according to type of evaluation.
- Type of court disposition.
- Mean number of days between referral and admission, admission and report, and report and disposition.
- Current offense according to age of defendant.
- Current offense according to race.
- Reason for referral according to current offense.

- Reason for referral according to criminal record.
- Current offense according to treatment received.
- Recommendation according to court decision.
- Professional staff time and costs in evaluation and treatment.
- Evaluation and treatment costs per day.
- Costs according to evaluation type.

THE SAN MATEO COUNTY (CALIFORNIA) MENTAL HEALTH COURTS AND CORRECTIONS UNIT

The Courts and Corrections Unit was established in 1961 as a criminal justice consultation service of the San Mateo County Mental Health Services Division. The Unit's offices originally were located in the adult probation department in Redwood City (the seat of the county government), seven miles from the city of San Mateo, where the other county mental health services had offices. The Unit still is located in Redwood City; however, it has moved into private offices apart from any particular department of the courts or corrections.

During most of its first decade of operation, the Courts and Corrections Unit's primary function was to provide "consultation" services for judges, probation officers, the sheriff's staff, and the District Attorney. The major services were as follows:

- evaluation of offenders or alleged offenders for recommendations concerning their disposition or management;
- consultation to the courts or corrections personnel regarding particular cases without the benefit direct contact with the offender or alleged offender involved;
- consultation with agency personnel regarding aspects of an agency's work not necessarily related to a particular case; and
- training for personnel of courts and corrections agencies having contact with offenders or alleged offenders.

One particularly interesting example of consultation was that provided to the county sheriff's department during the Republican National Convention in 1964. Anticipating friction between the forces supporting Senator Goldwater and a number of vigorous civil rights proponents, the sheriff arranged for a psychiatrist from the Courts and Corrections Unit to address a meeting of law enforcement personnel assigned to the convention. Arrangements also were made for the psychiatrist to attend the convention and be available for emergency consultation with the sheriff and his deputies. The psychiatrist's opinion was solicited with regard to a number of matters during the course of the convention.

During an especially volatile confrontation between police and demonstrators, the sheriff considered ordering the arrest of a number of demonstrators in an effort to dispel their defiance and mollify angry police officers as well. Before ordering the arrests, however, the sheriff called upon the consulting psychiatrist to review with him the issues relevant to the decision; as it transpired, no arrests were made.

Since the early 1970s, the primary mandate of the Courts and Corrections Unit has shifted from consultation to direct clinical service for jail inmates. The present director of the Unit suggests that this shift is a result of a number of factors, including a reduction in funding for the Unit and a broad movement to deinstitutionalize the mentally disordered: "The idea is that if everything else goes, we must continue to care for the acutely mentally ill; and with the deinstitutionalization movement, many people who previously would have been hospitalized now are in jail," he stated in an interview.

At this writing the Courts and Corrections Unit provides the following services:

- o clinical services for inmates of the San Mateo County jail;
- o court-requested evaluations to assess competency to stand trial and suitability for pretrial release;
- o coordination of the "1229 program" in the county (a program, named after a California Assembly Bill, determining the proper locus and plan of treatment for mentally disordered sex offenders and client-offenders found incompetent to stand trial or not guilty by reason of insanity); and
- o consultation services for staff of the county's probation department.

The Unit's staff consists of four full-time Ph.D. psychologists, one half-time psychiatrist, and two clerical staff. One psychologist is responsible for coordination of the 1229 program and probation consultation, and the rest of the staff provides jail clinical services and court-requested evaluations.

San Mateo County has a population of approximately 600,000. Its jail has an average daily population of 200.

Process Flow

The flow of cases into, through, and out of the Courts and Corrections Unit is illustrated in Figures 32-35.

Jail Services

Figure 32 indicates the manner in which jail inmates, believed to be in need of mental health services, are referred to and processed by the Courts and Corrections Unit.

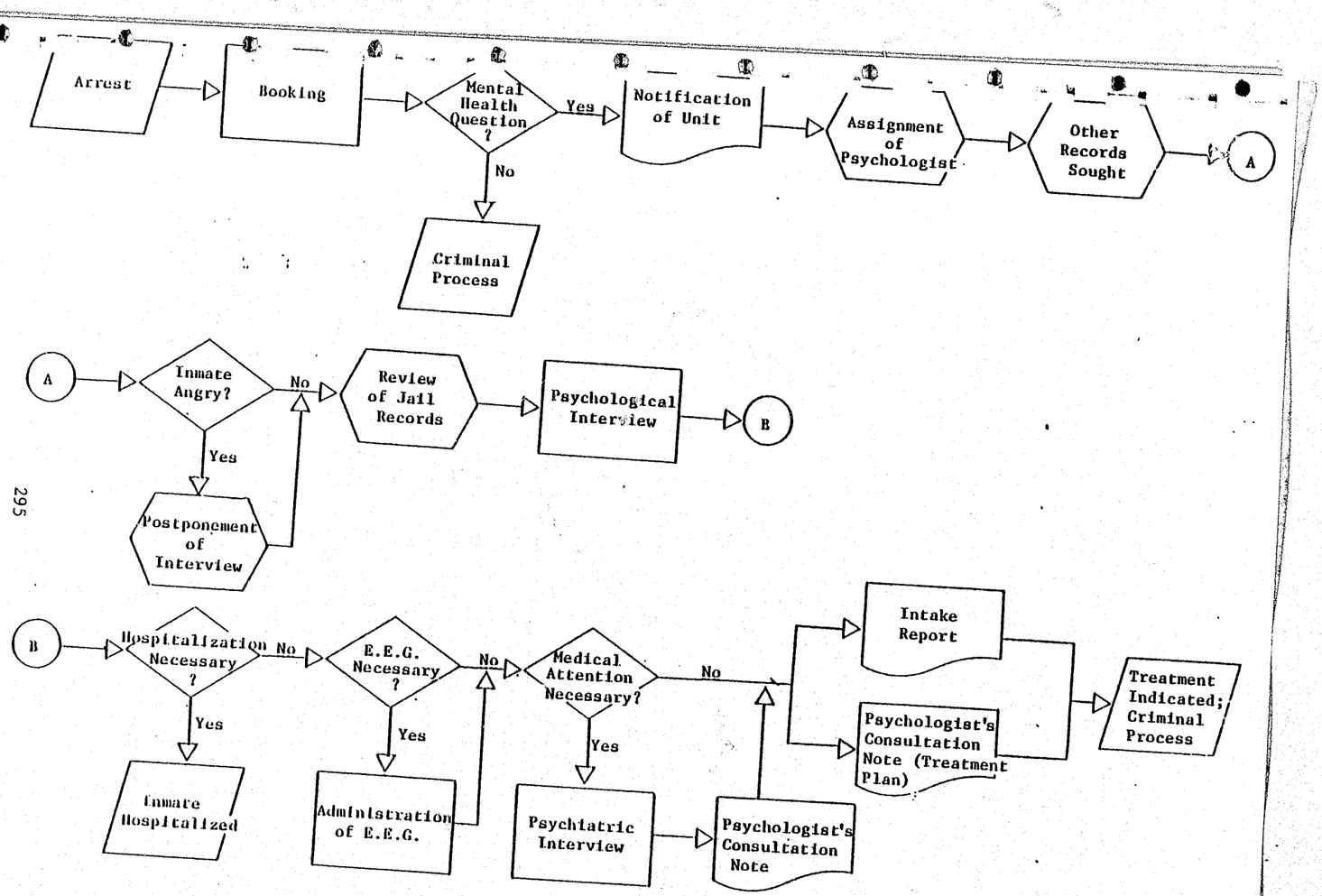


Figure 32. Process Flow of Jail Services Provided by the San Mateo Courts and Corrections Unit

When a person is arrested in San Mateo County, he is transported to the San Mateo County jail, where he is formally charged with a particular crime(s), "booked," and may be held pending arraignment. As part of the booking procedure, a police officer asks the person (hereinafter, the inmate) whether or not he or she has recently seen a physician or is taking medication. If the arresting or booking officer suspects that the inmate may be mentally or emotionally disordered, he may request a jail nurse to refer the inmate to the Courts and Corrections Unit. Further, if at any time during an inmate's period of incarceration a jail nurse has reason to believe that the inmate may require mental health services, the nurse may refer the inmate to the Unit.

The nurse makes the referral by a telephone call to the Unit's clerical staff. The clerical person obtains certain information from the nurse and assigns the case to the psychologist on call (the "officer of the day"). (One psychologist serves as officer of the day each day and is responsible for all cases referred that day.) The clerical person then telephones Chope Hospital (an area state hospital with a ward designed for corrections detainees) and the county probation department to determine whether other information is available on the inmate.

The psychologist ordinarily reports to the jail immediately. If the nurse indicates that the inmate is temporarily "angry," the visit may be delayed to allow time for the inmate to calm down. Upon arriving at the jail, the psychologist reviews the booking sheet, the medical chart (containing medical information obtained during booking), and the jail referral sheet (indicating the reasons for the referral) and speaks with jail personnel who have observed the inmate's behavior. The psychologist then conducts a clinical interview of the inmate. If the psychologist believes the inmate requires immediate hospitalization, he may order the inmate committed to Chope Hospital for up to 72 hours. If the psychologist believes neurological testing is needed, he may refer the inmate to Chope Hospital for an outpatient electroencephalogram. If the psychologist believes the inmate requires medication or other medical attention, he may arrange for the Courts and Corrections Unit's psychiatrist to examine the inmate. After his examination, the psychiatrist may make a consultation note on the inmate's medical chart recommending that the inmate receive medication. (Except in an emergency situation to prevent injury to the inmate, medication may not be administered involuntarily.)

Upon completion of his assessment of an inmate, the psychologist makes a consultation note on the medical chart (specifying a "treatment plan," if indicated) and prepares an "intake report." If the inmate is in need of treatment, copies of the intake report are sent to the jail medical staff and to Chope Hospital, which maintains records for the County Mental Health Services Division. If the inmate requires further attention, the psychologist may arrange for a follow-up visit.

Court-Requested Evaluations

Figure 33 indicates the manner in which the Court and Corrections Unit receives and processes court referrals for evaluation.

Only occasionally, a judge of the San Mateo County Municipal Court (or his clerk) will telephone the Unit and request that a particular defendant be evaluated. The staff person receiving the call obtains certain information from the judge or his clerk and arranges for assignment of the case to a staff psychologist (ordinarily the officer of the day). A clerical staff person telephones Chope Hospital and the county probation department to determine whether other information is available on the defendant. If the person is on pre- or post-trial release, the psychologist assigned to the case telephones the defense attorney to arrange for an interview appointment for the defendant at the Unit's offices.

The psychologist conducts a clinical interview (in the Unit's offices or in the jail) and reports his findings to the court. If the defendant is in jail, the psychologist also may provide certain "clinical" services, as described in section 3.1.1, above (i.e., hospitalization, referral for neurological testing or medical attention, treatment suggestions, and follow-up visits). The court may use the information provided by the psychologist in determining questions of pretrial release or deciding whether to transfer the case to the superior court for determination of the competency question.

The "1229" Program Coordination

In 1975, the California legislature passed Assembly Bill 1229, which amended sections of the Penal Code and the Welfare and Institutions Code to provide for a number of alternative mental health treatment modes (and enabling procedures) for persons found not guilty by reason of insanity, defendants found incompetent to stand trial, and mentally disordered sex offenders. The Courts and Corrections Unit evaluates each offender or alleged offender subject to the 1229 program in San Mateo County, recommends placement and a plan of treatment, and coordinates the treatment process. Figure 34 indicates the manner in which cases subject to the 1229 program are referred to and processed by the Courts and Corrections Unit.

Upon a verdict of not guilty by reason of insanity, a finding of incompetency to stand trial, or a sex offense conviction followed by a finding that the offender is a "mentally disordered sex offender" who would benefit by treatment, the San Mateo County Superior Court may order the offender or alleged offender evaluated by the Courts and Corrections Unit. The evaluation is mandatory for defendants found incompetent to stand trial. Offenders acquitted by reason of insanity may be found by the court to have recovered their sanity and thus not require evaluation by the Courts and Corrections Unit. (The Unit's evaluation does not address the question of recovered sanity.) With regard to mentally disordered sex offenders, the court in its discretion may either order an

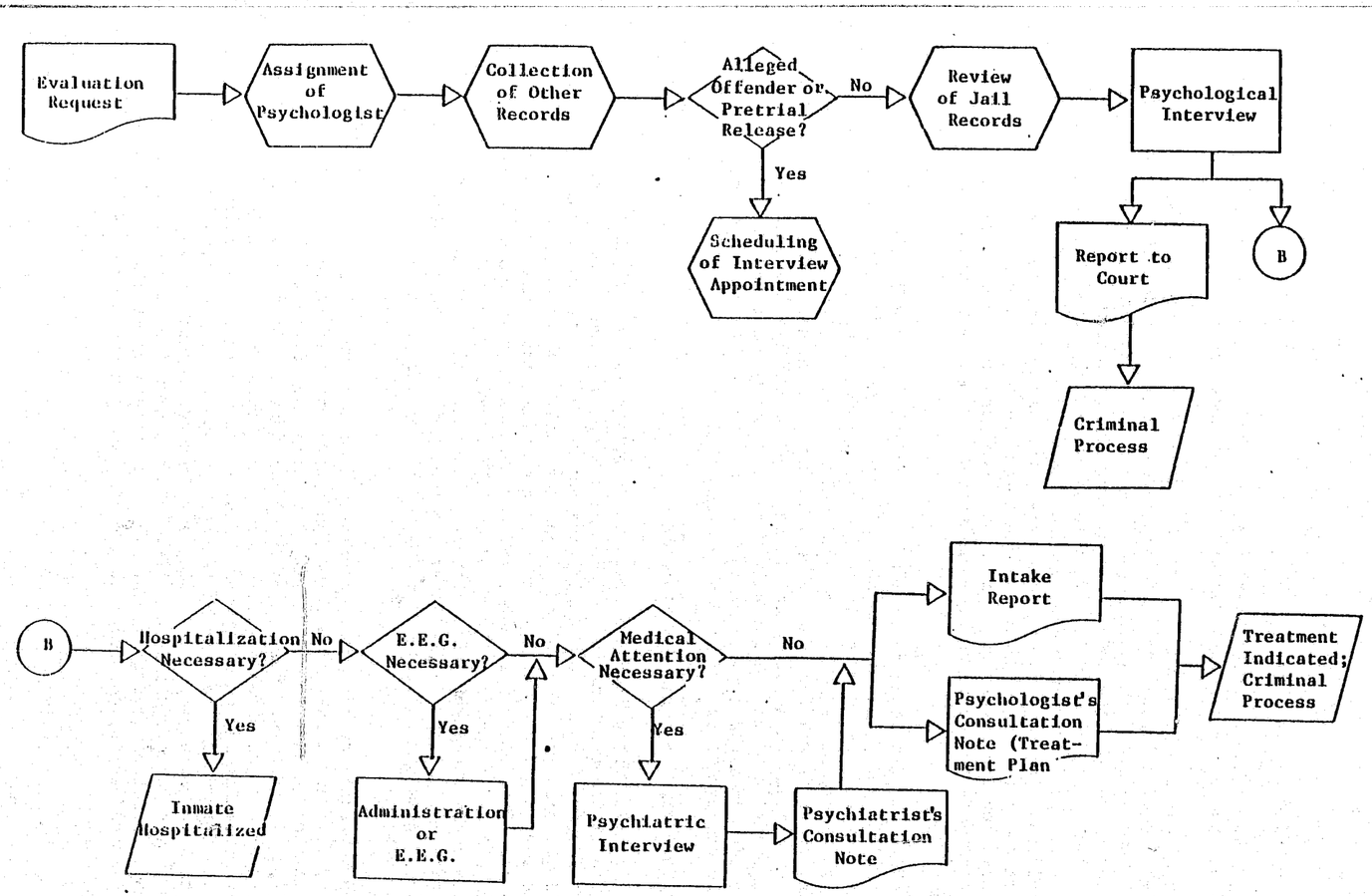


Figure 33. Process Flow of Court-requested Evaluations Conducted by the San Mateo Courts and Corrections Unit.

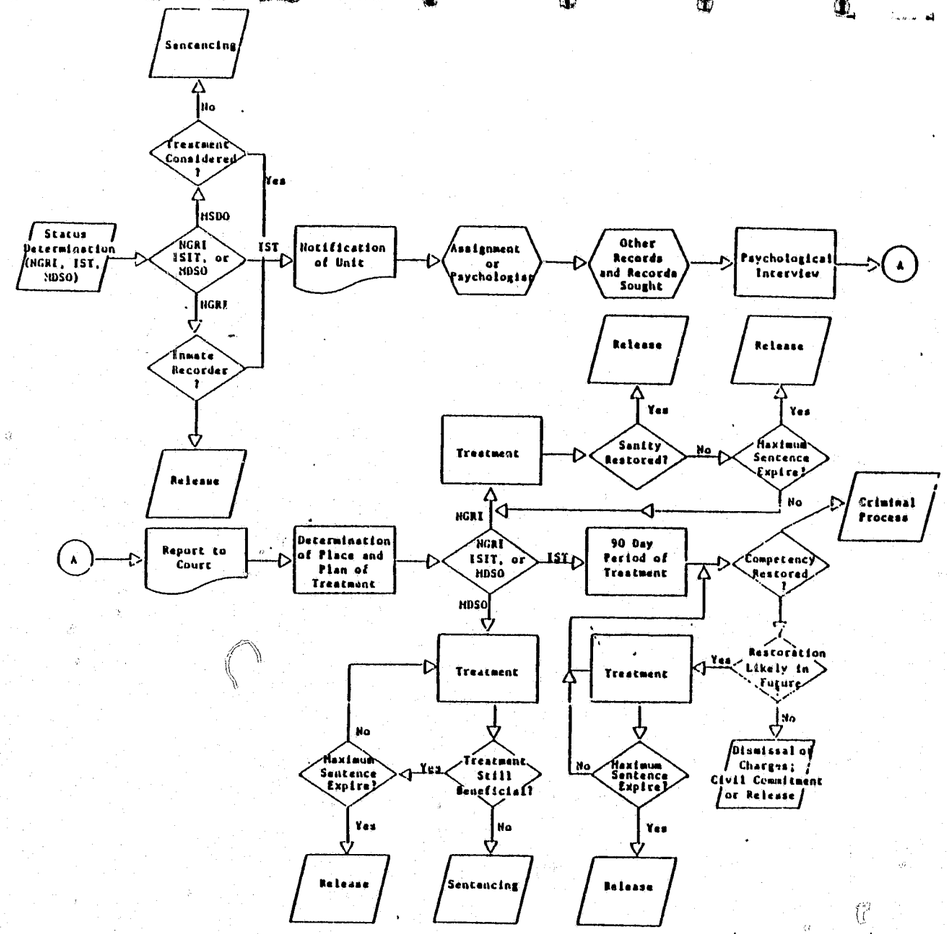


Figure 34. Process Flow of "1229" Cases Coordinated by the San Mateo Courts and Corrections Unit.

evaluation or dispose of the case in some other manner, but it may not order mental health treatment without first requiring an evaluation by the Courts and Corrections Unit. A Superior Court probation clerk telephones the referral to one of the Unit's clerical staff, who obtains certain information from the probation clerk and assigns the case to the Unit's psychologist responsible for coordinating the 1229 program. The probation clerk follows up the telephone call with a mailing of copies of the court order, the police report, any available probation reports, and psychiatrists' reports already prepared relative to examinations to assess criminal responsibility, competency to stand trial, or mentally disordered sex offender status.

If the client-offender is on pre- or post-trial release, the psychologist telephones the defense attorney to arrange an interview appointment at the Unit's offices. Unless a continuance is obtained, within 15 days of the order directing the evaluation the psychologist conducts a clinical interview with the client-offender (either in the Unit's office, in the jail, or at Chope Hospital if he is hospitalized) and submits a report to the court recommending placement and a plan of treatment. The court conducts a hearing to determine these issues. Except for persons charged with or convicted of certain specified violent crimes (who by law must be confined in a mental health facility for a minimum of 90 days before being released for outpatient treatment), client-offenders acquitted by reason of insanity, found incompetent to stand trial, or found to be mentally disordered sex offenders may be placed in outpatient treatment programs or may be confined in state or private hospitals.

Periodic reports are prepared by the agencies responsible for treatment pursuant to the 1229 program, and the Courts and Corrections Unit is responsible for ensuring that these reports are submitted to the court in a timely fashion. The Unit also may arrange for the transfer of a client-offender from in-patient to out-patient treatment status, based on information supplied by staff of the in-patient facility; however, the Unit ordinarily does not become involved in screening or evaluation of the client-offender after the initial placement and treatment plan assessment.

Persons acquitted by reason of insanity are released from treatment upon restoration of sanity and must be released from involuntary in-patient status before the expiration of the maximum period for which they could have been imprisoned if convicted.

Defendants found incompetent to stand trial typically are returned to court for trial upon restoration of competency. If at the end of a 90-day period of treatment the defendant has not recovered his competency but there is a substantial likelihood that competency will be restored in the foreseeable future, he will remain in treatment. If at the end of the 90-day period or at any subsequent time it is determined that there is no substantial likelihood of restoration of competency in the foreseeable future, the criminal charges usually are dismissed and civil commitment proceedings are initiated; if it appears to the court that the

defendant is "gravely disabled," conservatorship proceedings are initiated. The defendant must be released from treatment designed to restore competency before the expiration of the maximum period for which he could have been imprisoned had he been convicted.

Mentally disordered sex offenders remain in treatment for an indefinite period up to the maximum period of imprisonment provided by law for the offense. Upon a finding that the offender no longer is benefiting by treatment, he is returned to court for sentencing. Offenders determined no longer to be a danger to the health and safety of others may be placed on probation if probation otherwise is appropriate. The time an offender spends in treatment is credited to any sentence imposed.

Probation Consultation

The San Mateo County Probation Department serves the county's Superior Court and its Municipal Court. The Department regularly calls upon the Courts and Corrections Unit to conduct evaluations of persons on or being considered for probation. Figure 35 indicates the manner in which probation cases are referred to and processed by the Courts and Corrections Unit.

Prior to sentencing in all Superior Court and some Municipal Court cases, judges order the Probation Department to conduct presentence investigations of offenders. Probation officers often refer offenders to the Unit for mental health needs assessments and incorporate the information provided into presentence reports. Probation officers also occasionally refer offenders already on probation for evaluations to assess changes in treatment needs.

The probation officer assigned to a particular case accomplishes the referral by means of a telephone call or a personal visit to the Courts and Corrections psychologist responsible for probation consultation. (The psychologist maintains an office in the Probation Department suite in addition to his office in the Courts and Corrections Unit suite.) The psychologist obtains certain information from the probation officer and reviews the Probation Department's files on the case. If the offender is in jail, the psychologist conducts a clinical interview with the offender in the jail. If the offender is on presentence release or is on probation, the probation officer instructs the offender to telephone the psychologist to schedule an appointment in the psychologist's office.

Upon completion of the interview, the psychologist prepares a report summarizing his findings and submits it to the probation officer. If the probation file indicates that the court specifically requested a mental health evaluation as part of a presentence investigation, the psychologist ordinarily sends a copy of the report to the court.

The probation officer uses the presentence evaluation report in constructing a presentence report for the court. The court uses the

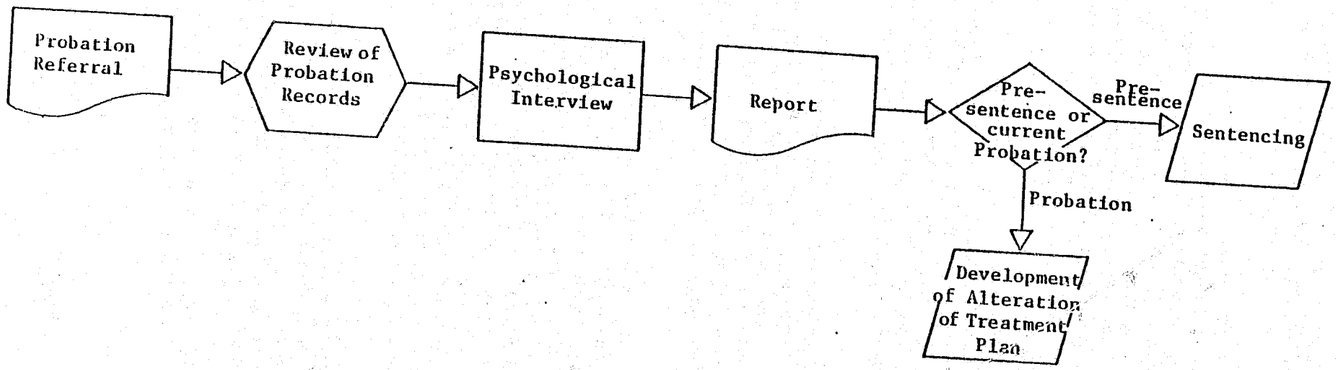


Figure 35. Process Flow of Probation Consultation Provided by the San Mateo Courts and Corrections Unit.

presentence report in determining an appropriate sentence for the offender. Evaluation reports for offenders on supervised probation are used by probation officers to develop or alter treatment plans for probationers.

Delineation of Mental Health Information Requirements

The Referral Source

The Unit receives referrals from the San Mateo County jail and from judges and probation officers of the San Mateo County Municipal and Superior Courts. The Municipal Court's criminal jurisdiction extends to all misdemeanors and to felony preliminary hearings. The Superior Court has criminal jurisdiction over felonies.

Jail Services

Referrals of jail inmates in need of clinical services are initiated by the jail nursing staff on its own accord or at the request of the arresting or booking officer or other jail personnel. Referrals are made by telephone call to a clerical staff person at the Courts and Corrections Unit. The clerical person collects the following information: date and time of referral, inmate's name and birthdate, name of the referring party, and reason for the referral. The clerical person then telephones Chope Hospital to request any mental health records that may be available on the inmate. (A staff psychologist at the Courts and Corrections Unit estimates that half of the jail inmates referred have records of previous treatment.) The Unit's clerical staff also checks the county probation department regarding the availability of records on the inmate, but the probation records are not sent unless the psychologist assigned to the case asks for them.

Before commencing the interview at the jail, the psychologist reviews the booking sheet (indicating limited biographical information and current charges), the medical chart (indicating current medications, physicians recently seen, limited medical and mental health history, and other medical information collected during booking or otherwise), and the jail referral sheet (indicating the reasons for the referral). Finally, prior to meeting with the inmate, the psychologist usually speaks with jail personnel who have observed the inmate.

Municipal Court-Requested Evaluations

Municipal court judges may request the Courts and Corrections Unit to evaluate defendants, either sua sponte or at the suggestion of the prosecution or the defense. The referral typically is made quite informally by the judge or his clerk in a telephone call to the Unit. According to the director of the Unit, the judge's question is usually a "fuzzy" one concerning the defendant's mental or emotional stability, treatment needs, and suitability for pretrial release. Occasionally, the judge will request an assessment of the defendant's competency to stand trial. A defendant is incompetent to stand trial if, "as a result of

mental disorder or developmental disability, he is unable to understand the nature of the proceedings against him and to assist counsel in the conduct of a defense in a rational manner" (California Penal Code, §1367). The competency evaluation amounts to a preliminary screening only, because the Municipal Court is powerless to determine the question of competency. (Should the Unit psychologist report that in his opinion the defendant is incompetent to stand trial, the Municipal Court judge transfers the case to the Superior Court for appointment of a private psychiatrist to assess competency.)

The telephone referral usually is received by a clerical staff person, although occasionally a staff psychologist will handle the call, particularly if the judge is calling personally. The staff person handling the call collects the following information: date and time of the referral; defendant's name and birthdate; defendant's present location; name of the defendant's attorney; name of the referring judge; reason for the referral; particular question posed (if applicable); and date by which the evaluation results are required. As with jail referrals, a clerical person telephones Chope Hospital to arrange for obtaining any mental health records of the defendant on file at the hospital, and the probation department is checked for information it may have on the defendant.

If the defendant is on pre- or post-trial release, the psychologist telephones the defense attorney to arrange an appointment with the defendant. In addition, the psychologist usually questions the attorney about the reasons for the referral. If the defendant is in jail, prior to commencing his evaluation the psychologist reviews the defendant's booking sheet and medical chart and may speak with jail personnel regarding the defendant's behavior in the jail.

The "1229" Program Coordination

California Penal Code §§1026 and 1370 and California Welfare and Institutions Code §6316 (all as amended by 1975 California Assembly Bill No. 1229), authorize evaluations by the Courts and Corrections Unit to assess the appropriate location and plan of treatment for persons found not guilty by reason of insanity or incompetent to stand trial and for mentally disordered sex offenders. As indicated above, Bill No. 1229 provides for a number of treatment alternatives (and enabling procedures) for these classes of offenders. Except for persons charged with or convicted of certain specified violent crimes, who by law must be confined in a mental health facility for a minimum of 90 days before being released for outpatient treatment, offenders or alleged offenders acquitted by reason of insanity or found incompetent to stand trial and mentally disordered sex offenders may be placed in outpatient treatment programs or may be confined in state hospitals for the care and treatment of the mentally disordered or in any other appropriate public or private mental health facilities. Because the only evaluative function of the Unit with respect to the 1229 program is the evaluation conducted prior to placement of the client-offender for treatment, the delineation aspects of only that function will be discussed in this section.

As indicated earlier, upon a verdict of not guilty by reason of insanity, a finding of incompetency to stand trial, or a sex offense conviction followed by a finding that the offender is a "mentally disordered sex offender" who would benefit by treatment, the court may order the client-offender evaluated by the Courts and Corrections Unit. A Superior Court probation clerk telephones the referral to one of the Unit's clerical staff, who collects the following information: date and time of the order and referral; client-offender's name, birthdate, legal status, and present location; name of the offender's attorney; name of the referring judge; and purpose of the evaluation (i.e., "to assess an appropriate locus and plan of treatment..."). Evaluations must be conducted and reports submitted to the court within 15 days of the evaluation order (unless a continuance is obtained). The probation clerk follows up the telephone call with a mailing of copies of the court order (specifying essentially the same information communicated in the telephone call); the police report (indicating the circumstances resulting in arrest); any available probation reports (generally containing a social history of the person); and psychiatrists' reports relative to examinations to assess criminal responsibility, competency to stand trial, or mentally disordered sex offender status. Further information about the client-offender's mental health or legal status is obtained from the defense attorney during the course of arranging an appointment for the evaluation (if the person is on release pending further disposition of his case) or from jail records and personnel (if the person is in jail).

Probation Consultation

The Courts and Corrections Unit may be called upon by officers of the San Mateo County Probation Department to evaluate offenders for whom presentence investigations have been ordered by the court or who are on supervised probation and show signs of requiring mental health treatment.

The referral process is quite informal, usually consisting of a telephone call or a personal visit by the probation officer to the Courts and Corrections Unit psychologist responsible for probation consultation. The probation officer summarizes the progress of the offender's court case, describes the offender's behavior, and indicates what information is needed. The psychologist makes a note of the date and time of the referral; the offender's name, birthdate, legal status, and present location; and the purpose of the evaluation. Prior to meeting with the offender, the psychologist reviews existing reports and records in the offender's probation file. These may include medical and mental histories, family and employment background information, and, occasionally, mental health evaluation reports prepared prior to trial.

Acquisition of Mental Health Information

The primary tool used by the courts and corrections staff to assess the mental orientation of offenders or alleged offenders is the personal clinical interview. In addition, 1229 evaluations and, to a lesser extent, probation evaluations rely heavily on mental health or

social information available in previously prepared psychiatrists' reports and probation records.

Courts and Corrections Unit psychologists are not bound to set guidelines in conducting clinical interviews. Assessments of the clinical needs of jail inmates focus on difficulties the inmates face in coping with jail life. Court-requested evaluations may focus on the defendant's cognitive functioning vis-a-vis the legal process (competency to stand trial) or his level of dangerousness in different situations (pretrial release risk). 1229 evaluations focus on the amenability of the client-offender to treatment in a community setting. Probation evaluations focus on the offender's treatment needs, generally.

The psychologist typically begins the interview by explaining the purpose of the evaluation and attempting to establish rapport. Since he need not adhere to an established interview protocol, the psychologist in his discretion may allow the client-offender to communicate with relative freedom or he may conduct a tightly controlled, question-and-answer interview. Areas of inquiry generally include the following:

- o family history;
- o medical and mental health history (including current medications or complaints);
- o arrest history;
- o alcohol and drug use; and
- o life functioning (sleeping and eating habits, etc.).

Every interview entails a mental status examination. Additionally, interviews to assess competency to stand trial generally include questioning with respect to the defendant's knowledge of the trial process (e.g., "what is the function of the prosecutor?" "what is the significance of a guilty plea?"). Psychological testing is almost never conducted. Interviews typically last about one hour.

If the psychologist desires psychiatric input (typically to assess medication needs), he may request the Unit's clerical staff to schedule the client-offender for an interview appointment with the consulting psychiatrist. The psychiatrist's interview consists essentially of a mental status examination and an assessment of medication needs. The psychiatrist reports his findings to the psychologist primarily responsible for the case and, in the case of jail inmates, may make a consultation note on the inmate's medical chart.

If he believes it necessary, the psychologist may refer the client-offender to Chope Hospital for an electroencephalogram. An appointment is scheduled by telephone, and the psychologist follows up the telephone call by mailing the hospital a copy of his preliminary report on the client-offender. A jail nurse arranges for the inmate to

be transported to the hospital by staff of the sheriff's department. Upon completion of testing, the hospital sends the results to the referring psychologist, who incorporates the information into his report.

Provision and Use of Mental Health Information

Jail Services

After interviewing a jail inmate, the courts and correction psychologist or psychiatrist makes a consultation note on the inmate's medical chart. The psychologist's note indicates the reason for the referral, a brief opinion concerning the inmate's mental or emotional condition, and a treatment plan, if appropriate. The treatment plan is oriented toward inmate maintenance. Traditional psychotherapy is not available in the jail. The treatment plan may recommend:

- o placement for the inmate in the jail's "medical tank" (which houses patients with medical or mental health problems or other weaknesses that render it prudent that they be segregated from the general jail population);
- o attendance at sessions held weekly in the jail by a rehabilitation counselor from the sheriff's office;
- o counseling by a San Mateo County Service League volunteer (volunteers act as "ventilators" for inmate's frustrations and assist with problems with living, i.e., helping inmates manage their community affairs);
- o periodic attention by the nursing staff (to monitor changes in the inmate's behavior); and
- o a schedule for subsequent visits by the psychologist to monitor the inmate's condition.

Psychiatrists' consultation notes present brief medical impressions and may contain medication recommendations for the jail medical staff.

In addition to the consultation note, the psychologist or psychiatrist prepares a two- to four-page report indicating:

- o inmate's name and age;
- o nature of offense charged;
- o reason for referral;
- o previous mental health history (only in psychologist's report);
- o observations and impressions;
- o clinical status; and,
- o treatment plan.

The reports are sent to the jail medical staff, and a copy of the psychiatrist's report is delivered to the psychologist primarily responsible for the inmate. A copy of the psychologist's report also is sent to Chope Hospital for inclusion in the County Mental Health Services Division records. Finally, each consultation with a particular jail inmate is recorded in that inmate's "patient activity record," which is kept in the Unit's files.

Municipal Court-Requested Evaluations

The results of court-requested evaluations may be reported quite informally over the telephone or more formally in a written report, depending on the formality of the request and the urgency with which the information is required. (Telephone reporting typically is used in urgent cases and in cases referred by telephone). Only the judge receives the psychologist's report. With regard to questions concerning the suitability of the defendant for pretrial release, the psychologist may describe the community support systems available to the defendant, render an opinion as to the dangerousness of the defendant in the community (opinion based primarily on past violence, taking into account whether the object of anger or violence is still in the community), and suggest conditions under which release might be safe. With regard to questions of competency to stand trial, the psychologist provides an opinion regarding the defendant's competency, noting whether he or she is able to understand the court process and cooperate with an attorney to conduct a rational defense.

If the judge finds that the defendant may be incompetent to stand trial, the case is transferred to the Superior Court for determination of the competency question. (Questions of competency to stand trial must be resolved in Superior Court, where a private psychiatrist is appointed to evaluate the defendant and a competency hearing is held.) Prior to transferring the case, however, Municipal Court judges typically conduct a hearing to establish probable cause for continuing to proceed against the defendant. In felony cases, this hearing serves as the preliminary hearing for certification of the case to the Superior Court. According to the director of the Courts and Corrections Unit, it is the position of the court that to hold a defendant without a probable cause determination is a greater evil than to conduct this "mini-trial" (preliminary hearing) of a possibly incompetent defendant.

The "1229" Program Coordination

Evaluations for placement of client-offenders under the 1229 program result in reports typically containing:

- a summary of the offender's legal status (including reason for referral);
- an account of the offender's mental health history, if any;

- an assessment of the offender's current mental status (including an opinion regarding the dangerousness of the offender to the community);
- a description of the offender's family and community support systems; and
- a recommendation concerning placement of the offender for treatment.

The report is submitted to the court and copies are sent to the defense attorney and the prosecutor. If outpatient treatment is recommended, the psychologist also submits a suggested treatment plan, which ordinarily is signed by the offender and the therapist proposed in the plan. Unless a continuance is obtained (i.e., to allow time to receive results of a neurological or psychiatric examination), the report is submitted within fifteen days after it was ordered by the court. The court uses the information provided in a hearing to determine the proper location and plan of treatment for the offender. The psychologist rarely is called to testify and his recommendations typically are adopted.

Offenders convicted of certain specified violent crimes, by law, must be confined in a mental health facility for a minimum of ninety days before being eligible for release to outpatient treatment. Particularly dangerous or psychotic offenders usually are sent to Atascadero State Hospital, a maximum security facility. Defendants found incompetent to stand trial are also frequently sent to Atascadero to benefit from the hospital's highly regarded competency restoration program (which includes the conduct of mock trials).

Probation Consultation

Evaluation reports in cases referred by probation officers present essentially the same type of information as that found in 1229 evaluation reports, discussed immediately above. The overarching concerns are the dangerousness of the offender to the community and his treatment needs, generally. If the psychologist suggests local, outpatient treatment, he will name treatment programs and agencies that provide the type of services the inmate requires. Additionally, the psychologist often arranges an intake appointment for the offender with the program or agency. The psychologist's report is delivered to the probation officer requesting it and, if the evaluation was ordered by the court, a copy of the report is sent to the court. As indicated above, the probation officer incorporates the presentence evaluation report into his presentence report for the court, and the court uses this report in determining an appropriate sentence for the offender. Probation officers use evaluation reports on probationers to develop or alter treatment plans.

Feedback, Monitoring, and Evaluation

There is no major program evaluation mechanism functioning in the Courts and Corrections Unit. However, a number of the Unit's activities serve to monitor operations and to provide a measure of quality assurance.

As indicated previously, the Unit's offices are located in a small suite independent of any branch of courts or corrections. Because of the small size of the staff and the informal working environment maintained, staff contact is frequent and congenial. The three psychologists who provide clinical services for jail inmates meet weekly with a jail nurse and a sheriff's deputy assigned to jail custody to discuss matters of case management for each inmate evaluated by the Unit during the previous week. The special needs of particular inmates are discussed, and plans for attending to these needs in the jail setting are formulated. These meetings enable the judgment of the psychologist primarily responsible for a particular case to be supplemented by those of other Unit professionals. In addition, the meetings serve as a forum for the exploration of effective methods for providing clinical and case management services.

There are no policy and procedures manuals or other written guidelines for use by the Unit's staff. While the director of the Unit acknowledges the utility of such devices in the management of an operation such as his, he opines that the professionalism of his staff combined with their frequent interrelationship and shared experience results in a service delivery of consistent quality.

The Courts and Corrections Unit is accountable to the San Mateo County Mental Services Division. Extensive information relating to the workload of the Unit and its staff is collected and entered into the county's Management Information System for Mental Health Services. The Unit receives monthly printouts indicating the number of hours each Unit professional spent performing a number of different services, including intake interviews, case conferences (with jail nurses, attorneys, etc.), individual therapy (follow-up consultation with client-offenders), and medical consultation. In addition, a monthly "assigned therapist roster" printout is received indicating this information with respect to each case serviced by a Unit staff member during the period. The director of the Unit uses this information in assessing the caseload capacity of the Unit and the productivity of its staff.

In addition to the informal feedback routinely received from judges, prosecutors, defense attorneys, probation officers, and jail personnel, the director of the Unit noted that the Unit's operation had been the subject of evaluations and reviews on a few occasions in the past. The Community Services Coordinator for the County Mental Health Services Division recently conducted a study that included a survey of consumers of the Unit's services; however, no report or other information concerning the study was available. A research team representing the state of California was said recently to have been engaged in a review of

all mental health consultation services in the state, including the Courts and Corrections Unit, but again no other information was available. Periodically, San Mateo County publishes a "county plan" in which the operations and activities of the Courts and Corrections Unit are summarized.

Finally, staff of the Courts and Corrections Unit on a number of occasions in the past have conducted studies and published papers, journal articles, and other writings relating, often in evaluative terms, to the work of the Unit. Among these are the following:

- "A Mental Health Courts and Corrections Unit" (McDonough, 1969), a journal article describing a survey of all users and potential users of the Unit's services in which the users' impressions of what services the unit offered are compared with what services the unit actually offered;

- "The Quality Control of Community Caretakers: A Study of Mental Health Screening in a Sheriff's Office" (McDonough and Monahan, 1975), a journal article describing the results of a study in which applicants for law enforcement jobs were subjected to a psychological test battery administered by Unit psychologists and in which subsequent performance on the job was matched to test results;

- "The Criminalization of Mentally Disordered Behavior: Possible Side Effects of a New Mental Health Law" (Abramson, 1972), a journal article in which the argument is made that a new law in California making the criteria for involuntary civil commitment more stringent was acting to divert many mentally ill persons into jails and prisons; and,

- "The Psychiatrization of Criminal Behavior: A Reply" (Monahan, 1973), a journal article rebutting the arguments presented in the article noted immediately above.

It should be noted in concluding this section that the above description of program evaluation efforts is not meant to be a critical review but rather is intended to highlight measurement points, measures, and variables that may prove to have future utility in constructing forensic program evaluation studies.

FORENSIC UNIT OF THE BARREN RIVER MENTAL HEALTH-MENTAL RETARDATION BOARD (BOWLING GREEN, KENTUCKY)

History and Overview of the Forensic Unit

The Forensic Unit provides a wide range of mental health evaluation services to the local courts and jails, mainly in Bowling Green, Kentucky. Most activity, however, is screening defendants for possible incompetency to stand trial. Funding for the Forensic Unit ended in January 1980, and the Unit has greatly reduced its services.

CONTINUED

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Although written in the present tense, this report describes the program as it existed before 1980, and it briefly describes how funding problems have affected the Unit's operations.

Bowling Green is a city of 40,000 in western Kentucky, 115 miles south of Louisville and 65 miles north of Nashville. It is the fifth largest city in Kentucky and is the market town for a large number of farm communities. The city is the county seat of Warren County, which comprises the 8th Judicial Circuit. The circuit has two courts, a Circuit Court (general jurisdiction) and a District Court (limited jurisdiction).

Forensic mental health services for Kentucky courts are generally provided by the Grauman Forensic Psychiatric Unit, a state inpatient facility in Louisville. The Warren County courts, however, have long used other services. The Kentucky Department of Mental Health operated a forensic unit in Bowling Green from 1972 to 1974 under a Law Enforcement Assistance Administration (LEAA) grant, but this was closed after a reorganization of the Department of Mental Health. Some requests for psychiatric evaluations then went to the Barren River Comprehensive Care Center, which is an agency of the Barren River Mental Health-Mental Retardation Board, the local community mental health center. The Board in 1975 submitted a grant application to the Kentucky Crime Commission, the state criminal justice planning agency, requesting $130,000 for a forensic program in the Comprehensive Care Center. More than a year later, in January 1977, the Crime Commission awarded a grant, but gave only $60,000 for the first year. The second phase, called "Community-Based Forensic Psychology," received $49,000 from the Crime Commission; and the final phase, "Community Based Forensic Unit," with $40,200, ended on January 14, 1980. And that was the end of the LEAA funding, although the Comprehensive Care Center still performs some forensic services.

Goals of the Forensic Unit

The major goals of the Unit, as given in a brief report it has distributed, are

- to provide diagnostic services and individual prescriptive case planning for juvenile and adult offenders and their families;
- to provide outpatient counseling, referrals to other agencies, and crisis intervention with criminal offenders and their families; and
- to provide consultation to the courts, state and federal parole boards and probation and parole officers, jail officials, and attorneys at any point during the judicial-penal process that will aid in formulating appropriate disposition of the alleged offender and working with his family.

These goals are very comprehensive. They encompass both juvenile and adult proceedings. (However, only the adult portion, which comprises the bulk of the Unit's caseload, will be described in this report.) The services can occur at almost any point in the criminal process, from jail admission to sentencing. The Unit seeks both to screen and treat defendants, and even seeks to treat the defendant's family. The most frequent Forensic Unit service, however, is the forensic evaluation for competency to stand trial.

Forensic Unit Staff

When the Unit was created, early in 1977, three individuals were hired: a psychiatrist, an MA-level psychologist, and a social worker who is a college graduate. All were assigned full time to the Unit. Their salaries were paid out of LEAA funds, while other project expenses (the project secretary, project evaluation, and administration) were funded by local match money. The psychiatrist originally hired left after six months. The project had trouble obtaining another psychiatrist; so the medical director of the Comprehensive Care Center, a psychiatrist, was assigned to the project, but only for 30 percent of his time. Midway through the project, the original psychologist was replaced with a Ph.D.-level psychologist, who, in turn, left when the grant terminated. The same social worker continued through all three years of the project.

Organizational Setting and Court System

The Forensic Unit is part of the Barren River Comprehensive Care Center, which in turn is under the Barren River Mental Health-Mental Retardation Board, one of fifteen community mental health organizations that encompass Kentucky. The Boards were created in the late 1960's under the impetus of substantial federal aid. The Barren River Mental Health-Mental Retardation Board is a private, nonprofit organization, but it is heavily regulated by the state government. It serves Warren County (Bowling Green) and nine rural counties, with a total population of about 200,000. The comprehensive care center has two substantial buildings in Bowling Green and nine smaller offices with some five to ten persons in the other counties. The professional staff consists largely of social workers and psychologists; additionally, there is one full-time psychiatrist, who provides limited clinical services for the Board's Comprehensive Care Centers in Bowling Green, Franklin, Scottsville, Munfordville, Brownsville, and Morgantown, and one part-time psychiatrist, who serves the Centers in Glasgow, Edmonton, Tompkinsville, and Russellville.

The Forensic Unit serves all ten counties in the service area of the Barren River Mental Health-Mental Retardation Board. However, its activity is concentrated in Bowling Green, primarily because it does not have enough staff to permit extensive traveling to the outlying counties.

Since 1978, Kentucky has had only two trial courts. The District Court has jurisdiction over juvenile cases, probate matters, civil commitment proceedings, civil cases involving $1,500 or less, and

misdemeanor cases. Misdemeanors are crimes punished by no more than 12 months in jail and for a fine not to exceed $500. The Circuit Court is the major trial court, with jurisdiction over felonies and major civil cases. The Circuit Court refers many more cases to the Forensic Unit than the District Court.

The Barren River service area includes all or parts of seven court circuits. Each circuit has one circuit and one district judge, except that the 8th Judicial Circuit in Warren County has two of each. The volume of criminal cases in Warren County is very high for its population; local residents attribute the volume to the large transient population resulting from two major north-south highways that pass through the county.

Process Flow

Figure 36 shows the Unit's process for court-ordered mental examinations. This section also summarizes the Unit's treatment programs for defendants and parolees. As noted previously, the procedures described here are those existing before the Unit curtailed its services in January 1980.

The court-ordered mental examinations are examinations to assess both competency to stand trial and criminal responsibility at the time of the offense. The court routinely orders mental examinations when requested by defense counsel and not objected to by the prosecutor. In the few times when the prosecutor objects, the court holds a brief hearing to determine whether to order an examination. A court order is prepared, and the Forensic Unit's secretary schedules interviews for the defendant with the Unit's social worker, psychologist, and psychiatrist. The social worker writes a social history, interviews the defendant, and administers a Minnesota Multiphasic Personality Inventory (MMPI). She sends the report and the test results to the psychologist; he then interviews the defendant and conducts further tests. He also prepares a report, which is sent to the psychiatrist along with the social worker's report and all test results. After reviewing this material, the psychiatrist interviews the defendant and, in some cases, investigates the facts further by obtaining hospital reports or interviewing parents and others. The psychiatrist writes a report for the court, usually recommending that the defendant be found competent and sane. He usually also includes treatment recommendations, which are often used during the sentencing phase of the case.

Treatment Screening

The Forensic Unit has an important treatment aspect that is intertwined with the mental examination function just outlined. The screening for treatment, which will be described more fully in the next section, falls into three categories. (1) The Unit handles emergency referrals from the jail quickly to screen and treat inmates whom the jailors believe to be mentally ill. (2) Defendants examined for competency are also screened for mental problems that might require

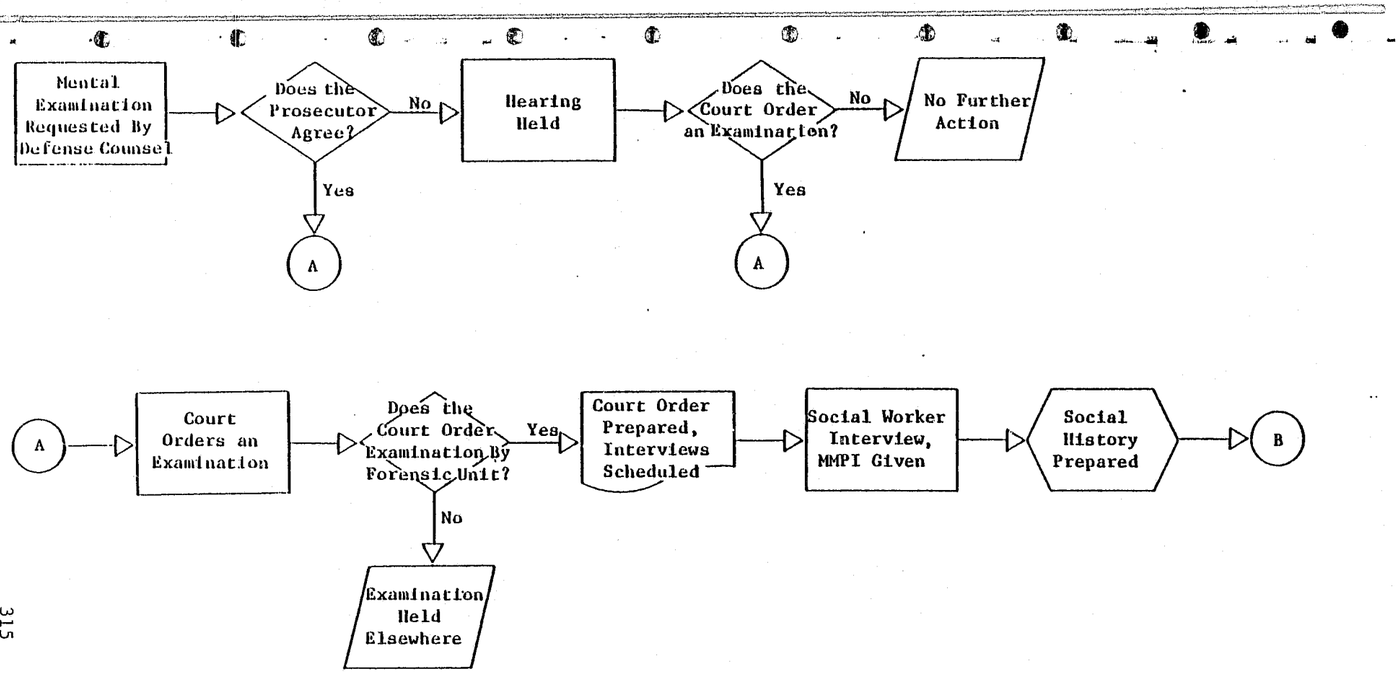


Figure 36. Barren River Forensic Unit.

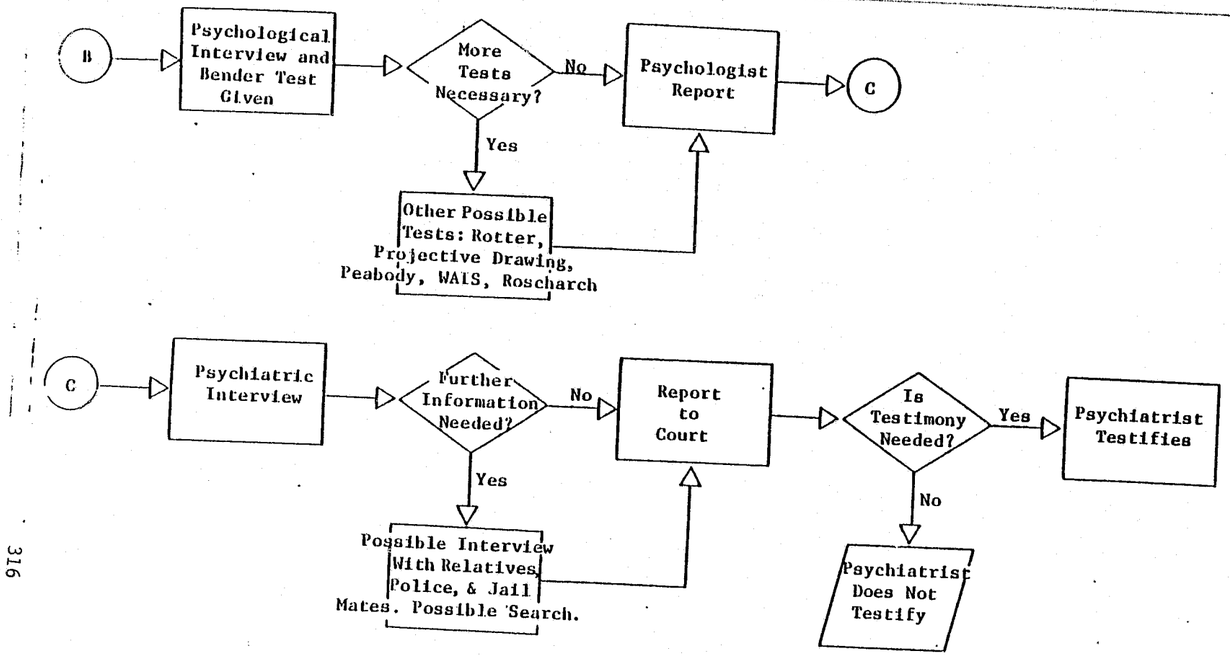


Figure 36. (Continued) Barren River Forensic Unit.

treatment by the Unit's psychiatrist or psychologist. Also, the Unit makes an effort to contact and treat the defendant's close relatives who might have mental problems, especially problems caused by the defendant's arrest. (3) The state and the federal parole offices refer a few parolees to the Unit for counseling.

Delineation of Mental Health Information Requirements

This section will describe the initial steps in the Unit's competency and sanity examination and all steps in the treatment screening. These two types of services involve different referral sources. Mental examinations are made pursuant to court order. Treatment screening involves inmates referred by the county jail, defendants undergoing mental evaluations, and parolees referred by the state or federal parole offices.

Court Referrals

The Forensic Unit receives only about 50 referrals per year for court-ordered forensic examination. Most referrals are from the Warren Circuit Court; only a few come from the nine outlying counties within the Unit's jurisdiction. This description, therefore, will focus on Warren County cases and will only mention the basic differences in procedures used for referrals from other counties.

In Warren County, the source of most referrals, the question of incompetency to stand trial or not guilty by reason of insanity typically arises at the arraignment hearing. The description here will be limited to this process, although the issues can be raised at later stages and by others than defense counsel. The preliminary hearing is held soon after the defendant has been indicted by the grand jury, and is the first time the defendant appears in court. The purpose of the arraignment is to advise the defendant of his rights and the charge against him, to appoint an attorney if the defendant is indigent, and to schedule further proceedings in the case. Public defenders typically have a few minutes to talk with prospective clients just before the arraignment hearing. In this initial conversation, before he is appointed, the attorney sometimes decides that the defendant's demeanor indicates a mental problem. When this happens, the attorney, several minutes later at the arraignment hearing recommends to the judge that the defendant be given a mental examination. The request is made by a court form, which is filled out by either the attorney or the court staff.

The request for a mental examination is routinely granted by the judge if the commonwealth attorney agrees. In the rare case where the commonwealth attorney contests the request, the judge holds a hearing to determine whether to order a mental examination. The Forensic Unit staff believe that the bulk of referrals do not present substantial issues of incompetency or insanity. Public defenders, in the staff's opinion, frequently realize that the defendant is not incompetent or insane but request an examination because they hope it will uncover mitigating circumstances useful during sentencing.

The judge may order an examination either in the Barren River Forensic Unit or in the Grauman Unit of Forensic Psychiatry in Louisville. The judge routinely specifies the unit recommended by the defense. In a few cases the commonwealth attorney disagrees with the defense's recommendation and a hearing is required. If the defense counsel does not make a recommendation, the judge generally orders the examination held in the local Forensic Unit. The Unit, in fact, performs the great majority of mental examinations for the Warren County Courts. (Since the termination of the Forensic Unit's grant in January 1980, however, more cases have been sent to the Grauman Unit. The Forensic Unit informed the court in May 1980 that it could no longer accept referrals, leaving the court with no choice but to use Grauman.)

The court promptly orders the examination. It has developed separate standard forms for referrals to the local Forensic Unit and to the Grauman Unit (Appendix F). Both forms state that the defendant must "be examined to determine if he is competent to stand trial and to determine his capacity to appreciate the nature and scope of his conduct or to conform his conduct to the requirement of the law." The order gives the name of the case, the crimes charged, and the date when the defendant is scheduled to appear again in court. The printed words on the form are never changed; hence both competency and sanity issues are always ordered. (This form, of course, only applies to referrals from the Warren County courts; referrals from other courts often request only the incompetency examination.)

Screening for Treatment

The Forensic Unit's treatment component necessarily involves screening to determine whether the person needs treatment and the type of treatment to be given. The Unit treats three types of clients: (1) mentally ill inmates, (2) defendants awaiting trial and their families, and (3) parolees.

Emergency screening of inmates. Inmates are by far the largest category of treatment clients. The county jail has a capacity of 150 inmates. About once per week jail personnel telephone the Forensic Unit about an inmate who seems mentally ill, for example because he or she threatens suicide or is showing bizarre behavior. Sometimes the Unit's social worker responds to the call, interviews the inmate, and determines whether a psychiatrist or psychologist is needed. At other times the psychiatrist or the psychologist responds and interviews the inmate. There are several possible outcomes of the interviews. The jailor might be told that the inmate is normal (e.g., that he is only attempting to obtain drugs). The Forensic Unit initiates civil commitment procedures in a few cases where the prisoner seems drastically ill, especially if the crime charged is minor. The psychiatrist often tells the public defender's office that defense counsel, when appointed, should present the mental status question and evoke ordinary forensic examination procedures that follow a court order. The psychiatrist might prescribe drugs, and the psychologist might give the defendant "across-the-bars" therapy (i.e., counseling sessions in jail).

Treating defendants and relatives. The next category of treatment occurs after the court has referred a defendant for a mental examination. There are two general types of treatment given. First, the psychiatrist often administers medicine to mentally ill defendants. The social worker refers some defendants to the psychiatrist for immediate treatment after her intake interview, and the psychiatrist may prescribe medicine upon noticing mental problems during the regularly scheduled mental examination interview.

Second, the Forensic Unit attempts, during the mental examination process, to determine whether the defendant or any of his relatives need and desire counseling or psychological therapy. During the initial interview with the defendant the social worker asks whether he or she has any relatives nearby and would object to the Forensic Unit's contacting them. Many defendants, especially transients, do not have relatives nearby; and others sometimes do not want the Unit to contact relatives. Otherwise, a letter is sent to close relatives encouraging them to contact the Unit for counseling services. Also, the Unit encourages defendants to enter therapy and it sends defendants a letter to that effect after a mental examination.

The psychologist conducts most therapy given defendants or family members. If the defendant seems particularly disturbed, the psychologist recommends counseling treatment and then provides it if the defendant consents. The psychologist also provides, free of charge, therapy to relatives desiring counseling.

Parolee counseling. State and federal parole offices occasionally refer parolees to the Forensic Unit for counseling. Many of these referrals had been referred to the Unit sometime earlier for mental examinations; others are parolees whom parole officers believe may have mental problems. The social worker prepares a social history for parolee referrals. The social history is the same as that prepared during mental examinations. The social worker prepares a social history even when the Unit had prepared one earlier, because there were probably many changes during the intervening period.

The psychologist determines whether and what treatment is needed. Some parolees are referred to other services, such as specialized alcohol or drug programs in the Comprehensive Care Center. The Forensic Unit psychologist provides individual or family therapy when needed.

Acquisition of Mental Health Information

In this section and in following sections, the discussion returns to the mental examinations to determine competency and sanity. This can precede, follow, or occur independently of the treatment screening discussed above.

Scheduling and Location of Interviews

Within 24 hours after the court order for mental examinations is prepared, the Circuit Court Administrator telephones the forensic center named in the order. If it is the Grauman Unit, the case may be placed on the waiting list until room is available; there is usually a delay of one or two months after the phone call before the defendant can be seen. The court administrator mails the order, together with a packet of forms required by the Unit. The forms total about 15 pages and contain extensive information about the defendant. The defendant is transported to and from Grauman by a deputy sheriff. He or she usually remains three or four weeks; when the examinations are completed, the Unit phones the court administrator, and an order is prepared for the defendant's return to the local jail. The whole process, therefore, takes two or three months, at least twice as long as the mental examinations in the Barren River Forensic Unit.

If the case is sent to the Forensic Unit, the court administrator telephones the Unit's secretary. While talking with the court administrator, she schedules appointments with the Unit's social worker, psychologist, and psychiatrist. She schedules the meetings about a week apart, usually on Mondays or Wednesdays, beginning with the social worker's next available free time period on a Monday or Wednesday. The social worker gives forensic cases priority over all other work, so her meetings are scheduled fairly soon—from one to seven days—after the call. The psychologist's meeting is usually scheduled seven days after the social worker's meeting, and the psychiatrist's seven days after that. This schedule is condensed considerably if more speed is necessary, for example, when the defense does not request a forensic examination until a few days before the trial date.

The secretary notes the dates and times of the meetings in the three professionals' appointment books. The court administrator places these dates and times on the court order and sends the order to the Forensic Unit. Copies of the order are sent to the defense attorney, the prosecutor, and the jailer if the defendant is in custody. If the defendant is in the Warren County Jail, the interviews are held there in a room specially prepared for that purpose. About a quarter of the interviews are held in the Comprehensive Care Center (where the three professionals have their offices) because the defendant is out on bond or is in jail in another county.

(Procedures in the Forensic Unit's first year were quite different in two major respects. First, the forensic examinations were scheduled to be completed within two days; however, the staff found it difficult to complete all the tests so quickly. Second, all examinations were held in the Comprehensive Care Center. A deputy sheriff transported the defendant to the Center and waited while the examinations were conducted. But this caused several problems: it required much personnel time from the sheriff's office; handcuffed defendants were not considered a favored sight at the Center; and in November 1978 a defendant escaped from the Center while waiting for a forensic examination. Soon after the escape, the Forensic Unit began to examine jailed defendants at the jail.)

Social Worker's Interview

The first stage of the screening process is the social worker's interview. If the case comes from the Warren County Circuit Court, the social worker is on the Forensic Unit staff. If the case comes from another court in the Unit's jurisdiction, a social worker in the outlying office of the Comprehensive Care Center does the initial interviewing. (The defendant is usually transported to the Forensic Unit for interviews with the psychologist and psychiatrist.) The following paragraphs will describe only the procedures used for Warren County defendants, who constitute the great bulk of Forensic Unit clients.

The social worker begins the interview with no information about the defendant other than that contained in the court order. During the interview she conducts an intake evaluation of the defendant, and she administers the Minnesota Multiphasic Personality Inventory (MMPI).

The intake evaluation entails filling out six forms that are used for all intakes at the Comprehensive Care Center. Most of the forms are straightforward, requiring the client to give his address, to waive objection to treatment, and to authorize release of information about prior treatment. The exception is a four-page Psycho-Social Evaluation form (see Appendix G). The social worker interviews the client for one or two hours while completing this form, exploring in detail matters concerning the client's prior legal involvement. Also, she attempts to obtain from defendants complete accounts of their involvement in the crimes charged. The social worker then prepares a social history report. The report is sent to the psychologist to read before his meeting with the client, a week or so later.

The MMPI test (the first 399 questions) takes one to one-and-a-half hours to complete. Defendants on pretrial release take the test in a spare room at the Comprehensive Care Center. Inmates take it in jail following the interview with the social worker, and she picks up the completed test on her next trip to the jail. The MMPI is usually received and scored (by volunteers manning the crisis-line phone) in time for the psychologist to interpret it before he meets with the defendant. The social worker does not incorporate the results in her report. The MMPI is not given to about 20 percent of the defendants because they cannot read. The social worker determines if defendants can read by asking them to read out loud the first five questions. (At one time illiterates were given a short version of the MMPI, with the questions read by the social worker, but this was abandoned because the results were not considered helpful.)

Psychological Interview

The next stage in the evaluation, the psychologist's interview, is typically a week or so after the social worker's interview. Like the social worker's intake evaluation, the psychological evaluation is essentially the same as that given all clients of the Comprehensive Care Center, except that the defendants are asked to describe in some detail their accounts of the crimes charged.

The information available to the psychologist before his interview consists of the court order, the social history and intake form forwarded by the social worker, and usually the MMPI. The psychologist spends about 2 1/2 hours with the defendant. There are three major phases of the interview:

1. The mental status examination. This examination consists of general conversation with the defendant, during which the psychologist observes the defendant closely and decides what steps to take later in the interview. The psychologist looks for such things as loose associations in speech, inappropriate affect (e.g., laughing or crying at inappropriate times), resistance to psychology and lack of cooperation, the client's personal hygene, and neatness of dress.

2. The defendant's account of the crime. The psychologist asks the defendant to describe the circumstances that led to the arrest. (The psychologist also makes certain that the client is aware of his rights, in order to ensure informed consent.)

3. Psychological tests. The last portion of the interview consists of a battery of tests administered by the psychologist. Some tests are administered to all or almost all defendants, while others are given only if the psychologist suspects certain problems, such as organic brain damage. The MMPI, as described above, is given by the social worker to all literate defendants. Other tests may be given:

   -Bender Gestalt Test (given routinely by the psychologist);

   -Rotter Incomplete Sentence Blank Test (given in most cases by the psychologist at his discretion);

   -Draw a Person-House-Tree Test (again, given in most cases by the psychologist, at his discretion);

   -Peabody Test (short test for IQ; used at discretion of psychologist if there are questions about whether a defendant is mentally retarded);

   -Wechsler Adult Intelligence Scale (used rarely, when there is question about the defendant's intelligence); and

   -Rorschach (used rarely to help determine if the client is malingering).

The psychologist's report, placed on form (see Appendix H), is usually about three pages long. The report is written for the psychiatrist and goes only to him, although it remains in the defendant's file. The report contains a summary of the social history gathered by

the social worker, the defendant's account of the crime, the test results and their interpretation, a summary and recommendation, and the psychologist's "clinical impression" of what the diagnosis should be.

Psychiatric Interview

The final stage in the mental examination is the psychiatric interview. All the test information and reports prepared by the social worker and the psychologist, as well as the latter's working notes, are forwarded to the psychiatrist. He reserves each Wednesday afternoon for forensic interviews (although he does forensic work at other times if there is an emergency). The psychiatrist reviews the files and interviews the defendant. The interview is conducted in jail if the defendant is in the Warren County Jail, as most are. There seldom is staff discussion of the case. The psychiatrist usually completes a report (as described in the next section) right after the interview.

In about 15 to 20 percent of the cases the psychiatrist conducts further investigation. He orders a neurological test if he suspects brain damage. He sometimes interviews the defendant's family, friends, jail mates, and jailors. He may secure the defendant's police report and records from mental or penal institutions where the defendant has spent time. There are no set criteria for determining whether to conduct this further investigation; the psychiatrist stated that he is more likely to investigate when he remains undecided following the interview and when he wishes to check whether the defendant is malingering. For example, he may check the defendant's account of prior mental difficulties by asking family members to corroborate the defendant's account.

Provision and Use of Mental Health Information

The psychiatrist's report is prepared on a form (see Appendix I), and it is usually about two pages long, single-spaced, and typed on the front and back of the form. The typical report contains the following topics, although not necessarily in this order:

- A short biographical description of the defendant, based largely on the social worker's social history and on the psychologist's interview (including the defendant's family history, his education, and alcohol and drug problems).

- The results of the MMPI and other tests, and interpretations of the results.

- The psychiatrist's assessment of the defendant, sometimes drawn from the psychologist's assessment.

- The diagnosis, often expressed in psychiatric terms.

- Opinion about the defendant's competency and, generally, about the defendant's sanity at the time of the offense. (Also, most reports contain treatment recommendations, even though not usually requested.)

In about 85 percent of the cases, the psychiatrist concludes that the defendant is competent and was sane at the time of the offense. The psychiatrist gives the treatment recommendations, even though not formally requested by the court or attorneys. The report does not contain the defendant's statements about the alleged offense, although those statements may be a basis for the psychiatrist's recommendations.

The report is usually mailed to the court, although a deputy sheriff hand-delivers it when speed is necessary. The defense attorney receives a copy; but the prosecutor usually does not.

According to the clinic's staff, the parties seldom contest the psychiatrist's recommendation. If, as happens infrequently, incompetency or insanity is diagnosed, the prosecutor generally accepts this judgment and agrees to drop charges on the condition that the defendant be civilly committed. Likewise, defense attorneys generally do not contest a report stating that the defendant is competent and sane, and the court proceedings continue as in a normal case.

The court refers a few defendants to the Grauman Forensic Unit in Louisville for further study. The Barren River Forensic Unit psychiatrist may tell the court that he is uncertain in his opinion and that the court should send the defendant to Grauman because it holds defendants for several weeks, allowing extended staff observations. In addition, the defense or prosecution on rare occasions disagrees with Forensic Unit recommendations and persuades the judge to seek a second opinion from the Grauman Unit.

The Forensic Unit staff usually has no further contact with the case after sending the report. The prosecutor and defense rely on the written report in most cases and do not request testimony. The psychiatrist, however, testifies in the few contested competency hearings or trials involving an insanity plea. More often, he testifies at sentencing hearings, where he supplements the treatment recommendations in the report.

Feedback, Monitoring, and Program Evaluation

Management, Monitoring, and Informal Feedback to Staff

Management and monitoring within the Forensic Unit is generally informal. The official project director, under LEAA grants, is also the Executive Director of the Unit's parent agency, the Barren River Mental Health-Mental Retardation Board; and he spends a small percentage of his time on Forensic Unit matters. The day-to-day management is performed by the Unit's psychiatrist, who is the medical director of the Comprehensive Care Center. The staff does not hold formal meetings, and seldom informal meetings, to discuss individual cases; yet there is frequent interaction between the staff. The psychiatrist, of course, routinely reviews the work of the social worker and the psychologist; and the psychologist reviews the social worker's reports. Also, the social worker uses the important feedback mechanism of comparing the

psychologist's and psychiatrist's reports with her own; and the psychologist can compare the psychiatrist's report with his work.

Informal feedback from the court and the county jail, the Forensic Unit's two major clients, takes several forms. Unit staff occasionally meet with court or jail personnel to discuss problems, especially procedural problems, involved in the mental health screening and evaluations. Also, Unit staff are frequently in contact with court and jail staff, permitting rapid flow of information about operating problems. Finally, the psychiatrist remains involved with some cases after submitting his report, most often by testifying at sentencing hearings, and thus receives feedback information about the court's use of his report.

Routine Statistical Reporting

The Forensic Unit made a considerable effort to collect statistics during the period of the block grants--that is, until January 1980. A part-time student research assistant compiled data from the Unit's client records. The data categories were established through negotiations with the Kentucky Department of Justice, and the statistics were submitted to the Department in quarterly and annual reports as required by the block grants. The data categories include standard demographic information about clients, criminal history, and any mental health treatment provided. Also, although not part of the required categories, the psychiatrist's recommendations and the disposition of the case also were recorded.

Special Studies and Reports

There have been no special studies of the Forensic Unit, although considerable information is available for one wishing to make a study. The Comprehensive Care Center maintains files, as it does for all clients, on defendants given forensic examinations by the Forensic Unit. These files are confidential, and their use for research would require permission from the state Department of Human Resources (DHR). Secondary to the management of the Comprehensive Care Center, this permission could easily be obtained. Access is available without DHR permission for research conducted by Center staff. The Forensic Unit reports sent to the court also are confidential; they are put in a separate file in the judges' offices, rather than in the central case file available to the public. The court, however, has made reports available to at least one researcher and presumably would permit access by others.

The record-keeping for the treatment screening is less comprehensive than that for the forensic examinations. A record is opened for defendants or parolees screened at the Comprehensive Care Center, but most treatment screening occurs in jail and no formal record is made.

THE FORENSIC SERVICES OF MALCOLM BLISS MENTAL HEALTH CENTER (ST. LOUIS, MISSOURI)

In the 1930s, Malcolm A. Bliss, a general practitioner in St. Louis, Missouri, discerned the need for a separate psychiatric facility within the city's general hospital system. Bliss aroused public interest in this project, and with the help of federal funds the Malcolm A. Bliss Psychopathic Hospital was erected in 1938. The five-story building was built adjacent to the St. Louis City Hospital and served as the Psychiatric Division for this general municipal hospital. The facility was intended for the evaluation and short-term treatment of indigent residents with mental health problems. However, St. Louis failed to provide adequate fiscal resources, and the Bliss pavilion deteriorated physically and soon became an overcrowded facility for chronically ill patients (Note 13).

In 1953 a team of researchers from Washington University in St. Louis acquired a basement wing of Malcolm A. Bliss Psychopathic Hospital for research space. Headed by George A. Ulett, the team began a controlled evaluation of convulsive therapy. This formed the beginning of a long, productive relationship between the Center and Washington University.

Ulett organized a Social Maladjustment Study Unit at the hospital in July of 1956. The Unit was created as an interdisciplinary research, teaching and consultation center focusing on individuals involved in aggressive, antisocial or delinquent acts (Blackman, Flynn, Melican, Napoli and Weiss, 1957). In 1964 the State of Missouri's Department of Mental Health assumed the funding and administration of this study unit. In 1971, the Unit's name was changed to its current designation of Forensic Services of Malcom Bliss Mental Health Center.

Malcolm Bliss, as a comprehensive community mental health center, provides the following services: inpatient and outpatient services; partial hospitalization; 24-hour emergency care; community consultation and education; diagnostic services; rehabilitative services; pre-care and after-care services; and training and research. The Center, a 210-bed facility, is accredited by the Joint Commission on Accreditation of Hospitals and serves a total of 966,103 residents (Note 13). Forensic Services provides psychiatric services for the Circuit Courts of St. Louis City and the surrounding counties of Franklin, Jefferson, Lincoln, St. Charles, St. Louis, and Warren.

Forensic Services conducts mental health evaluations while defendants are at the pretrial and post-conviction stages. Since 95 percent of the evaluations are performed at the pretrial stage of the criminal process, this report will focus on the pretrial evaluative process.

From July 1, 1978, to June 30, 1979, 95 inpatient evaluations and 21 outpatient evaluations were performed by Forensic Services at the Center. The professional staff was a full-time psychiatrist, a half-time

psychiatrist, and a full-time social worker. Seven other evaluations were conducted by Forensic Servies staff at jails or other state hospitals. In addition, the staff has responsibility for inpatient and outpatient treatment for individuals adjudged not guilty by reason of insanity.

To accommodate a larger service area, on July 1, 1980, the professional staff was increased to two full-time psychiatrists, one full-time social worker, a full-time social worker who is also an attorney, and a full-time licensed clinical psychologist. In addition, psychiatric residents, social work students and psychology interns assist in performing evaluations. The assistant superintendent of the Mental Health Center devotes approximately ten percent of his time to the administration of Forensic Services.

A Function Model

Figures 37-41 depict the flow of cases, operations, and processes characterizing the evaluation of client-offenders at Forensic Services. Figure 37 presents the specific activities and events prior to the entrance of the client-offender into Forensic Services, and the efforts involved in delineation of the information for the case. The acquisition phase of the evaluation process is depicted in Figures 38, 39, and 40. Each of the latter figures shows the procedures followed when a client is, respectively, an inpatient at Forensic Services, an outpatient at Forensic Services, or incarcerated at St. Louis City Jail at the time of evaluation. Figure 41 shows the schema for the provision of evaluative information to the requesting court.

The means by which a client-offender is moved from the trial docket into the caseload of Forensic Services is the delineation process illustrated in Figure 37. The courts of St. Louis City or surrounding counties request an evaluation by mailing a memorandum or a formal court order to Forensic Services. In emergency cases in which a client-offender seems to be in urgent need of mental health services and also poses a security risk, a judge or a court administrator telephones Forensic Services to request a jail evaluation. In these cases, scheduling arrangements are made on the phone and a court order follows in the mail. In routine cases, the court order is sent and evaluations are scheduled in chronological order as space becomes available. The secretary schedules appointments by phoning the sheriff's office to arrange transportation of the client.

The acquisition of evaluation information is dependent upon whether a client is seen as an inpatient, an outpatient, or in the jail. When a client-offender is admitted to Forensic Services on an inpatient basis (see Figure 40) a full array of medical, nursing, social, and mental data is acquired. A treatment-planning conference involving a psychiatrist, psychiatric resident, and social worker complements the evaluative process as data are collected. An outpatient is evaluated primarily by an emergency room screening, a social history and a psychiatric interview, as depicted in Figure 38. As Figure 39

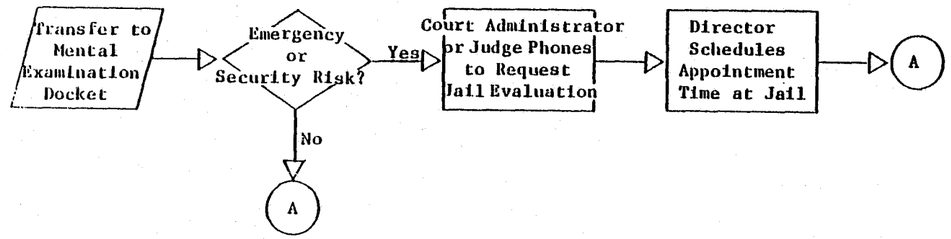


Figure 37. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Delineation of Evaluation Information.

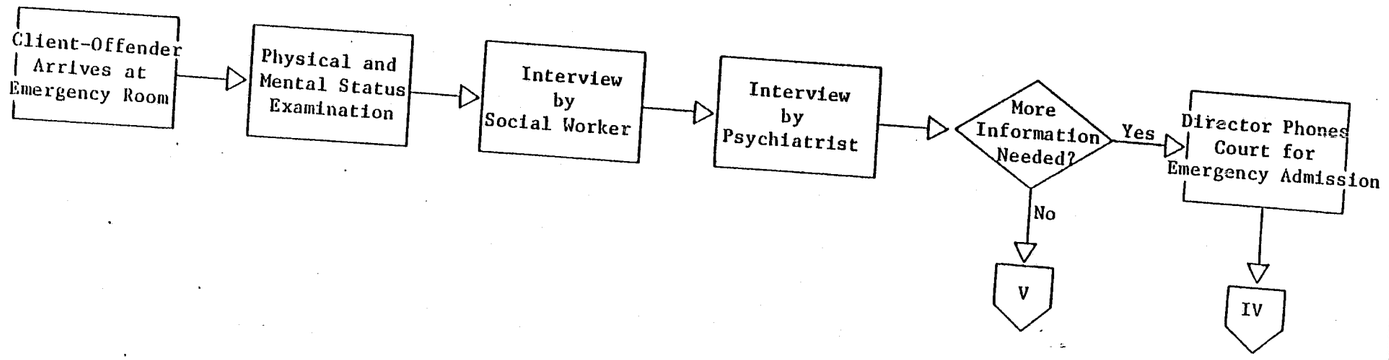


Figure 38. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Acquisition of Case Information for Outpatients.

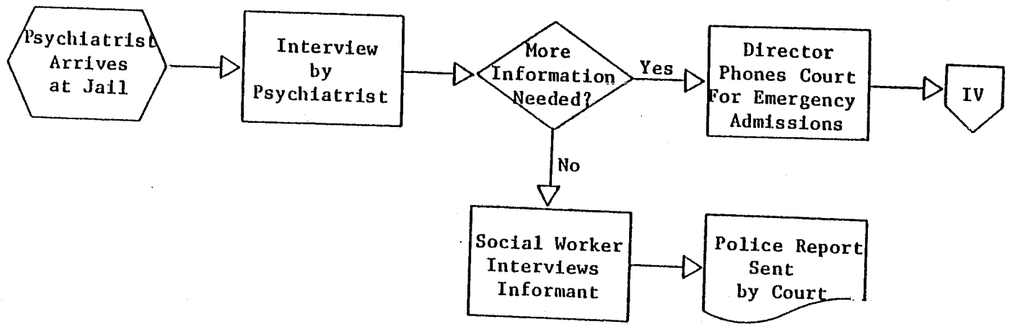


Figure 39. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Acquisition of Case Information for Client-Offenders at St. Louis City Jail.

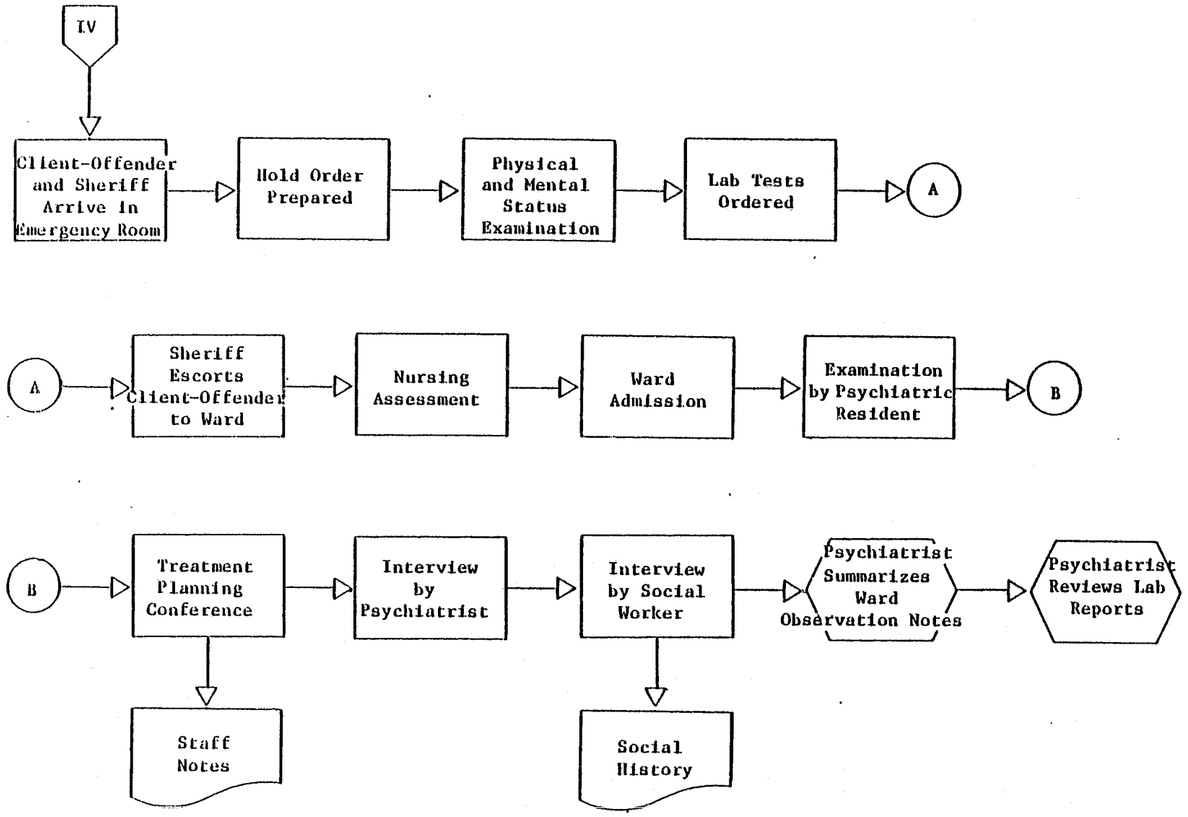


Figure 40. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Acquisition of Case Information for Inpatients.

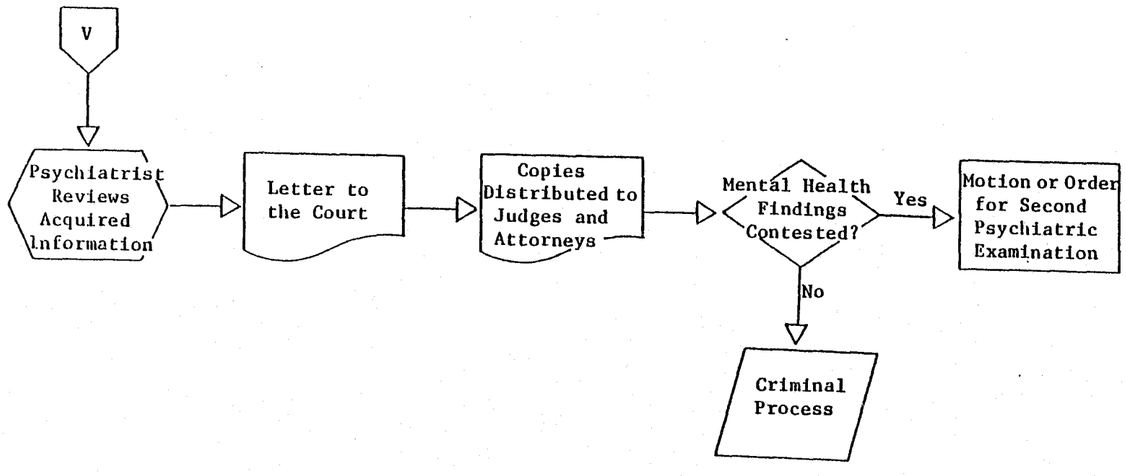


Figure 41. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Provision of Evaluation Information.

The State Director has also proposed the use of a "Background Information Sheet" (Appendix K). This sheet is a useful format for the transfer to the mental examiner of the information required by Mo. Rev. Stat. §552.045(3) (see Note 14). In view of the new sixty-day limit between the date of the examination order and the filing of the examiner's report, the expedient conveyance of this information is imperative.

The statutes also delineate the legal definitions of both competency to stand trial and criminal responsibility. Section 552.020.1 defines competency as the individual's "capacity to understand the proceedings against him or to assist in his own defense." A negative assessment of criminal responsibility means that

> A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he did not know or appreciate the nature, quality or wrongfulness of his conduct or was incapable of conforming his conduct to the requirements of law. (Mo. Rev. Stat. §552.030.1)

Inpatient and Outpatient at Forensic Services

Court requests for mental health evaluations are routinely received by mail. The St. Louis City Courts initially send a memorandum to Forensic Services, followed by a formal court order authorizing a mental health evaluation. The county courts always send a formal court order to notify Forensic Services of a needed evaluation.

The memorandum, the initial communication from the St. Louis City Circuit Courts, states the defendant's name and identification number and indicates the initial referral agent for the appointment of a psychiatrist: for example, upon motion by defendant or prosecuting attorney. The defendant is then committed to Forensic Services "for mental examination and evaluation." Release of information such as a police report to Forensic Services is authorized by the court order. The case is moved from the Trial Docket to the Mental Examination Docket, representing the client-offender's movement from the criminal justice to the mental health system. A copy of this memorandum is mailed by the court to the prosecuting attorney, the defense attorney, and the sheriff.

The formal court orders typically state defendant's name, number and charges. The court order, in varying terms, requests a "psychiatric examination and evaluation" of the client-offender. The order also provides for transfer of the client-offender by the Sheriff, if the individual is not released on bond. The courts in the surrounding counties mail a copy of the court order to the prosecuting and defense attorneys.

Once received, the court orders are reviewed by the Bliss Forensic Services director. The orders and memoranda are then given to the director's secretary, who maintains a log book in which the following information is immediately recorded: name of client-offender, court, judge, criminal cause number, date of order, and date order received at

Forensic Services. Later acquired information as to date of admission and ward location is entered as it becomes available.

There is currently a three- to four-week waiting period for scheduling an inpatient evaluation at Forensic Services due to a lack of beds. Inpatient beds are limited to fifteen and must accommodate persons needing pretrial examinations, emergency admissions from the jail, transfers from Fulton State Hospital, persons adjudged incompetent to stand trial who are awaiting civil commitment, persons recently found not guilty by reason of insanity (NGRI) who are beginning initial treatment after sentencing, and outpatient NGRIs in need of hospitalization. There are other delays in this process of transferring a case to the Mental Examination Docket, such as the time involved in mailing a court order to Forensic Services and the two to three weeks needed to get an incompetent individual civilly committed and then transferred to another facility for treatment.

These delays in processing evaluation requests and in waiting for available resources means that many client-offenders remain for lengthy times in jails or other detention facilities. Because of this problem, an effort is being made by State Forensic Staff to reduce the number of inpatient evaluations while increasing those evaluations performed on an outpatient basis at the Center and at the jail. Two obstacles prevent speedy adoption of this policy. One is the limited number of available sheriff's deputies to provide security for client-offenders at Forensic Services. The other obstacle is the attorneys' belief that their clients' needs are not being fully served by outpatient evaluation.

When there are beds available to conduct an inpatient evaluation, the Bliss Forensic Services director's secretary telephones the transportation department of the sheriff's office to arrange to have the incarcerated individual brought to Forensic Services within the next day or two. If the client-offender is on bond, an appointment is made by telephone with that client-offender, who can then arrive unescorted and be evaluated as an outpatient. An outpatient appointment is scheduled if a sheriff's deputy is available to provide security during the evaluation, or if the client-offender has been released on personal recognizance. The court order may provide that the client-offender's attorney be notified as to the appointment date.

The final step in the delineation phase for inpatient and outpatient admissions to Forensic Services occurs when the director's secretary phones the emergency room, informing them that an evaluation has been scheduled. This is necessary because all evaluations by Forensic Services begin with the regular hospital admission procedures.

Jail Evaluation

A mental health evaluation, as a possible preliminary to treatment, may be needed on a non-routine, emergency basis and the incarcerated client-offender may pose a security risk. In these situations, a St. Louis City Circuit Court judge or the St. Louis City

Court administrator responsible for the Mental Examination Docket coordination telephones the director of Bliss Forensic Services to request a mental health evaluation. An appointment is usually scheduled within two to three days. A memorandum is mailed to Forensic Services and follows the normal reviewing and logging procedures.

Acquisition of Mental Health Information

Mental health information is gathered in three ways: inpatient at Forensic Services, outpatient at Forensic Services, and while client-offender is incarcerated at St. Louis City Jail.

Inpatient at Forensic Services

Client-offenders arriving at Forensic Services as inpatients are first admitted to the Center through the emergency room. Next, the client-offender is taken to the ward and admitted there. A nursing assessment and psychiatric interview are performed, after which the Forensic Services' staff becomes involved in the evaluative process. These efforts are detailed further below.

Emergency Room Admission. Client-offenders arriving at Forensic Services for inpatient pretrial evaluations are usually being held in a jail or other detention facility and are classified as "Prisoners with a Hold Order." A client-offender may be on bond and arrive without escort; however, this situation is rare.

As soon as the client-offender arrives in the emergency room escorted by the sheriff's deputy, a "prisoner slip" (hold order) is filled out. The slip is addressed to the superintendent of the Center requesting that the client-offender be held by the Center. The name of the officer who brought the client-offender, the officer's identification number and charges against the prisoner are noted. Upon the client-offender's release from the Center, the receiving officer, district and date are once again noted. The prisoner slip is placed in a prominent spot in the client-offender's chart.

The emergency room psychiatric resident reads the court order for mental evaluation. The sheriff's deputy is asked if the client-offender has exhibited any behaviors or made any statements indicating the need for suicidal or elopement precautions. The physician or resident then conducts an emergency room examination of the client-offender to determine if there is an urgent medical or mental problem. Past medical history such as allergies to various medications and information as to previous hospitalizations is sought. If the client-offender has a history at the Center, the previous record is requested for review.

The physician or resident conducts a typical physical examination resulting in a report noting vital signs and impressions as to general appearance and condition of various bodily parts. The physical examination report ends with narrative and diagnostic comments.

A record is made upon each admission with notation of various identifying data. The name of the client-offender's best informant, i.e., relative or close friend who knows the client-offender well, is recorded. Information as to the type of admission and previous mental health service is noted. This record follows the client through the Center and eventually includes admitting or provisional diagnosis, staffing or working diagnosis, final diagnoses and procedures, and type of disposition, referral, or release.

A mental status examination is also conducted by the emergency room psychiatric resident. A Missouri Department of Mental Health form (see Appendix L) is used to record (1) impressions in the broad categories of general appearance, motor activity, speech, interview behavior, flow of thought, mood and affect, content of thought, sensorium, intellect, insight, and judgment, and (2) diagnosis according to DSM III codes.

The emergency room physician or resident summarizes the information gained from the physical exam, mental status exam, and interview. The evaluation time is approximately one hour. A report or emergency room note is prepared, which includes date and time of day, identifying data, informants, chief complaint, present illness, pertinent past history, brief mental status, pertinent physical findings, impression, recommendations, and signature.

Routine laboratory tests are ordered, including urinalysis, complete blood count, and SMA 12 (a blood analysis). In addition, a urine drug screen and a chest x-ray are obtained. Further tests may be ordered if indicated. Doctor's orders (special instructions to the nurses and psychiatric aides) are then recorded in the client-offender's chart. Those client-offenders with a hold order are entitled to the same privileges as general psychiatric patients, except that occupational therapy and recreational therapy may be ordered only on locked wards.

Ward Admission. The sheriff's deputy escorts the client-offender to the ward, where the client-offender is given pajamas; vital signs such as blood pressure and temperature are taken. A registered nurse on the floor conducts a "nursing assessment" within the first 48 to 72 hours of a client-offender's first admission to the Center. This nursing assessment consists of an interview lasting about one hour, and assists the nurses in formulating a plan of care. The assessment, guided by a standard form, is very comprehensive. The client-offender is asked for information on his or her previous hospitalizations, support systems, biophysical patterns, responses to stress, interpersonal relationships, motivation, life style, future plans, thought processes, awareness and handling of feelings, and talents, strengths, and assets. A family member or significant other person may be interviewed, if available. A summary reviews the nurse's impression of the client-offender and notes the individual's plans for the future with the purpose of assisting in the attainment of those plans. The form is then placed in the client-offender's ward chart.

Usually on the first day of admission, a psychiatric resident conducts an interview and physical exam. Typically the resident begins by asking the patient why she or he is here; i.e., what was the crime and why is a mental health exam necessary? Details on specific psychiatric symptoms are gathered. If the patient does not exhibit any symptoms, the resident will ask leading questions such as: Hearing voices? Do you think someone is talking about you or wants to hurt you? How's your appetite? Sleeping well? Crying spells? Are your thoughts too fast or too slow or too loud? Do you receive personal signals from the television or radio? Can you read someone else's mind? Do you have any special powers, abilities, or fears? Do you have any thoughts you can't get rid of? Any suicidal or homicidal thoughts?

Intellectual functioning and memory (recent, remote, and immediate recall) are then assessed. The resident asks the client-offender to recite address, phone number, and birthday. Simple arithmetic calculation is tested. The patient's general knowledge is gauged by asking questions about the current president and vice-president, five large cities and five past presidents, etc. Memory functioning is assessed by asking the client-offender to remember three things and to recall them five minutes later.

The resident then focuses on general medical history. Was the client-offender ever hospitalized? What is the history of substance use? The client-offender is asked to share information about family psychiatric and medical history.

Social history information is also elicited. How did the client-offender grow up? School, employment, marriages, children? How is leisure time spent? The client-offender is asked to share details as to a past criminal history, police problems, arrests and convictions.

The resident's interview is concluded with a physical exam which focuses on current medical problems. An admission note is then dictated, incorporating all of the above information. Any added doctor's orders for testing or medication may be carried out by nursing staff at this time. The admission note, along with progress discharge notes, are placed in the client-offender's ward chart, which provides a chronicle of medical information.

Treatment Planning. Following the emergency room and ward admissions, the resident telephones the Forensic Services psychiatrist assigned to the case to schedule a treatment-planning conference. This staff meeting is attended by the resident, a Forensic Services social worker, and the psychiatrist. After the resident presents the case, preliminary conclusions are reached. The psychiatrist then reinterviews the client-offender.

The psychiatrist's initial interview is very similar to that of the psychiatric resident. After an introduction, the psychiatrist explains the client-offender's rights, i.e., the right to remain silent, the right to an attorney, etc. The client-offender is asked about the

pending charges; however, the specifics of criminal responsibility and competency are not explored at this time, in the interests of building rapport. The standard information such as psychiatric history, medical history, family and social history and a mental status exam is again elicited.

A report or staff note of the meeting's findings is then prepared by the psychiatrist. Hospital policy provides that such a note be written within 72 hours of admission. The staff note lists the client's name, case number, and sex. The dates of admission and staffing are noted. The following information is included: staff members present at the conference; identifying data; reason for admission; informants; psychiatric history; legal history; medical history; family history; social history; results of mental status exam and physical exam. The note concludes with a statement that the Bliss Forensic director will review the case weekly, and itemizes the hold order and prisoner orders.

Social History. As part of the data collection, the Forensic Services social worker typically spends approximately two hours with each client-offender to gather social history information. This information aids in formulating a diagnosis. The social worker attempts to have a completed social service report (see Appendix M) in the client's file by the seventh day of hospitalization.

This report typically includes the following data: identifying information; description of present legal situation; informants; home; history of fire-setting, enuresis or cruelty to animals; educational history; employment history; source of income; military history; marital history; legal history; past problems; and significant others interested in patient.

The social worker asks the client-offender to choose an outside informant to help verify the social history. Either the interview with the informant is conducted on the telephone or the informant is able to come to the Forensic Services office. The same interview format is used with the outside informant as was used with the client. When the information differs, discrepancies are noted in the social service report. This second interview lasts approximately two hours and, in 75 percent of the cases, the informant is local and able to come to Forensic Services for the session.

Psychological Testing. Psychological testing is also part of the acquisition phase of mental health evaluation. In response to the treatment-planning conference, the supervising psychiatrist may ask the Center's Psychology Department to conduct various psychological tests on a client-offender. A licensed clinical psychologist assigned to Forensic Services screens the psychiatrist's referral forms requesting testing. The referral usually states the presenting problem, a brief history, and the psychiatric impression of the current problem. A referral question is posed addressing the presence or absence of psychosis, intellectual functioning or differential diagnosis.

The case is assigned to a psychology intern or staff psychologist. A clinical interview lasting approximately forty-five minutes to one hour addresses the following questions and issues: Why is the client here? Any psychiatric symptoms? Psychiatric history? Family history? Charge? Following the interview, a variety of tests may be administered. A Weschler Adult Intelligence Scale aids in estimating intelligence and a Bender Visual-Motor Gestalt Test is used to test for organicity. If psychosis is suspected, a Minnesota Multiphasic Personality Inventory, Rorschach or Thematic Apperception Test may be administered.

The licensed clinical psychologist for Forensic Services cosigns the written report after a conference with the examiner has been held to interpret the results. The report begins with the presenting problem, reason for referral and initial psychiatric impressions. Behavioral observations of the client-offender's appearance, demeanor, motivation for testing, and attitude toward the examiner are noted. Results of the intelligence test and organicity test are discussed first with attention paid to the client-offender's strengths and weaknesses in cognitive ability and in understanding of the surrounding world. Indications of organic brain syndrome are noted. The projective results are discussed in terms of the client's contact with reality and the presence or absence of psychosis. An opinion is made as to whether the client was psychotic at the time of the crime by commenting upon the chronicity of the condition.

Final Data Collection. Because the average inpatient stay is 21 days, the psychiatrist re-interviews a client-offender at least one time. The decision to interview the client-offender more than twice is dependent upon the quality and quantity of the information received. These later interviews focus upon the issues of competency and criminal responsibility. A partial mental status exam is conducted at each meeting. Talk focuses upon the client-offender's version of the crime, the six-month period prior to the crime, and any discrepancies in the histories. Attention is also paid to the nurses' ward observation notes.

Assessment of competency to stand trial may be performed more than once if the examiner is in doubt. Typical questions related to competency are as follows: Do you know what you are being charged with? What is your attorney's name? What is the function of a judge, prosecuting attorney and defense attorney? What happens in a jury trial? What happens if you are found guilty? What would you do if someone made a false statement about you in court?

Forensic Services uses the American Law Institute definition of criminal responsibility. The psychiatrist may ask: Does the client-offender appreciate the wrongness of the act? Is the client-offender aware of the consequences of the act? Is the client-offender capable of conforming conduct to the requirements of the law? If client-offender had been watched by the police, would the client-offender have done the same thing?

At this point, a file specifically for the use of Forensic Services staff is begun on each client. It will initially include the court order, staff note, police report, social service report, order for records from other hospitals, and various correspondences.

Outpatient at Forensic Services

About one-eighth of the Forensic Services caseload is serviced on an outpatient basis. An individual released on bond may arrive unescorted to Forensic Services. Or a sheriff's deputy, usually from the county, may bring a prisoner to be evaluated as an outpatient. This arrangement is rare, since a limited number of deputies would be available to spend all day at the Center.

Scheduling procedures used for outpatients are the same as those described for inpatients. The emergency room is notified to expect a Forensic Services client-offender. The client-offender signs into the emergency room and a data sheet is completed. Any old records are located and an emergency room note is written reflecting the results of the preliminary screening.

Following the emergency room admission, the client is checked in and escorted to the Forensic Services' social worker, who conducts a social history interview. The psychiatrist then conducts a standard interview. All the information needed may typically be gathered in one or two visits of two to three hours each; however, if more information and tests are needed, or if the client is too sick to be interviewed, then admission is indicated. The Bliss Forensic Services director is consulted, the reasons for admission are recorded, and the referring judge is then telephoned by the director to secure permission for an emergency admission. The court will be sent a letter recommending further evaluation or treatment within the next several days.

Once a client-offender is admitted, the regular inpatient procedures are initiated. The whole process of information gathering begins anew, since the usual reason for admission is a paucity of data because of the client-offender's inability to communicate with forensic staff during the outpatient evaluation.

Jail Evaluation

A very small number of evaluations are conducted at the St. Louis city jail. The Bliss Forensic Services Director, who typically conducts these evaluations, arrives at the jail at the scheduled time. He gives a copy of the court order or a memorandum to the sheriff, signs in, and is situated in an office. The client-offender is brought to the office and the interview is begun. The director, a psychiatrist, conducts a standard psychiatric interview and also assesses competency to stand trial and criminal responsibility. This first meeting may last three hours and may have to be continued to a second day if the case is difficult. A release of information form is signed by the client.

When the psychiatrist returns to the Center, the social worker is given the name of a family member or outside informant to contact. The court mails Forensic Services a copy of the police report of the client's crime, as usually provided in the court order.

If the individual appears psychotic or in need of immediate admission to Forensic Services, the director phones the St. Louis city court administrator for permission for an emergency admission. The court knows that a letter from Forensic Services will be received detailing the client's need for further evaluation or treatment.

Provision and Use of Mental Health Information

The psychiatrist compiles all the information collected during the acquisition phase in preparation for reporting to the court. The type of information collected depends on whether the client-offender was an inpatient or an outpatient, or remained incarcerated during evaluation. In the case of an inpatient, the data typically include a medical history, social history, lab reports, psychological tests, psychiatric interview reports, staffing note, and behavioral observation notes. An outpatient report will be based on an emergency room screening, a social history, and a psychiatric interview. The report of an individual interviewed at the city jail will be made on the results of a psychiatric interview, a social history interview with a family member or outside informant, and a police report.

Letter to the Court

The information to be provided in the formal court report is delineated in Mo. Rev. Stat. §§552.020.3 and 552.020.4. Under the newly enacted statute, the court may order an inquiry into the issue of competency alone, whereas under earlier law an assessment of both competency to stand trial and criminal responsibility was mandated. At the time of the authors' site visit, the old statute was in effect and the following section reflects the report format that conformed to the old statute's requirements. At that time, the letter to the court provided mental health information in the following format, as adopted by Forensic Services to conform with statutory requirements:

(1) Introduction: identifying data; psychiatric hospitalization history; how the client-offender was admitted and under whose authority; criminal charges; information sources.

(2) Detailed Findings:

(a) Present illness--defendant's current legal situation and version of the crime; present psychiatric illness as described by client; reasons for the examination.

(b) Past history--pertinent background social history of client that is diagnosis-relevant; short summary of all past psychiatric hospitalizations; history of

fire-setting, enuresis or cruelty to animals; discrepancies and inconsistencies in acquired information.

(c) Physical examination--physical and neurological exam findings, if remarkable; laboratory reports; psychological tests; comparisons of ancillary laboratory procedures on previous hospitalizations.

(d) Mental status examination--orientation to time, place and person; quality of communications; mood abnormalities; affect; symptoms characteristic of a thought process disorder (Schneiderian first-rank symptoms); disturbance of thought content; immediate, recent and remote memory; intellectual resources as measured by general fund of knowledge, simple calculation and reasoning ability; client's legal insight into the seriousness of the pending charges; judgment as indicated by client's willingness to cooperate with the evaluation process.

(3) Diagnosis: psychiatric diagnosis in medical terms; whether this diagnosis is a mental disease or defect as defined in the Missouri statute.

(4) Competency to Stand Trial: opinion.

(5) Criminal Responsibility: opinion.

(6) Recommendations:

(a) While the court determines the issue of fitness to proceed with trial, does the client require hospitalization for treatment?

(b) If the client is found mentally fit to proceed, is further hospitalizaton indicated pending further legal proceedings?

The letter to the court is signed by the psychiatrist (see Note 15).

Court Receipt and Use of Information

In the city of St. Louis, three copies of the court report are mailed to the court administrator, for the judge, prosecuting attorney, and defense attorney. In the surrounding counties, the court reports are mailed to the judge, whose court clerk distributes copies to the prosecuting and defense attorneys. Either party may contest the findings of the court report within five days of its filing. Under the new statute, the contesting party who moves for another psychiatric examination must pay for the second independent examination. If the court grants the examination, a report of the examination must be furnished to the court and the opposing party. (Mo. Rev. Stat. §552.020.5).

About five percent of the reports furnished to the St. Louis city courts are contested. More reports are contested in the counties; however, the Bliss Forensic Services director was unable to offer an estimate. The director estimated that requests to testify are received in one to two percent of the cases.

The court may use the report recommendation as to hospitalization pending determination of fitness to proceed with trial in order to commit an individual to a hospital for treatment to regain competency. (Mo. Rev. Stat. §552.020.6). The Forensic Services opinion as to the individual's competency to stand trial, if uncontested, may form the basis for a court order, without the necessity of a hearing. A hearing is in order only when the psychiatric finding is contested. (Mo. Rev. Stat. §552.020.6).

Quality Control and Program Evaluation

A variety of statistics are kept on a monthly and annual basis:

(A) A Center inpatient report is made for each month and summarized yearly. Data on Forensic Services admissions, referral sources, applicable law, discharges, and nature of releases are collected. Also, for each case, inpatients are classified by diagnosis, sex, and admission age.

(B) A monthly Forensic Services report contains the following information: referral court; inpatient admissions; outpatient admissions and the number of hold orders; inpatient and outpatient evaluations completed by submission of a report to the court; and inpatient and outpatient transfers to St. Louis State Hospital.

(C) A Forensic Services annual report indicates inpatient and outpatient admissions by type of forensic evaluation (pretrial, post-conviction, etc.) and ward location. The number of outpatient treatment visits is noted. The Forensic reports are mailed to the Director of Forensic Services for Missouri, the Assistant Superintendent of the Center, and the Medical Records Department of the Center.

(D) An annual listing of primary and secondary diagnoses is maintained.

(E) A monthly chart of discharges of client-offenders who have received pretrial evaluations includes the following information: name; Malcolm Bliss case number; court; criminal cause number; judge; date of discharge; and type of discharge.

(F) Additional statistics kept by Forensic Services are the number of referrals by court; the number of cases pending; and the average length of time elapsed between receipt of referral and submission of a report to the court.

The Missouri Department of Mental Health is implementing a forensic information system under the direction of the Director of Forensic Services for the State of Missouri. Court files and medical files are being reviewed with the primary purpose of empircally describing and analyzing the pretrial process currently in place in Missouri. The review includes tracing the eventual disposition of the cases. In addition, judges, attorneys, and mental health personnel are being interviewed to ascertain their preferences in form and content for psychiatric testimony, demonstration of reasonable cause in motions for psychiatric examination, and court reports.

Beginning July 1, 1980, the Director of Forensic Services for the State of Missouri was to be sent a copy of the court order, court report, and a form containing data on each forensic client-offender in the state. The director's staff will complete a standard data form (Appendix N) utilizing the court order and court report of mental health findings. It is anticipated that these data will be placed in a computer system making possible a tracking of patients by type, referral location, etc.

A Forensic Service Procedure Manual has recently been updated by the Bliss Forensic Services director. It reflects current procedures as well as changes in the mental health law effective August 13, 1980. (Note 16)

The Malcolm Bliss Mental Health Center is accredited by the Joint Commission on the Accreditation of Hospitals. The Center is also subject to Missouri Department of Mental Health standards.

FORENSIC UNIT OF THE PEACE RIVER CENTER FOR PERSONAL DEVELOPMENT (BARTOW, FLORIDA)

The Forensic Unit described in this section is a division of the Peace River Center for Personal Development, a community mental health center. The broad function of the Unit is to perform mental health screenings and examinations for the local criminal justice system. The present report will focus on the three most common types of screenings and examinations performed by the Forensic Unit: (1) screening county jail inmates whom jail personnel suspect may be mentally ill, (2) preliminary mental screenings of defendants, usually referred by the public defenders, to determine whether mental health problems warrant either (a) examination for competency to stand trial or sanity at the time of the offense or (b) possible sentence mitigation or provision of special mental health services upon sentencing, and (3) full-scale mental examinations by Forensic Unit psychologists for competency or sanity.

The Unit is located in Bartow, the county seat of Polk County, in the center of the Florida peninsula, east of Tampa. The population of Bartow is only about 12,000, but Polk County has almost 300,000 people. Covering almost two thousand square miles, it is one of the largest counties in the nation. The Forensic Unit serves the whole 10th Judicial Circuit, but almost all the Unit's cases come from Polk County rather than from the Circuit's other two counties, Hardee and Highlands, with a combined population of about 60,000.

Polk County is largely rural, dominated by citrus, cattle, and phosphate industries. There is a moderate amount of tourism; the county contains the Cyprus Gardens, and Disney World is only a few miles north. There is a marked amount of rural poverty, and Polk County residents are unusually prone to violence; the number of assaults per population ranks almost at the top of all counties in the nation.

Florida has two levels of trial court, the Circuit and the County Courts. The former have jurisdiction over felony cases, the latter over misdemeanors. In the 10th Judicial Circuit, there are eight county judges (six in Polk County) and 11 circuit judges. Two circuit judges are assigned to criminal cases; judges rotate this duty for one- or two-year terms.

The 10th Circuit has about 4,000 felony case filings per year. Court procedures in a felony case begin with a "first appearance" held before a county or circuit judge within a day of the defendant's arrest; the judge informs him of his rights, sets bond, and appoints counsel if the defendant is indigent. The prosecutor then files an "information." The Circuit Court holds an arraignment hearing some two or three weeks after the arrest, at which the defendant is informed of the charges. A trial is set for one to two months later. About ninety percent of the felony cases, however, end in a guilty plea, which is generally arranged at a pretrial conference held about a week before the trial date. The courts in Bartow act expeditiously in criminal cases, as can be seen from the times given above. But if a sentencing hearing is held, there is usually a delay of four to six weeks while the Probation and Parole Commission, which has a substantial backlog, conducts a presentence investigation.

Bartow has both a county and a city jail. The county jail contains defendants awaiting trial for felonies and some misdemeanors, as well as convicted defendants sentenced for short terms. The city jail contains defendants arrested by city police for city ordinance offenses. The Forensic Unit works with the county jail far more than with the city jail.

The Forensic Unit serves all of the 10th Judicial Circuit, even though its host agency, the Peace River Center for Personal Development, serves only the western half of the Circuit's three counties. The Peace River Center is a private nonprofit community mental health center, financed by federal, state, and county funds. It has outpatient offices in Bartow and in two other towns, and it operates an inpatient center, called "Wing E," in the county hospital. The Forensic Unit often refers patients to these other facilities for treatment.

The state pays for inpatient treatment of indigents for up to 15 days; after that, the state will pay only if the person is transferred to a state hospital. Wing E, unlike nearly all community mental health center inpatient units in Florida, has a secure unit and can take forensic cases. The state runs three large forensic mental health facilities around the state, with over a thousand beds in all. Most

courts, therefore, send defendants who are found incompetent to stand trial or not guilty by reason of insanity (or, in limited cases, mentally disordered sex offenders) to the state-run forensic units. But the 10th Judicial Circuit Court, in Bartow, can send these defendants to the secure facilities of Wing E, at least for the 15 days during which the state pays for inpatient treatment.

History of the Forensic Unit

The Forensic Unit began in July 1975 under a Law Enforcement Assistance Administration (LEAA) grant. The funding was continued by four yearly contracts (some with extensions) until September 30, 1979. Before the LEAA grant, psychiatrists or psychologists in the county hospital or in private practice performed forensic evaluations for the courts. The county, by law, is required to pay for forensic evaluations, and the federally-funded forensic unit relieved Polk County of this expense. Since the termination of LEAA funds, the Forensic Unit has been funded solely by the regular county, state, and federal funding sources for the Peace River Center for Personal Development; the Center now pays all of the Forensic Unit's expenses, whereas in previous years it paid only the 5 to 25 percent match money for the LEAA grant. The county, at this writing, has refused to contribute to the Forensic Unit above its regular appropriations to the Center. Consequently, the Forensic Unit has been gradually cut back since September 30, 1979, and has reduced its services to the courts, jail, and public defenders. It has virtually terminated examinations for competency to stand trial and sanity at the time of the offense, it has reduced the amount of screening and counseling of county jail inmates, and it "pre-screens" defendants referred by the public defenders.

Outline of the Functions and Activities of the Forensic Unit

The Forensic Unit performs a wide variety of services for the criminal justice system of the 10th Circuit. As one staff member said, the Unit "pampers" judges and other criminal justice personnel by providing services whenever needed, services that they could probably not obtain otherwise. The Forensic Unit was the first such project in Florida. Its staff and other Florida forensic mental health specialists generally consider it a model program, largely because of its comprehensiveness.

This section will describe in detail only three of the Unit's many activities and functions: inmate screening, screenings for the public defenders, and mental examinations for the courts. These are three of the four most important activities--the fourth is juvenile screening, which is outside the scope of our evaluability assessment. These will be summarized in the next section and described at greater length in later sections.

The following is a brief description of the other functions of the Unit, which will not be dealt with further in this report:

Custody evaluations. The Unit's psychologists perform mental examinations in custody cases, including child abuse cases. Since the Unit gets paid for these evaluations, they largely superseded the evaluations for competency and sanity after the LEAA grant terminated.

Juvenile screening. The Unit performs evaluations (about 10 per month) for the courts or the state youth services agency, mainly to aid in the disposition stage of juvenile proceedings.

Education and training. The Unit personnel have given many courses and other training programs to the police, parole officers, and other criminal justice system personnel. This function largely disappeared after the termination of the LEAA grant.

Liaison between the criminal justice system and mental health system. A Forensic Unit social worker serves part-time as liaison between these two systems, performing a wide variety of informational services, largely informing personnel in each system about the procedures in the other.

Presentence evaluations. As will be described later, the Forensic Unit provides much information used in sentencing when it evaluates and screens defendants during the pretrial stage. The Unit also performs some postconviction evaluations at the request of the court or the Parole and Probation Commission. Requests for these examinations are limited, however, because any defendant with mental problems would usually be screened by the Unit before trial. Until 1978, the Forensic Unit also scored and interpreted psychological tests given by Probation and Parole for presentence investigations.

Quick Screenings. A member of the Forensic Unit staff, usually a social worker, often performs quick screenings for various criminal justice system officials. Common examples are advising the court when setting bond, and advising the state's attorney of whether or not to drop charges against a mentally ill person and arrange for commitment or outpatient mental health services. The quick screenings, which are much less thorough than the screenings and evaluations discussed later, typically take only about 15 minutes and result in a short letter stating the social worker's findings. Also, the Unit occasionally advises the police in individual cases; examples are drawing a psychological profile of the murderer in an unsolved crime and advising policemen about how to handle individuals who appear mentally ill.

Treatment of inmates. The Forensic Unit has a rather limited treatment function. One of the more important programs in the past was social worker counseling of county jail inmates, but this has been virtually eliminated after the funding cutback.

Also, a psychiatrist goes to the jail one afternoon a week, mainly to prescribe drugs. This service was recently expanded from one visit every two weeks to one every week.

The Unit staff emphasize that this broad range of activities forms an interconnected and integrated set of services to the criminal justice system. Hence, the restrictions required by the funding problems may have broad repercussions beyond the particular activities cut back or eliminated.

Forensic Unit Staff

The Forensic Unit, while funded by LEAA, was staffed by a project director, a Ph.D. psychologist, who performed all the mental evaluations; a secretary; and four B.S. and M.A. level psychologists, social workers, or criminal justice specialists. For the sake of convenience, the last four staff members will be referred to as "social workers." The social workers tended to specialize in one or two of the following activities: juvenile work, jail screening and counseling, screening at the request of the public defenders, and compiling information supplementing the psychologist's mental examinations. All, however, have done a wide variety of work at the Unit.

The termination of federal funding resulted in the following staff changes: the project director has become the clinical director of the Peace River Center, the parent organization, and now spends only one day per week on Forensic Unit duties. A second doctorate-level clinical psychologist, the Center's director of program evaluation, has been assigned to the Forensic Unit for 20 percent of his time. Each performs one or two evaluations per week. The staff of social workers was cut from four to two full-time workers, plus a third for one afternoon a week. On the other hand, there has been a slight increase in the time spent in the jail by the Center's psychiatrist; but he is not in the Forensic Unit, and he treats prisoners rather than conducting forensic screening.

Case Process Flow

The process flow diagrams, Figures 42, 43 and 44, summarize the procedures used in the Forensic Unit evaluations and give an overall picture of the Unit's operations. In spite of its small staff, the Unit is very complex, largely because it performs many duties for the judges, public defenders, and other criminal justice system personnel. Also, the flow diagrams do not reflect the many changes in procedures, caused largely by financial problems. The diagrams represent procedures at the time of the present study, seven months after termination of LEAA funds.

The diagrams present simplified versions of the Unit's operations. First, they show only three of the Unit's many functions—treatment screening at jail, preliminary screening, and mental examinations. Second, they leave out some details, especially routes used in only a small portion of the cases. Third, the separation of the

three programs into separate flow diagrams hides the fact that there is much interaction between them.

Treatment Screening

Treatment screening is depicted in Figure 42. A Forensic Unit social worker screens county jail inmates to determine what, if any, treatment they should receive. Referrals are usually made by the jail nurse or by a jail guard, prompted by observations of the inmate's behavior in jail. The social worker interviews the inmate to determine if mental health treatment is needed. Treatment options are (a) referral to Wing E, an inpatient mental facility; (b) referral to a psychiatrist for possible medication; or (c) social worker counseling. The social worker may also recommend that the jail give the inmate special treatment, e.g., segregation, and may inform the inmate's attorney of the possibility of mental problems.

Preliminary Mental Screening

As shown in Figure 43, a social worker screens defendants with possible mental health problems, usually at the request of the public defender. These pretrial screenings have two purposes: (a) to determine whether a full mental examination for incompetency and insanity is warranted; and (b) to detect mental health problems and recommend treatment. The public defenders often use the latter information in plea bargaining discussions and in sentencing hearings, even though the preliminary mental screenings occurred at the pretrial stage.

A Forensic Unit social worker visits the public defender's office each week and pre-screens the lawyers' requests for screenings. The pre-screening is a quick preliminary screening without interviewing the defendant. If a case is accepted for screening, the social worker then takes from the public defender's files whatever information (e.g., the arrest report) may be helpful in the screening. The case is sent to another social worker, who studies the information obtained, interviews the defendant, and gives psychological tests. Occasionally, past mental hospital records are requested, and interviews may be held with police or others, especially to check the defendant's account of the crime.

The social worker then writes a report, which usually recommends against a mental examination. The person requesting the screening almost always follows the recommendation. Most reports also conclude that the defendant has some mental problems and would benefit from treatment. These suggestions are considered in plea bargaining negotiations and in sentencing decisions.

Mental Examinations

Mental examinations, which are the topic of Figure 44, are made pursuant to court order and are conducted by a psychologist, with preliminary research by a social worker. The basic purpose of the mental examination is to obtain expert advice about whether the defendant is

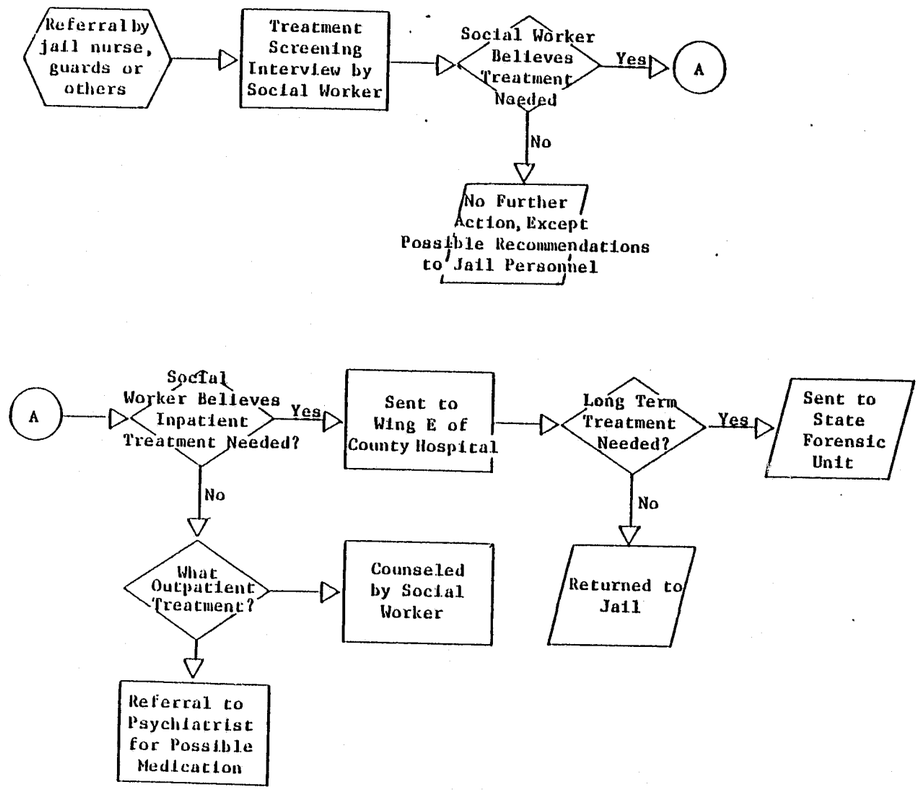


Figure 42. Forensic Unit, screening of jail inmates for possible mental health treatment.

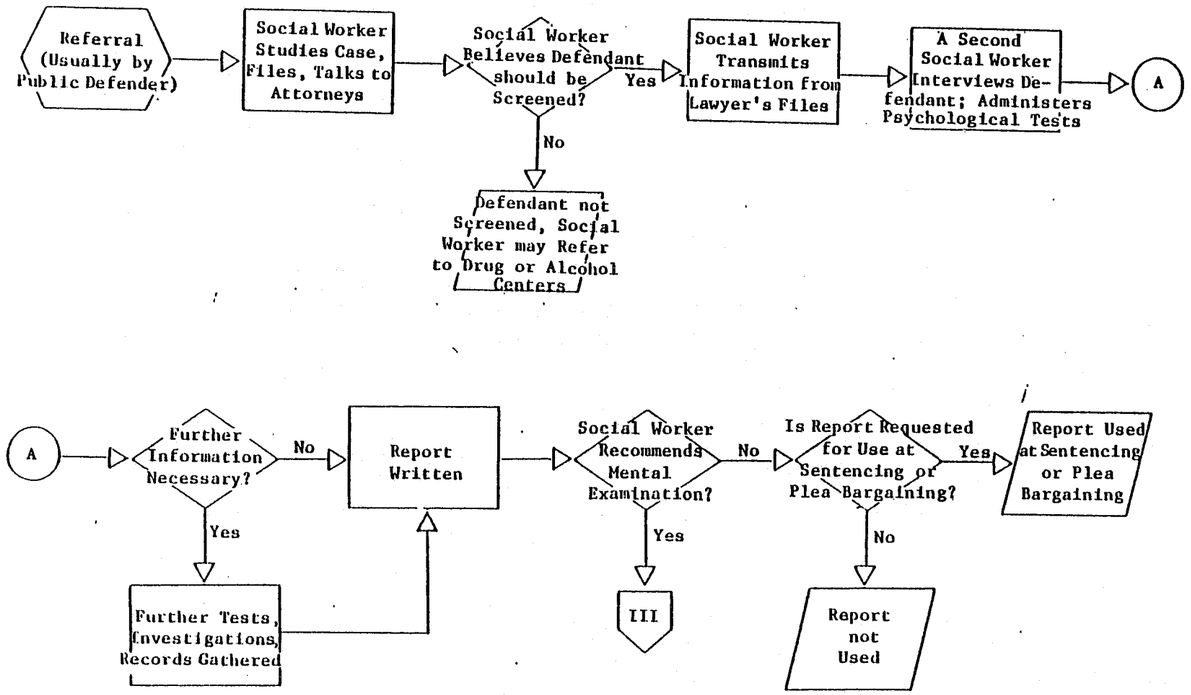
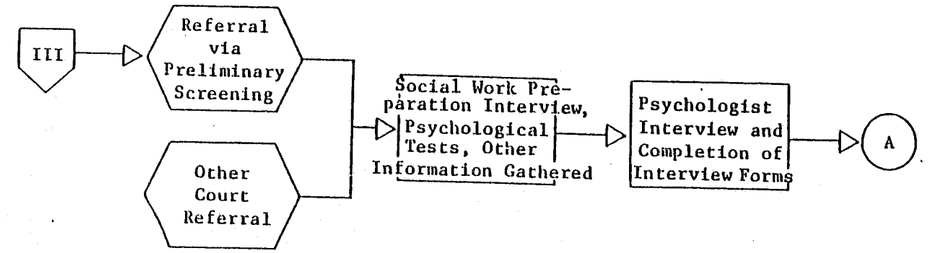


Figure 43. Forensic Unit, preliminary mental screening for possible mental examinations.



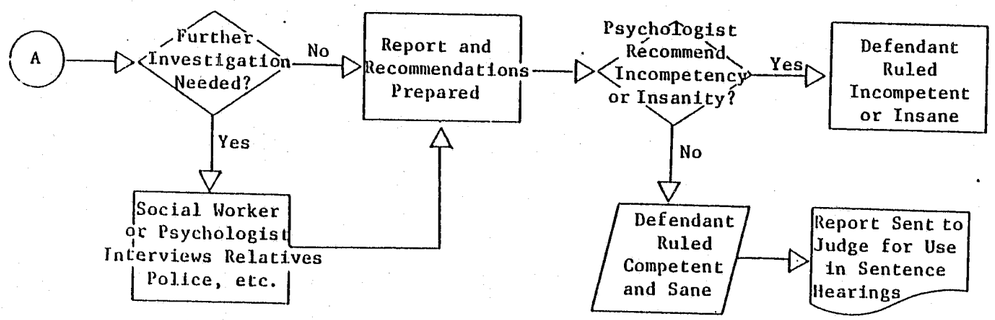


Figure 44. Forensic Unit, mental examinations to determine competency or sanity.

incompetent to stand trial or was insane at the time of the offense. Some 30 or 40 percent of the court orders for mental examinations follow preliminary screenings that recommend an examination. Usually, however, the court requests the examination, either sua sponte or at the request of defense counsel, because at the time of the request the defendant is in Wing E after a treatment screening in jail, or because the judge otherwise believes that the defendant's behavior shows he may well be mentally ill.

A social worker performs the first stages of an examination. The social worker gathers and studies the police report, interviews the defendant, administers the Minnesota Multiphasic Personality Inventory (MMPI) and sometimes other psychological tests, and acquires mental health records, if available. The psychologist, after reviewing the information gathered by the social worker, interviews the defendant and fills out two forms developed by the Unit, an Adult Evaluation form and a Competency Interview form (see Appendix Q). Before writing the report, the psychologist often orders an investigation to check statements the defendant made in the interview and usually discusses the case with other Forensic Unit staff.

The psychologist sends the court a letter giving his overall conclusions about the defendant's competency and sanity. The court virtually always follows the recommendation, which with few exceptions is that the defendant is competent and was sane at the time of the offense. The psychologist also prepares an extensive report of his findings, which is sent to the public defender. In most cases the judge receives this full report only if the defendant is convicted, to be used when sentencing the defendant.

Delineation of Mental Health Information Requirements

This section will describe the screening for treatment of jail inmates and the initial stages of preliminary screenings and mental examinations of defendants. These activities are largely devoted to determining when cases should go on to later screening stages and to providing information that will be used there.

The Forensic Unit staff, during federal funding, consisted of a full-time psychologist and three social workers, one of whom worked on juvenile matters, a facet of the Unit's work that is not described here. At the time of writing, one full-time and one part-time social worker and two part-time psychologists screen adult cases.

Treatment Screening of Jail Inmates

This screening is usually triggered by a request from the jail nurse for screening of an inmate whom she believes to have mental health problems. Many referrals are made by other jail personnel, too, especially jail guards; and a few are made by judges. Some treatment screening is done by the Forensic Unit in conjunction with preliminary screenings or mental examinations. The inmates screened are almost

always defendants in the county jail awaiting trial. Only a few are convicted and sentenced defendants, and few are defendants in the city jail. The requests are almost always made by telephone or in person when a social worker visits the jail.

Before the funding cutback in late 1979, a social worker went to the jail every day to screen or counsel inmates. Visits are still frequent, but occur only in response to emergency calls. (Some inmates who would ordinarily be screened by the social worker are now referred to the Peace River Center psychiatrist for possible medication.) The only information received by the social worker before the screening is a description of the inmate's activities as told by the jail nurse or other referral agent.

The social worker typically gives the inmate a quick mental status examination in an interview that takes about fifteen minutes to an hour. Psychological tests are rarely given. The social worker, after the short examination, sometimes informs the jail that the inmate is not mentally ill or has no problem amenable to mental health treatment. Otherwise, the social worker has several referral options.

Referral to Wing E. If the social worker believes the inmate needs inpatient mental care, she refers the inmate to Wing E, the psychiatric unit of the county hospital, operated by the Peace River Center. The staff of Wing E, however, actually determines whether the inmate is admitted, but few inmates referred are returned to the jail without staying in Wing E for at least one or two days. About a quarter of the inmates screened are sent to Wing E.

Referral to a psychiatrist. If the social worker believes the inmate does not need inpatient care but may need psychotropic medication, she makes an appointment for the Peace River Center psychiatrist's next weekly visit to the jail. Approximately, a third are referred to the psychiatrist.

Social worker counseling. Before federal funding ended, the social worker gave some inmates weekly counseling sessions. The Unit, at this writing, has almost completely terminated this service.

Advice to jail personnel. Finally, the social worker may advise the nurse or guards about the handling of the inmate, such as using an observation cell if the inmate is suicidal.

After the screening, the social worker often informs the inmate's attorney (generally a public defender) that the client has a mental problem. Also, counsel often learns of the mental problem because he or she is notified that the client was sent to Wing E. In this way, the treatment screening of inmates sometimes leads into the Unit's later evaluation activities, because the lawyer will generally request further evaluations whenever he learns that his client has a mental problem.

(Most defendants screened later, however, were originally not screened at the request of jail personnel; rather they are referred by public defenders who, rather than the jail personnel, first learn about possible mental health problems. Nevertheless, the defendants found incompetent to stand trial were generally first labeled as having a mental problem while in jail, and they were referred to Wing E before the mental examination.)

Delineations and Initiation of Preliminary Mental Screenings

In spite of the federal cutbacks, one of the major tasks of the Forensic Unit is still screening defendants, usually at the request of public defenders, before a full mental examination is ordered. Preliminary screenings are performed by Unit social workers; mental examinations are given by psychologists and are, typically, more thorough than screenings.

During the Unit's first year, the staff noticed that the Court, at the request of public defenders, asked for many mental examinations that were clearly not warranted by incompetency and insanity issues. At the same time, public defenders sometimes requested quick, informal evaluations from the Unit to determine if there were valid mental health issues. The Unit, in response, formalized the initial screening procedures; and the public defenders and the Court now use them for, among other purposes, determining whether a full mental examination should be requested. Preliminary screenings are not requested when it seems obvious that the defendant has a severe mental problem; defendants sent to Wing E after treatment screening by a Forensic Unit social worker, therefore, usually receive full mental examinations without a preliminary screening.

The main reasons, albeit implicit, for public defenders' requests for Forensic Unit screening are not incompetency or insanity issues, nor "to determine if a full-scale examination is necessary" as stated in the form for screening referrals. While these are reasons for some referrals, in most cases the public defenders' major, and sometimes the sole, reason for requesting screening is to identify mitigating factors that might persuade state's attorneys to lower their plea bargaining demands, or that might persuade judges to give more lenient sentences. The social worker's screening report, therefore, besides giving an initial determination of possible incompetency or insanity, usually gives mental health information that might explain the crime and suggest treatment or disposition alternatives for the defendant.

After several years of experience with this preliminary screening procedure, the Forensic Unit staff again concluded that public defenders refer too many cases without substantial mental health issues. The staff felt, for example, that the attorneys did not study the defendants closely enough before making referrals and that the attorneys sometimes used the screenings as a delay tactic. Under the constraints imposed by federal funding cutbacks, the Unit initiated still another screening level—i.e., a third level. A social worker now goes to the public

defender's office each Tuesday afternoon to "pre-screen" the screening requests. Each lawyer making a preliminary mental screening request tells the social worker why he thinks the client should be screened. Based on this informal discussion, the social worker decides whether or not there is a sufficient probability that the defendant has, or had, substantial mental health problems—problems that might lead to an incompetency or insanity finding or that might constitute mitigating circumstances. The social worker also often advises the public defenders to send specific cases to drug or alcohol units of other agencies, rather than to the Forensic Unit.

Although the screenings are performed mainly for the public defenders, some are requested by the courts, and a few by the state's attorney or the Probation and Parole Commission. Again, the most common purpose is to look for mitigating circumstances and for mental health treatment needs. A few requests from the courts, however, are to determine if there is enough probability of incompetency or insanity to justify full mental examination. During the period of federal funding, courts were far more likely than not to order a full examination without preliminary screening. As is discussed later in this section, however, the Forensic Unit, at this writing, no longer accepts requests for mental examinations (by Forensic Unit psychologists). Consequently, the courts are making more use of the screenings (by a Forensic Unit social worker) to decide whether to order mental examinations (by private psychologists and psychiatrists).

Screening requests from the public defenders are made using a simple form, which was developed jointly by the Forensic Unit and the public defender's office. A completed form requests a screening to determine if a full-scale examination is necessary. The form has space for the defendant's name, birth date, the date of the request, and the future court appearances scheduled. There is also a section for comments, but the comments are seldom extensive.

The complete screening request form is typically accompanied by a great deal of other information about the defendant. The pre-screening social worker writes a short note to the social worker who will do the screening, and the two often discuss the case informally. Also, the pre-screening social worker compiles as much information as possible from the public defender's records, including the intake form and the police report of the alleged crime. (Before the pre-screening procedure was initiated, the Unit continually urged the public defenders to send more information with their requests. The police offense report was, and is, considered especially important. The social worker, in addition, often discussed cases with the attorneys to obtain more information and to pinpoint the reason for the request.)

Initiation of Mental Examinations

The next aspect of Forensic Unit evaluation of defendants is the mental examination. The loss of federal monies has severely cut back examinations in criminal cases. Before the cutback, the Unit's

psychologist conducted 10 or 15 examinations per month. This number was ten or fifteen gradually decreased during the first months of 1980. Then, on May 19th, the Unit sent a letter to the courts, public defender and sheriff, announcing that it would no longer accept court-ordered competency and sanity examinations of indigent defendants (although it will perform examinations when reimbursed, for example in custody cases). The letter added that the Unit would resume the service to the courts if given $30,000 yearly for the necessary staff. Although not stated in the letter, these funds would probably have to come from the county. Without Forensic Unit services, the courts must use private psychologists and psychiatrists for mental examinations, and by law the County must pay their fees. (Because of the uncertain future, this section will describe the mental examinations as they were performed by the Unit during the period of federal funding and it will only briefly describe the subsequent changes.)

Requests for mental examinations are always made by the courts, and almost always by the Circuit Court rather than the County Court. Also, most orders are prompted by public defender petitions. The court issues a few orders sua sponte, typically in early stages of the court proceedings before the public defender is appointed.

Some orders, as mentioned above, follow from Forensic Unit screening reports recommending full mental examinations. A public defender receiving such a report routinely passes it on to the Circuit Court and petitions for an examination. A judge routinely orders a full mental examination whenever the court receives such a report, either from the public defender or directly from the Forensic Unit (when the screening is ordered by the court). If the screening report recommended against a mental examination, the court or public defender can, but rarely does, press further for an examination.

Although a large number of orders for mental examinations follow screening reports recommending them, 60 to 70 percent of the orders are in cases where the defendant was not screened. The public defender routinely requests, and the court routinely grants, examinations in capital cases without preliminary screening. Defendants placed in Wing E after the treatment screening in jail are considered to be certain candidates for mental examination, and judges typically do not require preliminary screening. Finally, a judge may believe that a defendant's behavior, during first appearance or arraignment, indicates the need for a mental examination. (A factor that sometimes enters a judge's decision to issue an order is the concern that a defendant may be dangerous and may harm others if out on bond. An order for a mental examination is often accompanied by a refusal to grant bond.)

Public defenders and other defense attorneys are free to petition that the mental examination be made by someone other than the Forensic Unit staff. Such requests are not unusual, especially in capital cases, probably because the Forensic Unit has a history of not often recommending incompetency or insanity. Judges have traditionally been reluctant to comply with such requests when made for indigent defendants,

because judges have confidence in the Forensic Unit staff, and because the county would have to pay for such examinations.

The public defender's office typically prepares a judge's order for a mental examination. After the court grants a petition for an examination, a secretary calls the Forensic Unit secretary and arranges a time for an interview with the Forensic Unit psychologist. The public defender's secretary places this date on the order, obtains the judge's signature, and sends the order to the Forensic Unit, where it is placed in the defendant's record. The psychologist typically has a substantial backlog; so the interviews are scheduled a month or two in the future.

The order is generally in standardized form (see Appendix O) and is directed to the Forensic Unit staff. The form order was composed jointly by the public defender, the Forensic Unit, and one of the Circuit judges. It directs the Unit to "determine the Defendant's mental condition at the present time, and at the time of the alleged offense." Although not specifically stated, the intent of the order is to obtain determinations concerning incompetency to stand trial and sanity at the time of the offense (Florida basically follows the M'Naghton rule). The order requests simultaneous incompetency and insanity examinations because, according to the Unit's director, there are few cases where only one is at issue (even though, as will be discussed below, if one is found, the other typically is not) and because the defense is particularly interested in the insanity issue, for that constitutes a defense.

Another provision of the order form, included at the request of the Forensic Unit, directs the police to provide the Unit with criminal reports and statements by the defendant or witnesses. Other information typically available to the Forensic Unit upon receipt of a mental examination order is the preliminary screening report and the file developed for that report by the Unit, but only in the 30 to 40 percent of cases where there was a screening before the mental examination.

Acquisition of Mental Health Information

In some respects, the preliminary screenings and full mental examinations are successive stages in the overall process of mental health evaluations, but they are more often separate stages because a defendant screened is usually not examined, and a defendant examined usually has not been screened. Also, although the screening is sometimes conducted for the purpose of determining whether a case should go to the mental examination stage, more often the screening has a different purpose, i.e., to provide information to be used at the time of sentencing.

Preliminary Mental Screenings

The preliminary mental screenings originate, as was stated earlier, with requests from public defenders or, less often, from judges or the Probation and Parole Commission. Once the screening request

arrives at the Forensic Unit, the Unit's secretary schedules a case interview with a social worker, usually for a date approximately a month later. At this writing, only one social worker conducts screenings, four per week. Screening interviews, however, are held promptly in emergency cases—when the defendant appears to need immediate treatment or when a judge requests a speedy screening.

The interview, lasting about sixty to ninety minutes, is usually conducted in the jail. If the defendant is free on bond, the interview is conducted in the social worker's office in the Forensic Unit. The social worker completes an "Intake Information Form" (filled out by the secretary if the defendant comes to the Forensic Unit) that requests personal information. The defendant is asked to sign the forms acknowledging services and authorizing the release of confidential information. (Copies of these three forms are in Appendix P).

The basic purpose of the interview is to gather the information required for the "Competency Interview" form and an "Adult Evaluation" form (see Appendix Q). The Forensic Unit director developed these forms for mental examinations, and social workers subsequently incorporated them into the preliminary screenings. They are completed by the social worker during and after the interview.

The social worker also administers the first 399 questions of the Minnesota Multiphasic Personality Inventory (MMPI). An oral version is administered to illiterate defendants. Although the MMPI is the only test given in most screenings, the Slosson Intelligence Test is given whenever the public defender raises the issue of mental retardation or the social worker suspects mental retardation during the interview. On very rare occasions the Bender Visual Motor Gestalt Test also is administered.

The social worker gathers no further information in most cases. A neurological examination may be ordered if the defendant is suspected to have organic brain damage. The Unit routinely gathers reports and records from mental institutions where the defendant was previously hospitalized. In a few cases, the social worker interviews the police or the defendant's relatives to verify statements made by the defendant during the interview. This investigation, however, is less frequent and less thorough than investigations conducted in full mental examinations.

After the interview, the social worker completes the "Competency Interview" and "Adult Evaluation" forms (see Appendix Q), scores the MMPI and other tests administered, and may write notes on a separate sheet of paper. This information is put in the defendant's file. The social worker also consults informally with the Unit's clinical psychologists. "Staffing" cases is part of the "quality assurance review" of the Peace River Center; and a "Peer Review Form," completed by a Forensic Unit psychologist and a social worker, must be completed and placed in the defendant's file. The social worker then prepares a report, which will be described later in the chapter.

Mental Examinations

Scheduling. Mental examinations are usually scheduled in a phone call between a public defender's secretary and the Forensic Unit secretary. The latter chooses the earliest opening in the psychologist's appointment book. The time between the order and the appointment lengthened during the life of the project and eventually reached four to six weeks. (After the termination of LEAA funds it reached two to three months.) The appointment date only approximates the actual time of the appointment, however, since the psychologist visits inmates in the jail when convenient, often before the appointment date. Examinations are performed with less delay when a judge requests emergency treatment.

When the defendant is in Wing E, for example following referral there after treatment screening in jail, the examination is typically delayed until Wing E decides whether to retain the defendant for extensive treatment or return the defendant to jail. Also, the Forensic Unit waits until the patient has had a chance to improve under treatment. It is senseless, according to the Unit director, to examine a patient when he may well improve later.

Preliminary Study. Before the psychologist's interview with the defendant, a social worker conducts a preliminary study. Unless previously obtained for a preliminary screening, the following information is gathered: the police offense report and witnesses' statements from the public defender, the state's attorney, or the police; these documents are culled for information important to the examination. The social worker then interviews the defendant in jail, principally to complete intake and release forms and to find out if the defendant has any mental hospital or clinic records. (These interviews became much less extensive after the loss of LEAA funds, and are now largely abandoned.) The social worker may request from other agencies any mental health or other records that may be of help during the examination.

The social worker also gives an MMPI (the first 399 questions), unless the defendant cannot read or is too distraught to take the test. The psychologist typically orders an oral MMPI for illiterate defendants and a written test for distraught defendants when they have calmed down. In most cases the Unit administers no other tests. The psychologist occasionally orders the Incomplete Sentence Blank test, for example when he is still undecided after conducting the interview and reviewing all the other information. The 16 Personality Factor test is given in a few instances when other tests prove inconclusive. Finally, the psychologist or the social worker administers a Wechsler Adult Intelligence Scale or a Slosson Intelligence Test when the defendant appears mentally retarded. Projective tests, such as the Thematic Apperception Test and Rorschach Test, are virtually never used.

The social worker then prepares a report of findings and places all test results and other information into a file on the defendant. If the defendant was given a preliminary screening, the results and working papers from the screening are included. The social worker usually

discusses the case with the psychologist before the latter interviews the defendant.

Clinical Interview. The next stage in the mental examination process is the psychologist's clinical interview. At the time of the site visit for this report, interviews were held in the Forensic Unit, except that patients in Wing E are examined there. Before October 1979, however, inmates were interviewed in jail.

The interview, which typically lasts ninety minutes, is aimed primarily at obtaining information required for two forms prepared by the Forensic Unit, the "Adult Evaluation" form and the "Competency Interview" form (Appendix Q). The "Adult Evaluation" form indicates general information about the purpose of the examination and about the defendant, including social and criminal histories. The more important is the "Competency Interview" form, which is adapted from the "Competency to Stand Trial Assessment Instrument" (McGarry, 1973), and which in July 1980 was included in the Florida Rules of Criminal Procedure as a mandated assessment in all court-ordered competency examinations. The "Competency Interview" form directs the examiner to rank the defendant as "acceptable," "questionable," "unacceptable" (or "not applicable") on eleven specific aspects related to the defendant's ability to assist in the defense. An example of one such aspect is the defendant's "capacity to disclose to attorney pertinent facts surrounding the alleged offense."

The psychologist does not rigidly structure the questioning along the format provided in the forms. Rather, he engages the defendant in a general conversation, typically beginning with the charge against the defendant and the circumstances surrounding the alleged offense. The psychologist weaves the items on the "Adult Evaluation" form into the general conversation. Finally, any topics in the "Competency Interview" form that were not covered earlier in the interview are addressed. The psychologist fills out the two forms after the interview, a task that takes another 60–90 minutes. The completed forms go into the defendant's folder.

Further Information. In many cases the psychologist requests an investigation, typically because he desires to verify the defendant's account of the alleged crime. This investigation consists of interviews with persons (e.g., the arresting officer, other police, jail staff, witnesses, and family members) to corroborate or refute the defendant's statements or to learn of behavior that suggests mental illness. A social worker does most interviewing, although the psychologist does some.

The case is usually "staffed" before the report is prepared, in accordance with the quality assurance review procedures of the Peace River Center. The psychologist speaks informally with the social worker involved in the case and, sometimes, with other Forensic Unit staff members.

Provision and Use of Mental Health Information

This section describes the final stages of the preliminary screenings and mental examinations, especially the preparation of written reports and the actions of judges and others after receiving the report. Again, the screening and examination procedures will be treated largely as separate processes.

Preliminary Mental Screening

Soon after interviewing the defendant, the social worker telephones the public defender (or the court, or Probation and Parole Commission, if these were the referral agents) and gives the screening results. The reason for this call is to speed transmittal of the results, for the report is not sent until about a week after the interview.

The preliminary screening report is typically one to two pages, single spaced, on letter-sized paper. Attached to the report is a checklist recording the results from the "Competency Evaluation" form; the form itself is not sent, but remains in the defendant's file in the Forensic Unit. The report states the test results and the social worker's general impressions obtained from the interview. The last section contains the conclusions and recommendations. If the social worker concludes that the defendant may be incompetent or insane, the report recommends a mental examination by the Unit. The frequency of such recommendations varies among the social workers, from about one-fifth to about one-third of the screenings. In addition, the proportion recommending examinations has decreased in the past few years.

The remaining conclusions and recommendations in a preliminary screening report are descriptions of the defendant's mental problems, predictions about the defendant's future behavior, and recommendations for treatment. This section almost always points out at least one mental problem attributed to the defendant and recommends some type of treatment. The recommendations are general in nature; reports do not contain full treatment plans. Although presented as mental health recommendations, they often have clear implications for sentencing. For example, recommendations occasionally imply that probation would serve a defendant's mental health needs better than incarceration. More often, however, the reports recommend treatment methods for defendants while imprisoned.

The social worker hand-carries the report to the public defender, judge, or whoever requested the screening. Until recently, the social worker usually discussed the report at some length with the person requesting it, but this practice was abandoned after the staff cutbacks. The report is sent only to the person requesting it, unless other distribution is authorized. The public defender, therefore, has an option to keep the report secret or to use it openly to advance the client's cause when requesting a mental examination, during plea negotiations with the state's attorney, or during the sentencing hearings.

The public defender, court, or others receiving the report almost always comply with the recommendations concerning the need for a mental examination. After receiving a report recommending an examination, a public defender routinely uses it to justify a motion for a court-ordered mental examination. Judges, likewise, virtually always grant a motion accompanied by such a recommendation from the Unit. Public defenders are free to ignore a recommendation against a mental examination and to request one from the court, while not disclosing the contents of the report. This seldom occurs, mainly because the court generally requires a recommendation from the Unit before ordering an examination in doubtful cases.

As has been emphasized, preliminary screening reports are often used for sentencing rather than to determine whether a mental examination is warranted. If the public defender considers the report favorable to the defendant, he may show it to the state's attorney during plea bargaining in the hope of reducing the sentence or obtaining agreement for probation, accompanied by court-ordered treatment. The judge typically accepts such a plea bargaining agreement.

The public defender often releases the preliminary screening report so that it can be used in the sentence hearing. The report may be given to the judge as a separate document for consideration at the hearing, or the Probation and Parole Commission may incorporate the report's reasoning and recommendations in its presentence investigation report. Again, the purpose is to mitigate the sentence.

Mental Examinations

Mental Examinations Report. The mental examination report is typically issued about two weeks after the interview is conducted. The report is similar to, but more elaborate than, the social worker's screening report. It is about three single-spaced, letter-sized pages long, and contains a lengthy narrative of the psychologist's conclusions drawn from the interviews and testing. Reports also contain a summary checklist of the "Competency Evaluation" form results.

The report always provides recommendations about a defendant's competency to stand trial and sanity at the time of the offense. The Unit staff expressed the belief that they are "stricter" on these issues than most psychologists and psychiatrists. A finding of incompetency is recommended in approximately ten percent of the cases, and insanity in only five percent (rarely are both recommended).

Consequences of the Recommendations. The Unit's recommendations are almost always accepted. Generally they are the only recommendations solicited and are routinely adopted by attorneys and judge. In a few cases, especially when the defendant is charged with a major crime, the defense or state obtains additional expert opinion. In these cases, however, perhaps because of the Forensic Unit's reputation with its referring agents, the Unit's recommendations generally prevail. Public defenders are seldom able to obtain a second opinion when the Unit

recommends competency and sanity, on account of the court's reluctance to authorize county funds for second evaluations. The public defender's office can seldom afford to pay for such second evaluations.

The Forensic Unit report also contains the psychologist's findings concerning mental problems of the defendant and recommendations for treatment. The recommendations, like those in preliminary screening reports, are often directed toward sentencing. The reports do not actually recommend a specific sentence, but they often suggest that specific dispositions may benefit or harm the defendant's mental health. The psychologist who wrote the report sometimes testifies in the sentencing hearing following conviction, elaborating on the recommendations made in the report. (In Florida, psychologists, but not social workers, can testify as expert witnesses on these matters; hence, the social worker does not testify concerning the sentencing and treatment recommendations made in the screening report.)

Confidentiality of the Report. An important problem is who should receive the Forensic Unit mental examination reports. Traditionally the Unit sent them to the public defender, the court, and the state's attorney. But the public defenders requested that the report be confidential, arguing that if the defendant were not indigent the lawyer would order a psychological report that would be protected by the patient-client privilege. Also, they argued that defendants would be more candid in the interviews if reports were confidential. At least one judge has agreed with these contentions. The formal order for mental examinations (see Appendix O) now requires the Unit to send the report only to the public defenders until the defendant is convicted, when it is also sent to the court and the Probation and Parole Commission (and is then used for sentencing purposes). Before conviction, the court and the state's attorney receive only a terse notification of the Unit's overall recommendations. These procedures, however, are not routinely followed in all cases; some judges issue orders requiring the Unit to send the report initially to them as well as to the public defender.

If the Unit recommends incompetency to stand trial, the court will usually go along with the recommendation after receiving the terse notification of this recommendation without seeing the report. When the Unit recommends "not guilty by reason of insanity," the Court and the prosecutor will eventually see the report if the defense raises that issue at trial.

The Unit staff are careful not to place incriminating evidence in the mental examination or preliminary screening reports. For this reason, reports are silent about the offense charged, even though the offense and the defendant's explanation of it are major factors leading to the report recommendations.

Further Involvement by the Forensic Unit. The Forensic Unit's involvement in a case usually ends when the mental examination report is sent to the court, mainly because the reports generally recommend a finding of competency and sanity, and this recommendation is generally

accepted by the parties. Even when the Unit report recommends a finding of insanity or incompetency, the case may end without further need for involvement by the unit: when the prosecutor and defense attorney receive such a report, they often agree that the defendant should be committed to a mental institution under civil commitment procedures, and in return the prosecutor drops charges against the defendant. This procedure is typically used when the defendant is not charged with a violent or major crime.

In about twenty percent of the cases, however, the psychologist preparing the report testifies in court. The testimony in about half of these concerns competency or sanity questions; the psychologist is called as a witness, either for the defense or the prosecution, depending on whether or not the report recommended incompetency or insanity. On rare occasions the defense or the prosecutor secures other mental examinations, usually from private psychologists or psychiatrists, who may subsequently testify against the conclusions of the Forensic Unit.

The psychologist testifies in about ten percent of the cases at a disposition hearing, where he supplements the examination report's recommendations about placement and treatment. This testimony may be in a hearing following a finding of incompetency or insanity; or it may be in a sentencing hearing following a guilty plea or guilty verdict (the reports make treatment recommendations even when finding that the defendant is competent and sane).

If a defendant is found incompetent to stand trial, he is usually sent to Wing E and treated until found competent. The defendant is sent to a state forensic unit, either initially or after a stay in Wing E, only when long-term hospitalization is required. (The 10th Circuit Courts, therefore, send only the most seriously mentally ill defendants to the state forensic unit. Most other Florida courts send all defendants found to be incompetent even though the incompetency is of short duration.)

The Forensic Unit may become involved in the case again when the state forensic unit returns the defendant, stating that the defendant has regained the competency to stand trial, or when it recommends involuntary civil commitment because the defendant is not likely to become competent. In some cases, the court requests a recommendation from the Forensic Unit as a check on the state unit's report. In other cases the Unit's role is simply to review a copy of the state hospital records and ensure that the defendant maintains his medication. The Unit may also become involved later in cases where the defendant is adjudged not guilty by reason of insanity. When the hospital where the defendant is committed recommends release, the court often asks the Unit to review the recommendation before ruling on it.

Feedback, Monitoring, and Program Evaluation

Except for general praise from the criminal justice community, the Forensic Unit receives limited feedback about its

operations. The Unit's primary clients, the judges and the public defenders, in our interviews expressed satisfaction with the services it has provided. Judges, who are typically suspicious of mental health professionals, praise the Unit as a trustworthy source of mental health evaluations. They base this assessment largely on comparison between the Unit's work and that of private psychologists and psychiatrists who submit reports and testify in court. Another possible indication of the Unit's effectiveness is, as was discussed earlier, that public defenders and judges follow the Unit's recommendations as a matter of course. (This, however, may be an invalid indication of quality because it might indicate that the judges and public defenders do not give the Unit's work sufficient review.) The Unit's work, moreover, has withstood the rigors of the adversary system in that prosecutors rarely have successfully attacked the Unit's conclusions. Overall, there is a large amount of informal evidence suggesting that the Unit's work is well received.

The Unit generally sends the screening or examination report to the court or public defender office, and then hears no more about the case. The Unit seldom receives feedback in individual cases. Judges and attorneys seldom ask for clarification of reports (this in itself, of course, can be considered evaluation information). The staff, out of simple curiosity, calls the court to find out what happened in a few cases. Whenever the examination report recommends incompetency or insanity, the Forensic Unit psychologist usually continues to receive information about the case during court appearances for testimony.

Social workers often receive feedback about their treatment screenings and preliminary mental screenings, because the defendants screened may subsequently be given mental examinations. Especially relevant are the social workers' opportunities to compare their screening reports with the psychologist's mental examination reports of the same people, although the original screening report is often influenced by the psychologist's input during staff consultation.

During the period of federal funding (July 1975 to October 1979) the Forensic Unit compiled data about its operations. This included quarterly and yearly data about the following:

- number of competency evaluations;
- percentage of evaluations completed within fifteen working days;
- number of psychological evaluations of juveniles;
- treatment sessions with jail inmates; and
- number of preliminary screenings.

The Peace River Center has not compiled routine statistics for the Forensic Unit after the termination of federal funding.

There is considerable information available for program evaluation and there is the potential for gathering even more. The Peace River Center has an evaluation component, administered by the Center's Director of Program Evaluation. A computer contains information about each Center

client, including those screened or examined by the Forensic Unit. This information is derived from:

- o "Intake Information" forms (Appendix P), which contain basic demographic information about clients;
- o "General Mental Health Service Ticket" forms, which contain the time, length, and type of service for each client contact, and the staff involved; and
- o "Discharge Summary" forms, containing the reasons for termination, the treatment outcome, and places for which the client was referred.

The Center now uses this information primarily to satisfy state and federal demands for data. However, it plans to expand the collection and analysis of evaluation data. The Director of Program Evaluation has requested advice concerning possible data inputs into the computer and methods of analysis that might be used to evaluate activities of the Forensic Unit.

Another potential source of data may be the client files in the Forensic Unit. The files contain the completed reports and forms, examples of which are shown in the Appendices. Employees of the Peace River Center are free to use these files for research purposes; and the Center, according to senior staff, would probably grant outside researchers permission to use these files. Unfortunately, the files seldom have information about the outcome of the cases and the uses of the Unit's reports. Some of this information, however, can be obtained from court records and from the court's automated data processing system.

THE RIVERSIDE HOSPITAL COMMUNITY MENTAL HEALTH CENTER

The present community-based facility in what is known as the Peninsula region of Virginia began as a Community Mental Hygiene Clinic, established in 1947 under the Mental Health Act of 1946. Psychiatrist T.J. Lassen joined the clinic as Director in 1956. He believed there was a need for a larger clinic and in 1958 he proposed the development of a new facility. Dr. Lassen joined forces with Riverside Hospital, applied for, and received federal monies under the Mental Health Act of 1964 that allowed for the establishment of the Riverside Hospital Community Mental Health Center (RHCMHC). Since then the operation has expanded to include cooperation with the Hampton-Newport News (Virginia) Mental Health and Mental Retardation Services Board.

Riverside is a comprehensive Community Mental Health Center providing services in five designated areas:

(1) Outpatient mental health services, including aftercare for patients discharged from state mental health facilities;

(2) short-term hospitalization (62 beds);

(3) partial hospitalization (adult day care);

(4) twenty-four hour emergency services (through the emergency room); and

(5) community consultation and education.

These services are provided at various satellite locations as well as at RHCMHC; however, this report will focus only upon aspects of the operation of the central clinic housed at Riverside Hospital.

RHCMHC provides services to the residents of the cities of Hampton and Newport News, Virginia. The catchment area includes a population of approximately 284,000. Services are provided to all residents regardless of age, income, or degree of pathology (Note 17). Additionally, RHCMHC provides forensic services for the Circuit Court and General District Court for the cities of Hampton and Newport News.

Mental health services are provided to the courts and individuals at various stages in the criminal justice system:

(1) Crisis counselors perform a pre-screening evaluation and arrange for psychiatric consultation to aid a judge in considering issuance of a detention order to send an individual to Eastern State Hospital in Williamsburg, Virginia. This process may have been initiated by family members or others seeking a petition for involuntary civil commitment.

(2) Crisis counselors are called upon to provide psychological services to inmates of the city farm and jail who are acting in a bizarre manner or have medication needs. In crisis situations, the individual is brought to the Riverside Hospital emergency room.

(3) RHCMHC provides treatment for certain persons at the Virginia Alcohol Safety Action Program of the Division of Alcoholic Services. About four or five persons a month voluntarily come to Riverside under this program which attempts to reduce or nullify criminal charges involving alcohol and driving.

(4) A victim of sexual assault who is admitted to the emergency room is referred to "Contact Peninsula," a sexual assault team. The police are notified also, which may result in RHCMHC contact with the criminal justice system.

(5) Judges, usually from the Juvenile and Domestic Relations Court, sometimes order treatment at RHCMHC for the family of an abused child. The order is usually verbal, but if not complied with, the order will be placed in writing. A formal written order is necessary an average of once a year.

(6) Parole officers, court services workers and attorneys may request an evaluation of a client-offender by a letter or a telephone call. Judges from the Circuit Courts and General District Courts of Newport News and Hampton may order a mental health evaluation informally or by written court order. RHCMHC processes approximately two hundred court-related cases each year, as estimated by the Chief Clinical Psychologist. About twenty-five of these evaluations are requested for presentencing purposes, as provided in Va. Code §19.2-300.

This last section of Chapter 6 will focus only upon RHCMHC's involvement in pre-screening for a detention order resulting in possible civil commitment, and with court-ordered mental health evaluations, as described in (1) and (6) above. These two activities represent the clinic's primary activity in the area of screening and evaluation of alleged criminal offenders. The pre-screening evaluative process as undertaken in the hospital's emergency room is essentially an alternative resolution representing either a temporary or permanent diversion from the criminal justice system. For example, the police may detain a person on a drunk-in-public charge and bring him to the emergency room at Riverside to be screened for indications of a need for mental health services. The person may be detained and sent to Eastern State Hospital and civil commitment proceedings initiated there. If a person is sent to Eastern State, criminal charges are not filed.

A Function Model

Organization

Figures 45 and 46 depict the flow of cases, operations and processes which characterize court-initiated evaluations and pre-screenings. Each figure represents the entire process for one type of evaluation, with Figure 45 emphasizing court-ordered evaluations and Figure 46 describing the pre-screenings for civil commitment.

Process

The process of delineation includes the various ways in which an individual case comes to the attention of RHCMHC and is prepared for evaluation. An individual who is escorted by a police officer or a family member to the emergency room of the Riverside Hospital for a pre-screening evaluation typically arrives with a minimum amount of documentary materials. The verbal report of the escort forms the sole basis of the intake process. In contrast, an individual needing a mental evaluation requested by agents of the court is usually accompanied by some identifying or demographic data. An attempt to screen out inappropriate referrals is made prior to the scheduling of a case, which begins the acquisition phase.

The next process, that of acquisition of mental health information, begins for non-emergency, routine cases with an intake interview by the assigned social worker. If indicated, psychological

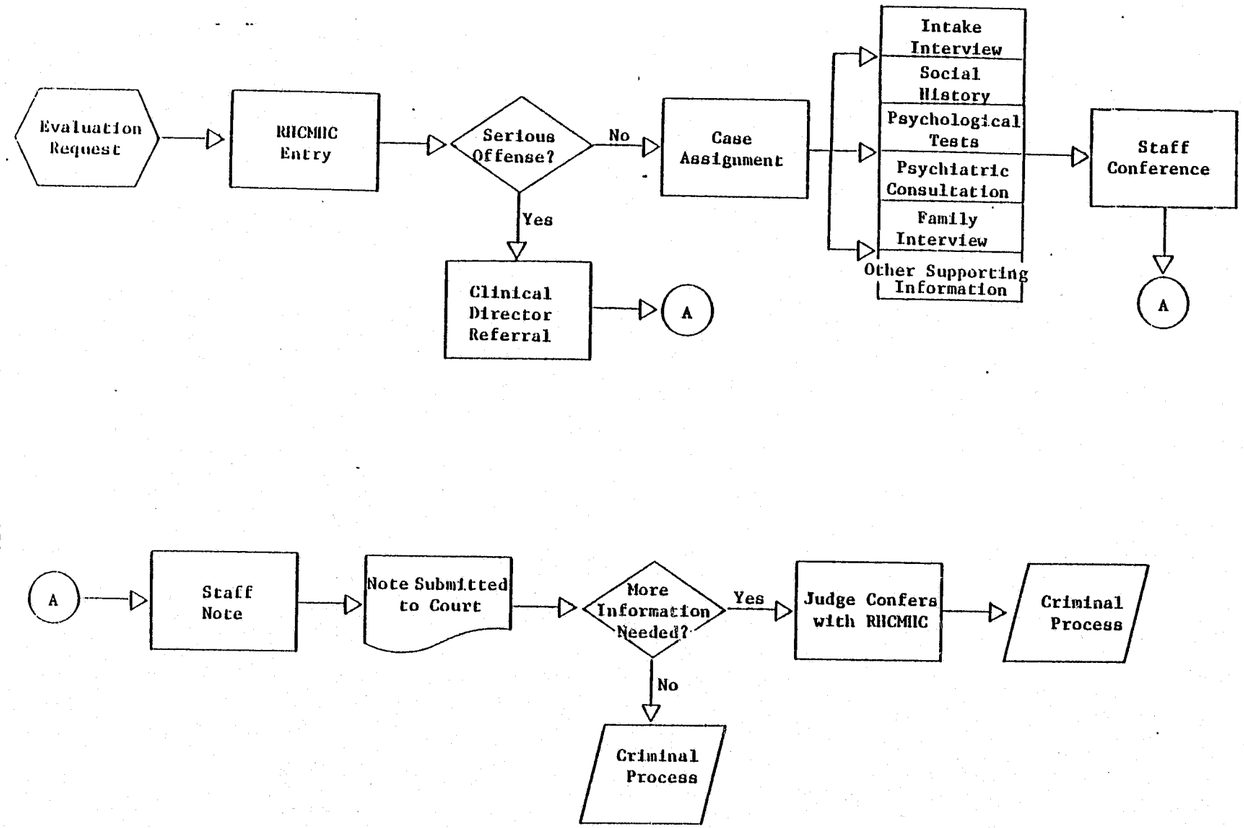


Figure 45. Case processing function model of the Riverside Hospital Community Mental Health Center for court-initiated evaluations.

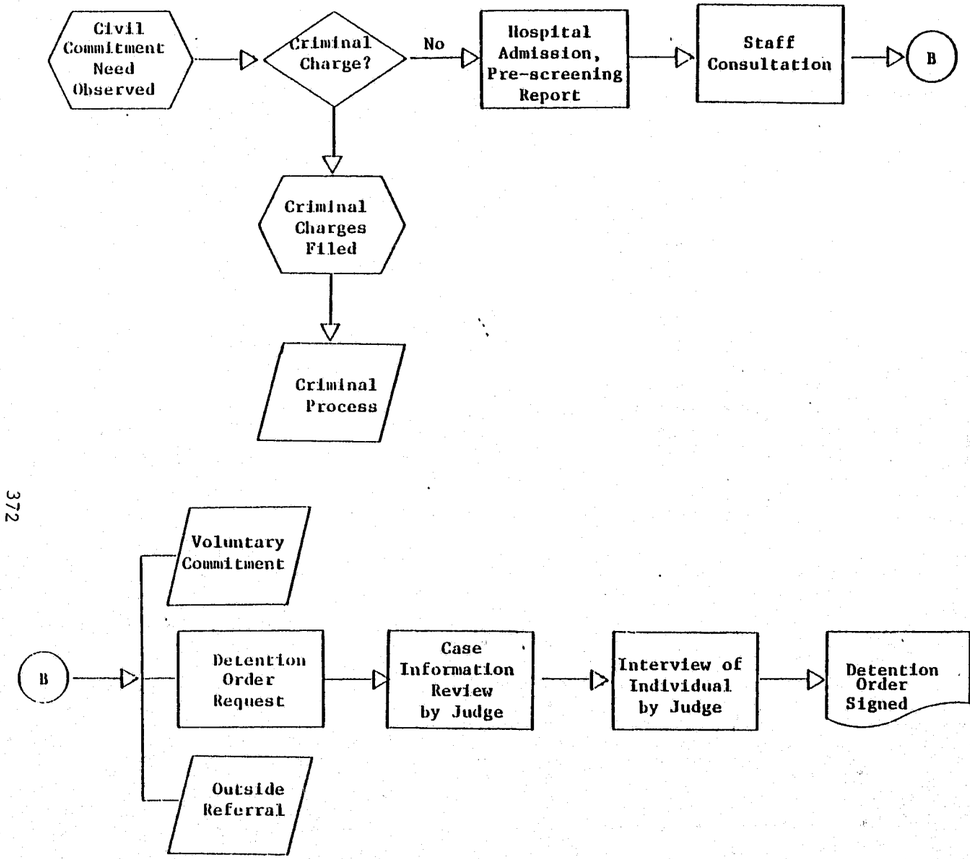


Figure 46. Case processing function model of the Riverside Hospital Community Mental Health Center Pre-screening for Civil Commitment.

tests, a psychiatric consultation, or a family interview may be conducted. Other supporting information may be gathered from outside sources. A "staffing" conference with the social worker and a licensed clinical psychologist is held and results in a "staffing note." This note indicates diagnosis, disposition, recommendations and treatment goals. This process may be circumvented if the date of the court hearing is immediately pending. It is also circumvented for individuals involved in murders, attempted shootings, or other serious and violent crimes. These cases are routed directly to the Clinic Director. The collecting of information in the pre-screenings for civil commitment consists of an emergency room report, a report completed by a crisis counselor, consultation with the attending physician, and an interview by a judge. These steps are shown in Figure 46.

The final process is the provision of the acquired information to the appropriate source. A copy of the mental health evaluation as summarized in the "staffing note" is usually sent to the defense attorney or parole officer, and is frequently sent to an agent of the court. The note provides evaluative information regarding the mental status of the defendant; issues of competency to stand trial and insanity are addressed only when the court order specifically requires such information. The judge may telephone RHCMHC for further information or clarification, if needed. In rare instances, RHCMHC staff may be subpoeaned to testify in court. The judge may also request a second evaluation from another agency. The variety of dispositions that may result from a pre-screening for civil commitment are shown in Figure 46.

Delineation of Mental Health Information

Court Request for a Mental Health Evaluation

The primary way in which RHCMHC becomes involved with the criminal justice system is in response to a court request for a mental health evaluation. The request may be made by telephone or by a letter from an attorney and is followed by a formal court order. The court orders are of two types. The standard court order, used in 95 percent of the court-ordered referrals, specifies an independent psychiatric examination and directs the psychiatrist

> . . . to examine and observe the defendant as to his mental condition and intellectual capacity and whether or not in his opinion the said defendant was sane at the time of the commission of said crime with which he is now charged, and at the time said defendant gave a statement or confession regarding said crime with which he is now charged, to police authorities . . . FURTHER ORDERED that all police and jail personnel who have investigated or observed the defendant shall cooperate . . . in this making of his determination as to the mental condition of the defendant at the time of the commission of the crime and his making of any statements relating thereto (Note 18).

RHCMHC staff interpret this order as requesting a determination as to competency to stand trial as well as a determination of the individual's criminal responsibility.

The other rarely used court order is termed by one staff member as the "ruffles and flourishes order." This order is used for individuals who are charged with murder, attempted shootings, or other serious crimes. According to one staff member, the court order specifically directs "[Clinic Director] as a psychiatrist skilled in the art and science of healing" to examine the defendant and offer an opinion as to his competency to stand trial and his criminal responsibility. This order dictates a circumvention of the normal evaluative process for routine, court-initiated cases. Because this is such a rare occurrence, the exact process is not clear.

RHCMHC utilizes the M'Naghten test to determine criminal responsibility. This test asks the following questions: Does the defendant understand his actions, the character of the act and its consequences? Does the defendant have the knowledge that it is wrong and criminal? Does the defendant have the mental power to appreciate that a wrong act deserves punishment? (Michie's Jurisprudence of Virginia and West Virginia, 1977).

A determination as to competency to stand trial usually accompanies an assessment of criminal responsibility. A staff psychologist paraphrased the test applied by RHCMHC as follows: Is defendant aware of the nature of the charges brought against him? Is defendant able to seek counsel and appear in court? The Virginia legal standard for competency to stand trial has been interpreted as the defendant's present ability to understand the nature of the charges brought against him, and defendant's ability to assist in his defense (Michie's Jurisprudence of Virginia and West Virginia, 1977).

Competency to stand trial is distinguished from a judgment as to legal incompetency. A legally incompetent person has been found to be incapable of "taking proper care of his person or properly handling and managing his estate"(Va. Code §37.1-128.01). A determination of legal competency is ascertained by knowledge of a person's ability to drive a car or handle his own funds and is reached by state hospitals for the purposes of civil commitment proceedings.

The court order is usually hand carried to RHCMHC but may be mailed to the clinic. However, the clinic is not responsible for ensuring that the defendant present himself for evaluations. At the hearing where an evaluation is ordered, the judge makes a determination as to the defendant's responsibility for initiating the evaluation process. If the person seems incapable of arranging an appointment, the bailiff is ordered to take the defendant to the emergency room of Riverside Hospital. Or if the individual is incarcerated, a crisis counselor will go to the jail to conduct a pre-screening evaluation. But if a person is able to make his own arrangements, it is expected that the person contact RHCMHC. A family member or attorney may try to make the

appointment, but the alleged offender must initiate the process. RHCMHC is not responsible for notifying the court that a defendant has failed to make contact with the clinic; however, RHCMHC will provide that information if the court requests it. An exception to these procedures is allowed for an incarcerated defendant accused of a violent or serious crime. In such cases, the defendant is brought to RHCMHC in chains for a special appointment with the Clinic Director.

When the client is on the telephone or arrives in person to make an appointment, the intake social worker completes a green referral form (Appendix R). This green form includes basic descriptive data, name of attorney, other RHCMHC cases in his family, information on the alleged crime, previous counseling or hospitalization, medication information, income and health insurance data, and next court hearing date. The client is informed of the need for a release of information form to be signed. The staff member to whom the case is assigned has responsibility for securing the release.

The intake worker assigns the case to a social worker or psychologist, depending upon schedules of appointments and her knowledge of the therapist's particular areas of expertise or preference. The case assignments are maintained in a record book. Each staff has a predetermined schedule so that no further communication with staff is necessary at this point.

Notification of Need for Pre-screening for Civil Commitment

Riverside Hospital serves a diversionary function by evaluating individuals as to their mental health needs prior to their entering the criminal justice system. This pre-screening for possible civil commitment occurs approximately three times a month.

A police officer, family member, or other person observes an individual who is acting in a bizarre manner or who appears psychotic. The police officer, if involved, may choose to file criminal charges if such acts are involved, and in that situation the individual is taken to the jail. If the decision is made not to press charges, the officer will bring the individual to the emergency room of Riverside Hospital. Likewise, a family member or other individual may escort the person to Riverside. A crisis counselor, who will be the primary staff coordinator, is informed by a nurse or the emergency room physician that a pre-screening evaluation is needed.

Acquisition of Mental Health Information

Staff

The staff of RHCMHC consists of psychiatrists, social workers, licensed clinical psychologists, psychological technicians, and administrative and support personnel. Case responsibility rests primarily with the staff of ten social workers. Psychological technicians, Master's level psychologists with specialized training,

administer the psychological tests routinely ordered. Licensed clinical psychologists head the staff conferences with the primary evaluator. The Clinic Director provides psychiatric input as needed. Social work students from local schools assist the staff social workers in the evaluative process.

Procedures and Techniques

Movement of a client through the system begins when an appointment is scheduled. The intake worker completes the green referral form (Appendix R) and gives it to the receptionist. She attaches a record of referrals and a blank Staffing Note (Appendix S) to the referral form and takes all forms to the person in charge of the clinic's record room. There records are checked to see if the client or any other family members have been seen previously at RHCMHC. If there is a record, it is pulled and attached to the forms.

When the client arrives for his appointment, the file is pulled by a records clerk. The person meets with a statistician in the records room who completes a face sheet (Appendix T). The face sheet includes such information as descriptive and social data, source of referral, other agencies involved with the case, previous hospitalizations, reason for referral and precipitating event. Once the face sheet is completed, a case number is assigned. The statistician then takes the record to the assigned social worker. The social worker reads the green referral form, focusing on the presenting problem, and peruses the record, if any. The client is then brought into the social worker's office to begin the intake interview.

The social workers' intake interview lasts approximately one to two hours and results in one and a half to two pages of social history. The interview focuses on the presenting problem; precipitating factors, both situational and emotional; how the client feels about the alleged crime; family history; emotional tone; home status; indications of emotional problems; and competency to stand trial. The social worker may follow up the interview by speaking with family members or otherwise gathering supporting information from outside sources.

A battery of psychological testing is routinely requested in court-ordered cases. The social worker completes a Referral for Psychological Testing form (Appendix U) and indicates an opinion as to the testing needed. The tests are administered by psychological technicians in the Psychology Department of Riverside Hospital. The Minnesota Multiphasic Personality Inventory (MMPI) is always given. The Wechsler Adult Intelligence Scale (WAIS) is administered if mental retardation is suspected, and the Rorschach Test is given if there are suspicions of psychosis. The Halstead-Reitan Test is administered if organic brain syndrome is suspected.

The entire evaluative process usually takes four to six weeks and the alleged offender is an outpatient during this time. However, the evaluation may be expedited if there is an emergency or if the court date

is immediately pending. At the completion of the social worker's information gathering and the psychological testing, a conference is held to interpret and discuss the results. At the staffing conference, the social worker and a licensed clinical psychologist are present. Results of the intake interview and psychological tests are presented orally. A clinical diagnosis may be offered by the psychiatrist, who participates in cases of a particularly serious or violent nature. The client's impulse control is also assessed at this time.

At the conclusion of the staffing, the clinical psychologist then dictates a staff note in the presence of the social worker. The note includes abbreviated social and psychological facts, diagnosis, recommendations and treatment goals. A statement as to competency and criminal responsibility is included only if requested by the court. The dictated staff note is then typed in a letter format (see Appendix S).

Pre-screening for Civil Commitment

The acquisition of information needed to "pre-screen" an individual for detention at Eastern State Hospital and a possible civil commitment begins with the emergency room admission. The physician on duty conducts a physical examination, and observes the individual to formulate impressions as to his mental status.

A crisis counselor completes a Hospital Pre-screening Report (Appendix V). This report includes such information as community supports, previous hospitalizations, legal status, present symptoms of mental illness, physical health problems, and home status. The counselor forms an impression as to the person's need for mental health services, and as to whether the person "pose[s] an imminent danger to himself or others" (Va. Code §37.1-67.1). Hospital clerks and family members, if present, aid the professional staff in gathering information.

The crisis counselor and physician then consult and share impressions gathered during the physical and mental exams. If they decide that the person is in need of mental health services and the person refuses to be voluntarily admitted to Eastern State Hospital, a judge of the General District Court is telephoned by the crisis counselor.

The judge arrives at the hospital and is briefed on the case by the counselor and physician. The judge will speak with the patient briefly to confirm the hospital staff's recommendation. The judge then decides whether to detain the individual, and, if so, he signs the detention order (Appendix W). RHCMHC staff indicate that the judge always concurs with staff recommendations on the issuance of detention orders.

Provision and Use of Mental Health Information

Court-Ordered Mental Health Evaluation

The staff note (Appendix S) outlining diagnosis, disposition, and treatment goals is forwarded to the requesting agent or agency. A copy

is usually sent to an attorney or parole officer and frequently, but not always, to a judge or court clerk.

The judge makes several uses of the information provided in the staff note. If a judge needs clarification or additional information, he may call RHCMHC and confer with the psychologist or psychiatrist. This happens only rarely, about once a year. The court may request RHCMHC staff to testify in court, perhaps six or eight times a year. The judge also has the option of asking for an evaluation from a second source. If no further information or services are requested, RHCMHC's involvement ceases.

Dispositions of Prescreening for Civil Commitment

Several recommendations and outcomes may arise from a prescreening evaluation:

(1) The individual may voluntarily admit himself or herself to Eastern State.

(2) Emergency room staff may refer the individual to RHCMHC, to a private psychiatrist, or to some other outside agency.

(3) A detention order may be signed by the judge if it is determined that civil commitment may be indicated and if the individual refuses to be voluntarily admitted. The judge telephones the Sheriff of Newport News to transport the individual to Eastern State Hospital. Copies of the detention order, prescreening report and the emergency room report of the attending physician accompany the patient to Eastern State.

A civil commitment hearing must be held at Eastern State within 72 hours of arrival. If a family member takes out a petition for commitment, the hearing may be held at Riverside prior to transport to Eastern State. The hearing incorporates due process procedural elements (i.e., the right to counsel, etc.). The judge may commit an individual for up to 180 days, but the case must be reviewed every six weeks by Eastern State personnel.

Quality Control and Overall Program Evaluation

External Standards of Licensure, Certification, and Accreditation

RHCMHC and Riverside Hospital are subject to the following review processes:

(1) Joint Commission on the Accreditation of Hospitals—for acute services, consolidated standards for psychiatric facilities, and community mental health centers;

(2) State Department of Mental Health and Mental Retardation—licensure for psychiatric beds, alcohol programs, and residential facilities;

(3) State Health Department—licensure to operate;

(4) Medicare—certifications (to receive monies);

(5) Medicaid—certifications;

(6) Professional Standards Review Organizations (PSRO)—monitoring by physicians of care received by recipients of Medicaid, Medicare, and Title V;

(7) Health Services Agencies—locally operated groups which review charges for services, purchases over $150,000, and federal grants;

(8) State Department of Mental Health and Mental Retardation—certification standards for mental health;

(9) State Department of Mental Health and Mental Retardation—certification standards for mental retardation;

(10) Blue Cross/Blue Shield—certification for participation;

(11) State Department of Education—standards for participation in residential programs for children;

(12) State Department of Corrections—standards for participation in residential programs for children;

(13) State Department of Mental Health and Mental Retardation—standards for participation in residential programs for children;

(14) State Department of Welfare—standards for participation in residential programs for children;

(15) Mental Retardation and Mental Health Services Board—local Chapter X ongoing review;

(16) Title XX—regulations as provider of services such as case management and special services to the disabled;

(17) National Institute of Mental Health—statistics provided annually until 1988 on the numbers of clients, services, etc;

(18) Office of Civil Rights of the Department of Health and Human Services—statistics under Title VI and VII;

(19) Rate Review--legislative program in Virginia; and

(20) Legislation all businesses are subjected to--local health and fire codes, Occupational Safety and Health Administration, Rehabilitation Act, etc.

The typical process of review for the majority of the above organizations begins with a written application for review. A site visit is then made by the reviewing organization. An application for certification involves more stringent review procedures because public monies are involved. An exception to this normal process is the Professional Standards Review Organizations which conduct numerous reviews throughout the course of the patient's hospital stay. Also, each organization reviews annually, except that the Professional Standards Review Organizations and the Chapter X boards conduct an ongoing review. In addition, the Joint Commission on the Accreditation of Hospitals may grant a two-year accreditation, thus precluding annual review.

Internal Quality Assurance Mechanisms

Various methods of internal evaluation are currently operating:

(1) Orientation for new employees;

(2) Weekly department meetings;

(3) Recording of numbers of hours spent in direct contact with clients, administrative duties, etc;

(4) Monthly meetings of administrative staff; and

(5) Monthly meetings of general staff.

In addition, case files are selected randomly for review each quarter. A records clerk pulls the files, which are then reviewed by a team of at least three professionals. The reviewers may include physicians, psychologists, and social workers. The goal is to review each case every ninety days.

A variety of demographic data such as clients' age, income, sex, race, and diagnosis is computerized. A goal in this area is to develop a database management system to facilitate cross-tabulation of several indices.

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12. Dayton Area Forensic Psychiatry Services. Competency, O.R.C. 2945.371 (Memorandum) Author, no date.

13. A Case Study of the Malcolm Bliss Mental Health Center, St. Louis, Missouri, No Author, Draft, September 14, 1972.

14. The preliminary letter shall include, if available, the following:

    (1) A statement of the person's family and occupational status, past delinquency and criminal records;

    (2) a summary of the facts surrounding the alleged crime, including reports of police investigation, if such document exists, a statement of his behavior while under arrest; and

    (3) an opinion as to whether he has a violent nature and what degree of security detention seems appropriate. (§552.045[3])

15. Co, B.T., How Medical Reports Are Done. Speech to the Missouri Bar Association, April 24, 1980.

16. Forensic Service Procedure Manual, Malcolm Bliss Mental Health Center, St. Louis, Missouri, May, 1980.

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DAYTON AREA

FORENSIC PSYCHIATRY SERVICES

ron R. Bussey, ACSW, Coordinator
Abbott Tower • 131 N. Ludlow Street • Suite 268 • Dayton, Ohio 45402
Telephone 513/253-3988 or 223-0081

INFORMED CONSENT

You have been referred to our service by the Court or Adult Parole Authority. The Court or Parole Officer who referred you is asking us to see you in order to help reach a decision about your situation. Your interview with a member of our staff is not confidential and a report will be written to the Court or Parole Officer who referred you. We will use our professional judgment as to what will be included in the report. The report becomes the property of the Court or Adult Parole Authority.

If for your own reasons you cannot, and/or refuse to talk with us, the Court or Adult Parole Authority will be so informed.

Your signature below indicates that you understand the above statement.

Witness_____ Date_____

_____
(Your Signature)

Forensic No._____

APPENDIX B

DAYTON AREA

FORENSIC PSYCHIATRY SERVICES

Harold R. Bussey, ACSW, Coordinator
Talbott Tower • 131 N. Ludlow Street • Suite 268 • Dayton, Ohio 45402
Telephone 513/253-3988 or 223-0081

AUTHORIZATION FOR RELEASE OF INFORMATION

DAYTON AREA FORENSICE PSYCHIATRY SERVICES

Name:_____ Date of Birth:_____

I hereby authorize_____ to exchange/release
(indicate one)

information concerning myself and case situation, with/to_____

_____. Nature and extent of information to be disclosed:_____

_____

_____

_____
Witness

_____
Signature of Client
(Parent or Guardian if client is a minor)

Date:_____

This consent for the release of information expires 90 days from the date signed and is subject to revocation at any time prior to that date. A copy of this release will be kept in the client's chart. Please retain this copy for your records.

Revised 10-1-78
F-7
FC-3

APPENDIX C

State of Ohio
Department of Mental Health and Mental Retardation
Division of Forensic Psychiatry

APPLICATION FOR CERTIFICATION

Certification is requested for the calendar year of _____ _____ *Initial* _____ *Renewal*

*Name of Center*_____

*Address*_____

_____

_____

*Telephone*_____

*Geographic Area Served (Counties)*_____

_____

_____

*Parent Organization (if any)*_____

Does the Center (or Parent Organization) have a Board of Directors?

_____ *(Yes)* _____ *(No)*

If no, to whom does the Center report? _____

_____

Does the Board of Directors have community representation? Explain

_____ _____ *(Yes)* *(No)*

Does the Center report statistics to the

(a) State of Ohio?

_____ *(Yes)* _____ *(No)*

(b) '648' Board?

_____ *(Yes)* _____ *(No)*

Name, signature, title and telephone listing of person compiling report who may be contacted for further information: _____
(Name)

_____ _____
(signature & title) *(telephone listing)*

APPLICATION FOR CERTIFICATION AND RE-CERTIFICATION
FOR FORENSIC PSYCHIATRIC CENTERS

A. Describe your Forensic Psychiatric Center by responding to the following questions.

1. Is your Center free-standing or is it a specific subsection of a larger mental health facility? (Describe or explain)

2. What is your center's location and who is served (City and/or County), or the population served?

3. What portion of your center's services are on an outpatient basis, and what other services are offered?

4. What hours are your center's services available?

5. Is your center exclusively state-supported? If not, is it responsible at some level to a community-based board? (Describe or explain)

B. Describe services provided by your Forensic Psychiatry Center by responding to the following questions.

1. Who are the Q.M.H.P.'s that will be doing written evaluations for pretrial, presentence, or postsentence clients?

2. Do the Q.M.H.P.'s offer emergency assistance to Common Pleas Court, Probation and Adult Parole in the geographic area the center serves?

3. Do the Q.M.H.P.'s offer case consultation on an informal basis to Common Pleas Court, Probation and Adult Parole in the geographic area the center serves?

4. Who will provide the expert testimony when requested by the Common Pleas Court in the geographic area the center serves?

Additional points may be obtained by responding to as many of the following questions as desired. On any question with a response of "yes", please describe or explain.

1. Does your center's service include treatment to clients in the criminal justice system? Specify.

2. Does your center's service include diagnostic services to the other criminal court systems - Municipal Courts, Juvenile Courts? Specify.

3. Does your center's service include emergency and consultation services to local incarceration facilities and police departments? Describe.

4. Does your center provide training and liaison to both mental health and criminal justice agencies?

5. Does your center provide research in forensic psychiatry issues? Specify.

6. Does your center provide public information? Specify.

Describe your staff by responding to the following.

1. Is there at least one full-time Q.M.H.P. in an administrative position? In a supervisory position?

2. Is there representation on staff of at least one board-eligible psychiatrist, one licensed clinical psychologist, and one M.S.W. with two (2) years experience who are directly involved in performing clinical evaluations? (Please include future planning.)

CONTINUED

5 OF 8

3. a. In regard to Common Pleas Court-ordered evaluations, are these evaluations in accordance with the law?

b. In regard to Common Pleas Court-ordered evaluations, whom on the bench may we refer to as to the acceptability of your reports?

4. On all other evaluations, are they performed by a Q.M.H.P., or are they supervised and individually reviewed by a Q.M.H.P.?

5. Is all treatment performed by, or under direct clinical supervision of a Q.M.H.P.?

D. Give data on the work of your center for the past year in the areas listed below.

	Common Pleas Court	Municipal Court
Competency Evaluation		
Presentence Evaluation		
Not Guilty by Reason of Insanity Evaluation		
Probations		
Paroles		

E. Respond to the following questions regarding reporting.

1. Does your center report monthly statistics on designated forms to the Ohio Bureau of Statistics in compliance with the rules and policies of the Division of Forensic Psychiatry?

2. Does your center report statistics to the Association relevent to these certification standards on a semi-annual basis on dasignatad forms?

F. Respond to the following regarding records and confidentiality.

1. Describe your center's standards of confidentiality and the complete process for achieving these standards. (Refer to the confidentiality statement.)

APPENDIX C (Continued)

2. Describe your center's record-keeping system in detail.

C. Regarding inservice training, please respond to the following questions.

1. Does your center have an inservice training program? If so, describe learning opportunities offered in forensic psychiatry areas.

2. Provide data on continuing education meetings attended by each Q.M.H.P. full-time staff member during the past year.

APPENDIX E
FORENSIC PSYCHIATRY ADMISSION REPORT

[illegible] Revised 10-73

A - Identification - Required of all agencies.

Agency Name: — Agency Number ▶ 1

2 State Case Number: ▶ 4

(Assigned by the Agency from a block of numbers provided by the Bureau of Statistics or the Bureau of Support. See instructions.)

3 Admission Date: (First contact resulting in a data workup under the supervision of a professional.) ▶ 12 — month / day / year

4 County of Ohio Residence: (YY-Unknown) (90-Out of State) ▶ 18

Census Tract Number: (if any) ▶ 20

B - Identification - Required of State Operated Agencies, otherwise optional.

1 Agency File Number on the patient: (if any)

2 Patient or Client:

Name — last / first / middle

Address — zip

3 Social Security No.

4 Responsible Authority or Guardian (if other than the patient):

Name

Address

C - Personal History - Required of all agencies:

Date of Birth: (If unknown make an age estimate) ▶ 26 — month / day / year

Sex: M - Male, F - Female ▶ 32

3 Ethnic Group: 1 - White, 2 - Black, 3 - Oriental, 4 - American Indian, 5 - Puerto Rican, 6 - Mexican American, 9 - Other, Y - Unknown ▶ 33

Marital Status: 1 - Never married, 2 - Married, 3 - Widowed, 4 - Divorced, 5 - Separated, 6 - Remarried, 9 - Other, Y - Unknown ▶ 34

5 Education: 0 - None, 1 - Grades 1-8, 2 - Grades 9-11, 3 - High School Graduate, 4 - Some College, 5 - College Graduate, 6 - Post-graduate Studies, 7 - Graduate Degree, 8 - Vocational, Technical or Business (Beyond high school), 9 - Other, Y - Unknown ▶ 35

6 Normal Occupation: ▶ 36

(Name the usual occupation even if unemployed or underemployed now)

7 Major Source of Income: E - Employment, U - Unemployment Compensation, P - Pension, Retirement or Disability, W - Public Assistance, Welfare, N - None, X - Other, Y - Unknown ▶ 37

Annual Family Income (in dollars) (YYYYY-Unknown) ▶ 38

9 Number of Persons in the Household: (Enter number of persons up to 9. Enter 9 for households of more than 9 persons. Enter Y if unknown) ▶ 43

Military Service: ▶ 44

Y - Unknown
0 - None
1 - Veteran
2 - Reservist
4 - Active Duty Now
Total

Prior Mental Health Evaluation, Counseling, or Treatment:

This Fiscal Year ▶ 45

Prior Fiscal Years ▶ 47

This FY / Prior FYears

YY - Unknown
0 - None
1 - Ohio State Operated Mental Hospitals
2 - Community Mental Health & Retardation Agencies (Both local and state operated)
4 - This Agency (Do not count in "2" also)
8 - Private Practice Mental Health Professionals
16 - Other Public Mental Hospitals (city, county, states other than Ohio, federal)
32 - Other Agencies or Hospitals (Psychiatric ward in General Hospitals, Private Hospitals or clinics)
Total

D - Administrative Data - Required of all agencies.

1 Source of Referral: ▶ 49

(See Source Code on the back of this sheet.)

2 Presenting Problem Admitting Diagnosis: ▶ 51

(See Diagnosis Code on the back of this sheet.)

3 Type of Service Environment: (Choose only the primary type) ▶ 52

1 - Inpatient (24 hour care)
2 - Intermediate Residential Care
3 - Partial Care (day care, night care)
4 - Sheltered Workshop
5 - School, Training Center
6 - Outpatient
7 - Emergency
8 - Home Visits
9 - Custodial Confinement (prison, jail, etc.)
0 - Other

4 Agency Program: ▶ 53

(Code the primary program if the agency is a multi-program agency; code the program if the agency is a single purpose agency)

Mental Health Services:
A - for the General Public
B - for Adults
C - for Children
D - for Mentally Retarded
E - for Drug Abusers
F - for Alcoholics
G - for the Handicapped
H - for Aftercare, Extramural patients
I - for Forensic referrals
J - for Crisis Intervention
K - Other

F - Administrative Data - Required of all Forensic agencies.

1 Date of Receipt of Referral: ▶ 54 — month / day / year

2 Type of Evaluation Requested: ▶ 60

1 - Pretrial; Expert Witness (2945.40)
2 - After Conviction, before sentencing (2947.25, Aschermen Act)
3 - Probation for Treatment of Drug Dependence (3719.51)
4 - Adult Probation
5 - Adult Parole Authority
9 - Other

3 County Where Charged: ▶ 64

4 Offense Charged With (most extreme penalty):

Ohio Revised Code: ▶

Number of Other Charges: (If more than 9, enter 9) ▶

[If the requested service is for a person already incarcerated and not in connection with a new charge, leave this block blank and use the following alternate block 5.]

5 Ohio Correction Institution Inmate Number: ▶ 71

Institution Code: (See Institution Code on the back of this sheet) ▶ 77

This block for State use only:

A - Admission
X - Delete this Record from the File

If you need help with this form call: (514) 466-2342
Out-patient Section/Bureau of Statistics

CODES FOR FORENSIC PSYCHIATRY ADMISSION REPORT

SOURCE OF REFERRAL

Select the individual, agency or facility recommending to the patient (or collateral) that he apply for service. Enter the code number in space provided. Classify by agency rather than worker, e.g., referral by school health nurse, record as a school referral.

01 - Self

10 - Family, Relatives

11 - Friends

21 - Private mental hospital

22 - Public mental hospital (federal, state, county, city)

23 - Psychiatric service of general hospital

24 - Residential treatment service for children

25 - Training school for mental retardation or epilepsy

26 - Psychiatric nursing home

29 - Other psychiatric inpatient facility

31 - Private psychiatrist

32 - Outpatient psychiatric clinic

33 - Psychiatric day care center

41 - Private physician

42 - Local health department

43 - General hospital

44 - Nursing home (skilled nursing and related medical services)

49 - Other medical or health agency, nurse

51 - Private psychologist

59 - Other psychological services (e.g., psychological counseling service)

60 - Social service agency (as in public welfare agency, family service agency, settlement house, child placement agency, marriage counseling, private welfare agency)

70 - Court, correctional institution, police, probation and parole service, attorney

71 - Common Pleas Court

72 - Municipal Court

73 - County Court

74 - Prosecutor's Office

75 - Client's Attorney

76 - Police, Sheriff

77 - Common Pleas Probation Department

78 - Municipal Court Probation Department

79 - County Court Probation Department

7A - Correctional Facility

7B - Adult Parole Authority - Parole

7C - Adult Parole Authority - Probation

7D - Re-referral for Aschernan Act

80 - School (elementary, high school, etc.)

91 - Clergy

92 - Alcoholics Anonymous

93 - Vocational rehabilitation

94 - Employment service, employer

95 - Boarding care home for the aged (personal and custodial care only)

99 - Other (specify)

YY - Unknown

PRESENTING PROBLEM / ADMITTING DIAGNOSIS

(Codes indicated are from the Second Edition of the Diagnostic and Statistical Manual, American Psychiatric Association)

A - Mental Retardation (310-315)

B - Organic Brain Syndromes (Excluding Alcoholism & Drug Abuse) (290, 292-294.2, 294.4-294.9, 309.0, 309.2-309.9)

C - Schizophrenia (295)

D - Affective Disorders (Including Psychotic Depressive & Depressive Neurosis) (296, 298.0, 300.4)

E - Other Psychotic Disorders (297, 298.1-299)

F - Alcoholism (Including Alcoholism associated with Organic Brain Syndrome) (303, 291, 309.13)

G - Drug Abuse (Including Drug Abuse associated with Organic Brain Syndrome) (304, 294.3, 309.14)

H - Behavior Disorders of Childhood and Adolescence (Including Adj. Reaction of Infancy, Chld. & Adol.) (307.0-307.2, 308)

J - All other mental disorders

K - Social Maladjustments without Manifest Psychiatric Disorder and No Mental Disorder (316)

Y - Unknown or undiagnosed mental disorder

MAJOR OCCUPATIONAL GROUPS AND DIVISIONS

The following code is based on the major occupational groups taken from the Dictionary of Occupational Titles. The numbers in parenthesis refer to major classifications used in the Dictionary of Occupational Titles.

A - Professional	(00-03)
B - Semi-Professional	(04-06)
C - Managerial and Official	(07-09)
D - Clerical and Kindred	(10-14)
E - Sales and Kindred	(15-19)
F - Domestic Service (employed privately)	(20-21)
G - Personal Service (open to the public)	(22-25)
H - Protective Service	(26-27)
I - Building Service Workers and Porters	(28-29)
J - Agriculture, Horticultural, and Kindred	(30-31)
K - Fishery	(38)
L - Forestry	(39)
M - Skilled Labor	(40-59)
N - Semi-Skilled Labor	(60-79)
O - Unskilled Labor	(80-99)
Q - Student	
R - Housewife	
S - Preschool	
Y - Unknown	

CORRECTION INSTITUTIONS

3 - Ohio State Reformatory

4 - Ohio Women's Reformatory

5 - London Correctional Institution

6 - Ohio Penitentiary

8 - Marion Correctional Institution

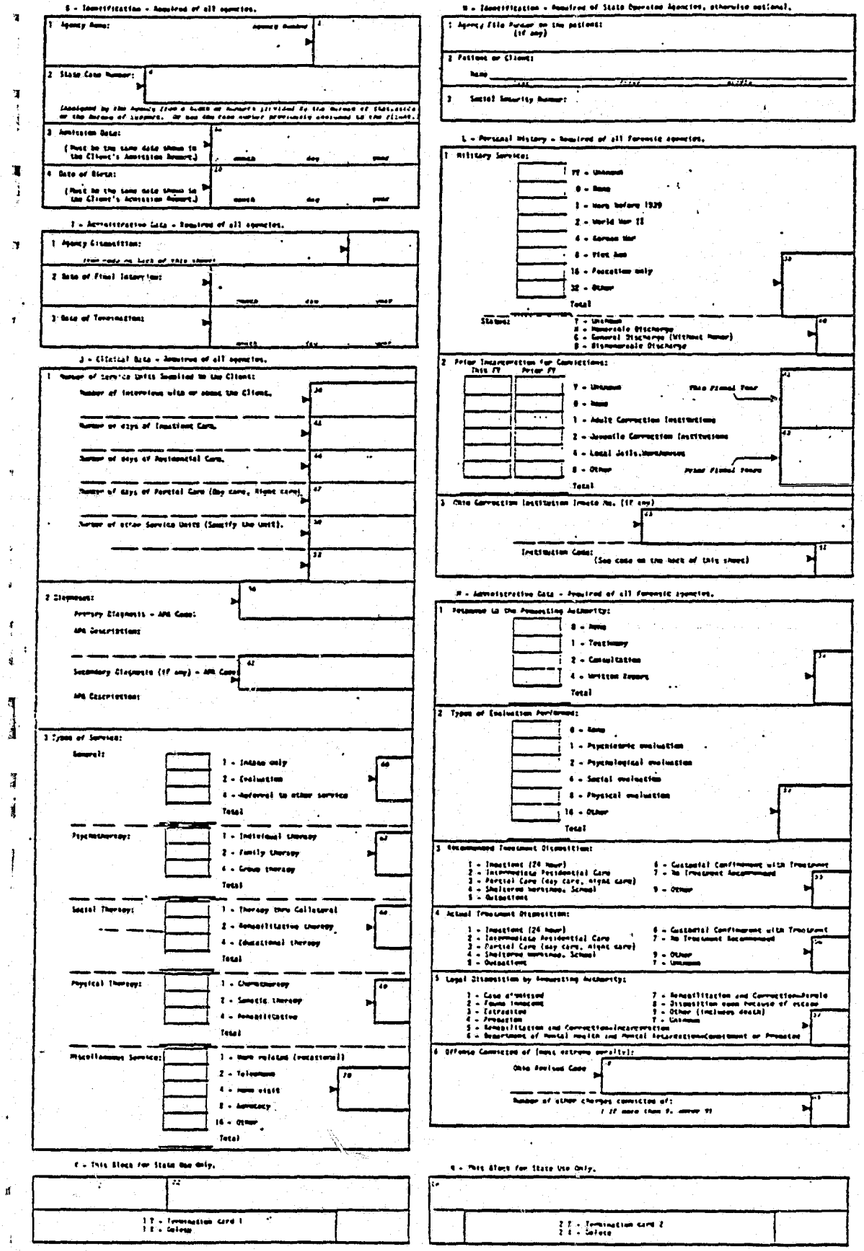
A - Lebanon Correctional Institution

F - Chillicothe Correctional Institute

S - Southern Ohio Correctional Facility

FORENSIC PSYCHIATRY TERMINATION REPORT

Revised Rpt 650-780TPP
Revised 10-79



CODES FOR FORENSIC PSYCHIATRY TERMINATION REPORT

DISPOSITION OF CASE

Select one category only, and enter the code number in the space provided.

If the patient withdraws from service, select one of the categories 01 through 03. If termination is at the initiative of the Community Mental Health Facility or by mutual agreement, select one of the categories 10 through 99.

If referral is made to more than one type of agency listed, check the most important referral only. If a patient has moved, select category '01' even though patient has been referred to an agency at his new location.

PATIENT WITHDREW FROM COMMUNITY MENTAL HEALTH FACILITY PROGRAM

- 01 - Facility notified - moved, died or ill
- 02 - Facility notified - other reasons
- 03 - Facility not notified

FACILITY TERMINATED - WITHOUT REFERRAL

- 10 - Further care not indicated at this time

FURTHER CARE INDICATED:

- 11 - Additional facility service needed but not available at this time
- 12 - Community resource other than this facility service needed but not available at this time
- 13 - Community resource other than this facility service needed and available, but patient or family not ready at this time
- 14 - Additional facility service(s) needed, but patient or family not ready at this time

FACILITY TERMINATED - WITH RECOMMENDATION OR REFERRAL FOR FURTHER SERVICE TO:

- 21 - Private mental hospital
- 22 - Public mental hospital (federal, state, county, city)
- 23 - Psychiatric service of general hospital
- 24 - Residential treatment center for children
- 25 - Training school for mental retardation, epilepsy or other disabilities
- 26 - Psychiatric nursing home
- 29 - Other psychiatric inpatient facility
- 31 - Private psychiatrist
- 32 - Outpatient psychiatric clinic
- 33 - Psychiatric day care center
- 41 - Private physician
- 42 - Local health department
- 43 - General hospital
- 44 - Nursing home (skilled nursing and related medical service)
- 49 - Other medical or health agency, nurse
- 51 - Private psychologist
- 59 - Other psychological services (e.g., psychological counseling service)
- 60 - Social service agency (as in family service agency, public welfare agency, settlement house, child placement agency, marriage counseling, private welfare agency)
- 70 - Court, correctional institution, police, probation and parole service, attorney
- 71 - Common Pleas Court
- 72 - Municipal Court
- 73 - County Court
- 74 - Prosecutor's Office
- 75 - Client's Attorney
- 76 - Police, Sheriff
- 77 - Common Pleas Probation Department
- 78 - Municipal Court Probation Department
- 79 - County Court Probation Department
- 7A - Correctional Facility
- 7B - Adult Parole Authority - Parole
- 7C - Adult Parole Authority - Probation
- 7D - Re-referral for Ascherman Act
- 80 - School (elementary, high school, etc.)
- 91 - Clergy
- 92 - Alcoholics Anonymous
- 93 - Vocational rehabilitation
- 94 - Employment service, employer
- 95 - Boarding care home for the aged (personal and custodial care only)
- 99 - Other (specify)
- YY - Unknown

CORRECTION INSTITUTIONS

- 3 - Ohio State Reformatory
- 4 - Ohio Women's Reformatory
- 5 - London Correctional Institution
- 6 - Ohio Penitentiary
- 8 - Marion Correctional Institution
- A - Lebanon Correctional Institution
- F - Chillicothe Correctional Institute
- S - Southern Ohio Correctional Facility

WARREN CIRCUIT COURT

INDICTMENT NUMBER_____ DIVISION NUMBER_____

COMMONWEALTH OF KENTUCKY PLAINTIFF

VS: ORDER FOR MENTAL EXAMINATION OF DEFENDANT AND NARRATIVE REPORT

_____ DEFENDANT

OFFENSE:_____

The above-named defendant having this day moved the Court for an Order directing that the said defendant be examined for the purpose of determining his competency to stand trial and his capacity to appreciate the nature and scope of his conduct or to conform his conduct to the requirements of law, on or about_____the date of the above-captioned offense(s) and the Court being sufficiently advised:

IT IS ORDERED that said Motion be and same is hereby sustained.

IT IS FURTHER ORDERED that the Court Administrator shall make arrangements with the Barren River Comprehensive Care Center for the examination ordered herein with notice thereof to the said defendant and/or the jailer, if in custody, otherwise to the defendant's attorney in writing. This forensic evaluation is to be conducted at the WARREN COUNTY JAIL, if in custody, or at the Barren River Comprehensive Care Center, 707 East Main Street, Bowling Green, Kentucky, if out on bond. Following the said examination a comprehensive narrative report thereof shall be furnished to the defendant's attorney _____as soon as practicable.

This _____day of _____,19___.

_____
JUDGE, WARREN CIRCUIT COURT
DIVISION NUMBER_____

HAVE SEEN:

_____ 1st Appointment:_____
ATTY. FOR THE COMMONWEALTH

TENDERED BY: 2nd. Appointment:_____

_____ 3rd. Appointment:_____
ATTY. FOR DEFENDANT

DEFENDANT'S STATUS:

TRIAL DATE_____ IN JAIL_____

OUT ON BOND_____ AS OF_____

APPENDIX G

COMPREHENSIVE CARE CENTER

NAME OF CLIENT | DATE

NAME OF EVALUATOR

_____, KENTUCKY
LOCATION

PSYCHO-SOCIAL EVALUATION

IDENTIFYING DATA	AGE	SEX	MARITAL STATUS M S D W SEP.	EDUCATION

Referral source (Information Requested ____ yes ____ no; Release Signed ____ yes ____ no)
Name:
Address:

Informant:

Chief Complaint (In client's words, why he or she is here now) ; Present Problem (Onset, Frequency, Intensity, Variations)

Interpersonal Status (Lifestyle, Family History; Family Relationships; Peer Relationships; Socialization Experiences, Financial Situations, Etc.)

Interpersonal Status (cont.)

Average Daily Routine (Including Eating/Sleeping patterns)

E[illegible]ployment and/or Educational History

S[illegible]ual Data (Education, Information, Traumatic experiences, Current functioning).

MEDICAL PROBLEMS ((PAST and PRESENT– Include physician, type treatment received; hospitalizations; medication given; allergies to medications; current physical condition. Describe any possible neurological problems (e.g. headaches; seizures, sudden personality changes, numbness, vision or hearing difficulties; difficulty talking, walking, swallowing) Note onset, duration, frequency.))

FAMILY PHYSICIAN:
Address:

DATE OF LAST PHYSICAL EXAM

CURRENT MEDICATION CLIENT IS TAKING (In past 2 weeks; kind, dosage, frequency).

DEVELOPMENTAL HISTORY (Include birthweight and length; Length of pregnancy; Problems in pregnancy/delivery; Birth Injuries; Feeding Problems; Age(s) of sitting unassisted; crawling; walking; toilet training; speech in words, phrases, sentences; special problems of childhood)

PSYCHIATRIC HISTORY (Include dates, places and treatment given during previous hospitalizations; Outpatient Treatment; or Treatment for Drug Abuse; Family History of Psychiatric or Other Neurological Disorder)

APPARENT HOMOCIDE OR SUICIDE RISK

Yes__ No__

(Circle above if appropriate)

HOMOCIDE or SUICIDE RISK (Describe thoughts, Recent attempts, Past attempts, Approximate dates)

MENTAL STATUS: Descriptive (Describe Appearance (Posture, Dress, Grooming, Outstanding Physical Feature); Motor Activity (Include–Gait, Tremors, Eye Contact); Mood and Affect; Verbal Communication, Rapport; Symptomatic Thoughts, Feelings, Actions)

MENTAL STAUTS: Cognitive Functions (Desctibe Orientation, Memory, Attention and Concentration, Judgement, Abstraction, Vocabulary, Perceptual Motor; Note Any Apparent Impairment)

Include Physical, Social, Legal, Employment, Academic, Religious, Dyadic Relationships, Children, Family, Sexual, Etc.

CUMMARY OF ROBLEMATIC LIFE AREAS

LINICAL IMPRESSION (May Include DSM II Diagnosis)

THER COMMENTS (Social Service Planning Activities Included Here)

Evaluator's Signature
Title

Supervisor(s) Signature
Title

APPENDIX H

COMPREHENSIVE CARE CENTER

REGION _____ LOCATION _____, KENTUCKY

FILE NUMBER _____

LAST NAME _____ FIRST _____ MIDDLE _____

BIRTHDATE _____ SEX _____ RACE _____

PSYCHOLOGICAL EVALUATION

DATE OF EXAMINATION: _____

CONFIDENTIAL

FOR PROFESSIONAL USE ONLY

EXAMINER (S):

TESTS ADMINISTERED: _____

CODE

KY-CCC-2-2

APPENDIX I

COMPREHENSIVE CARE CENTER

NUMBER _____ COUNTY _____

NAME _____ REGION _____ LOCATION _____, KENTUCKY

CONTRACT NAME _____ CONTRACT NO. _____

HISTORY (Medical and Psychiatric Evaluation)

(1) INFORMANT (2) CHIEF COMPLAINT (3) HISTORY OF PRESENT ILLNESS (4) PAST HISTORY (Illnesses, habits, etc.) (5) FAMILY HISTORY (6) REVIEW OF SYSTEMS (subjective symptoms) (7) MENTAL STATUS (general appearance and behavior, interpersonal attitudes, speech and communication, affect, ideation, perception, orientation and memory, intellectual function, judgment and insight) (8) DIAGNOSIS (9) TREATMENT PLAN (10) SIGNATURE.

DATE: | CODE

Continued on reverse side

KY-CCC-2-7(3-63)

APPENDIX J
SUGGESTED ORDER

STATE OF MISSOURI)
)
-vs-) CASE NO. _____
)
DEFENDANT)

ORDER FOR MENTAL EXAMINATION

The Court having examined the Motion for a Mental Examination filed herein, finds that there is reasonable cause to believe that the accused has a mental disease or defect excluding fitness to proceed.

WHEREFORE, IT IS ORDERED that the Director of the Department of Mental Health or his designee cause the accused to be examined by one or more individuals designated by the Director or his designee. The accused is hereby committed to the custody of the Director or his designee for such time and under such conditions as are necessary to complete the examination into the mental condition of the accused.

It is further ordered that those examining the accused report the results of such examination within sixty days of the date of this order, in writing and in triplicate to the Clerk of this Court. Such report shall contain:

(1) An opinion as to whether the accused, as a result of a mental disease or defect, lacks capacity to understand the proceedings against him or to assist in his own defense;

(2) A recommendation as to whether the accused should be held in a suitable hospital facility for treatment pending determination by the court of the issue of mental fitness to proceed; and

(3) A recommendation as to whether the accused, if found by the court mentally fit to proceed, should be detained in such hospital facility pending further proceedings.

(NOTE TO COURT: If the defendant has pleaded lack of responsibility or given notice of his intent to do so pursuant to § 552.030.2, you may wish to order the report to include the following in addition to the above:

(1) Detailed findings;

(2) An opinion as to whether the accused has a mental disease or defect, and the duration thereof; and

(3) An opinion as to whether at the time of the alleged criminal conduct the accused as a result of mental disease or defect did not know or appreciate the nature, quality or wrongfulness of his conduct or as a result of mental disease or defect was incapable of conforming his conduct to the requirements of law.)

It is further ordered that the parties provide the examiners forthwith the information cited in §§ 552.045.2 and 552.045.3, RSMo 1978, and any other information requested by the examiners. The examiners may also interview witnesses.

It is further ordered that the Sheriff's Department provide transportation to and from _____, the costs for transportation being taxed as costs in this action.
(Site of Exam)

Dated this _____ day of _____, 19___.

_____
JUDGE

APPENDIX K

BACKGROUND INFORMATION SHEET

General Information

Case No. _____

Defendant's Name: _____

Charges: _____

_____

Defendant's Occupation: _____

Prosecuting Attorney: _____
(County)

Defendant's Attorney: _____

_____
(Address)

_____

Psychiatric Background

Are any reports of a psychiatrist or psychologist available, and if so, where are they located?

Have authorizations for release of medical information been mailed to those noted above?

This Request for Mental Examination

What knowledge in your possession or observation of the defendant's behavior causes you to believe that the mental examination is necessary?

Are other individuals in possession of information possibly relevant to the individual's mental condition (e.g., use of alcohol or drugs, history of head injury, etc.)?

APPENDIX L

MENTAL STATUS EXAMINATION

(MISSOURI DEPARTMENT OF MENTAL HEALTH)

USE APGRESSOGRAPH OR FILL IN:

PATIENT NAME: _____
LAST NAME ONLY

REPORT DATE: _____ _____ _____
MONTH DAY YEAR

PATIENT NUMBER: _____ _____ _____
HOSPITAL NUMBER CASE NUMBER C.D.

INSTRUCTIONS: 1. IF ANY MAJOR SECTION IS NORMAL OR UNTESTABLE, CIRCLE "1" OR "2" AND GO TO NEXT SECTION.
2. IF NOT NORMAL OR UNTESTABLE, RATE ALL PERTINENT ITEMS BY CIRCLING: 1 = MILD, 2 = MODERATE, 3 = SEVERE.

122 GENERAL APPEARANCE 1=NORMAL 2=UNTESTABLE

FACIAL EXPRESSION:
123 SAD. 1 2 3
124 EXPRESSIONLESS 1 2 3
125 HOSTILE . . . 1 2 3
126 WORRIED 1 2 3
127 AVOIDS GAZE . . 1 2 3

DRESS:
128 METICULOUS . . 1 2 3
129 CLOTHING, HYGIENE POOR . 1 2 3
130 ECCENTRIC 1 2 3
131 SEDUCTIVE. . . 1 2 3

132 MOTOR ACTIVITY 1=NORMAL 2=UNTESTABLE
133 INCREASED AMOUNT 1 2 3
134 DECREASED AMOUNT 1 2 3
135 AGITATION . . . 1 2 3
136 TICS 1 2 3
137 TREMOR. . . . 1 2 3
138 PECULIAR POSTURING 1 2 3
139 UNUSUAL GAIT 1 2 3
140 REPETITIVE ACTS . 1 2 3

141 SPEECH 1=NORMAL 2=UNTESTABLE
142 EXCESSIVE AMOUNT. 1 2 3
143 REDUCED AMOUNT 1 2 3
144 PUSH OF SPEECH 1 2 3
145 SLOWED 1 2 3
146 LOUD 1 2 3
147 SOFT. 1 2 3
148 MUTE 1 2 3
149 SLURRED. . . . 1 2 3
150 STUTTERING 1 2 3

151 INTERVIEW BEHAVIOR 1=NORMAL 2=UNTESTABLE
152 ANGRY OUTBURSTS 1 2 3
153 IRRITABLE . . . 1 2 3
154 IMPULSIVE 1 2 3
155 HOSTILE . . . 1 2 3
156 SILLY 1 2 3
157 SENSITIVE . . . 1 2 3
158 APATHETIC . . . 1 2 3
159 WITHDRAWN 1 2 3
160 EVASIVE. . . . 1 2 3
161 PASSIVE 1 2 3
162 AGGRESSIVE. . . 1 2 3
163 NAIVE 1 2 3
164 OVERLY DRAMATIC . 1 2 3
165 MANIPULATIVE 1 2 3
166 DEPENDENT . . . 1 2 3
167 UNCOOPERATIVE 1 2 3
168 DEMANDING . . . 1 2 3
169 NEGATIVISTIC 1 2 3
170 GALLOUS. . . . 1 2 3

222 FLOW OF THOUGHT 1=NORMAL 2=UNTESTABLE
223 BLOCKING . . . 1 2 3
224 CIRCUMSTANTIAL . 1 2 3
225 TANGENTIAL. . . 1 2 3
226 PERSEVERATION 1 2 3
227 FLIGHT OF IDEAS . 1 2 3
228 LOOSE ASSOCIATION 1 2 3
229 IMPRECISIVE. . . 1 2 3

230 MOOD AND AFFECT 1=NORMAL 2=UNTESTABLE
231 ANXIOUS. . . . 1 2 3
232 INAPPROPRIATE AFFECT . . . 1 2 3
233 FLAT AFFECT 1 2 3
234 ELEVATED MOOD. . 1 2 3
235 DEPRESSED MOOD . 1 2 3
236 LABILE MOOD . . 1 2 3

237 CONTENT OF THOUGHT 1=NORMAL 2=UNTESTABLE
238 SUICIDAL THOUGHTS 1 2 3
239 SUICIDAL PLANS . 1 2 3
240 ASSAULTIVE IDEAS 1 2 3
241 HOMICIDAL THOUGHTS 1 2 3
242 HOMICIDAL PLANS . 1 2 3
243 ANTISOCIAL ATTITUDES . . 1 2 3
244 SUSPICIOUSNESS 1 2 3
245 POVERTY OF CONTENT 1 2 3
246 PHOBIAS . . . 1 2 3
247 OBSESSIONS — COMPULSIONS. . 1 2 3
248 FEELINGS OF UNREALITY . . 1 2 3
249 FEELS PERSECUTED 1 2 3
250 THOUGHTS OF RUNNING AWAY . . . 1 2 3
251 SOMATIC COMPLAINTS 1 2 3
252 IDEAS OF GUILT . 1 2 3
253 IDEAS OF WORTHLESSNESS . 1 2 3
254 IDEAS OF WORTHLESSNESS . 1 2 3
255 EXCESSIVE RELIGIOSITY. . 1 2 3
256 SEXUAL PREOCCUPATION . 1 2 3
257 PLANS OTHERS ILLUSIONS: 1 2 3

258 PRESENT. . . . 1 2 3
HALLUCINATIONS:
259 AUDITORY . . . 1 2 3
260 VISUAL 1 2 3
261 OTHER . . . 1 2 3
DELUSIONS:
262 OF PERSECUTION . 1 2 3
263 OF GRANDEUR 1 2 3
264 OF REFERENCE . . 1 2 3
265 OF INFLUENCE 1 2 3
266 SOMATIC. . . . 1 2 3
267 OTHER 1 2 3
268 ARE SYSTEMATIZED. 1 2 3

322 SENSORIUM 1=NORMAL 2=UNTESTABLE
ORIENTATION IMPAIRED:
323 TIME 1 2 3
324 PLACE 1 2 3
325 PERSON. . . . 1 2 3
MEMORY:
325 CLOUDING OF CONSCIOUSNESS. 1 2 3
327 INABILITY TO CONCENTRATE . 1 2 3
328 AMNESIA 1 2 3
329 POOR RECENT MEMORY . . 1 2 3
330 POOR REMOTE MEMORY . . 1 2 3
331 CONFABULATION . 1 2 3

332 INTELLECT 1=NORMAL 2=UNTESTABLE
333 ABOVE NORMAL . . 1 2 3
334 BELOW NORMAL 1 2 3
335 PAUCITY OF KNOWLEDGE. . 1 2 3
336 VOCABULARY POOR 1 2 3
337 SERIAL SEVENS DONE POORLY. . 1 2 3
338 POOR ABSTRACTION 1 2 3

339 INSIGHT AND JUDGMENT 1=NORMAL 2=UNTESTABLE
340 POOR INSIGHT . . 1 2 3
341 POOR JUDGMENT 1 2 3
342 UNREALISTIC REGARDING DEGREE OF ILLNESS . . 1 2 3
343 DOESN'T KNOW WHY HE IS HERE . . 1 2 3
344 UNMOTIVATED FOR TREATMENT . . 1 2 3

345—GLOBAL RATING — SEVERITY OF ILLNESS (CIRCLE ONE NUMBER):

1	2	3	4	5	6	7
NO DISORDER		MILD		MODERATE		SEVERE

DSM III DIAGNOSIS (TRANSPOSE CODES FROM REVERSE SIDE):

PRIMARY ☐☐☐.☐☐ SECONDARY ☐☐☐.☐☐

ADDITIONAL COMMENTS:

PHYSICIAN'S LAST NAME (PRINT) _____ SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

INSTRUCTIONS: RECORD DIAGNOSES CODES ON REVERSE SIDE.
Indicate the patient's diagnosis by placing a heavy mark in the box next to the appropriate diagnosis.
In cases of multiple diagnoses, underscore the underlying diagnosis and circle the primary diagnosis (see DSM-III, Section 1, Page 2).
To use "Fifth Digit Qualifying Phrases" (see below), write the digit behind the diagnosis to be qualified.

I MENTAL RETARDATION
☐ 310. Borderline
☐ 311. Mild
☐ 312. Moderate
☐ 313. Severe
☐ 314. Profound
☐ 315. Unspecified

ith each: Following or associated with
☐.0 Infection or intoxication
☐.1 Trauma or physical agent
☐.2 Disorders of metabolism, growth or nutrition
☐.3 Gross brain disease (postnatal)
☐.4 Unknown prenatal influence
☐.5 Chromosomal abnormality
☐.6 Prematurity
☐.7 Major psychiatric disorder
☐.8 Psycho-social (environmental) deprivation
☐.9 Other condition

II ORGANIC BRAIN SYNDROMES (OBS) PSYCHOSES
nile and pre-senile dementia
☐ 290.0 Senile dementia
☐ 290.1 Pre-senile dementia

Alcoholic psychosis
☐ 291.0 Delirium tremens
☐ 291.1 Korsakov's psychosis
☐ 291.2 Other alcoholic hallucinosis
☐ 291.3 Alcohol paranoid state
☐ 291.4* Acute alcohol intoxication*
☐ 291.5* Alcoholic deterioration*
☐ 291.6* Pathological intoxication*
☐ 291.9 Other alcoholic psychosis

Psychoses associated with intracranial infection
☐ 292.0 General paralysis
☐ 292.1 Syphilis of central nervous system
☐ 292.2 Epidemic encephalitis
☐ 292.3 Other and unspecified encephalitis
☐ 292.9 Other intracranial infection

Psychoses associated with other cerebral condition
☐ 293.0 Cerebral arteriosclerosis
☐ 293.1 Other cerebrovascular
☐ 293.2 Epilepsy
☐ 293.3 Intracranial neoplasm
☐ 293.4 Degenerative disease of the CNS
☐ 293.5 Brain trauma
☐ 293.9 Other cerebral condition

Psychoses associated with other physical condition
☐ 294.0 Endocrine disorder
☐ 294.1 Metabolic and nutritional disorder
☐ 294.2 Systemic infection
☐ 294.3 Drug or poison intoxication (other than alcohol)
☐ 294.4 Childbirth
☐ 294.8 Other and unspecified physical condition

III NON-PSYCHOTIC OBS
☐ 309.0 Intracranial infection
☐ 309.13* Alcohol* simple drunkenness
☐ 309.14* Other drug, poison or systemic intoxication
☐ 309.2 Brain trauma
☐ 309.3 Circulatory disturbance
☐ 309.4 Epilepsy
☐ 309.5 Disturbance of metabolism, growth, or nutrition
☐ 309.6 Senile or pre-senile brain disease
☐ 309.7 Intracranial neoplasm
☐ 309.8 Degenerative disease of the CNS
☐ 309.9 Other physical condition

* Categories subject to ICD-9 for use in the U.S. Only

III PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY

Schizophrenia
☐ 295.0 Simple
☐ 295.1 Hebephrenic
☐ 295.2 Catatonic
☐ 295.23* Catatonic type, excited*
☐ 295.24* Catatonic type, withdrawn*
☐ 295.3* Paranoid
☐ 295.4 Acute schizophrenic episode
☐ 295.5 Latent
☐ 295.6 Residual
☐ 295.7 Schizo-affective
☐ 295.73* Schizo-affective, excited*
☐ 295.74* Schizo-affective, depressed*
☐ 295.8* Childhood
☐ 295.90* Chronic undifferentiated*
☐ 295.99* Other schizophrenia*

Major affective disorders
☐ 296.0 Involutional melancholia
☐ 296.1 Manic-depressive illness, manic
☐ 296.2 Manic-depressive illness, depressed
☐ 296.3 Manic-depressive illness, circular
☐ 296.33* Manic-depressive, circular, manic*
☐ 296.34* Manic-depressive, circular, depressed*
☐ 296.8 Other major affective disorder

Paranoid states
☐ 297.0 Paranoia
☐ 297.1 Involutional paranoid state
☐ 297.9 Other paranoid state

Other psychosis
☐ 298.0 Psychotic depressive reaction

IV NEUROSES
☐ 300.0 Anxiety
☐ 300.1 Hysterical
☐ 300.12* Hysterical, conversion type*
☐ 300.14* Hysterical, dissociative type*
☐ 300.2 Phobic
☐ 300.3 Obsessive compulsive
☐ 300.4 Depressive
☐ 300.5 Neurasthenic
☐ 300.6 Depersonalization
☐ 300.7 Hypochondriacal
☐ 300.8 Other neurosis

V PERSONALITY DISORDERS AND CERTAIN OTHER NON-PSYCHOTIC MENTAL DISORDERS

Personality disorders
☐ 301.0 Paranoid
☐ 301.1 Cyclothymic
☐ 301.2 Schizoid
☐ 301.3 Explosive
☐ 301.4 Obsessive compulsive
☐ 301.5 Hysterical
☐ 301.6 Asthenic
☐ 301.7 Antisocial
☐ 301.81* Passive-aggressive*
☐ 301.82* Inadequate*
☐ 301.89* Other specified types*

Sexual deviation
☐ 302.0 Homosexuality
☐ 302.1 Fetishism
☐ 302.2 Pedophilia
☐ 302.3 Transvestitism
☐ 302.4 Exhibitionism
☐ 302.5* Voyeurism*
☐ 302.6* Sadism*
☐ 302.7* Masochism*
☐ 302.8 Other sexual deviation

Alcoholism
☐ 303.0 Episodic excessive drinking
☐ 303.1 Habitual excessive drinking
☐ 303.2 Alcohol addiction
☐ 303.9 Other alcoholism

Drug dependence
☐ 304.0 Opium, opium alkaloids and their derivatives
☐ 304.1 Synthetic analgesics with morphine-like effects
☐ 304.2 Barbiturates
☐ 304.3 Other hypnotics and sedatives or "tranquilizers"
☐ 304.4 Cocaine
☐ 304.5 Cannabis sativa (hashish, marihuana)
☐ 304.6 Other psycho-stimulants
☐ 304.7 Hallucinogens
☐ 304.8 Other drug dependence

VI PSYCHOPHYSIOLOGIC DISORDERS
☐ 305.0 Skin
☐ 305.1 Musculoskeletal
☐ 305.2 Respiratory
☐ 305.3 Cardiovascular
☐ 305.4 Hemic and lymphatic
☐ 305.5 Gastro - intestinal
☐ 305.6 Genito - urinary
☐ 305.7 Endocrine
☐ 305.8 Organ or special sense
☐ 305.9 Other type

VII SPECIAL SYMPTOMS
☐ 306.0 Speech disturbance
☐ 306.1 Specific learning disturbance
☐ 306.2 Tic
☐ 306.3 Other psychomotor disorder
☐ 306.4 Disorders of sleep
☐ 306.5 Feeding disturbance
☐ 306.6 Enuresis
☐ 306.7 Encopresis
☐ 306.8 Cognalgia
☐ 306.9 Other special symptoms

VIII TRANSIENT SITUATIONAL DISTURBANCES
☐ 307.0* Adjustment reaction of infancy*
☐ 307.1* Adjustment reaction of childhood*
☐ 307.2* Adjustment reaction of adolescence*
☐ 307.3* Adjustment reaction of adult life*
☐ 307.4* Adjustment reaction of late life*

IX BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE
☐ 308.0* Hyperkinetic reaction*
☐ 308.1* Withdrawing reaction*
☐ 308.2* Overanxious reaction*
☐ 308.3* Runaway reaction*
☐ 308.4* Unsocialized aggressive reaction*
☐ 308.5* Group delinquent reaction*
☐ 308.9* Other reaction

X CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON-SPECIFIC CONDITIONS
Social maladjustment without manifest psychiatric disorder
☐ 316.0* Marital maladjustment*
☐ 316.1* Social maladjustment*
☐ 316.2* Occupational maladjustment*
☐ 316.3* Dyssocial behavior
☐ 316.9* Other social maladjustment*

Non-specific conditions
☐ 317* Non-specific conditions*

No Mental Disorders
☐ 318* No mental disorder*

XI NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE
☐ 319.0* Diagnosis deferred*

DX Limited To Five Digits

FIFTH DIGIT QUALIFYING PHRASES

SECTION II	SECTION III	SECTIONS IV THROUGH IX	ALL DISORDERS
1 Acute	5 Not psychotic now	6 Mild	5 In remission
2 Chronic		7 Moderate	
		8 Se	

DMH-01 Rev. 9/79

APPENDIX M

NAME, HOSPITAL NUMBER, SEX

SOCIAL SERVICE REPORT

Forensic Social Service Data Base

Name
MB#:
Sex:
D.O.B.
SS#:
Address

Admitted: date
Ward: floor

PRESENT SITUATION:
- Patient is a age, marital status, race, employment status, sex, ordered to Malcolm Bliss by court, by judge. Patient is charged with_____. Information for this report taken from _____.

I. HOME:
Where and when patient was born and raised. Who are parents. How many siblings, and what order. Siblings psychiatric history and present status.
Patient's history for running away from home.
Patient's history for enuresis.
Patient's childhood history for treatment of animals.
Patient's history for lying.
Patient's childhood history for stealing.
Patient's childhood history for fighting and/or friendships.
Patient's childhood history for firesetting.

II. EDUCATIONAL HISTORY:
Where did patient attend elementary and high school.
What grades did the patient complete.
How did patient perform in school.
Was patient ever suspended, expelled or truant.
How were patient's peer relationships in school.
Did patient have any vocational or additional education.

III. EMPLOYMENT HISTORY:
Include full time or part-time, longest job, present job, reason for termination, any history of poor peer relationships or poor relationships with supervisors.

IV. SOURCE OF INCOME:

V. MILITARY HISTORY:
Dates of service, Branch, highest Rank, Discipline problems, type of discharge.

VI. MARITAL HISTORY:
Marriages, offspring, their ages and current status.

VII. LEGAL HISTORY: (chronological)
A. Juvenile:
B. Adult:

VIII. PAST PROBLEMS:
Miscellaneous, e.g. alcohol and drug abuse history; significant & relevant

NAME OF PATIENT	HOSPITAL NO.	LOCATION
Name	MB#:	Floor

DMD-110
Rev. 8/1/70

SOCIAL SERVICE REPORT

An Equal Opportunity Employer - A Non-Discriminatory Service

SOCIAL SERVICE REPORT

DMD-110

--medical problems, etc.

IX. SIGNIFICANT OTHERS INTERESTED IN PATIENT:

X. PLAN:
1) Patient is not to leave the ward unless ordered by Dr. Co or the Court.
2) Patient should be encouraged to participate in ward activities when appropriate.
3) This worker will maintain necessary social service contact with the patient and significant others.

Worker
Extension

SOCIAL SERVICE REPORT (Continued)

APPENDIX N

DEPARTMENT OF MENTAL HEALTH

FORENSIC INFORMATION SYSTEM

_____ Facility

_____ Date Referral Notice Received

SEQUENCE NUMBER: _ _ _ _ _

I. DEMOGRAPHIC INFORMATION

1. _____ Patient Number

_____ Date First Staff Contact

2. _____ Patient Name (Last, First, M.I.)

_____ Date Report Sent to Court

3. _____ Patient Alias(es)

Patient Missed Appointments _____ Yes _____ No

4. D.O.B. _____ Month _____ Day _____ Year

5. Sex _____ M _____ F

6. Race _____ Black
_____ White
_____ Am. Ind.
_____ Hisp.
_____ Other

7. Patient Status _____ Bond
_____ Jail

8. Patient Attorney _____ (Last, First, M.I.)

II. REFERRAL INFORMATION (From Court Order)

9. County of Referring Court _____

10. Judge _____ (Last, First, M.I.)

11. Offense(s) Charged

_____ _____

_____ _____

_____ _____

12. Questions for Evaluation (check applicable items)

_____ Chapter 552
_____ competency to stand trial
_____ whether hospitalization required pending determination of competency
_____ whether hospitalization required if found competent
_____ whether client has mental disease or defect
_____ whether client responsible at time of offense
_____ whether "diminished responsibility" exists
_____ recommendations for sentencing
_____ other than above (describe) _____

III. HISTORIC INFORMATION

13. Grade Achieved _____

14. Psychiatric History

_____	in-patient	_____	most recent year
_____	out-patient	_____	most recent year
_____	alcohol/drug	_____	most recent year
_____	M.R. facility	_____	most recent year
_____	none		

15. Most Recent Diagnosis Prior to Current Evaluation

_____

16. Number of Previous Felony Convictions

_____ 1
_____ 2 - 4
_____ more than 4
_____ none

17. Offense(s) for Which Convicted

_____ _____
_____ _____
_____ _____

18. Date of Most Recent Felony Conviction _____

19. A. Previous Misdemeanor Conviction _____ yes
_____ no

B. Previous Juvenile Offense _____ yes
_____ no

IV. EVALUATION INFORMATION

20. Site of Evaluation _____ in-patient
_____ out-patient
_____ jail

21. Signatory of Report _____ / _____
(Last, First, M.I.) SSN

_____
Profession (From DMH Code)

_____ / _____
(Last, First, M.I.) SSN

_____
Profession (From DMH Code)

22. Client Competent to Stand Trial? _____ Yes
_____ No
_____ Deferred
_____ Not Answered
_____ Not Asked

23. Client Sane at Time of Offense? _____ Yes
_____ No
_____ Deferred
_____ Not Answered
_____ Not Asked

24 Diminished Capacity Available? _____ Yes
_____ No
_____ Deferred
_____ Not Answered
_____ Not Asked

APPENDIX N (Continued)

25. Hospitalization Pending Trial?
_____ Yes
_____ No
_____ Not Answered
_____ Not Asked

26. Mental Disease or Defect?
_____ Yes
_____ No
_____ Deferred
_____ Not Answered
_____ Not Asked

27. Diagnoses DSM III
_____ Primary
_____ Secondary

28. Therapeutic Recommendations (check appropriate items)

_____ medication
_____ alcohol/drug rx
_____ out-patient rx
_____ no recommendations
_____ psychotherapy
_____ in-patient rx
_____ other

29. Sources of Information Available for Evaluation

_____ psychiatric interview
_____ social worker interview with client
_____ psychological testing
_____ written client statement
_____ police report
_____ autopsy
_____ confession
_____ interview(s) with family member(s)
_____ laboratory tests
_____ other

IN THE CIRCUIT COURT OF THE TENTH JUDICIAL CIRCUIT OF FLORIDA,
IN AND FOR POLK COUNTY. CRIMINAL DIVISION

APPENDIX O

STATE OF FLORIDA,

Plaintiff,

vs. CASE NO.

Defendant.

ORDER APPOINTING QUALIFIED EXPERTS TO EXAMINE DEFENDANT

The Motion of counsel for Defendant stating that he has reasonable grounds to believe that the Defendant may be suffering from serious mental problems came on for consideration and it appearing to the Court that a qualified expert should be appointed to determine the Defendant's mental condition at the present time, and at the time of the alleged offense, it is, therefore,

ORDERED AND DIRECTED that the Staff of the Peace River Center for personal Development under the direction of Dr. Kaplan, examine said Defendant. Regardless of the conclusion reached, said doctor shall furnish a written report to Honorable Jack O. Johnson, Public Defender, and shall furnish to the Court file, to the State Attorney and to the Public Defender a letter containing Defendant's name and case number, the date of this Order, the date of evaluation, and the doctor's ultimate conclusions regarding the defendants mental condition at the time of the offense and at the present time. The Mental Health Center of Polk County shall not disclose any communication made by the Defendant until further order of this Court, except that the doctor's evaluation report shall be given to this Court and to the Probation and Parole Commission upon the resolution of this case by a verdict of guilty or by a plea of guilty or nolo

APPENDIX O (Continued)

ORDERED that said examination by said doctors shall be held in the Polk County Jail, on the _____ day of _____, 1980, at _____. It is further

ORDERED that the arresting agency in this case be and they are hereby directed to provide, upon request, to the Staff of the Peace River Center for Personal Development, Forensic Unit, under the direction of Dr. Burt E. Kaplan, available criminal reports, and any statements made by the defendant or by witnesses pertinent to these reports. All copies of the foregoing documents shall be maintained in confidence by the Staff of the Forensic Unit.

ORDERED that provision of the Speedy Trial Rule shall be and the same hereby is, tolled for the period of time necessary to complete said examination and for ten (10) days after the filing of the conclusions with the Clerk of the Circuit Court, not counting the day of filing.

DONE AND ORDERED, in Bartow, Polk County, Florida, this _____ day of _____, 1980.

Copies furnished to:

Quillian Yancey
Public Defender
Forensic Unit
Sheriff/Jail

APPENDIX P

INTAKE INFORMATION FORM

1. FACILITY

Phone
Home
Work

2. PROGRAM | 3. CASE NO. | 4. CLIENT LAST NAME | 5. SUFFIX | 6. FIRST NAME | 7. MI

8. TRANSACTION TYPE
- O-Original
- M-Change or Correction
- M-Echo Request

12. ADDRESS

17. SEX
- M-Male
- F-Female

9. TRANSACTION DATE (MO. DAY Year)

11. BIRTHDATE (MO. DAY Year)

13. CITY

18. RACE/ETHNIC
- W-White
- B-Black
- I-American Indian
- A-Asian
- S-Spanish
- O-Other

19. MEDICAID CASE NO.

22. MONTHLY GROSS INCOME

14. STATE

15. ZIP

20. MEDICARE CLAIM NO.

10. SOCIAL SEC. NO.

39. FEE

16. COUNTY OF RESIDENCE CODE

21. NO. of dependents

23. YEARS OF EDUCATION

24. CATCHMENT AREA RESIDENT

25. LENGTH OF RESIDENCE

26. LIVING ARRANGEMENT
(Check One Box)
- 01-Independent
- 02-Parent's Home
- 03-Relative's Home
- 04-Emergency Shelter
- 05-Boarding Home
- 06-Foster Home
- 07-Group Home
- 08-Transitional Living
- 09-Child Care Inst.
- 10-Nursing Home
- 11-Retirement Home
- 12-Other Institution
- 13-Criminal Justice Facility
- 14-Other Living Arrangement

27. FAMILY ROLE
(Check One Box)
- 1-Head of Family Unit
- 2-Spouse Of Head
- 3-Child Of Head
- 4-Other Related Person

28. MARITAL STATUS
(Check One Box)
- 1-Married
- 2-Separated
- 3-Divorced
- 4-Widowed
- 5-Never Married
- 6-Cohabitation

29. PRIMARY PROBLEM AREA
- 1-Mental Health
- 2-Alcohol Abuse
- 3-Drug Abuse

30. OCCUPATION
(Check One Box)
Employed
- 1-White Collar
- 2-Blue Collar
- 3-Service Worker
- 4-Farm Worker
- 5-Homemaker
- 6-Student
- 7-Retired

31. EMPLOYMENT STATUS
(Check One Box)
Employed
- 1-Full Time ≥30 hrs/wk
- 2-Part Time<30 hrs/wk
- 3-Job Training

Unemployed
- 4-Under Age 18
- 5-Over Age 64
- 6-Mother With Child Under Age 6
- 7-Disability
- 8-No Job

32. PREVIOUS MENTAL HEALTH SERVICE
(Check All Appropriate Boxes)
- 1-Emergency
- 2-Inpatient (other than #3)
- 3-State Hospital
- 4-Partial Care
- 5-Outpatient
- 6-None

33. SOURCE OF REFERRAL IN
(Check One Box)
- 01-Self
- 02-Family Or Friend
- 03-Clergy
- 04-Priv. Prac. M.H. Professional
- 05-Non-Psychiatric Physician
- 06-Public Psychiatric Facility
- 07-Private Psychiatric Facility
- 08-MR Hospital/Program/
- 09-Public Physical Health
- 10-Vocational Rehabilitation
- 11-Adult Protective Services
- 12-Children & Youth Services
- 13-School System
- 14-Civil Court
- 15-Criminal Justice System
- 16-Public/Private Social Comm. Agency
- 17-Nursing Home
- 18-Other Medical Facility
- 19-Public/Private Alcohol Program
- 20-Public/Private Drug Program
- 21-Other

34. ADMISSION TYPE
- 1-First Admission to Service
- 2-Readmission to Service prior fiscal year
- 3-Readmission to Service after fiscal year

35. PRIMARY DIAGNOSIS

36. SECONDARY DIAGNOSIS

37. EMPLOYEE ID

38. TITLE XX ELIGIBLE
- 1. No
- 2. AFDC
- 3. SSI
- 4. Income Eligible
- 5. Grp. Eligibility
- 5. Medicare

ACKNOWLEDGMENT OF SERVICES

(Forensic Unit)

I understand that the Mental Health Center has been requested to evaluate me by _____.

I have had the nature of this evaluation service explained to me as well as the responsibilities of both the mental health staff and myself in this evaluation process.

I understand that a report of this evaluation will be submitted to _____ _____.

_____ _____
Patient's signature Date

_____ _____
Witness/Staff Member Date

PEACE CENTER CENTER FOR PERSONAL DEVELOPMENT, INC.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

RE: _____

DOB: _____ SOC. SECURITY # _____

I, _____, hereby give my permission for the _____ to release/obtain any information as indicated pertaining to my contacts or treatment to/from

NAME _____

ADDRESS _____

RELATIONSHIP _____

FOR THE PURPOSE OF _____

_____ SOCIAL DATA

_____ HOSPITAL DATE: HISTORY, PHYSICAL, LAB & X-RAY REPORTS, AND DISCHARGE SUMMARY

_____ PSYCHOLOGICAL REPORTS

_____ PERTINENT MEDICAL INFORMATION

_____ OTHER

All information I hereby authorize to be released will be held strictly confidential and cannot be released again without my written consent. I understand that the above authorization remains in effect until _____ I understand that I may revoke this authorization at any time, unless I am in treatment under special conditions which limit my rights to revocation.

WITNESS: _____ CLIENT SIGNATURE: _____

RELATIONSHIP TO CLIENT _____ DATE: _____

3.27.79

FORENSIC UNIT

APPENDIX Q

Peace River Center for
Personal Development, Inc.

COMPETENCY INTERVIEW

EXAMINEE_____ EXAMINER_____ DATE_____

1. APPRECIATION OF CHARGES: Assessment of the accused's understanding or literal knowledge of the charges against him, and to a lesser extent, the seriousness of the charges. It is important that the defendant understands that he is being accused of having committed an offense. Seriousness is important only insofar as it contributes to his indifferent cooperation.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

2. APPRECIATION OF RANGE AND NATURE OF POSSIBLE PENALTIES: Assessment of the accused's concrete understanding and appreciation of the conditions and restrictions which could be imposed on him if found guilty, and their possible duration.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

3. UNDERSTANDING OF THE ADVERSARY NATURE OF THE LEGAL PROCESS: Does the defendant understand that (1) his attorney is trying to assist him, (2) the State Attorney is trying to convict him, and (3) the Judge and jury are impartial.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

4. CAPACITY TO DISCLOSE TO ATTORNEY PERTINENT FACTS SURROUNDING THE ALLEGED OFFENSE: Assessment of the accused's capacity to give a basically consistent, rational, and relevant account of his movements and mental state at the time of the alleged offense. Intelligence, memory, and the validity of claimed amnesia should be assessed. Disparity between what an accused is willing to share with a clinician versus what he will share with his attorney should be considered.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

ABILITY TO RELATE TO ATTORNEY: Assessment of the capacity of the accused to communicate relevantly with his attorney. Assessment is based on accused's interpersonal communication with the interviewer. If the defendant has interacted with his attorney, assess the defendant's attitude toward him.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

6. ABILITY TO ASSIST ATTORNEY IN PLANNING DEFENSE: Assessment of the degree to which the accused can understand, participate and cooperate with his counsel in planning a defense consistent with the reality of his circumstances.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

7. CAPACITY TO REALISTICALLY CHALLENGE PROSECUTION WITNESSES: Assessment of the accused's capacity to recognize distortions in prosecution testimony and to aid his attorney in the confrontation of other witnesses. Relevant factors include attentiveness and memory.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

ABILITY TO MANIFEST APPROPRIATE COURTROOM BEHAVIOR: Assessment of the defendant's current behavior and his probable behavior when placed under the stress of courtroom proceedings. Evaluate his attitude and beliefs toward the legal system and the legal process.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

CAPACITY TO TESTIFY RELEVANTLY: Assessment of the accused's ability to testify with coherence, relevance, and independence of judgment, including both cognitive and affective factors which might influence his ability to communicate.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

10. MOTIVATION TO HELP SELF IN LEGAL PROCESS: Assessment of the accused's motivation to appropriately utilize legal safeguards to adequately protect himself. Passivity or indifference do not justify low scores on this item although actively self-destructive manipulation of the legal process arising from mental pathology does.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

11. CAPACITY TO COPE WITH STRESS OF INCARCERATION PRIOR TO TRIAL: Assessment of the stability of defendant's mental condition with regard to his ability to maintain adequate functioning for a reasonable duration while in the jail setting. The ability of the jail facility to cope with manipulative or malingered acting-out behaviors must be taken into account.

UNACCEPTABLE QUESTIONABLE ACCEPTABLE NOT APPLICABLE

ADULT EVALUATION CLIENT _____

INTERVIEWEE _____ DATE _____

EXAMINER _____ TIME _____

A. Purpose
B. Mental Status
C. Legal Issue (Offense, MDSO, Custody, Dependency)
D. Mental Health Treatment History
E. Medical Status and Treatment History
F. Substance Abuse
G. Interpersonal Relationships (Family, Friends, Frequency, Activities)
H. Personality/Characterological (Aggression, Planning, Motivation and Energy, Self-concept, Affectional)
I. Social History (Family, Residential, Economic, Education, Recreation, Religion)
J. Criminal History
K. Impressions (Competency, Personality Summary, Legal Disposition, Treatment)

APPENDIX R

REFERRAL

PERSON CALLING: _____

PT'S NAME: _____

DATE OF BIRTH: _____

DATE: _____

PARENTS OR SPOUSE: _____

ADDRESS: _____

PHONE: HOME: _____ ATTNY: _____

WORK: _____ OTHER: _____

RELATED CASE: _____

PROBLEM: _____

_____

_____

_____

_____

_____

_____

_____

PREVIOUS COUNSELING OR HOSPITALIZATION: _____

_____

MEDICATION: _____ DRUG ALLERGIES: _____

APPT ACCEPTED BY: _____ WITH _____ DATE & TIME: _____

FEE: _____ MEDICAID # _____

GROSS INCOME: _____

REASON FOR REFERRAL: _____

REFERRED BY: _____

RH-0251

APPENDIX S

STAFFING NOTE

NAME: _____

DIAGNOSIS:

DISPOSITION:

TREATMENT GOALS:

COMMENTS:

_____

signature

APPENDIX T

DATE OPENED_____ FEE_____ CASE NUMBER_____

INCOME_____ SOCIAL SECURITY NUMBER_____

HEALTH COVERAGE AND POLICY NUMBER_____

PATIENT_____ HOME PHONE_____

ADDRESS_____ WORK PHONE_____

_____ OTHER PHONE_____

DATE OF BIRTH_____ PLACE OF BIRTH_____ SEX_____ RACE_____

OCCUPATION_____ RELIGION_____

MARITAL STATUS_____ VETERAN STATUS_____

SCHOOL_____ GRADE REACHED_____ AGE LEFT SCHOOL_____

FATHER_____ D.O.B._____ OCC._____ D M W S SEP.

MOTHER_____ D.O.B._____ OCC._____ D M W S SEP.

STEP/
FOSTER PAR._____ D.O.B._____ OCC._____ D M W S SEP.

SPOUSE_____ D.O.B._____ OCC._____ D M W S SEP.

SIBLINGS OR CHILDREN	ADDRESS	BIRTH DATE	SCHOOL GRADE	OCCUPATION

OTHERS IN HOME_____ RELATED CASES_____

SOURCE OF REFERRAL_____ FAMILY DOCTOR_____

OTHER AGENCIES WITH CASE_____

PREVIOUS MENTAL HOSPITAL_____ DATE DISCHARGED_____

REASON FOR REFERRAL_____

PRECIPITATING EVENT_____

DIAGNOSIS_____

RECOMMENDATION_____

DATE CLOSED_____ IMPROVED_____

REASON FOR CLOSING_____ DIAGNOSTIC ONLY_____ TREATMENT_____

RH-0246

APPENDIX U
REFERRAL FOR PSYCHOLOGICAL TESTING

Date: _____

Name: _____

Age: _____ D.O.B. _____

Address: _____

_____

Phone: _____

Referred By: _____

Reason for Referral:

Appointment Date: _____

Notified By: _____

_____ Patient kept scheduled appointment for Psychologial Testing.

_____ Patient scheduled for additional testing:

Date: _____

Notified By: _____

_____ Patient did not keep scheduled appointment for Psychological Testing.

_____ Patient rescheduled for Psychological Testing:

Date: _____

Notified By: _____

_____ Patient did not keep scheduled appointment for Psychological Testing and no further appointments scheduled by the Psychology Department. Please refer the patient's folder back to the source of the referral or the staff member currently responsible for treatment.

Disposition of referral by staff member currently responsible for referral and/or treatment:

RH-0378

APPENDIX V

HOSPITAL PRE-SCREENING REPORT

DMH 223T

(For person age 18 and under or age 65 and above, attach CHILD & YOUTH or GERIATRIC PRE-SCREENING SUPPLEMENT)

NAME_____ DATE_____

AGE_____ DATE OF BIRTH_____ MARITAL STATUS_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE_____

WHAT IS THE NEXT LEAST RESTRICTIVE ALTERNATIVE TO HOSPITALIZATION AND WHY IS THAT INAPPROPRIATE COMPARED TO HOSPITALIZATION?

_____

_____

_____

NEAREST CMHC AFTERCARE PROGRAM_____

NAMES AND ADDRESSES OF COMMUNITY SUPPORT PEOPLE WHO CAN ASSIST IN DISCHARGE PLANNING OR PROVIDE ADDITIONAL ADMISSION DATA:

1. Name_____
   Address_____
   Phone_____
2. Name_____
   Address_____
   Phone_____

KNOWN PREVIOUS HOSPITALIZATIONS AND DATES_____

_____

_____

LEGAL STATUS

Are there criminal charges pending against the applicant....yes_____ no_____

Alleged charges_____

PRESENT SYMPTOMS OF MENTAL ILLNESS

Beside each of the symptoms listed below indicate the degree of severity on a scale of 0-5. If the symptom does not exist, list 0. A rating of 5 indicates extreme severity:

Poor judgment_____ Disoriented_____ Memory Loss_____ Paranoia_____ Delusions_____

Withdrawn_____ Depressed_____ Suicidal_____ Propensity to harm others_____

Hallucinates_____ Alcohol abuse_____ Drug abuse_____ Manic_____ Poor personal hygiene_____

Poor impulse control_____ Trouble in maintaining thought processes_____

Bizarre ideation_____ Inappropriate affect_____ Poor concentration_____ Uncooperative_____

Summary statement giving pertinent details about symptoms_____

_____

_____

_____

_____

Date of approximate onset of present condition_____

RH-0914

APPENDIX V (continued)

PHYSICAL HEALTH PROBLEMS

Cardiovascular Disorder.....yes____ no____ Respiratory Disorder.....yes____ no____

Neurological/Seizure Disorder...yes____ no____ Gastrointestinal Disorder.....yes____ no____

Diabetes.....yes____ no____

Other_____

Give Details_____

_____

Pertinent hereditary factors_____

Allergies....yes____ no____ Allergic to_____

Special diet....yes____ no____ Describe_____

All medications currently used (give dosage)_____

_____

_____

Date of last physical exam_____ Physician's Name and Address_____

_____

HOME STATUS

Employed....yes____ no____ Where?_____

Social Security #_____ Insurance Co._____ #_____

Medicaid #_____ Medicare #_____

Gross Family Income $_____

Does Applicant receive SSI checks?....yes____ no____ Amount $_____

Who is the payee?_____

Veteran.... yes____ no____ Retirement or other income....yes____ no____

FURTHER COMMENTS on any other factors or problems concerning the Applicant including such factors as repcipitating events, family situation, unique talents, strengths or skills and issues which could affect discharge planning. Name specific goals that should be met before the Applicant can return to the community.

_____

_____

_____

_____

_____

AUTHORIZATION

Source of Information_____

Relationsship to Applicant_____

I hereby authorize_____ to submit pre-screening admissions
(Name of CMHC)

data to _____ Hospital.

Date_____ _____
Signature of Applicant or Petitioner

Date_____ _____
Signature of Screener

APPENDIX W

VIRGINIA: IN THE CRIMINAL DIVISION, GENERAL DISTRICT COURT FOR THE CITY OF NEWPORT NEWS

DETENTION ORDER

It having been reliably reported to the undersigned that _____ is mentally ill and in need of hospitalization, and it appearing that such person cannot be conveniently brought before the undersigned or any other Judge forthwith, it is hereby ORDERED that any law enforcement officer finding such person within his jurisdiction shall take him/her into custody and place him/her in Eastern State Hospital, Williamsburg, Virginia.

It is further ORDERED that such person alleged to be mentally ill shall be detained in Eastern State Hospital for a period not to exceed the maximum period permitted by law, subject to further order by the undersigned or any other Judge having jurisdiction, and shall be, during such period of detention, examined by a physician or a physician and clinical psychologist licensed in Virginia who are skilled in the diagnosis of mental illness and not related by blood or marriage to the individual alleged to be mentally ill, and who shall report their findings to a District Court Judge or Special Justice of the Ninth Judicial District.

_____ Date _____ Hour

_____ JUDGE

_____ Typed Name of Judge _____ Address _____ Phone Number

INFORMATION ON PATIENT

_____ Full Name _____ Date of Birth _____ County/City of Residence

_____ Social Security Number _____ Marital Status _____ Name of Spouse

_____ Name, Address & Phone Number for Next of Kin

_____ Any Previous Hospitalization for Mental Problems-Names of Hospitals

Summary of Circumstances Requiring Detention Order:

_____

_____

_____

Chapter 7

CENTRALIZED FORENSIC MENTAL HEALTH FACILITIES

As already mentioned in Chapter 3, the oldest element of the forensic mental health service system is the centralized or "total" institution. This type of forensic unit--a maximum security, inpatient facility located within a prison or hospital for the criminally insane--typically serves an entire state or region. Client-offenders must be transported, often over long distances, to these centralized facilities and are usually hospitalized on an in-patient basis for mental health screening, evaluation, and observation. These centralized facilities generally have two main purposes. First, they serve as institutions of custody for "criminally insane" offenders, including persons found incompetent to stand trial, persons committed under special laws pertaining to sexual offenders or others deemed especially "dangerous," and those committed after being found not guilty by reason of insanity. Secondly, they serve as centers for the in-patient screening and evaluation of offenders (cf. Carlson, 1979).

The first American hospital exclusively for the care of mental patients was established in Williamsburg, Virginia, in 1770. Governor Fauquier first proposed the hospital in a speech opening Virginia's General Assembly on November 6, 1766:

> It is expedient I should also recommend to your Consideration and Humanity a poor unhappy set of People who are deprived of their Senses and wander about the Country, terrifying the Rest of their Fellow Creatures. A legal Confinement, and Proper Provision, ought to be appointed for these miserable Objects, who cannot help themselves. Every civilized Country has a hospital for these People, where they are confined, maintained and attended by able Physicians, to endeavour to restore them their lost Reason. (Dain, 1971, p. 7)

Nearly four years later on June 28, 1770, the General Assembly may have created the first service for the "criminally insane" in a central institution by approving "[a]n Act to make provision for the support and maintenance of ideots, lunatics, and other persons of unsound minds." The Act provided that a magistrate who knows or learns of a disordered person who is roaming about at large issue a warrant to the sheriff or constable commanding the appearance of the disordered person before three magistrates. The magistrates could examine the person and consider any written evidence as to the causes of his or her insanity. If a majority of the magistrates agreed, the person would be transported to the hospital. The court would later convene at a convenient time to reevaluate their initial decision, formalize the decision on the record, and make any other necessary arrangements for the disordered person.

Virginia still retains the centralized facility model for providing forensic screening and evaluation services. Forensic

evaluations are presently performed in the maximum security environment of Central State Hospital. However, there is some movement within the state to decentralize the process so that evaluation and treatment will occur initially in the community (Note 1). Nationwide,

> [d]ecentralization has occurred for several reasons. First, the community mental health movement has affected more and more types of mental health services and has finally reached the area of forensics. Second, lawsuits have exposed the often inhumane conditions existing in maximum security units and have ordered states to remedy the conditions. In developing remedies, states inevitably consider the alternative of decentralization. Third, a series of lawsuits has developed and validated the "least restrictive environment" doctrine. As a result, some states have studied their forensic populations and determined that not all need a maximum security environment. Fourth, economics have contributed to the trend. Doing out-patient exams in scattered communities is perceived as being both less costly and more efficient than performing forensic exams on an in-patient basis in a unit often located hours from the point of origin. (Petrila, 1981, p. 2)

But decentralization presents its own set of constraints and problems. Training of forensic specialists is complicated, and quality assurance has become increasingly attentuated. Because of these and other constraints, it is likely that the decentralization movement will evolve into a regional system. "In such a system, forensic units would be established in regions large enough to generate a case-load justifying a full-time forensic staff and small enough so that services are accessible to the courts." (Petrila, 1981, p. 2)

Nonetheless, forensic screening and evaluation persists in antiquated isolated institutions, and new centralized facilities are under construction and in planning stages (Note 2). And the old problems persist--difficulty in attracting competent staff to isolated locations; the often lengthy distance a client-offender and security personnel must travel; physical deterioration of the facilities; lengthy hospitalization; and the inappropriateness of a maximum security environment for many client-offenders.

This chapter describes three centralized facilities or "total" institutions that provide forensic mental health services to individuals accused or convicted of crimes: the Biggs Unit of the Fulton (Missouri) State Hospital; the Pretrial Branch, Division of Forensic Programs, St. Elizabeths Hospital, Washington, D.C.; and the Center for Forensic Psychiatry, Ann Arbor, Michigan.

THE BIGGS UNIT OF THE FULTON STATE (MISSOURI) HOSPITAL

The Biggs Unit of the Fulton State Hospital in Fulton, Missouri, began operation in 1938 as the sole maximum security mental health facility for Missouri's male forensic client-offenders. The Biggs Unit

was responsible for both forensic mental health evaluation and treatment. The 50 beds that were originally designated to accommodate pretrial client-offenders undergoing forensic evaluation soon became inadequate, and treatment facilities began to be used for evaluation purposes. Biggs was conducting 50 to 55 pretrial evaluations each month. Also, Biggs became a repository for a number of client-offenders who posed management problems but were inappropriately housed at this maximum security facility. This transformation occurred over several decades.

In 1974, the hospital changed from a departmental organization to a "unit" system and the Forensic Unit was created. This reorganization facilitated independent management control and policymaking. At the same time, Biggs instituted a plan to gain more control over its admissions. A memorandum was mailed to all county personnel who were responsible for bringing forensic client-offenders to Fulton. The sheriffs' and prosecutors' offices were given operational guidelines: appointments must be made in advance, prior to the client-offender's arrival at Biggs; a court order and police report must accompany the client-offender; any significant information as to medical needs or suicidal tendencies must be shared with the hospital. According to the admissions officer at Biggs, it took between nine months and one year to implement these new procedures. But even today, a newly elected sheriff may arrive at Biggs' door with an unscheduled forensic client-offender.

In 1978, the Committee on State Institutions and Property of the Missouri House of Representatives, chaired by State Representative Sue Shear, released a report entitled "Mental Health Care in Missouri's Criminal Justice System" (Note 3). The report addressed the issues of pretrial evaluations, placement of forensic client-offenders, treatment services available to female forensic client-offenders, and mental health services available to correctional inmates. As a result of this report and both public attention and internal movements within the State bureacracy, several significant changes in the resources devoted to forensic client-offenders took place. A Forensic Services Division was formed under the Comprehensive Psychiatric Services Division of the Missouri Department of Mental Health. A state director provides an organizational structure with goals and objectives to coordinate and plan delivery of services (Note 4). Effective decentralization of services has occurred as the forensic caseload is now more evenly distributed between Missouri's five state hospitals and three mental health centers scattered throughout the state. For example, Biggs is now performing 29 percent of the pretrial evaluations for the entire State, down from a 90 percent share in prior years.

The Fulton State Hospital Forensic Unit is divided into the Biggs Unit and the Rehabilitative Unit. The Rehabilitative Unit is a minimum security, locked ward serving non-dangerous client-offenders who have been set free before trial on their own recognizance or after paying bail. This Unit performs only six pretrial evaluations each year. The Biggs Unit conducts nearly all of the pretrial evaluations, since the majority of the client-offenders referred to Biggs are dangerous to

themselves or others, or could not pay bail, and must be housed in a maximum security facility. Biggs offers five programs serving chronic client-offenders, antisocial personalities, mental retardates, acute and recent admissions, and client-offenders awaiting trial. This chapter will focus upon the activities of the Biggs Unit.

The Biggs Pretrial Psychiatric Unit Team provides both evaluative and treatment services. The Biggs Admissions Director administratively classifies each referral according to the available case information and the court's opinion of the client-offender's needs. The classification codes are as follows:

C-1 Pretrial Observation
C-2 Incompetent to proceed with trial
C-3 Not guilty by reason of mental disease
C-4 Criminal sexual psychopath
C-5 Missouri State Penitentiary transfer
C-6 Other

Client-offenders classified by C-1 and C-2 codes receive the full battery (further explained below) of pretrial evaluation efforts. Client-offenders found incompetent to proceed with trial (C-2) by Biggs staff may be treated at Biggs for up to eighteen months or until competency is regained. Those client-offenders adjudged to be "Not guilty by reason of mental disease" (C-3) receive treatment at Biggs. Three-quarters of those classified C-3s are evaluated by the "Pretrial Team" prior to beginning treatment. Since the provision of the mental health statute delineating criminal sexual psychopaths was repealed as of August 13, 1980, the C-4 code applies only to those committed for treatment prior to that date. A C-5 code identifies client-offenders housed in a Department of Corrections facility who have been considered psychotic by a prison psychiatrist and transferred to Biggs for treatment. The C-6 category is used to describe those client-offenders who have been transferred from other state hospitals because of management problems or administrative difficulties.

This section is restricted to discussion of those client-offenders who are administratively classified as either C-1 or C-2. Client-offenders in need of pretrial evaluation (C-1) and client-offenders judged by the referring jurisdiction to be incompetent to stand trial (C-2) receive evaluations of their competency to stand trial or criminal responsibility. The other classifications of client-offenders are primarily recipients of treatment, as opposed to evaluative, services.

A Function Model

Figures 47, 48, and 49 depict the flow of cases, operations and processes characterizing the evaluation of client-offenders at Biggs. Figure 47 presents the specific activities and events prior to the client-offender's arrival at Biggs and the efforts involved in delineation of information on the case. The acquisition phase of the

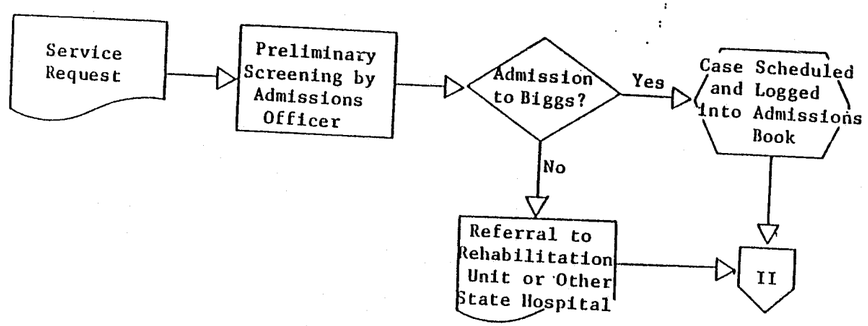


Figure 47. Case Processing Function Model of the Biggs Unit of Fulton (Missouri) State Hospital, Evaluation Information.

evaluation process is illustrated in Figure 48. Information collection begins the moment the client-offender is admitted to Biggs and continues throughout his stay at Fulton State Hospital. The third and final diagram (Figure 49) represents the provision of the evaluative information to the requesting court. The generation of court orders for commitment or motions to proceed with trial is also related to the provision function.

The delineation of the mental health evaluation process, as shown in Figure 47, begins when a request for services is received by the Biggs Admissions Officer. The request for mental health services by courts or detention facilities may be made by telephone or sent through the mail. The admissions officer conducts a preliminary screening by telephone to ascertain the appropriateness of the request for a mental health evaluation in a maximum security facility. The screening also serves to identify client-offenders in a crisis state needing emergency priority. Nonemergency cases are accepted chronologically. There is currently a four-month waiting period between date of request for services and scheduling of nonemergency evaluations. The number of possible admissions is dictated by the number of available beds, since all client-offenders at Biggs are evaluated as inpatients. (At this writing, the lengthy waiting time is exacerbated by renovation efforts which have caused only 20 beds to be available for pretrial evaluations. Ordinarily, 36 beds are available). If the requesting agent is not referred to another facility, the admissions officer schedules an appointment date and enters the following information into a ledger known as the admissions book: date of request, date scheduled, county of referring agent, name of client-offender, type of commitment, criminal charges, and any recommendation as to the use of suicidal precautions.

The essential operations and events conducted to acquire evaluative information about the client-offender are outlined in Figure 48. At the appointed time, a sheriff's deputy escorts the client-offender to Biggs and remains on guard as the admission process is completed. After the client-offender surrenders his personal belongings and enters the gates to the wards, the hospital becomes responsible for his security. During the average stay of 25-30 days, the client-offender is observed and evaluated by a physician, psychiatrist, psychologist, social worker, and ward attendants. A police report, if available, and social worker contact with an outside informant complements information acquired directly from the client-offender. According to the team director, under the best of circumstances a forensic evaluation team composed of a psychologist, social worker, psychiatrist, registered nurse, and attorney would discuss and interpret the evaluation results. In actuality, a forensic psychiatrist reads the reports of the various evaluators and summarizes the findings in a certificate of findings, a report which is forwarded to the referring court.

The provision of mental health information as delineated by the court and acquired by Biggs is illustrated in Figure 49. A client-

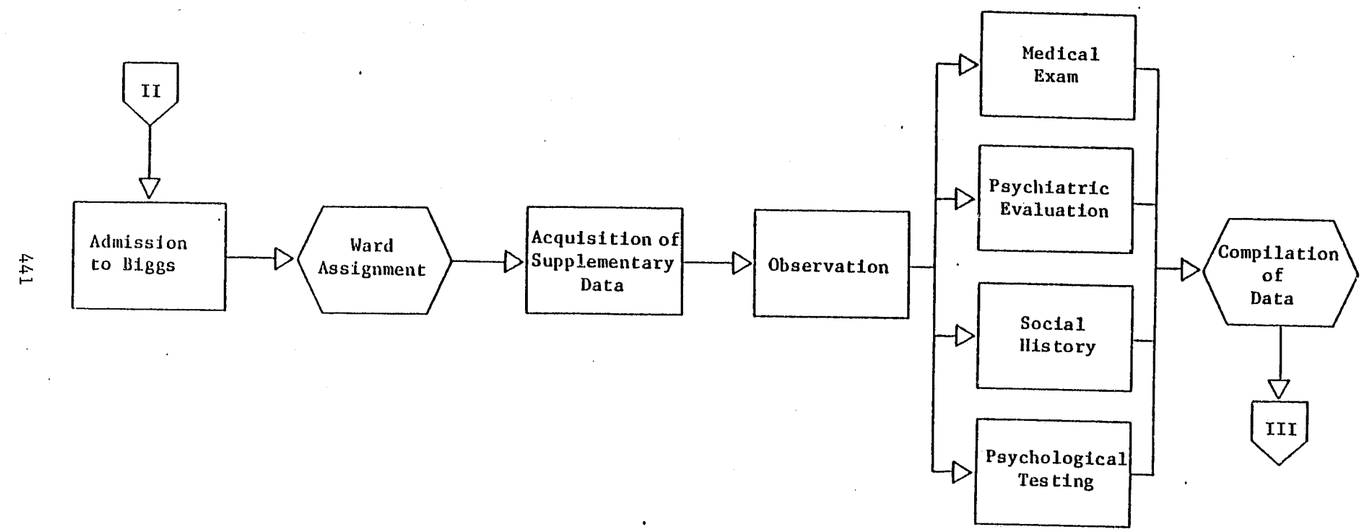


Figure 48. Case Processing Function Model of the Biggs Unit of Fulton (Missouri) State Hospital, Acquisition of Case Information.

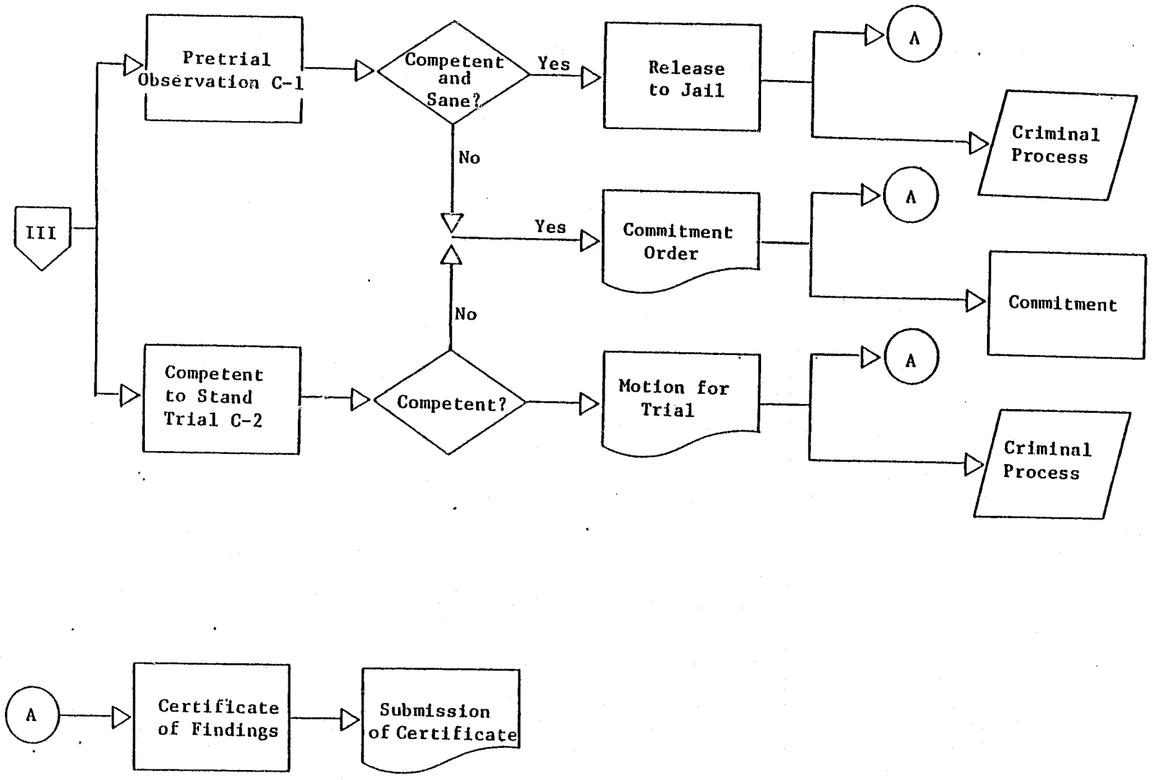


Figure 49. Case Processing Function Model of the Biggs Unit of Fulton (Missouri) State Hospital, Provision of Evaluation Information.

offender administratively classified as C-1 or C-2 who is found to be competent and without mental disease or defect is released to the referring court's sheriff's office. Following evaluation, civil commitment may be indicated for client-offenders who are classified as C-1 or C-2, and both are detained at Biggs while waiting for a court order authorizing commitment. If a client-offender once found incompetent to stand trial is judged to be competent, Biggs initiates the process to obtain a motion to proceed with trial. Two to four weeks later the court receives the motion and authorizes its jail to pick up the client-offender. In all cases, a certificate of findings is prepared, summarizing pertinent history, physical and mental status, course in hospital, condition at present, diagnosis, discussion, mental health findings presented in legal terms, and recommendations. Copies are made available to the judge, prosecuting attorney, and defense attorney.

Delineation of Mental Health Information Requirements

This section deals with statutory criteria relating to evaluation, criteria for admission to Biggs, and a chronology of procedures to request Biggs's assistance in mental health evaluation.

Criteria for Admissions to the Biggs Unit

In 1977, a memorandum was circulated among Fulton State Hospital staff delineating requirements for all admissions to Biggs (Lange and Bratkowsky, Note 5). For a client-offender needing a pretrial evaluation, the following information is needed for admission purposes:

(1) a court order;

(2) a letter from the referral agent which includes

  (a) a statement of the person's family and occupational status, past delinquency and criminal records;

  (b) a summary of the facts surrounding the alleged crime, including reports of police investigation (if such document exists), a statement of his behavior while under arrest; and

  (c) an opinion as to whether he has a violent nature and what degree of security detention seems appropriate (Mo. Rev. Stat. §552.045); and

(3) a determination by the referral agent indicating the necessity of maximum security evaluation.

A client-offender classified as Incompetent to Proceed With Trial (C-2) must arrive at Biggs with a "court order, police reports and/or any pertinent information regarding reasons for hospitalization" (Note 5). The memorandum also advises that the following questions be answered:

- Is the client-offender suicidal?
- Are there any significant medical problems?
- Is the client-offender combative in that he would be a danger to himself or others?

Biggs accepts emergency admissions with the stipulation that all the materials detailed above are received within ten days.

Court Orders

Since Biggs serves as Missouri's sole maximum security facility providing mental health evaluations for male forensic client-offenders, requests for services are received from all cities and counties of the state. The format of the court orders varies by jurisdiction and case. The order may simply provide for commitment to Fulton State Hospital for a "mental examination and evaluation." Or a client-offender viewed by the referring court as incompetent to stand trial (C-2) may be committed with an order for a psychiatric examination to evaluate competency to stand trial and to predict if competency may be regained in the future. The order may also direct that an examination be conducted in accordance with the applicable Missouri statutes, detailed in the next section.

The court order may frequently note that the reasonable cause requirement, a justification for the request for a mental health evaluation, has been met. Also, the order may include instructions as to transfer and release of the client-offender. Often the court order specifies those who are to receive a copy of the certificate of findings. And less frequently, the order may note that the case has been removed from the Trial Docket and placed on the Mental Examination Docket. This transfer from the Trial to the Mental Examination Docket represents the client-offender's temporary or possibly permanent transfer from the criminal justice system to the mental health system.

Statutes

In 1980, the Missouri General Assembly passed H.B. 1724, a comprehensive revision of the state's mental health code. The statutory changes governing pretrial examinations became effective August 13, 1980 (Note 6):

- Examinations may be conducted by private psychiatrists or individuals certified by the State Department of Mental Health. Formerly, only "licensed physicians" could perform the exams.
- Pretrial examinations must be completed within 60 days of the court order, unless there is "good cause" to increase the examination period.

- The examination is narrowed to allow a court to request only an evaluation of competency to stand trial; whereas formerly evaluations of both competency and criminal responsibility were inseparable.

The statute delineates the legal definitions of both competency to stand trial and criminal responsibility. Mo. Rev. Stat. §552.020.1 defines competency as the client-offender's "capacity to understand the proceedings against him or to assist in his own defense." A positive assessment of criminal responsibility means that

> [A] person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he did not know or appreciate the nature, quality or wrongfulness of his conduct or was incapable of conforming his conduct to the requirements of law (Mo. Rev. Stat. §552.030.1).

Referral Procedures for Telephoned Requests

Biggs may receive requests for evaluations by telephone or by mail. When the request is made by telephone, the caller is usually a sheriff or, in urban areas, a court clerk or judge. The admissions officer takes the call and asks several questions to ascertain the appropriateness of the request for admission. The following information is elicited by the admissions officer during the telephone call.

- "Is the client-offender in jail?" If the answer is yes, the questions continue. If the answer is no, the caller is referred to the minumum security Rehabilitation Unit of Fulton State Hospital or to another state hospital in the caller's area.
- The caller is asked to read the court order to ensure that the order is for a mental examination and not for commitment.
- Questions are asked to determine the possible emergency nature of the request. Typically, the caller is asked, "Is the client-offender acting strangely or harming himself? Does he have a history of attempted suicide?"
- The nature of the charges against the client-offender are discussed.

Once the admissions officer is assured that the incarcerated client-offender needing a mental health evaluation faces serious charges (typically involving violent behavior) and must be secured in a maximum security facility, an evaluation is scheduled. In determining the time of scheduling, information as to the emergency nature of the situation is crucial. The following information is entered into the "admissions book": date call received, date evaluation scheduled, county, name of client-offender, type of commitment (C-1, C-2, etc. classification), charge(s), and whether suicidal precautions are advisable.

Referral Procedures for Mailed Requests

Court orders for mental evaluations are also received in the mail without a prior phone call. If the request originates from the city of St. Louis or St. Louis County, the case is assigned to a Biggs psychiatrist, who typically conducts an interview at the jail where the client-offender is incarcerated. The psychiatrists may reach one of three alternatives: the client-offender may be found to have no mental dysfunction; further evaluation may be needed and the client-offender is sent to Biggs for a more extensive evaluation; or the client-offender may be found incompetent to stand trial and sent to Biggs for treatment to regain competency. As a result of this psychiatric evaluation at the jail, a client-offender may be admitted to Biggs and classified as either a C-1 needing further pretrial evaluation or as a C-2, an incompetent who is awaiting a court order for commitment. Since a Biggs staff member has judged this client-offender to be incompetent, no further in-house evaluation is needed.

If the mailed order does not originate in St. Louis City or County, the admissions officer telephones the referring court for more information, since a psychiatrist is not available to conduct an interview at a detention facility outside the St. Louis environs. The first question focuses upon the nature of the charge(s). If the client-offender is accused of a lesser nonviolent offense such as forgery, arson, or writing a bad check, and is unable (usually for financial reasons) to deposit bail, the admissions officer will suggest that the client-offender be evaluated at a minimum security state facility in his catchment area. Once information similar to that of any other telephone referral is gathered and the appropriateness of the referral is determined, an appointment for evaluation is scheduled. The information is then entered into the admissions book, as described above.

Acquisition of Mental Health Information

The typical length of a client-offender's stay at Biggs is 25 to 30 days. This section on the acquisition of mental health information begins with a short description of the staff who collect the information. Subsequent subsections summarize chronologically the numerous evaluative procedures, beginning with the hospital admission and continuing through each discipline's evaluation.

Staff

The acquisition of mental health information is conducted by a team of professionals representing a number of disciplines. The team is composed of one full-time Master's level social worker, one full-time licensed clinical psychologist, one psychometrician who specializes in administering psychological tests, three part-time psychiatrists who work a total of 41 hours per week; one physician who works 10 hours per week, and one registered nurse who works 2 hours per week. In addition, the team may be assisted by laboratory technicians, dentists, and neurologists.

Admission to Biggs

The acquisition of evaluative information about a client- offender begins shortly after the client-offender arrives as scheduled with the escorting sheriff's deputy. The admissions clerk welcomes new admissions and initiates the hospital's admitting procedures. Nursing personnel are notified that a client-offender is checking in and a nursing staff member is present during the client's admission interview.
The admissions clerk speaks with the client-offender and completes a "face sheet" (Appendix A). The Medical Records Department is telephoned to determine if the client-offender has been previously hospitalized at Fulton. If so, client-offender has a hospital record, the case number is reactivated. A folder containing a variety of forms to be used by ward staff is assembled and given to the attending nurse.

The nurse then escorts the newly admitted client-offender to the reception area where personal belongings are taken and placed in storage. The client-offender enters the maximum security ward. At this point, the hospital's responsibility for the client- offender's security begins; the sheriff returns to his jurisdiction.

Medical Examination

Hospital policy dictates that an examination by a physician occur within the first day of admission. The medical examination is in four parts.

(a) Psychiatric History. Data acquired include such information as: client-offender's name and case number; chief complaint; history of present illness; previous hospitalizations; past family history; medical history; substance use habits; and review of present medical status. (The form used to record psychiatric history is in Appendix B.)

(b) Mental Status Examination. A Missouri Department of Mental Health computerized form (Appendix C) suggests the information to be sought in this part of the medical examination: general appearance; motor activity; speech; interview behavior; flow of thought; mood and affect; content of thought; sensorium; intellect; insight; and judgment. A global rating as to severity of illness and a diagnostic code from the DSM-III (American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders--Third Edition) completes the form. Additional comments may be included.

(c) Admission Note. The preparation of this report (typically about two pages in length) is an incorpora- tion of many of the observations involved in the mental status examination. The physician dictates information relating to pertinent background facts; general knowledge; simple calculation skills; motor activity; speech; flow of thought; thought content; sensorium; insight; and judgment.

(d) Physical Examination. A routine physical examination is summarized in a report noting vital signs and general impressions of all physical functions and body parts. The physical examination report ends with narrative and diagnostic comments.

Laboratory Testing

Simultaneously with the medical examination, the physician routinely orders the following tests and procedures:

- Urinalysis;
- Chemical tests for blood sugar, cholesterol, liver, calcium, uric acid, etc.;
- Chest and skull x-rays;
- Complete blood count;
- Electroencephalogram; and
- Neurology examination.

If the client-offender is black, a test for sickle cell anemia is administered. An electrocardiogram is mandatory only if a client-offender is to be administered lithium, a psychotropic medication. A serologic test may be run to check for syphilis. An anagram to measure the level of psychiatric tranquilizers in the blood may be indicated if the client-offender is on medications at the time of admission.

The physician reviews the laboratory test results before placing them in the client-offender's chart. If there are any problems, tests may be administered a second time or the result may be reviewed by an internist who serves as a consultant to the hospital.

Because client-offenders are housed at Biggs for the purposes of pretrial evaluation only, the physician must obtain permission to treat from the referring court. However, if a client-offender is suicidal, a mood-elevating medication may be administered. In such cases, a telephone call or letter to the judge explaining the need for psychiatric medications and requesting permission to treat must follow shortly after treatment begins. The same provisions apply to a client-offender who needs restraint and relaxing medications.

Psychiatric Evaluation

By the end of the client-offender's second week at Biggs, the psychiatrist has typically received laboratory test results and other supporting information to aid in the evaluation of the client-offender. At this point, an initial clinical interview is conducted. The client-offender is first informed of his rights and notified that the interview

is not compulsory. If consent is granted, the client-offender is asked to state his or her version of the alleged crime. This is analyzed by the psychiatrist as to its form and content.

A complete mental status examination is conducted:

- Orientation--time, person, place, situation;
- Memory--recent, remote, of the crime;
- Retention and recall;
- Hallucinations, delusions, illusions;
- Knowledge of proverbs and similarities--e.g., "people who live in glass houses ...";
- Mood and affect;
- Ability to calculate;
- Insight and judgment;
- General appearance and behavior; and
- Intelligence as measured by general knowledge.

In addition to the above, competency to stand trial is assessed by the client-offender's response to the following questions: What are the duties of a judge? What are the duties of a jury? How many persons are on a jury? What is the judge supposed to do? What is your lawyer supposed to do for you? What is the function of a prosecuting attorney? What is the duty of a bailiff? What does "change of venue" and "appeal" mean? Are you willing and able to assist your attorney? What kind of defense will your attorney raise? Do you understand the charges against you?

The initial clinical interview lasts approximately one hour and fifteen minutes. The psychiatrist tries to build rapport and avoid antagonizing the client-offender at this time. Following the first encounter, the psychiatrist will review any notes and read the client-offender's chart looking for any discrepancies or inconsistencies in the information gathered. The ward attendants are often asked their opinion as to whether or not they feel the client-offender is mentally upset.

A second clinical interview is conducted one to three days after the first. The client-offender is asked about the alleged crime and then confronted with any discrepancies. At this point in the interview, the psychiatrist assesses the client-offender's use of lying and other defense mechanisms.

The psychiatrist then assesses the client-offender's criminal responsibility. The most important pieces of information used by the psychiatrist are the client-offender's version of the crime, police report(s), history surrounding the alleged crime's occurrence, and prior psychiatric history. The degree of "purposefulness" exhibited by the client-offender is gauged by the understanding of the rightness or wrongness of the alleged act.

Social History

During the initial days of admission, the social worker interviews the client-offender focusing upon the following concerns:

- o Client-offender's version of the crime and reactions to it;
- o Past psychiatriac hospitalizations or criminal incarcerations;
- o Past diagnoses and treatment;
- o Family psychiatric history;
- o Relationship with family and community;
- o Client-offender's amenability to treatment; and
- o Dangerousness to self or others.

During the interview, the client-offender is asked to identify a family member or another person who could help the social worker with the case. A packet of information is routinely sent to the person named, with an invitation to visit the client-offender at Biggs; visiting hours; general rules relating to visiting (such as restrictions on food and tobacco items); a social history questionnaire (Appendix D); and an invitation to come to the hospital to have a personal interview with the social worker.

Family members and friends are extremely helpful in the production of a social history. For many, the social worker is their sole informant as to the client-offender's whereabouts. Usually the family members wish to talk with the social worker. When they arrive at Biggs, the nursing supervisor typically calls the social worker. The social worker meets the family members in the visiting room and talks with them for twenty to thirty minutes. The social worker asks, "Is this man crazy? Do you think he should be here? Can you tell me about his past history?"

The social worker then compiles all available data into a social history report of approximately two pages in the following format:

- o Legal status of client-offender;
- o Type of admission to Biggs;

- o Informants--sources of information and the reliability of each source; and
- o Pertinent history that aids understanding of the present circumstances of the client-offender.

Psychological Evaluation

Concurrent with the other evaluations, a full battery of tests is routinely administered by the team's psychotechnician.

- o Wide Range Achievement Test--Reading;
- o Peabody Picture Vocabulary Test;
- o Revised Beta Test;
- o Graham-Kendall Memory-for-Designs;
- o Bender Visual-Motor Gestalt Test;
- o Sentence Completion Test;
- o A Competency Screening Test (Appendix E); and
- o Minnesota Multiphasic Personality Inventory.

These tests require approximately eight hours and several testing sessions to administer.

To complement the psychotechnician's testing, a clinical psychologist conducts an interview with the client-offender in which more information is sought.

- o Background information. Age, marital status, charge, prior felonies and arrests, prior psychiatric hospitalization, birth order, caretakers, highest grade completed, work history, military history.
- o Current medications.
- o Behavioral observations. General demeanor, speech, mood, ability to abstract, hallucinations, delusions, judgment, seizures, amnesia, severe headaches or severe blows to the head, sleep habits, appetite, suicidal or homicidal ideations.
- o General functioning. Account of the arrest, relevant background information concerning childhood, history of substance abuse, plans for the future.
- o Competency evaluation. Quality of relating to attorney, understanding of court procedures, appreciation of range and

nature of possible penalties, appraisal of likely outcome, capacity to function at trial.

The information gathered by the psychologist is recorded on a mental status examination form (Appendix C) identical to the one used by the admitting physician. The completed form is fed into a computer, which generates a compiled summary of the mental health findings.

The clinical psychologist then interprets the test results and summarizes all the evaluative data in a "Psychology Service Report." The format of the report is as follows:

- o Dates of testing;
- o Name of psychotechnician;
- o Tests administered;
- o Background information;
- o Medication at the time of testing;
- o Behavioral observations;
- o Intellectual evaluation;
- o Personality evaluation;
- o Summary; and
- o Tentative diagnosis.

Compilation of Data

The compilation and summary of data is done by the psychiatrist, who reads the report of each discipline's evaluation, as described above. This is necessitated by the fact that the psychiatrists perform the pretrial evaluation work on a part-time basis, frequently after normal business hours. The data compilation is followed by the preparation of a certificate of findings, discussed in greater detail below.

Provision and Use of Evaluation Information

Statutes

Missouri's mental health code specifies the format of reports submitted to the courts by mental health evaluators. Legislation, effective August 13, 1980, includes instructions for reports on competency to stand trial and criminal responsibility. Mo. Rev. Stat. §552.020.3 addresses the content of reports of competency evaluations:

(1) An opinion as to whether the accused, as a result of a mental disease or defect, lacks capacity to understand the proceedings against him or to assist in his own defense;

(2) a recommendation as to whether the accused should be held in custody in a suitable hospital facility for treatment pending determination by the court of the issue of mental fitness to proceed; and

(3) a recommendation as to whether the accused, if found by the court mentally fit to proceed, should be detained in such hospital facility pending further proceedings.

Details of an assessment of criminal responsibility are outlined in Mo. Rev. Stat. §552.020.4. The report should include:

(1) Detailed findings;

(2) an opinion as to whether the accused has a mental disease or defect, and the duration thereof; and

(3) an opinion as to whether at the time of the alleged criminal conduct the accused as a result of mental disease or defect did not know or appreciate the nature, quality, or wrongfulness of his conduct or as a result of mental disease or defect was incapable of conforming his conduct to the requirements of law.

Reports to the Court and Court's Use of the Reports

The certificate or court report represents a psychiatrist's compilation of all the data acquired during the course of the client-offender's stay at Biggs. The psychiatric staff have developed a model certificate (Appendix F). The certificate presently in use is divided into the following major categories: legal authority to conduct examination; reason for admission; legal status; pertinent social history; physical status; mental status; psychological testing; behavior in hospital; condition at present; diagnosis; discussion; findings; and recommendations.

Three copies of the completed report are mailed to the referring court. One copy of the report is for the referring judge. Typically a court clerk delivers copies to the prosecuting attorney and defense attorney. Both the defense and the prosecution have five days from receipt of the report to file a written request for a second mental health examination, the costs to be paid for by the requesting party (Mo. Rev. Stat. §552.020.5).

Although few empirical data are available, the Program Coordinator estimates that Biggs's recommendations are followed in ninety percent of the cases. The recommendations conclude the certificate of findings or court report. For example, the psychiatrist may recommend that a

client-offender stand trial or perhaps that a client-offender be committed for the purposes of care and treatment.

Consequences of Evaluation at Biggs

Several dispositions of a client-offender at Biggs may follow the completion of an evaluation and are dependent upon the staff's recommendations.

- If a client-offender is found to be sane and competent and his competent state was not obtained by the administration of treatment, the admissions officer is responsible for telephoning the sheriff's office to request a transfer back to the referring court's detention facility. The attending physician or social worker informs the admissions officer that the client-offender is ready to be returned to the deputy's custody. According to the program coordinator, eighty percent of the client-offenders evaluated at Biggs at the pretrial stage are found to be both competent and sane.

- If a client-offender undergoing a pretrial evaluation is not competent and sane and requires hospitalization, the referring court is asked for an order committing the client- offender to Biggs or another facility. The client-offender remains at Biggs while waiting for the court order.

- If an incompetent client-offender regains competency while at Biggs, a form is completed by Biggs staff to generate a motion to proceed with trial. The form is signed by the hospital superintendent and forwarded to the director of the Department of Mental Health in Jefferson City, Missouri. The director typically signs the form and sends it back to Fulton, and Fulton then forwards it to the court. The court initiates a motion to proceed with trial, and then authorizes their jail personnel to pick up the client-offender at Biggs. The entire process takes two to four weeks.

Quality Control And Overall Program Management

Internal Management and Statistical Reporting

A variety of mechanisms are in place to provide continuous monitoring of case processing in the Biggs Unit.

- An annual report of "workload indicators" is prepared for budgetary purposes: the number of admissions and transfers; average daily census; number of discharges; number of transfers to and from other programs; number of readmissions; number of clients and hours spent in individual, group and adjunctive therapies; number of pretrial evaluations; number of treatment plans and hours spent planning; number of court appearances; and number of contacts other than client contacts.

- A weekly Forensic Service Report is prepared for all inpatient pretrial cases. The report details the client- offender's name and case number, admission date, length of stay, and referring judge. This report is used by Fulton State Hospital.

- Another report prepared for the hospital's use focuses upon client-offender discharges from pretrial status. This report provides information on discharge date, total length of stay, and name of person to whom the client-offender was released.

- The program coordinator for the Pretrial Psychiatric Unit Team maintains a "log book" chronicling each client- offender's progress through the evaluative process. The following information is recorded: admission date; referring county; charge(s); consulting physician; opinion as to competency and criminal responsibility; diagnosis at discharge; and recommendation as to client-offender's discharge. In addition, a record is maintained of the completion of the medical history and physical examination, laboratory tests, social history, and psychological testing.

- The Missouri Department of Mental Health is implementing a Forensic Information Service collecting forensic data under the direction of the Missouri Director of Forensic Services. Court files and medical files are currently being reviewed to develop a centralized database dating from 1978. Judges, attorneys, and mental health personnel are being interviewed to ascertain their preferences in form and content for psychiatric testimony, demonstration of reasonable cause in motions for psychiatric examination, and court reports.

  Since July 1, 1980, the director of Forensic Services has been sent a copy of the court order, court report, and a data sheet on each Forensic client in the State of Missouri. The director's staff completes the remainder of the data on a standard form (Appendix G) utilizing the court order and court report of mental health findings. It is anticipated that these data will be placed in a computer system enabling a tracking of client-offenders by classification, referral location, and other indices. This tool will provide demographic, referral, historical, and evaluation information on Missouri's forensic population. The system was to be fully computerized by January 1, 1981.

- Client-offenders are informed of Biggs's procedures by the Handbook for Residents and a memorandum entitled Your Civil Rights. Through these documents, the client-offender learns of rights to receive visitors and to vote, and of the legitimate restrictions on receipt of mail, for example. It is possible that a client-offender could alert Biggs staff through the social worker of any irregularities in operating procedures, thus providing another form of internal management control.

Operating Standards

The Biggs Unit is subject to a number of standards and procedures imposed by governing agencies.

1) The Missouri Department of Mental Health has standards for the evaluation and treatment of mentally ill offenders and dangerous client-offenders in maximum security psychiatric facilities. One example is the procedures governing treatment plans. An initial temporary treatment plan must be completed within five working days of admission (Appendix H). A fourteen-day plan (Appendix I) finalizes the initial plan and records progress through the evaluative process. A client-offender receiving a pretrial evaluation is usually discharged before any further plans are required. A Biggs staff member serves as a treatment plan monitor to assure regular review and update.

2) Standards of the Missouri Department of Health and Medicare must be observed.

3) Biggs's location within a hospital places it under the purview of the Joint Commission on the Accreditation of Hospitals. Standards particularly applicable to Biggs are those relating to the environment and the staff.

Judicial Interventions

On August 11, 1979, Judge Hunter, of the United States District Court for the Western District of Missouri, issued an opinion in Eckerhart v. Hensley, 475 F. Supp. 908 (1979). This class action suit was sponsored by the Legal Aid Society of St. Louis and concerned the treatment and conditions at Fulton State Hospital. The opinion identified areas that need changes:

(a) Physical environment. Heating, air conditioning, painting, dormitories, lavoratories and bathrooms, facilities for the handicapped, windows, furniture, and personal belongings.

(b) Transfers to other facilities.

(c) Policies relating to visitation, receipt of mail and use of the telephone.

(d) Use of restraint and seclusion.

(e) Review of treatment plans.

As a result of this litigation, substantial renovation of the hospital's physical plant is under way to assure compliance with the court's directives. Procedures have been initiated to speed client-

offenders' transfers to a less restrictive environment. The visiting room is being remodeled and new visiting rules are in effect. Access to the telephone has been greatly increased and mail is opened only to check for contraband. Treatment plans are now monitored, as described earlier.

In addition to the above changes, a Unit Seclusion and Restraint Committee has been established. The members are the Program Coordinator, a registered nurse, a physician, and a representative from the security team. They randomly select files each week to review the forms completed by staff whenever a client-offender is restrained or secluded. If a problem surfaces, a lengthy review may be undertaken. If an employee has abused the procedures for restraint and seclusion, the supervisor is alerted to counsel the employee.

This court case also spurred administrative rules regarding the transfer and placement of client-offenders at Biggs. The Department of Mental Health's operating regulations Numbers 137 and 138 provide for pre-transfer hearings and placement staffing conferences related to the necessity of the client-offender's presence in a maximum security facility.

Quality Assurance

The Director of Forensic Services, John Petrila, has prepared a report entitled "A Proposal for Missouri Forensic Services in the Eighties" (Note 4) that identifies several quality assurance issues related to the provision of forensic services:

- Standards and certification for professionals performing forensic examinations;
- In-service training and continuing education for forensic staff;
- Creation of a Law-Mental Health Institute;
- Fellowship program in forensic psychiatry; and
- Standardization of forensic examinations and reports.

Petrila has also raised several questions addressing the role of Biggs as a maximum security unit. Further research will be needed to answer the following questions:

- What are the characteristics of the population being treated currently?
- Are all client-offenders being treated there actually in need of a maximum security environment?
- If not, are there programs elsewhere within the Department where they might be more appropriately treated?

- Should the capacity of the Biggs Unit be expanded, reduced, or remain the same?

- Should existing programs within the Biggs Unit be retained and should new programs be added?

Another issue relating to the provision of forensic services concerns facilities for female forensic client-offenders. There is presently no maximum security ward in Missouri for female client-offenders. At Fulton, for example, women requiring maximum security detention and pretrial evaluations are sent to the Acute Intensive Treatment Unit, a locked ward providing only minimal security. These women are often disruptive of normal ward routine because of bizarre behavior and actual or threatened violent activity. The solution to this problem is not an easy one. According to the Director of the Acute Intensive Treatment Unit, it is difficult to justify the costs of creating and operating a maximum security facility solely for the evaluation and treatment of female forensic client-offenders. Their numbers are small, but they are a population in need of improved services.

PRETRIAL BRANCH, DIVISION OF FORENSIC PROGRAMS, ST. ELIZABETHS HOSPITAL

St. Elizabeths Hospital is a psychiatric hospital located in Washington D.C. The hospital is a federal facility administered by the National Institute of Mental Health, Department of Health, Education and Welfare. It opened in 1858 and has had as its superintendents such noted forensic psychiatrists as William Alanson White and Winfred Overholser.

The hospital's organization includes a Division of Forensic Programs, which was established in 1969 and is located in the hospital's John Howard Pavilion. The Division of Forensic Programs consists of a number of branches, including the Pretrial Branch and the Posttrial Branch. Both branches are responsible for mental health evaluation and treatment of patients referred as a result of criminal court proceedings. The Pretrial Branch addresses questions of competency to stand trial and criminal responsibility, while the Posttrial Branch primarily is responsible for treatment of persons adjudicated not guilty by reason of insanity and sentenced prisoners transferred from correctional institutions. Only the Pretrial Branch is described in this section.

The Pretrial Branch serves the criminal divisions of the District of Columbia Superior Court and the United States District Court for D.C. The Branch may be called upon to provide any of three services: to assess whether a patient is competent to stand trial; to assess whether at the time that a patient is alleged to have committed an offense, he was criminally responsible; and to provide patients adjudicated incompetent to stand trial with treatment designed to restore them to competency. Evaluations are conducted on an in-patient basis. Persons admitted for evaluation may be hospitalized for as long as 60 days.

The Pretrial Branch consists of four wards containing a total of 100 beds (31 for females, 69 for males). The Branch processed approximately 600 patients in 1979.

A Function Model

The flow of criminal defendants into, through, and out of the Pretrial Branch is depicted in Figures 50, 51, and 52. Figure 50 indicates the various paths along which a defendant in the D.C. Superior Court whose mental state has been questioned might be directed. Figure 51 presents the same information for defendants in the U.S. District Court. Figure 52 indicates in detail how defendants admitted to the Pretrial Branch are processed.

The flow of the D.C. Superior Court defendant from the court into the Pretrial Branch and back to the court is represented in Figure 50. Questions relating to the defendant's competency to stand trial or criminal responsibility may be raised during any of a number of court hearings prior to trial. The question of competency to stand trial most commonly is raised at the defendant's first appearance before the court. Upon motion of the prosecution or defense, or sua sponte, the court may order a defendant screened for competency to stand trial by the D.C. Forensic Psychiatry Division (FPD) in its field office in the courthouse. The FPD conducts the screening and reports back to the court, usually within 24 hours. Based on the FPD's report, the court may take several actions.

- It may declare the defendant incompetent to stand trial and order him admitted to the Pretrial Branch for treatment and for evaluation for criminal responsibility if the insanity defense has been raised. This is discouraged by the Pretrial Branch administration and Superior Court Chief Judge because the practice may contribute to overcrowding at the Pretrial Branch; thus, it is rarely done.

- It may order the defendant to be evaluated more thoroughly. If he makes bail, evaluation is done on an outpatient basis in the FPD's D.C. office. If he fails to make bail, evaluation is done at the jail, or, if hospitalization is necessary, evaluation is done in a hospital setting (the Ugast Pavillion at D.C. General Hospital or, if Ugast is full, the Pretrial Branch of, Division of Forensic Programs at St. Elizabeths). An order may specify a criminal responsibility evaluation as well as a competency evaluation if the insanity defense has been raised.

- It may find the defendant in need of emergency hospitalization and order him immediately committed to the Pretrial Branch. This requires the concurrence of the Chief Judge.

- It may declare the defendant competent to stand trial.

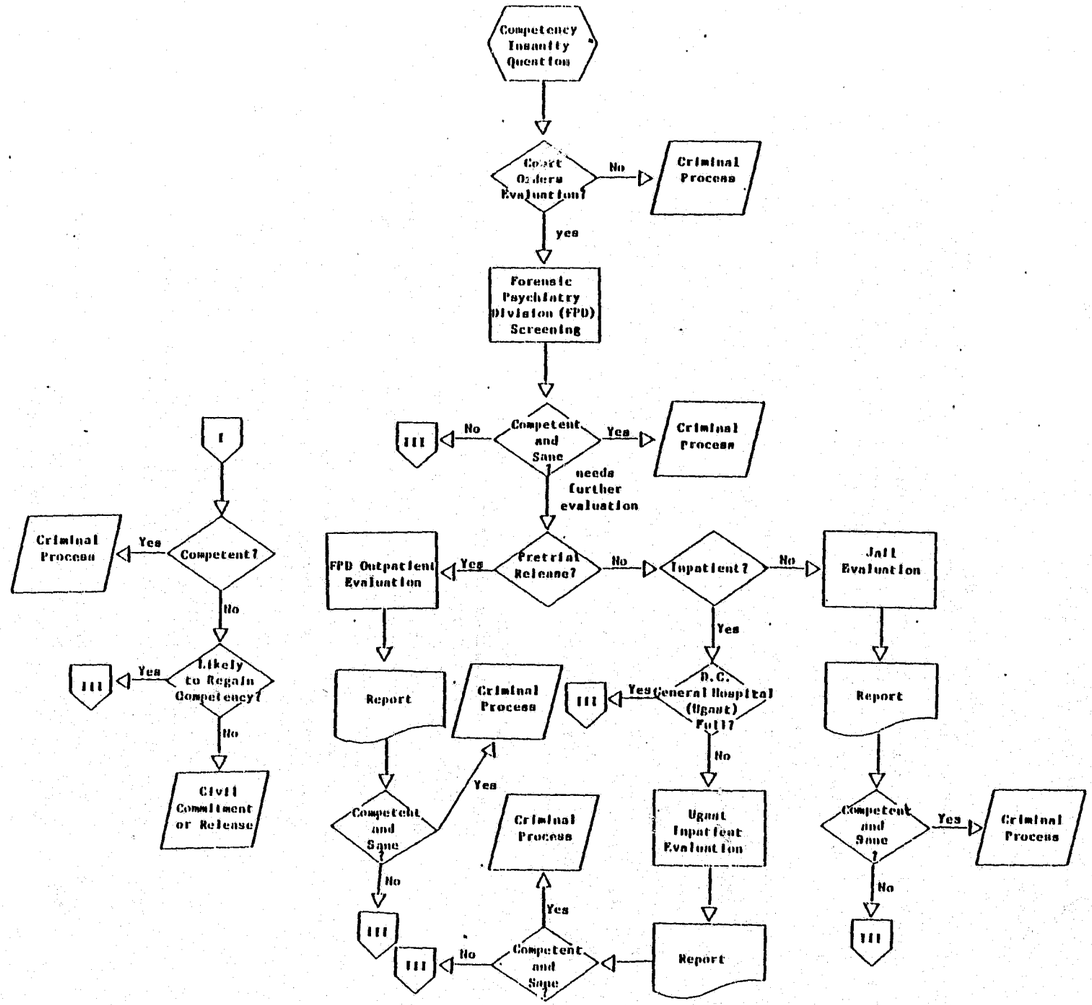


Figure 50. Case flow of Superior Court defendant whose mental condition has been questioned, Pretrial Branch of St. Elizabeths Hospital.

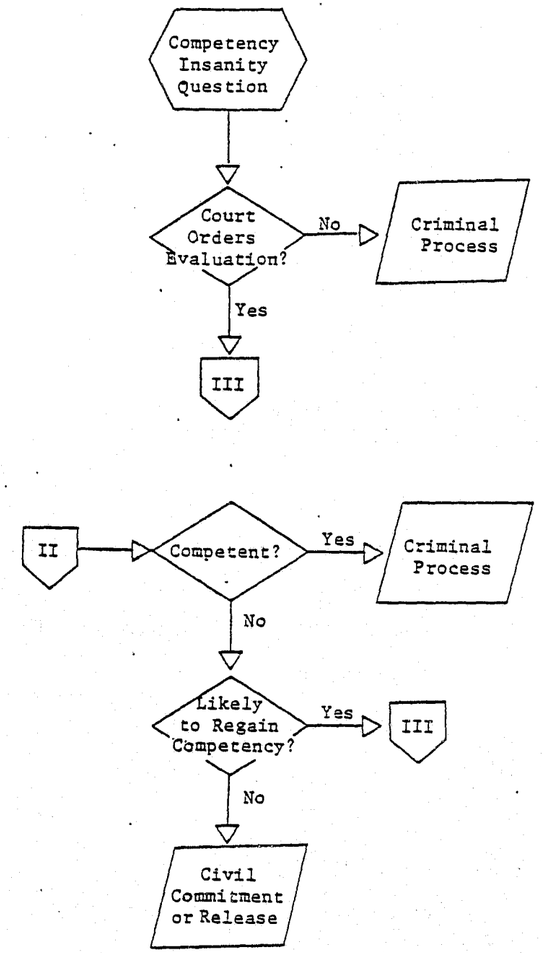


Figure 51. Case flow of U.S. District Court defendant whose mental condition has been questioned, Pretrial Branch of St. Elizabeths Hospital.

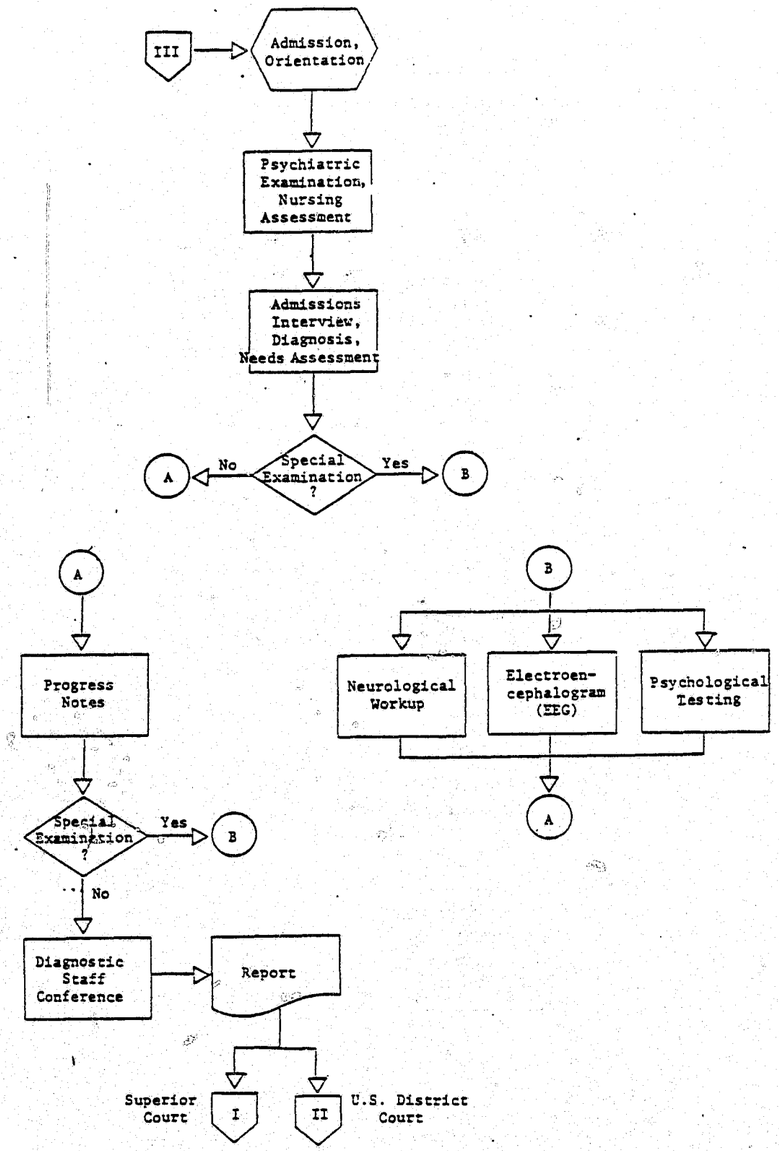


Figure 52. Case flow of defendant through Pretrial Branch of St. Elizabeths Hospital.

If the defendant is referred for further evaluation after the courthouse screening, the unit conducting such evaluation (i.e., FDP, jail, Ugast, Pretrial Branch) will report to the court its findings regarding competency to stand trial and, if requested, criminal responsibility. Opinions regarding criminal responsibility are not acted upon until trial. With regard to the question of competency to stand trial, the court will either find the defendant competent to stand trial or find him incompetent and order him committed to the Pre-Trial Branch for treatment designed to restore him to competency and possibly for further evaluation of criminal responsibility. After a period of treatment and evaluation, the Pretrial Branch will report to the court whether the defendant has regained his competency to stand trial. The Branch also will communicate its findings regarding criminal responsibility if a responsibility evaluation was ordered. If the defendant is found not to have regained his competency, he will remain with the Pretrial Branch for another period of treatment. At the expiration of this second period, the Branch again will report to the court, and the court either will find the defendant competent or conduct a Jackson v. Indiana hearing (see below). If at the hearing the Pretrial Branch reports that the defendant has made progress toward recovery and that it is likely that he will regain his competency in the foreseeable future, the court may return the defendant to the Pretrial Branch for further treatment; if the Pretrial Branch reports that it is unlikely that the defendant will regain his competency in the foreseeable future, the court will order the defendant released, staying the order for long enough to allow the government to institute civil commitment proceedings.

If the insanity defense is raised independently of the question of competency to stand trial, the defendant is ordered evaluated by the Forensic Psychiatry Division or the Ugast Pavillion at D.C. General Hospital. Unless he is admitted to the Pretrial Branch relative to the question of competency to stand trial, he will not be examined by Pretrial Branch staff. With respect to the patient evaluated for criminal responsibility while at the Pretrial Branch, the evaluation results are submitted to the court, and if the defendant is competent to stand trial, a trial will be held and the issue of sanity will be determined. If he is found not guilty by reason of insanity, he may be admitted to St. Elizabeths Hospital's Posttrial Branch for treatment.

The flow of the U.S. District Court defendant from the court into the Pretrial Branch and back to the court is indicated in Figure 51. The flow is the same as that indicated for the D.C. Superior Court defendant (Figure 50), except that the District Court defendant is not screened or evaluated by other units before he is admitted to the Pretrial Branch for evaluation. Upon the court's order that the defendant be evaluated for competency to stand trial or criminal responsibility, he will be admitted immediately to the Pretrial Branch and processed through in exactly the same manner as is the Superior Court defendant.

The flow of a defendant through the Pretrial Branch is indicated in Figure 52. (Throughout the discussion of the process that occurs during hospitalization, the defendant will be referred to as the

"patient.") At the time of the patient's admission to a ward of the Pretrial Branch, a brief clinical admission procedure is performed by a forensic psychiatric technician who obtains such basic personal information as the patient's age and date of birth. The technician makes a note of any unusual behavior exhibited by the patient. The patient then is provided an orientation to the ward.

Shortly after admission (within 8 hours), the patient is seen by a physician for a physical examination and a medical history. The patient also is seen by a member of the division nursing staff who conducts an interview and assesses the patient's nursing needs. Within 24 hours of the admission, the patient is seen for a clinical admission interview conducted by the ward administrator or the ward psychiatrist. At this time, an initial diagnostic impression is formulated and an initial assessment of potential psychiatric needs is made. Medication may be prescribed and the patient may be referred for a neurological "workup," an electroencephalogram (EEG) reading, or psychological testing. Plans are made to obtain such materials as police records (RAP sheet, arrest report, etc.), social history, and previous hospital records. Subsequent to these procedures and throughout the period of the evaluation, a continuing observation is undertaken by all members of the ward staff. The evaluation process culminates in a diagnostic staff conference in which all available members of the ward team participate. A review is made of all clinical materials, test results, hospitalization records, court-obtained materials, and social work reports. Generally, the patient is interviewed again by those attending the conference. Following this, a formal diagnosis of the patient is made, and opinions on competency and criminal responsibility are formulated. This information is summarized in a letter for the court, and the hospital awaits the court's determination of the questions involved.

If the individual is found to be competent, he is discharged from the hospital; if he is found to be mentally incompetent, he is remanded back to the hospital for treatment and further evaluation. In cases of continuing incompetency, the hospital may be asked to initiate and participate in a civil commitment proceeding if it is felt that the patient's mental illness is such that he is likely to be a danger to himself or to the community if released.

With respect to criminal responsibility, the findings of the Pretrial Branch are summarized in a letter to the court. Unless the patient is adjudicated incompetent to stand trial and detained in the hospital on that basis, he is released. The question of criminal responsibility is, of course, resolved at trial.

Delineation of Mental Health Information Requirements

Questions concerning the mental health of a person who has been arrested in the District of Columbia may be raised by any of a number of persons, including the arresting officer, officers transporting the person to the stationhouse, booking officers, bail agency representatives, the defense attorney, jail personnel, the prosecutor, or the

judge. When such a question is brought to the attention of the court, the court may order the person screened or evaluated for competency to stand trial or criminal responsibility.

The standard for determining whether a patient is mentally competent to stand trial, applicable in both the D.C. Superior Court and the U.S. District Court, is whether the defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding--and whether he has a rational as well as factual understanding of the proceedings against him" [Dusky v. U.S., 362 U.S. 402 (1960)]. The standard for criminal responsibility, virtually identical in the D.C. Superior and U.S. District Courts, is as follows:

> A person is not responsible for criminal conduct if at the time of such conduct, as a result of a mental disease or defect, he lacked substantial capacity either to appreciate [recognize] the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law [U.S. v. Brawner, 471 F2d 969 (D.C. Cir. 1972); Bethea v. U.S., A.2d (D.C. App. 1976)].

With respect to patients who are admitted after having been adjudicated incompetent to stand trial, the case of Jackson v. Indiana [406 U.S. 715 (1972)] has established that such patients cannot be held more than a reasonable period of time necessary to determine whether there is substantial probability that they will become competent in the foreseeable future. If it is determined that a patient will not become competent in the foreseeable future, the government must either institute the customary civil commitment proceedings against the person or release her or him from the hospital.

In federal court, the order for a mental health evaluation directs the defendant to the Pretrial Branch. The information required of the Pretrial Branch by the order is psychiatric opinion as to the defendant's competency or criminal responsibility (or both). The police report is supposed to accompany the order but often does not. In such cases, the chief of the Pretrial Branch or his secretary arranges for the police report to be sent.

The first mental health referral in the Superior Court ordinarily is to the D.C. Forensic Psychiatry Division's field office in the courthouse (see Figure 50). That office is directed to conduct a screening examination of the defendant and report whether he or she is competent to stand trial or whether further evaluation is necessary before such a determination can reliably be made. If further evaluation is indicated, such is ordered, and further psychiatric opinion is obtained. On rather rare occasions, this initial referral is to the Pretrial Branch; ordinarily, it is first directed to other units of the Forensic Psychiatry Division. The referral to the Pretrial Branch comes upon a court order and will either specify an evaluation to assess competency to stand trial and criminal responsibility (if the insanity defense has been raised) or declare that the defendant already has been adjudicated incompetent to stand trial (based on mental health

information obtained and provided by the Forensic Psychiatry Division) and direct that the defendant be treated for incompetency, evaluated for restoration to competency, and evaluated further for criminal responsibility if the insanity defense has been raised. The police report and any psychiatric reports resulting from prior screening by the in-court FPD staff or evaluation by FPD or Ugast staff are supposed to accompany the order. However, these reports often are not received and the chief of the Pretrial Branch or his secretary arranges by telephone for them to be sent.

Acquisition of Mental Health Information

Staff

The staff of the Pretrial Branch is multi-disciplinary and works as a team. There are 13 full-time professional staff and three consulting psychiatrists. The staff assigned to a particular ward typically will consist of a clinical administrator, a psychiatrist, a psychologist devoting approximately ten percent of his time to the ward, a social worker, and 17 nurses working in three shifts.

The chief of the Pretrial Branch has the responsibility for coordinating all pretrial evaluation and treatment activities in collaboration with the supervisory psychiatrist of the Pretrial Branch. This coordination involves scheduling all pretrial examinations, ensuring that the results of evaluations conducted by the clinical administrators and psychiatric consultants are reported to the court in a proper and timely fashion, serving as liaison to the courts with respect to scheduling admissions and discharges, and discussing administrative policy with representatives of the courts, the Department of Corrections, the United States Attorney's Office, and the Public Defender Service. The supervisory psychiatrist of the Pretrial Branch coordinates the evaluations conducted by the psychiatric consultants. In addition, he and the other staff psychiatrists provide consultation concerning medication and treatment planning. The psychologists assigned to the Pretrial Branch provide psychological assessments.

Social workers assigned to the Pretrial Branch prepare social histories on all patients and provide a liaison to various community agencies. Social workers are college graduates with at least two years of additional specialized training. Clinical administrators and clinical psychologists or psychiatrists are responsible for coordinating the evaluation and treatment programs on their respective wards, preparing reports to the court regarding these evaluations, and appearing in court as expert witnesses on issues of competency and criminal responsibility. The nursing staff perform day-to-day nursing functions. Additionally, they contribute to treatment planning, evaluation, and reports to the court.

The administrative assistant for the Pretrial Branch exercises general supervision over the clerical staff, the admissions coordinator, and the medical records monitor. He assigns and coordinates the

preparation of court reports and ensures that such reports are sent to the appropriate courts in a timely fashion. The clerk prepares letters to the court and drafts reports concerning staff conferences, psychiatric case studies, and treatment plans. The admissions coordinator is responsible for coordinating all of the information received on patients, including notifying the personnel involved in an evaluation when certain material arrives, notifying the registrar's office about the legal status of patients who are admitted, and obtaining information relating to psychiatric treatment received by patients on previous occasions in other institutions. The medical records monitor is responsible for organizing the charts of all patients and ensuring that all necessary information is in the chart before the patient is discharged. Also, he is responsible for obtaining records of previous hospitalization within Saint Elizabeths Hospital for patients who are readmitted.

Procedures and Techniques

Upon admission, the patient is taken to the ward in which he will reside during his stay in the hospital. There the patient is assigned a bed; provided a shower; and introduced to the ward staff, the clinical administrator of the ward, and the other patients. A copy of the Freedom of Information Act is provided along with an explanation of its purposes. At this time, a forensic psychiatric technician asks the patient basic questions relating to age, birth date, etc., and notes any unusual behavior on the part of the patient.

Shortly after admission (within 8 hours), the patient is given a complete physical examination by a physician. A member of the nursing staff also meets with the patient and speaks with the examining physician to determine the nursing needs of the patient (i.e., medication, allergies, etc.). As a result of the physician's examination, the patient may be transferred to a medical/surgical facility located elsewhere on the campus of the hospital for further treatment or testing.

Following the physical and the nursing assessment, the clinical administrator of the ward conducts an "admission interview" with the patient. This interview is conducted within 24 hours of the patient's admission and is designed to ascertain

- the reason for admission;
- the patient's mental status (including general appearance; behavior; orientation [knowledge of who he is and where he is and knowledge of day, month, and year]; attention; perception; memory; observed "mood" and "feelings;" quality of speech; and presence of any abnormal ideas or suicidal tendencies);
- the history of any previous psychiatric hospitalizations; and
- any current medical problems, current medication, and any known allergies related to food or medicine.

If the clinical administrator of the ward is not a psychiatrist (which is presently the case on the male wards), the patient also will be examined by a psychiatrist. The psychiatrist may be a staff member at the hospital or a doctor in private practice retained as a consultant by the hospital to examine the particular patient. The clinical administrator of the ward may refer the patient for psychological testing, an EEG, or a neurological workup as a result of the admission interview or at any time during the patient's hospitalization. The patient also will be interviewed by a psychiatric social worker. The social worker usually concentrates on the "social history," which includes family and community relationships. He usually interviews members of the family and others who have known the patient prior to his arrest. Observations made during interviews conducted by clinical administrators, psychiatrists, and social workers are documented and attached to the patient's chart.

Patients referred for psychological testing and evaluation are seen by a staff psychologist who determines what tests, instruments, and procedures are to be used in completing the evaluation. A number of different tests and techniques are employed to assess the patient's intellectual and emotional functioning. The following tests and techniques are commonly administered (some or all may be administered at the discretion of the evaluating psychologist):

- Face-to-face interview with patient
- Wechsler Adult Intelligence Scale (WAIS)
- Bender Gestalt Test
- Figure Drawings
- Thematic Apperception Test (TAT)
- Rorschach
- Record Review (history, social service/nursing notes, etc.)

Additional tests may be used to complement the evaluation and to address particular referral questions:

- Quick Test
- Benton Test of Visual Retention
- Memory for Designs Test
- Wechsler Memory Scale
- 16 Personality Factors Questionnaire (16PF)
- Minnesota Multiphasic Personality Inventory (MMPI)

In cases where the psychologist has determined that there may be brain damage and that a more extensive evaluation is needed, the Reitan Neuropsychological Test Battery or another equally comprehensive battery such as the Luria Battery may be administered. Psychologists are expected to function independently in assessing patients, and the use of tests, instruments, and procedures is at their discretion, depending, among other things, on the nature of the referral question, time limitations, and the patient's condition, disposition, and ability to cooperate. Upon the completion of psychological testing, the psychologist provides the clinical administrator of the ward with a written report of his findngs and summarizes his findings in the patient's chart.

If other tests or special examinations have been ordered (e.g., x-rays, blood tests, or neurological examinations), these will be performed and the results will be recorded in the patient's chart.

Subsequent to these procedures and throughout the period of the evaluation, an ongoing observation is undertaken by all members of the ward staff. These observations are recorded either on a psychiatrist's progress note or on a clinical record form and are attached to the patient's chart. The progress notes are recorded in sequential, chronological order. They reflect staff observations of the patient's behavior and thought processes as well as any particular problems that may exist with respect to patient management or medical issues. Patients' progress, problems, and mental status commonly are discussed informally by members of the team, usually at change of shift. When appropriate, referrals to other disciplines are made, such as referral for neurological evaluation, EEG, or psychological testing. Clinical interviews may be conducted by the psychiatrist or clinical administrator for the purpose of assessing changes in the patient's mental status and his understanding of the legal issues. Findings are documented in clinical notes and attached to the patient's chart.

After sufficient information becomes available, the clinical team holds a clinical "staff conference" to consider and attempt to answer the questions asked by the court. This conference, presided over by the clinical administrator, typically includes the psychiatrist, the psychologist who administered the psychological tests, the social worker, the ward's chief nurse, and the forensic psychiatric technicians. The patient's history is carefully reviewed and his behavior prior to and during hospitalization is assessed. The patient ordinarily is brought before the staff conference and interviewed. Following the interview, a discussion is held among the conference participants and a vote is taken on diagnosis, custody, medication, and other aspects of the treatment plan.

Provision and Use of Mental Health Information

Following the staff conference held by the clinical team at the conclusion of a patient's period of evaluation in the Pretrial Branch, the clinical administrator writes an official report from which a letter

is derived. The letter varies in length and style but always includes opinion responsive to the legal criteria of the particular question(s) posed and a basis for the opinion. Some letters, depending on the author and the judge for whom they are prepared, discuss other clinical findings possibly unrelated to the questions posed but descriptive of the mental status of the defendant. Copies of the letter are furnished to the court, the prosecutor, and the defense attorney. If there is disagreement among the staff regarding the diagnosis, this fact may be noted in the cover letter to the court.

The court may make the legal determinations of competency and criminal responsibility on the basis of the letter alone or may require expert testimony. A psychiatrist or clinical psychologist might be called to testify in a competency hearing or in a trial involving the insanity defense. Furthermore, should civil commitment proceedings be initiated, a psychiatrist may be called upon to testify at a mental health commission hearing.

Feedback, Monitoring, and Program Evaluation

The only apparent formal mechanism for program feedback, monitoring, or evaluation that functions externally of the Pretrial Branch is an evaluation conducted periodically (probably every two years or so) by the Joint Commission of Accreditation of Hospitals. The Office of Quality Assurance for the hospital is responsible for responding to the Joint Commission. The basis of the evaluation by the Joint Commission is documented in Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs (Joint Commission, 1979). This document contains standards of all programs covered by the accreditation program for psychiatric facilities, with the exception of community mental health services, which fall under a separate set of standards. This document also is used as a self-evaluation tool.

It is arguable whether the standards utilized by the Joint Commission effectively and efficiently accommodate the unique characteristics of forensic mental health programs. While Consolidated Standards deals extensively with such critical issues of quality of patient care as program management, patient management, patient services, and facility management, very little recognition of the interaction of the mental health and criminal justice systems is evident. Two entries in the document's index, "on court order" and "legal assessment," are the only mentions of criminal justice involvement made in the Consolidated Standards.

> When a patient is admitted on court order, the rights and responsibilities of the patient and family should be explained . . . this explanation should be fully documented in the patient's record. (p. 56)

In drug abuse programs, a legal assessment of each patient shall be undertaken which shall include the following areas as

> a minimum: (a) a legal history; and (b) a preliminary discussion to determine the extent to which the individual's legal situation will influence progress and treatment and the urgency of the legal situation. No part of these standards dealing with legal assistance is intended to contravene any established laws or rules of court or any principle of ethics related to the practice of law. Where a conflict exists between these standards and the laws or the rules of courts or ethical principles, said laws, rules, or principles shall prevail. (p. 62)

The Consolidated Standards contains a section specifying that a program shall have "a written statement of goals and objectives," "a written plan for evaluating the program's level of attainment of its goals and objectives," and "written evidence [to] verify that the findings of the evaluation have influenced program planning." The term "program" is defined in the glossary section as "an organized system of services designed to address the treatment needs of patients. Program is synonymous with facility, agency, unit, and organization." Thus, it appears that the Division of Forensic Programs shall, according to the Joint Commission's Consolidated Standards, give evidence of program evaluation capabilities and achievements.

Another informal feedback or monitoring system functioning in the Pretrial Branch is seen in the reaction of judges who receive reports prepared by Pretrial Branch staff. Because of the strictness of the legal requirements attaching to cases of this sort (relating to timeliness, patients' rights, etc.) and the adversary system's tendency to search for error, judges demand carefully produced assessments. According to staff, judges on a number of occasions in the past have telephoned the chief of the Pretrial Bench or the clinical administrator of a ward for clarification of a report or to comment on the quality of a report received.

In addition to the external feedback received from the Joint Commission of Accreditation of Hospitals and the judges receiving Pretrial Branch reports, a certain degree of program monitoring occurs internally. As described above, the administrative structure of the Pretrial Branch includes a chief of the operation who, in addition to attending to general management responsibilities, works informally with a supervisory psychiatrist to ensure that examinations are scheduled in a timely fashion and that the results of evaluations performed by clinical administrators and psychiatric consultants are properly reported to the court. Further, each ward is served by a clinical administrator, to whom the ward staff are responsible. The nursing staff report to a head nurse.

The Pretrial Branch maintains a loose-leaf procedures manual in which are filed such items as an organizational plan for the Pretrial Branch, a statement of Pretrial Branch philosophy, an outline of the evaluation process, a summary of the legal categories and standards applying to patients admitted for evaluation, ward philosophies and goals, inter-department memoranda, etc. It is not known to what extent the manual is used by staff or how often outdated information is purged.

CENTER FOR FORENSIC PSYCHIATRY, ANN ARBOR, MICHIGAN

The Center for Forensic Psychiatry was created by state statute in 1967 for the purpose of "diagnosis, evaluation, and treatment of patients committed to the Department of Mental Health by the criminal courts" (§330.11[c] of the Compiled Laws of Michigan, 1970). Ames Robey was the first director of the Center and served until 1975. Bill Meyer followed Dr. Robey as director and serves in that capacity at this writing.

The Center for Forensic Psychiatry functions as an agency of the Department of Mental Health and provides its services on a statewide basis. The Center consists of several units: an "evaluation unit" responsible for outpatient evaluations (evaluations conducted without requirement of hospitalization or commitment) to assess competency to stand trial and criminal responsibility; two "admissions units" responsible for short-term, inpatient evaluations and treatment of men; a women's unit responsible for short-term, inpatient evaluations and treatment of women; and a long-term unit responsible for long-term, inpatient treatment and diagnostic work.

The Center performs seven basic functions:

- o outpatient evaluations to assess competency to stand trial (for all Michigan courts except the Detroit Recorders Court);
- o outpatient evaluations to assess criminal responsibility and diminished capacity (for all Michigan courts);
- o inpatient evaluations of persons adjudicated not guilty by reason of insanity, to assess civil committability (for all persons so adjudicated in Michigan);
- o inpatient treatment services for persons adjudicated incompetent to stand trial;
- o inpatient treatment services for persons acquitted by reason of insanity and committed for treatment;
- o inpatient treatment services for "convict transfers" (Michigan corrections inmates in need of mental health attention);
- o outpatient and inpatient evaluations of persons adjudicated "guilty but mentally ill" and placed on probation, to assess treatment needs.

In addition, the center performs a training and research function, which largely entails providing training for new staff and continuing education for existing staff. Only those functions primarily concerned with screening and evaluation (the first three and the last listed above) are treated in detail in this section.

In 1979, the Center for Forensic Psychiatry performed 1,963 outpatient evaluations, 1,015 to assess competency to stand trial and 948 to assess criminal responsibility. Inpatient services entailed 338 admissions to respond to 267 orders to treat persons adjudicated incompetent to stand trial, 69 orders to evaluate persons adjudicated not guilty by reason of insanity to assess current committability, 59 orders to treat persons acquitted by reason of insanity, and 27 other orders (primarily treatment of convict transfers and evaluation of persons adjudicated guilty but mentally ill and placed on probation).

The Center for Forensic Psychiatry was designed and is funded to provide 112 beds, 96 for men and 16 for women. However, because of high demand, the Center's patient population presently is approximately 130. An expansion was planned to increase the size of the facility by 90 beds by December 1, 1980.

A Function Model

The flow of mental health evaluation cases into, through, and out of the Center for Forensic Psychiatry is depicted in Figures 53-56.

Competency to Stand Trial

Figure 53 indicates the process by which the question of competency to stand trial is raised, referred to the Center, addressed and responded to by Center staff, and resolved.

The question of competency to stand trial may be raised by the defense, the prosecution, or the court. The question most commonly is raised at the defendant's first appearance before the court; however, it may be raised at any time prior to trial. If the court determines that the defendant should be evaluated for his competency to stand trial, it will order that he be so evaluated during a period not to exceed 60 days. For defendants in the criminal justice system in the city of Detroit, this order directs that an evaluation be conducted at the Detroit Recorder's Court Clinic. For defendants in all other Michigan courts, the order specifies that the evaluation be performed at the Center for Forensic Psychiatry. Virtually all of these evaluations are conducted on an outpatient basis.

The order is sent to the Center for Forensic Psychiatry along with a copy of the police report. These materials are received by the Center's Forensic Services department (a case-coordinating and statistics-gathering department within the Center), which enters certain case-identifying information into a computer and prepares a "case history cover sheet" for the file and an index card for the paper record.

Within one week of receipt of the court order, Forensic Services attempts to contact the defense attorney to obtain further information about the defendant (i.e., circumstances surrounding the referral, nature of the attorney-defendant relationships as perceived by the attorney). Information obtained as a result of this call is indicated in an "administrative green note," which is attached to the file.

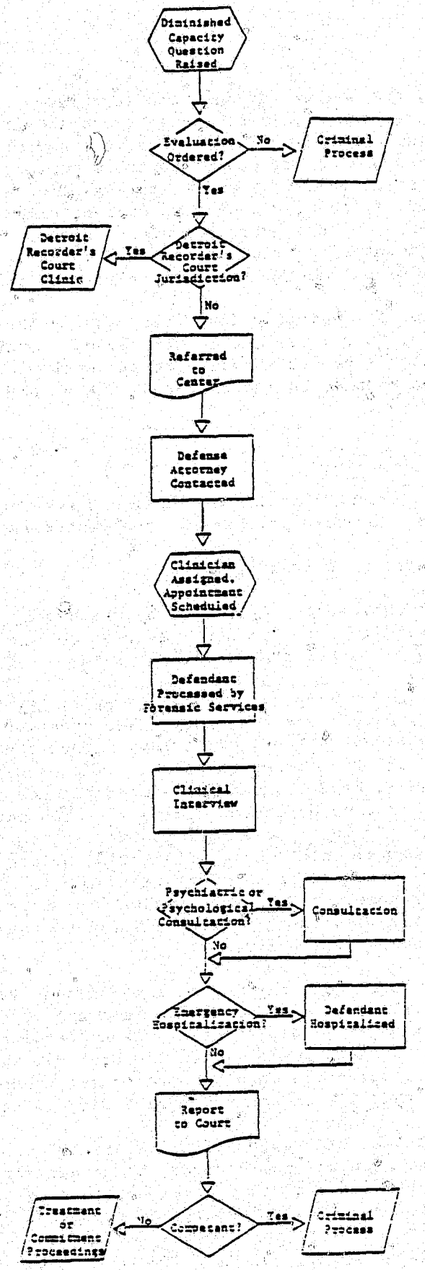


Figure 53. Case processing function model, Center for Forensic Psychiatry: Competency to stand trial.

The Director of the Evaluation Unit meets with Forensic Services staff on a weekly basis to assign clinicians to new cases and schedule clinical interviews. If a defendant is on bond, Forensic Services notifies his attorney by mail of the interview appointment; if a defendant is incarcerated, Forensic Services notifies the sheriff by telephone.

After the interview appointment has been confirmed, Forensic Services sends the file (containing the court order, police report, case history cover sheet, and administrative green note, if available) to the clinician assigned to the case. If the file does not contain an administrative green note, the clinician makes an attempt to contact the defense attorney by telephone for "green note" information. If the clinician is unable to reach the attorney, he makes a note to this effect.

When the defendant arrives for his evaluation, he is met by staff of Forensic Services, who obtain brief personal information from him and make certain he is in fact the person scheduled to be evaluated. Forensic Services then notifies the security staff that the defendant is ready to be escorted to the interview area. Once in the interview area, the defendant is met by forensic aids who photograph him and have him complete a detailed personal history questionnaire, indicating family, school, and military background and medical and mental health history.

The clinician meets the defendant in the interview area and conducts a clinical interview addressing the question of the defendant's competency to stand trial. If the clinician believes that a consultation with a psychiatrist (if the clinician is a psychologist or social worker) or psychologist (if the clinician is a psychiatrist or social worker) is essential before a recommendation about competency can be reached, such a consultation may be requested.

Upon completion of the competency evaluation (interview and any psychiatric or psychological consultation), the defendant ordinarily is released from the Center (in the custody of the sheriff if the defendant is not on bond). If the clinician is of the opinion that the defendant requires immediate treatment, he may contact the defense attorney and the court by telephone and request that the defendant be hospitalized immediately for treatment. Occasionally, in particularly serious cases the court will order hospitalization over the telephone if the defense attorney has no objection; however, an emergency competency hearing usually is held before hospitalization is ordered.

Following the competency evaluation, the clinician prepares a report summarizing the findings. The original is sent to the court, and copies are sent to the prosecutor and the defense attorney. If the clinician is of the opinion that the defendant is incompetent to stand trial, he submits his report within 24 hours of the evaluation, and a separate letter is sent recommending whether placement for treatment (to restore competency) should be at the Center or elsewhere. If the clinician is of the opinion that the defendant is competent to stand trial, he submits his report within five days following the evaluation.

Within five days following receipt of the evaluation report, the court must hold a hearing to determine the defendant's competency to stand trial (unless the prosecution or defense, for good cause, requests a continuance for a reasonable time). If the court finds the defendant competent, he proceeds to trial. Upon a finding of incompetency, the court determines whether there is a substantial probability that the defendant, if provided treatment, would attain competency within 15 months or one-third of the maximum sentence he could receive if convicted of the charges against him, whichever period of time is shorter. If the court determines that competency could not be restored by treatment within such period of time, it may direct the prosecutor to petition for civil commitment. If the court determines that competency could be restored in such a period, the court orders the defendant to undergo treatment designed to render him competent to stand trial and appoints a medical supervisor of the course of treatment (Michigan Mental Health Code, §330.2032). Incompetent defendants thought to be a security risk or highly dangerous are treated at the Center; others are treated at regional psychiatric hospitals, usually in accordance with the Center's placement recommendations.

The court order directing treatment is sent to the Forensic Services department at the Center for Forensic Psychiatry (even in the event that the treatment is to be provided by some other facility). Forensic Services makes arrangements for the defendant to be placed in the treatment program specified in the order. Treatment is administered by the clinicians (psychologists and social workers) serving the ward in which the defendant is placed. The medical supervisor of treatment is responsible for submitting progress reports to the court (with copies to the prosecutor and defense) at least every 90 days, and whenever he is of the opinion that the defendant is no longer incompetent to stand trial, or whenever he is of the opinion that there is not a substantial probability that the defendant, with treatment, will attain competency to stand trial within the statutory period (15 months or one-third of the maximum sentence, whichever is less) (Michigan Mental Health Code, §330.2038). If the defendant does not or is not expected to regain competency within the statutory period, he is evaluated for civil committability and either hospitalized or discharged.

Criminal Responsibility and Diminished Capacity

Figure 54 indicates the process by which questions of criminal responsibility and diminished capacity are raised, referred to the Center for Forensic Psychiatry, addressed and responded to by Center Staff, and resolved. This process, which is virtually the same for questions of criminal responsibility and diminished capacity, is quite similar to that described above for the handling of competency-to-stand-trial questions. Therefore, only the major differences between the two processes will be noted in this description.

Questions of criminal responsibility and diminished capacity may be raised by the defense, the prosecution, or the court; however, the defenses of insanity and diminished capacity ordinarily may be asserted

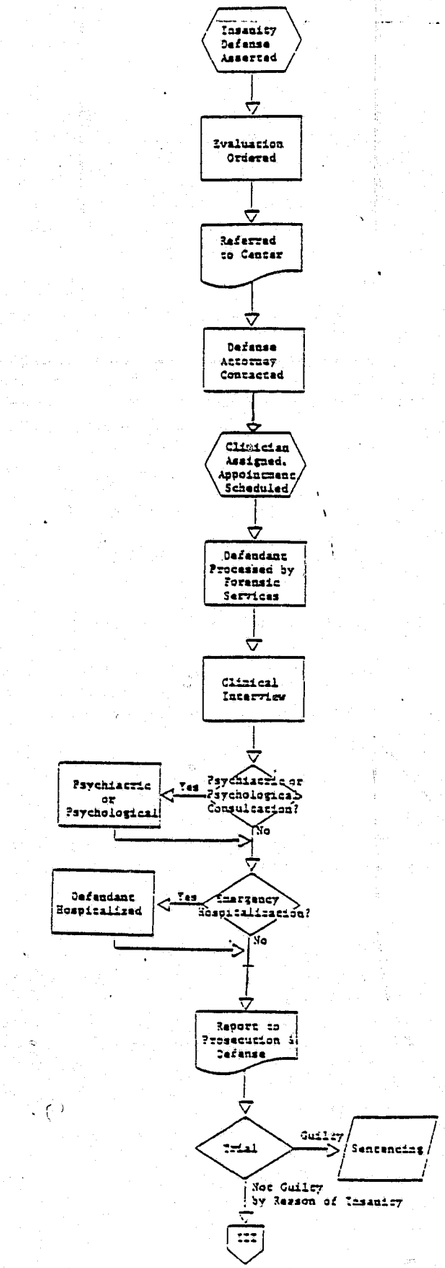


Figure 54. Case processing function model, Center for Forensic Psychiatry: criminal responsibility, diminished capacity.

only by the defendant or his attorney, and written notice of an intention to assert either of these defenses must be provided to the court and the prosecuting attorney at least 30 days before trial. When a question concerning criminal responsibility or diminished capacity arises, the court may order the defendant to be evaluated at the Center for Forensic Psychiatry during a period not to exceed 30 days. (All cases in which the insanity or diminished capacity defense is raised are referred to the Center for evaluation).

The process by which the defendant is referred to and received by the Center is the same as that by which defendants evaluated for competency to stand trial are referred and received. The evaluation to assess criminal responsibility or diminished capacity, however, differs somewhat from that designed for competency assessments. The report prepared by the clinician is submitted to the defense attorney and the prosecutor but not to the court. A trial is held. If the defendant is found not guilty by reason of insanity, he is immediately remanded to the custody of the Center for Forensic Psychiatry for an evaluation to determine whether he meets the criteria for civil commitment under the Michigan Mental Health Code. A finding of diminished capacity may negate the intent element of the offense charged and result in acquittal or conviction of a less serious, included offense.

Adjudicated Not Guilty by Reason of Insanity

Figure 55 indicates the process by which a person adjudicated not guilty by reason of insanity is referred to the Center for Forensic Psychiatry, evaluated by Center personnel, and treated after evaluation.

Immediately upon the acquittal of any person by reason of insanity, the court orders that person admitted to the Center for Forensic Psychiatry for a period not to exceed 60 days for an evaluation to assess his civil committability. The order is mailed to the Center along with a full report of the facts concerning the crime which the person was found to have committed but of which he was acquitted by reason of insanity.

Upon receipt of the order, Forensic Services arranges for the person to be transported by the sheriff to the Center and admitted to an admissions ward, where he is assigned a bed, provided a bath, and given an orientation. Forensic Services notifies the clinical director of the admission, and he assigns two physicians to evaluate the person and complete "physicians' certificates" indicating their opinions regarding the civil committability of the person. If the two physicians disagree regarding the committability of the person, a third is assigned also to evaluate him. The clinical director prepares a "summary report" based on the findings presented in the certificates. This summary report and the physicians' certificates are sent to the committing court judge three weeks prior to the expiration of the 60-day order. Copies are mailed to the defense attorney and the prosecutor.

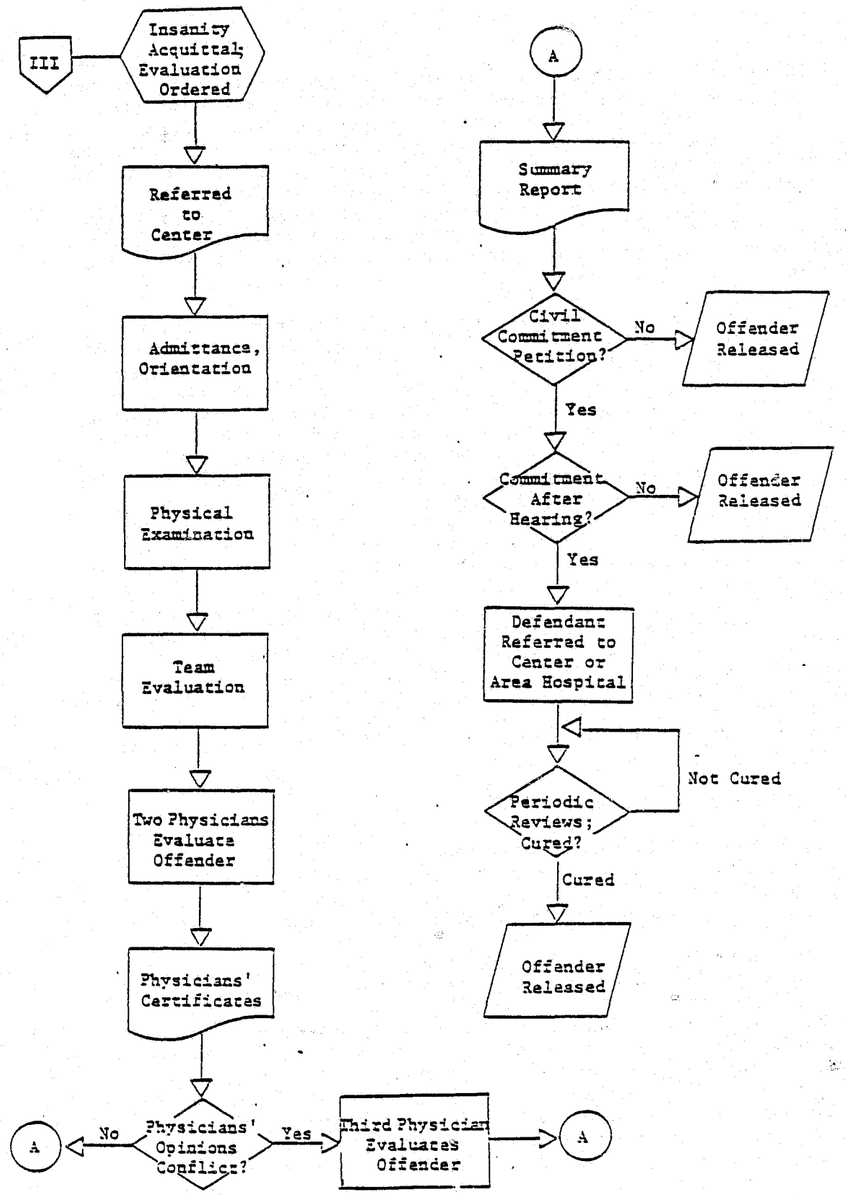


Figure 55. Case processing function model, Center for Forensic Psychiatry: Offender acquitted by reason of insanity.

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If the summary report recommends that the person be committed, the prosecutor in the county of the court that ordered the person for the evaluation ordinarily will petition the appropriate probate court to civilly commit the person. (Probate courts in Michigan have jurisdiction in juvenile proceedings, adoptions, supervision of probating of wills and administration of estates and trusts, guardianships, condemnation of land, and civil commitment.) The person typically remains at the Center for Forensic Psychiatry pending the hearing on the petition in the probate court. Should the prosecutor decide not to file a petition, the Center must release the person.

If a petition is filed and the person is civilly committed, he will be hospitalized either in a facility in or near his community or at the Center for Forensic Psychiatry (if he is particularly dangerous). Further hearings on the question of commitment must be held within 60 days of commitment and then again 90 days later. At the initial hearing, a physician's certificate and a summary report (which acts as a petition for further hospitalization) must be completed. Thereafter, only a physician's certificate is required. If the person is recommitted at the 90-day hearing, another hearing is scheduled at the expiration of another 90 days. Commitment at this hearing places the person on a "continuing order." When a patient is placed on such an order, the probate court reviews the commitment every six months. For each such review, a report prepared on the basis of records concerning the patient's hospitalization is submitted. In addition to the six-month reviews, the committed person is entitled to petition the court for a review hearing once per year, before which he is entitled to evaluation by a psychiatrist of his own choosing or a psychiatrist appointed by the probate court. For persons hospitalized at the Center for Forensic Psychiatry, the Center's Forensic Services department assigns the physician to prepare the physician's certificate, and the clinical director ordinarily completes the summary report.

Guilty but Mentally Ill

As Figure 56 indicates, the process by which the Center for Forensic Psychiatry receives referrals, conducts evaluations, and reports its findings regarding treatment needs of persons found guilty but mentally ill and placed on probation has not yet been fully established.

The Center for Forensic Psychiatry has only very recently begun to receive court orders specifying evaluations to assess the mental health needs of persons found guilty but mentally ill and placed on probation. Since this function is so new and so few cases have been referred with this question (only five as of April 1980), the mechanics of the process still are in the formative stages. It appears, however, that upon a verdict of guilty but mentally ill, the judge may sentence the person to probation and order that he be evaluated by the Center to determine whether mental health treatment should be ordered as a condition of probation. Upon receipt of the order, the Center will process the case in much the same fashion as cases involving the question of competency to stand trial are processed. Most evaluations probably will be conducted

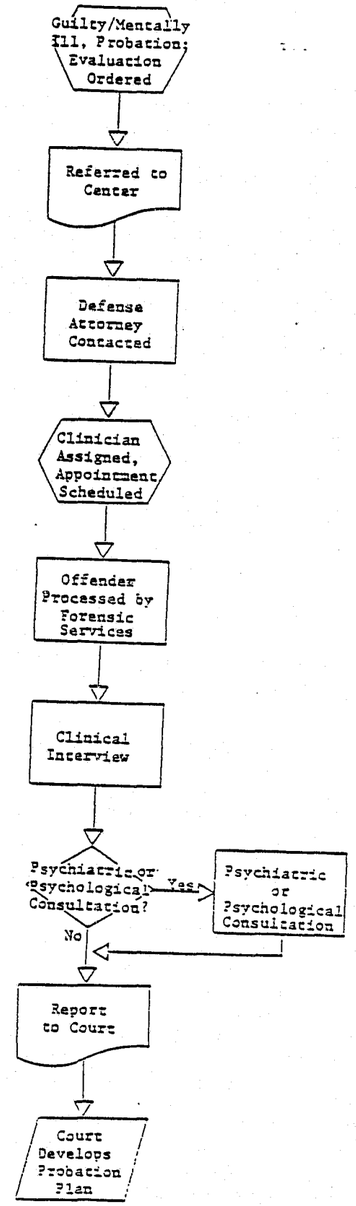

Figure 56. Case processing function model, Center for Forensic Psychiatry: Guilty but mentally ill.

on an outpatient basis, and a report will be submitted to the court and the probation officer specifying mental health needs that might be addressed by an appropriate probation plan.

Delineation of Mental Health Information Requirements

The Center for Forensic Psychiatry provides its services exclusively at the direction of the courts of Michigan. The courts are its only referral sources, and the court order is the only legitimate referral instrument. Of course, the question that ultimately is posed in the court order may initially be raised by the defense or the prosecution, but it is only through the mechanism of the court that the question finds its way to the Center.

Court orders for evaluation are reduced to writing, signed by the judge, and mailed to the Center. An examination of sample orders specifying evaluations to assess competency to stand trial, criminal responsibility, diminished capacity, and civil committability (after acquittal by reason of insanity) revealed a consistent format which included reference to the appropriate legal authority (i.e., statute, public act), a clear statement of the purpose of the examination, and certain indication of time constraints. No order requiring an evaluation of a person adjudicated guilty but mentally ill was examined.

The standard in Michigan for determining incompetency to stand trial is whether a person "is incapable because of his mental condition of understanding the nature and object of the proceedings against him or of assisting in his defense in a rational manner" (Michigan Mental Health Code, §330.2020).

The standard in Michigan for determining criminal responsibility ("legal insanity") is whether ". . . as a result of mental illness . . . or as a result of mental retardation . . . that person lacks substantial capacity to either appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law" (Michigan Compiled Laws, §768.21a). The Michigan Mental Health Code (§330.1440a) defines mental illness as "a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life." Mental retardation is defined as "significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior" (Michigan Mental Health Code, §330.1600e). "Diminished capacity comes within the codified definition of insanity" and is subject to the same provisions governing evaluation for the condition and notification of an intention to assert the defense [People v. Mangiapane, 271 N.W. 2d 240, 248 (1978)].

With respect to patients who are admitted after having been adjudicated incompetent to stand trial, the case of Jackson v. Indiana [406 US 715 (1972)], has established that such patients cannot be held more than a reasonable period of time necessary to determine whether there is substantial probability that they will become competent in the

foreseeable future. If it is determined that a patient will not become competent in the foreseeable future, the government must either institute the customary civil committment proceedings against the person or release him. The manner in which the requirements of Jackson v. Indiana are met in Michigan is discussed further below.

The standard in Michigan for determining the civil committability of a person adjudicated not guilty by reason of insanity is whether the person is

- a person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation; [or]

- a person who is mentally ill, and who as a result of that mental illness is unable to attend to those of his basic physical needs such as food, clothing, or shelter that must be attended to in order for him to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs; [or]

- a person who is mentally ill, whose judgment is so imparied that he is unable to understand his need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent medical opinion, to result in significant physical harm to himself or others (Michigan Mental Health Code §330.1401).

A finding of "guilty but mentally ill" may be made if the defendant asserts the insanity defense and the trier of fact finds, beyond a reasonable doubt, that the defendant is guilty of an offense and was "mentally ill" but not legally insane at the time of the commission of the offense. The finding may be made if the defendant has pleaded not guilty by reason of insanity or if the defendant has asserted the insanity defense, waived his right to trial (by jury or by judge), and pleaded guilty but mentally ill. Persons found guilty but mentally ill are subject to the same sentences that could be imposed pursuant to law upon persons guilty of the same offense. Persons found guilty but mentally ill and placed on probation may be required, upon recommendation of the Center for Forensic Psychiatry, to undergo treatment as a condition of probation (see §36 of Act No. 180 of the Michigan Probate Acts of 1975).

Acquisition Of Mental Health Information

Staff

The Center for Forensic Psychiatry maintains a large multi-disciplinary staff presently numbering 237. Included in this group are 7

psychiatrists, 15 psychologists, 12 psychiatric social workers, 16 registered nurses, an audio-visual specialist, a librarian, a pharmacist, a number of secretaries and administrative assistants, and approximately 130 para-professional forensic security aides. The director of the Center is an attorney, and the clinical director is a psychiatrist.

The outpatient "evaluation unit" is staffed by psychiatrists, psychologists, and social workers. Representatives of any of these disciplines may serve as "clinicians" to assess competency to stand trial. Social workers may not conduct evaluations to assess criminal responsibility, however.

Each inpatient ward is staffed by a psychiatrist, a chief clinician (social worker or psychologist), several registered nurses, and a number of para-professional forensic security aides.

Procedures and Techniques

Competency to Stand Trial. The general processing of competency-to-stand-trial referrals and the legal standard for determining competency have already been discussed earlier. The following is a description of how the clinician conducts the evaluation and otherwise acquires the information upon which he bases his recommendation regarding competency to stand trial.

The evaluation is conducted by clinical interview, which typically involves a face-to-face dialogue between the clinician and the defendant. At the outset of the interview, the clinician discusses the intent of the evaluation with the defendant. The defendant is informed of the type of evaluation ordered by the court and the limits of confidentiality. Specifically, the clinician tells the defendant that he may be required to relate to the court what the defendant tells him and what he observes. The patient's response to this information is recorded on a "notification of rights" form, which the defendant then signs. The defendant also is asked to sign an "information about return to jail form," which authorizes the clinician to advise the jail to which the defendant is to be returned about any special problems the defendant has had adjusting to incarceration. Should the defendant refuse to sign these forms, his refusal is noted by the clinician. The information provided to the jail is intended to be helpful to jail personnel in the care and management of the defendant in the jail setting.

During the course of the interview, the clinician completes any items on the detailed personal history questionnaire not completed by the forensic aid during intake.

The clinical interview includes:

- dialogue concerning the circumstances surrounding the alleged crime;

- social history (information concerning family, education, occupation, previous mental health contacts, previous criminal activity, history of substance abuse, and current medications);
- mental status examination (to assess attitude, dress/behavior, speech/motor, mood, thought processes, thought content, somatic/mood variations, and intellectual functioning utilizing the Wechsler Adult Intelligence Scale); and
- questions relating to the workings of the criminal justice system (i.e., questions concerning the roles and responsibilities of the judge, prosecutor, defense attorney, jury; defendant's concept of plea bargaining; defendant's understanding of the consequences of different pleas and of conviction).

If a clinician, after interviewing a defendant, feels that before he can decide upon a recommendation regarding the defendant's competency to stand trial he needs the advice of someone from another discipline, he may request a psychiatrist or psychologist also to evaluate the defendant. Such psychiatric or psychological "consultations" are rarely requested.

The Center's policy is that a psychiatric consultation should be requested only when it is felt that there are medical issues involved which require the assistance of a psychiatrist to evaluate. For example, such a consultation would be in order if a defendant presented a history of adverse side effects from prescribed medication that could be the basis of present amnesia. Psychiatric consultation is provided by staff psychiatrists at the Center. After psychiatric consultation, the psychiatrist dictates a note summarizing clinical findings, but the assigned clinician retains responsibility for completing the evaluation.

It is the position of the Center for Forensic Psychiatry that psychological testing is rarely essential to formulating a recommendation about competency to stand trial. If testing is deemed absolutely necessary by the assigned clinician, a "request for psychological testing form" is obtained by the clinician and filled out in detail, documenting the specific information sought. This form is taken to a psychologist, and if time permits (given the type of testing needed, staff availability, and so on), the testing is performed the same day. Otherwise, the defendant is rescheduled for testing at some later time. The assigned clinician makes these arrangements with Forensic Services.

The absence of a police report in the defendant's case record may in some cases affect how far an evaluation of competency can proceed, since part of the clinician's report has to do with accounts of the alleged crime as given both by the police and by the defendant. If there is no police report, the clinician telephones the sheriff's department and attempts to have the report read over the telephone. If this information cannot be obtained but the defendant clearly is incompetent, the lack of a police report does not impede a report to the court recommending

adjudication of the defendant as incompetent to stand trial. If the police report is unavailable and the defendant clearly is competent, the evaluation proceeds as if a police report were present, and the clinical notes and court report are dictated. The court report, however, is not sent. In all such cases, the police report must be received and reviewed by the assigned clinician before the court report can be issued. If the police report, once received, is found to be generally consistent with the defendant's version of what happened, or if inconsistent the inconsistency is explainable, then the report to the court is issued. However, if there is any substantial discrepancy between the police report and the defendant's version, which cannot be explained or resolved by telephone calls to the court, the defendant is rescheduled for further evaluation. The assigned clinician notifies Forensic Services of the need for such further evaluation.

Criminal Responsibility and Diminished Capacity. The general processing of criminal responsibility and diminished capacity referrals and the legal standard for determining these conditions are indicated in previous sections. The following is a description of how the clinician conducts the evaluation and otherwise acquires the information upon which he bases his recommendation regarding criminal responsibility or diminished capacity.

Evaluations to assess criminal responsibility and diminished capacity are conducted in much the same manner as are competency evaluations. One major difference is that while social workers (as well as psychiatrists and psychologists) are permitted to assess competency, only psychiatrists and psychologists may qualify as certified examiners for responsibility and capacity evaluations.

The evaluation is conducted by clinical interview. If the evaluation is conducted on an inpatient basis, the clinician, prior to commencing the interview, reviews the physician's note and chief clinician's clinical evaluation report prepared during the defendant's hospitalization. At the beginning of the interview, the clinician notifies the defendant of the nature of the evaluation and of the limits of confidentiality. The "notification of rights form" and the "information about return to jail form" are signed, or notification is made of the defendant's refusal to sign.

The interview itself is quite similar to that conducted to assess competency except that:

- the clinician's inquiry concerning the circumstances surrounding the alleged crime is emphasized;
- the clinician's inquiry concerning the defendant's understanding of the workings of the criminal justice system is de-emphasized; and
- the Minnesota Multiphasic Personality Inventory is administered.

Referrals for psychiatric or psychological consultation may be made as with competency evaluations. Psychological consultation is not discouraged in the course of an evaluation to assess criminal responsibility or diminished capacity.

The policy with respect to the absence of a police report, described above with respect to competency evaluations, is equally applicable to the conduct of evaluations to assess criminal responsibility and diminished capacity.

Adjudicated Not Guilty by Reason of Insanity. The following is a description of how the two physicians assigned to evaluate a person for civil committability conduct their evaluations. The general processing of persons referred after having been adjudicated not guilty by reason of insanity and the legal standard controlling the civil committability of such persons are described in previous sections.

Each physician evaluates the person independently. Prior to commencing the evaluation, the physician reviews the admitting physician's notes from the physical examination and the chief clinician's clinical evaluation report prepared during the patient's hospitalization. At the beginning of the evaluation, the physician introduces himself; he explains that his reason for conducting the evaluation is to collect information to assist the court in determining whether the person has a mental condition that requires treatment and whether such treatment should take place in a hospital or some other place; and he notifies the person that he (the physician) may be required to reveal to the court information obtained during the evaluation. The evaluation that follows takes the form of an interview and includes a mental status examination identical to that performed during evaluations to assess competency to stand trial and criminal responsibility. Additionally, the person's account of events leading to his present hospitalization is noted, as is his satisfaction with services offered by the hospital. Drug and alcohol dependencies also are areas of inquiry. In addition to interviewing the person, the physician studies his current hospitalization record and notes the extent to which he has adjusted to hospitalization.

Guilty but Mentally Ill. The general processing of persons referred after having been found guilty but mentally ill and placed on probation (to the extent that the process is established) and the statutory authority for this disposition have already been described. The following is a description of how the evaluation to assess treatment needs is conducted.

The evaluation may be conducted on an inpatient or an outpatient basis. Persons appearing for this evaluation ordinarily have been evaluated at the Center before (for assessments of competency to stand trial and/or criminal responsibility), and old records generally are reviewed. The interview is similar to interviews conducted to assess competency to stand trial, criminal responsibility, and civil committability. A mental status examination is performed, but less historical information is collected. The focus of the evaluation is on present treatment needs of the offender.

Provision of Mental Health Information

Competency to Stand Trial

Following an evaluation to assess competency to stand trial, the examining clinician dictates a "clinical note" containing

- o identifying data (name, address, etc.);
- o notice that informed consent was obtained;
- o special circumstances regarding referral of defendant;
- o review of alleged crime;
- o defendant's version of circumstances regarding alleged crime;
- o socio-cultural history;
- o mental status;
- o opinion regarding defendant's competency to stand trial (with reasons relating to the legal criteria);
- o recommendations regarding placement and treatment for defendants felt to be incompetent to stand trial;
- o prognosis, indicating whether it is felt the defendant can attain competency within the statutory period (necessary only for defendants felt to be incompetent to stand trial); and
- o) diagnosis (i.e., schizophrenia, inadequate personality, anxiety, depression, etc.).

The clinical note is dictated within 24 hours if the defendant is felt to be incompetent to stand trial. Otherwise, the note is dictated within five days. The clinician prepares a report to the court based on the information in the clinical note. The report is prepared in letter form and represents a summary of the information contained in the clinical note. If the defendant is felt to be competent to stand trial but mentally ill, this is indicated.

If the clinician recommends that the defendant meets the criteria required to be found incompetent to stand trial, he will so notify the executive assistant of the Center for Forensic Psychiatry and recommend whether treatment (to restore competency) should be at the Center or at an area hospital. The executive assistant, in turn, writes a separate letter to the court recommending appropriate placement for treatment.

The court report is mailed to the court, and copies are sent to the prosecutor and defense attorney. The clinician may be subpoenaed to testify at the hearing to determine competency. After appearing, the

clinician completes a court appearance form (containing administrative information) and a "green note" (summarizing the court appearance and indicating the outcome of the hearing, if known).

Criminal Responsibility and Diminished Capacity

Following an evaluation to assess criminal responsibility or diminished capacity, the examining clinician dictates a clinical note containing

- o identifying data;
- o notice that informed consent was obtained;
- o special circumstances regarding referral of defendant;
- o an indication that defendant was notified of his rights (non-confidentiality);
- o review of alleged crime;
- o defendant's version of circumstances regarding alleged crime;
- o socio-cultural history;
- o mental status;
- o opinion regarding defendant's criminal responsibility or diminished capacity (with reasons relating to the legal criteria); and
- o diagnosis.

The clinician prepares a report based on the clinical note. The report is prepared in letter form and represents a summary of the information contained in the clinical note. The report is <u>not</u> sent to the court; the only recipients of the report are the prosecutor and the defense attorney. The clinician may be subpoenaed to appear at the trial and testify with respect to criminal responsibility or diminished capacity. After appearing, the clinician completes a court appearance form (containing administrative information) and a "green note" (summarizing the court appearance and indicating the verdict, if known).

Adjudicated Not Guilty by Reason of Insanity

Following an evaluation to assess the civil committability of a person adjudicated not guilty by reason of insanity, the examining physician completes a physician's certificate and a clinical note. Because two physicians (or three if necessary for majority opinion) independently evaluate the person, two (or three) physicians' certificates and two (or three) clinical notes are prepared.

The physician's certificate is a Michigan Department of Mental Health form with spaces for a provisional diagnosis (choices are: mental illness, mental retardation, convulsive disorder, other drug dependence, no evidence of mental illness, developmental disability, alcoholism, mental processes weakened or impaired by reason of advanced years); facts serving as a basis for the diagnosis; clinical opinion regarding committability (responsive to each legal criterion for committability); and recommendations regarding placement for treatment. The clinical note contains a review of the offense, legal history, mental status assessment, indication of behavior since admission, review of present medications and treatment, opinion regarding present mental illness, diagnostic impression, and recommendations for future treatment.

The clinical director reviews the physicians' certificates and clinical notes and prepares a summary report for the court. The summary report essentially integrates and summarizes the information contained in the clinical notes. The summary report and copies of the physicians' certificates are sent to the committing court judge three weeks prior to the expiration of the 60-day commitment-for-evaluation order. Copies are sent to the defense attorney.

Guilty but Mentally Ill

Following an evaluation to assess the treatment needs of a person adjudicated guilty but mentally ill and placed on probation, the examining clinician prepares a report specifying treatment needs that might be addressed by an appropriate probation plan. Since the process is quite new and so few evaluations have been conducted to date, no format for the evaluation report has been developed. The court receiving the evaluation report considers its contents in determining conditions of probation.

Feedback, Monitoring, and Evaluation

There is no formal, ongoing program evaluation mechanism operating in the Center for Forensic Psychiatry. However, the training and research functions of the Center to some extent serve to monitor the program's operations and provide quality assurance.

Initial training for professional staff consists of approximately 240 hours, which is a requirement prior to becoming certified as a Forensic Examiner in Michigan. The training program includes the following: observation of expert testimony; observation of clinical interviews; reading of criminal statutes, mental health laws and administrative rules; reading of the Department of Mental Health and Center for Forensic Psychiatry policies; consulting with attorneys for the prosecution and defense; reading of legal and psychiatric, psychological and social work literature on forensic issues; designing treatment programs for those defendants found incompetent to stand trial; attending guest lectures; reviewing video tapes; and professional discussions of forensic programs and formal seminars on criminal responsibility. During the training period, a new staff member conducts forensic evaluations under the close supervision of certified staff.

Recertification as a Forensic Examiner is required every year and ordinarily is based on participation in programs of continuing education. Seminars and guest lectures are presented at the Center on a regular basis and qualify as programs of continuing education for recertification purposes.

Staff members of the Center for Forensic Psychiatry frequently engage in research that may or may not be sponsored by the Center. They are presently engaged in a study to determine what percentage of cases in which the criminal responsibility defense is raised result in acquittals by reason of insanity. The study will indicate the extent to which Center recommendations regarding criminal responsibility are followed. Forensic Services staff also are researching the impact on insanity acquittals of a recent change in the legal standard for criminal responsibility in Michigan.

A number of Center psychologists have conducted research studies relying to some extent on cases evaluated at the Center. Reports resulting from these studies include Outpatient Evaluations for the Criminal Courts: A Qualitative and Interdisciplinary Study, by Norm Poythress, Jr., and Russ Petrella; The Quality of Forensic Examinations: An Interdisciplinary Study, also by Poythress and Petrella; and Psychologists' Opinions on Competency and Sanity: How Reliable, by Poythress and Harley Stock.

Another, informal feedback or monitoring mechanism operating at the Center is represented by the reaction of judges who receive evaluation reports. While no evidence was located of cases in which judges either praised or criticized a particular mental health assessment or evaluation procedure, it is reasonable to suppose that, considering the strictness of the legal requirements attaching to cases of this sort (relating to timeliness, patients' rights, etc.) and the adversary system's tendency to search for error, judges will require carefully produced assessments and will not hesitate to object to even the appearance of impropriety in the mental health evaluation process.

Statistics are kept tracking and recording the flow of cases through the Center. This information is used by management to maximize the efficiency of the operation and provide a basis for appeals to the Department of Mental Health and the legislature for adequate resources.

Finally, the procedures recommended for conducting evaluations, preparing reports, etc., are documented in an orientation manual available to all employees of the Center. The manual is updated regularly and serves to assure a degree of consistency in work product. The input of the training and research staff is particularly effective in enabling the manual to remain responsive to changes in the law.

REFERENCE NOTES

1. Gary B. Melton, Institute for Law, Psychiatry, and Public Policy, University of Virginia. Personal Communication, February 26, 1981.

2. Ohio, for example, has built two regional forensic inpatient units on the grounds of existing facilities. The Central Ohio Regional Forensic Unit in Dayton, designed to receive patients committed after being found incompetent to stand trial or found not guilty by reason of insanity, is expected to open in August 1981, according to Ronald J. Averbeck, Chief of Ohio's Community Forensic Centers. In Florida, the State Department of Rehabilitative Services is planning to construct a $17 million, 200 bed facility on the grounds of an existing hospital in Chatahoochee. The Department is also negotiating the construction of a $24 million facility in Dade County, near Miami, according to John J. Wright, the state's Forensic Program Supervisor.

3. Committee on State Institutions and Property of the Missouri House of Representatives. Mental health care in Missouri's criminal justice system. Jefferson City, Missouri, January 18, 1978.

4. Petrila, J. A Proposal for Missouri Forensic Services in the Eighties. Division of Forensic Services, Department of Mental Health, State of Missouri, March 26, 1980.

5. Lange, W.O. and Bratkowski, H.R. Criteria for Admissions to Biggs Unit. Memorandum. Fulton, Missouri, March 8, 1977.

6. Revisions of Chapter 552. (No date, unpublished document).

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Carlson, E.W. Findings: The Statewide Service Delivery System. In N.J. Beran and B.G. Toomey (eds.), Mentally ill offenders and the criminal justice system: Issues in forensic services. New York: Praeger Publishers, 1979.

Dain, N. The first century of eastern state hospital in Williamsburg, Virginia, 1766-1866. Williamsburg: The Colonial Williamsburg Foundation, 1971.

Joint Commission on Accreditation of Hospitals. Consolidated standards for child, adolescent, and adult psychiatric, alcoholism, and drug abuse programs. Chicago: Author, 1979.

Petrila, J. Forensic psychiatry and community mental health. Developments in Mental Health Law, 1981, 1(1), 1-4.

Poythress, Jr., N., and Petrella, R. Outpatient evaluations for the criminal courts: A qualitative and interdisciplinary study. Ann Arbor, Michigan: Center for Forensic Psychiatry, no date.

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APPENDIX A

MI MRS - 100 (3-73)

Hosp Code	† Case Number	† C.D.	Court Code	† Admission/Transfer Date Mo - Day - Yr	† Unit/Service	† Ward/Clinic	† Status	Team Unit or Sec

Pt Name - Last	First	M.I.	† Birthdate Mo - Day - Yr	† Age	† Sex	† Race*	Ethnic Background*

Street No. Direction Street Name	St., Rd., etc.	City	State	Zip Code

Catchment	Census Tract	County	Phone	Social Security No.	Birthplace (State or Country)

	Education Level	Marital Status	Number of Children	Maiden Name	Usual Occupation

Veteran ☐Yes ☐No ☐Unknown	Admitted From	Referred By	Accompanied By

Mother's Name	Address - Write "Deceased" if not living	Phone

Father's Name Maiden Name	Address	Phone

Person Responsible Party (Spouse, Guardian, etc.) Relationship	Address	Phone

Best Informant Name (May be one of the above) Relationship	☐No CAPS Desired	Phone

First M.I.		
Street No. Direction Street Name St., Rd., etc.	City	State Zip Code

Admission

† Previous Mental Health Service (Record Details on Reverse Side)

a. Prior inpatient care at any State or County hospital? ☐Yes ☐No ☐Unknown
b. Previous care (any type) at a Community Mental Health Center? ☐Yes ☐No ☐Unknown
c. Prior Missouri DMH care (any type) ? ☐Yes ☐No ☐Unknown
d. If so, was last care at this facility? ☐Yes ☐No ☐Unknown
e. Type of previous mental health care : "1" - Inpatient care only
"2" - Partial hospitalization and/or outpatient care only CODE _____
"3" - Inpatient and outpatient care "8" - None "9" - Unknown

† Type of Application and/or Commitment
*(See codes on reverse side)
CODE: _____

Admitting or Provisional Diagnosis	Codes

	Admitting Physician	Physician SSAN

Working or Working Diagnosis	Codes

	Physician's Signature	Physician SSAN

Final Diagnoses and Procedures (Including Physical Diagnoses)	Codes

Type of Disposition / Referral

Referred to Halfway House?
☐DMH ☐Non-DMH ☐NO ☐Unknown
b. Referral Code*: _____
*See Codes on reverse side

Patient Released To

Name of Individual or Institution	Release Date Mo - Day - Yr
Street Address	Relationship
City State Zip Code	Phone

Patient's Signature SSAN Date	Physician's Signature SSAN Date

Admission and/or Face Sheet CMH-MRS - 100 001 - Fulton State Hospital MISSOURI DIVISION OF MENTAL HEALTH

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APPENDIX A (Continued)

Details of Previous Mental Health Service

(Complete one line for each separate Hospitalization, Out-Patient Treatment or care by Private Agency)

Dates		Check One			Name of Inpatient Care Facility	Name of Outpatient Care Facility	Private Agency
Admitted	Discharged	In Pat	Out Pat	Private Agency			

Additional Details

es

RACE

W - White
N - Negro
O - Other
U - Unknown

ETHNIC BACKGROUND

- Spanish American
- American Indian
- Oriental
- Other

TYPE OF APPLICATION AND/OR COMMITMENT

01 Voluntary
02 Standard Non-Judicial
03 Emergency with Medical Certificate
04 Emergency without Medical Certificate
05 Probate Court
06 or C1 Pre-Trial Observation
07 Juvenile Division
or J1 Commitment by Juvenile Court, the Court retaining Jurisdiction
J2 Voluntary patient
J3 Probate Court Commitment
J4 Transfer from Training School
J5 Other
J6 Juvenile Court Commitment, the Court having relinquished its Jurisdiction
J8 Juvenile Court Commitment for evaluation only
06 Circuit Court (Criminal)
or C2 Incompetent to proceed with trial
C3 Not guilty by reason of mental disease
C4 Criminal sexual psychopath
C5 Missouri State Penitentiary transfer
C6 Other (Circuit Court)
09 Other
10 Magistrate Court

TYPE OF DISPOSITION/REFERRAL

Public mental hospital (unspecified)
Veterans Administration
DMH Regional Diagnostic Clinic
DMH Residential Treatment Center For Children
DMH State School and Hospital
Other mental health facility (including private psychiatric hospitals psychiatric services of general hospitals partial hospitals partial hospitalization or out-patient facility)
39 Nursing home
40 Medical facility (Non-mental health)
41 Non-psychiatric physician
50 Social or community agency (unspecified)
51 Department of Public Welfare
52 Head Start
53 Office of Economic Opportunity
54 United Cerebral Palsy
55 Association for Retarded Children - Chapters or Classes
56 Sheltered Workshop
60 Private practice mental health professional
70 School system (unspecified)
71 State School for Retarded
80 Court, law enforcement or correction agency
90 Other known referral (Specify)
91 Clergy
92 Alcoholics Anonymous

NOT REFERRED ELSEWHERE--

Treatment discontinued by client:
01 Client dropped out or rejected treatment
02 Other (e.g., died, moved, etc.)

Treatment discontinued by facility:
03 Appropriate referral unavailable
04 Client not in need of further treatment
05 Discontinued for unknown reasons
99 Unknown

APPENDIX B

PSYCHIATRIC HISTORY

Name of Patient _____
Case No. _____

I. CHIEF COMPLAINT (Patient's reason for this hospital admission)

II. HISTORY OF PRESENT ILLNESS

Name _____ Age ____ Race ____ Sex __ Marital Status ____

Brought to hospital by _____

Type of Admission _____ Admitted from _____

Police Charges/hold orders _____

Reason patient came to the hospital. Chronological history with dates and precipitating cause of hospitalization:

a. Previous Attacks of Mental Disorders

Dates	Hospitals	Diagnoses	Doctor's Name

III. PAST HISTORY

A. Familial Diseases (note only positives)

Mental Disorders _____
Allergies _____
Alcoholism _____
Diabetes _____
Tuberculosis _____
Epilepsy _____
Others _____

Cancer _____
Thyroid _____
Cardiovascular _____
Blood Disease _____
Genitourinary _____
Pulmonary _____
Gastrointestinal _____

III. PAST HISTORY (CONTINUED)

B. Medical History

1. Previous Medical Diseases (note only positives) _____

2. Allergies _____

3. Blood transfusions _____

4. Surgeries _____

5. Traumas _____

6. Current Medications Prior to Admission _____

7. OB/Gyn (Gravida, para, aborta, and menstrual history, i.e., intervals, duration, amount, regular or irregular) _____

C. Habits (Alcohol, Drugs, Cigarettes - name specific amounts)

D. Review of Systems

Head _____

Eyes _____

Ears _____

Nose _____

Mouth _____

Neck _____

Cardiorespiratory _____

Gastrointestinal _____

Genitourinary _____

Neuromuscular _____

Date Dictated: _____ _____

Medical Extern

MENTAL STATUS EXAMINATION

(MISSOURI DEPARTMENT OF MENTAL HEALTH)

USE ADDRESSOGRAPH OR FILL IN:

PATIENT NAME: _____ (LAST NAME ONLY)

REPORT DATE: ____ (MONTH) ____ (DAY) ____ (YEAR)

PATIENT NUMBER: _____ (HOSPITAL NUMBER) _____ (CASE NUMBER) ____ (C.D.)

INSTRUCTIONS: 1. IF ANY MAJOR SECTION IS NORMAL OR UNTESTABLE, CIRCLE "1" OR "2" AND GO TO NEXT SECTION.
2. IF NOT NORMAL OR UNTESTABLE, RATE ALL PERTINENT ITEMS BY CIRCLING: 1 = MILD, 2 = MODERATE, 3 = SEVERE.

NERAL APPEARANCE
.-NORMAL 2-UNTESTABLE
FACIAL EXPRESSION:
SAD. 1 2 3
XPRESSIONLESS 1 2 3
OSTILE . . . 1 2 3
RRIED 1 2 3
AVOIDS GAZE . . 1 2 3
DRESS:
ITICULOUS . . 1 2 3
.OTHING,
HYGIENE POOR . 1 2 3
ECCENTRIC 1 2 3
SEDUCTIVE. . . 1 2 3

OR ACTIVITY
-NORMAL 2-UNTESTABLE
I..REASED AMOUNT 1 2 3
DECREASED AMOUNT 1 2 3
AGITATION . . . 1 2 3
T S 1 2 3
T MOR. 1 2 3
P CULIAR POSTURING 1 2 3
UNUSUAL GAIT 1 2 3
REPETITIVE ACTS . 1 2 3

S. ECH
NORMAL 2-UNTESTABLE
EXCESSIVE AMOUNT. 1 2 3
REDUCED AMOUNT 1 2 3
PITCH OF SPEECH 1 2 3
S WED 1 2 3
L D 1 2 3
SOFT. 1 2 3
MUTE 1 2 3
SLURRED. . . . 1 2 3
S TTERING 1 2 3

151 **INTERVIEW BEHAVIOR**
1-NORMAL 2-UNTESTABLE
152 ANGRY OUTBURSTS 1 2 3
153 IRRITABLE . . . 1 2 3
154 IMPULSIVE 1 2 3
155 HOSTILE . . . 1 2 3
156 SILLY 1 2 3
157 SENSITIVE . . . 1 2 3
158 APATHETIC . . . 1 2 3
159 WITHDRAWN 1 2 3
160 EVASIVE. . . . 1 2 3
161 PASSIVE 1 2 3
162 AGGRESSIVE. . . 1 2 3
163 NAIVE 1 2 3
164 OVERLY DRAMATIC . 1 2 3
165 MANIPULATIVE 1 2 3
166 DEPENDENT . . . 1 2 3
167 UNCOOPERATIVE 1 2 3
168 DEMANDING . . . 1 2 3
169 NEGATIVISTIC 1 2 3
170 CALLOUS. . . . 1 2 3

222 **FLOW OF THOUGHT**
1-NORMAL 2-UNTESTABLE
223 BLOCKING . . . 1 2 3
224 CIRCUMSTANTIAL 1 2 3
225 TANGENTIAL. . . 1 2 3
226 PERSEVERATION 1 2 3
227 FLIGHT OF IDEAS . 1 2 3
228 LOOSE ASSOCIATION 1 2 3
229 INDECISIVE. . . 1 2 3

230 **MOOD AND AFFECT**
1-NORMAL 2-UNTESTABLE
231 ANXIOUS. . . . 1 2 3
232 INAPPROPRIATE AFFECT . . . 1 2 3
233 FLAT AFFECT 1 2 3
234 ELEVATED MOOD. . 1 2 3
235 DEPRESSED MOOD 1 2 3
236 LABILE MOOD . . 1 2 3

237 **CONTENT OF THOUGHT**
1-NORMAL 2-UNTESTABLE
238 SUICIDAL THOUGHTS 1 2 3
239 SUICIDAL PLANS . 1 2 3
240 ASSAULTIVE IDEAS 1 2 3
241 HOMICIDAL THOUGHTS 1 2 3
242 HOMICIDAL PLANS . 1 2 3
243 ANTISOCIAL ATTITUDES . . 1 2 3
244 SUSPICIOUSNESS 1 2 3
245 POVERTY OF CONTENT 1 2 3
246 PHOBIAS . . . 1 2 3
247 OBSESSIONS -- COMPULSIONS. . 1 2 3
248 FEELINGS OF UNREALITY . . 1 2 3
249 FEELS PERSECUTED 1 2 3
250 THOUGHTS OF RUNNING AWAY 1 2 3
251 SOMATIC COMPLAINTS 1 2 3
252 IDEAS OF GUILT . 1 2 3
253 IDEAS OF HOPELESSNESS . 1 2 3
254 IDEAS OF WORTHLESSNESS . 1 2 3
255 EXCESSIVE RELIGIOSITY. . 1 2 3
256 SEXUAL PREOCCUPATION . 1 2 3
257 BLAMES OTHERS 1 2 3
ILLUSIONS:
258 PRESENT. . . . 1 2 3
HALLUCINATIONS:
259 AUDITORY . . . 1 2 3
260 VISUAL 1 2 3
261 OTHER 1 2 3
DELUSIONS:
262 OF PERSECUTION . 1 2 3
263 OF GRANDEUR 1 2 3
264 OF REFERENCE . . 1 2 3
265 OF INFLUENCE 1 2 3
266 SOMATIC. . . . 1 2 3
267 OTHER 1 2 3
268 ARE SYSTEMATIZED. 1 2 3

322 **SENSORIUM**
1-NORMAL 2-UNTESTABLE
ORIENTATION IMPAIRED:
323 TIME 1 2 3
324 PLACE 1 2 3
325 PERSON. . . . 1 2 3
MEMORY:
326 CLOUDING OF CONSCIOUSNESS. 1 2 3
327 INABILITY TO CONCENTRATE . 1 2 3
328 AMNESIA 1 2 3
329 POOR RECENT MEMORY . . . 1 2 3
330 POOR REMOTE MEMORY . . . 1 2 3
331 CONFABULATION . 1 2 3

332 **INTELLECT**
1-NORMAL 2-UNTESTABLE
333 ABOVE NORMAL . . 1 2 3
334 BELOW NORMAL . 1 2 3
335 PAUCITY OF KNOWLEDGE. . . 1 2 3
336 VOCABULARY POOR 1 2 3
337 SERIAL SEVENS DONE POORLY. . 1 2 3
338 POOR ABSTRACTION 1 2 3

339 **INSIGHT AND JUDGMENT**
1-NORMAL 2-UNTESTABLE
340 POOR INSIGHT . . 1 2 3
341 POOR JUDGMENT 1 2 3
342 UNREALISTIC REGARDING DEGREE OF ILLNESS . . 1 2 3
343 DOESN'T KNOW WHY HE IS HERE . . 1 2 3
344 UNMOTIVATED FOR TREATMENT . . 1 2 3

345-GLOBAL RATING -- SEVERITY OF ILLNESS (CIRCLE ONE NUMBER): 1 (NO DISORDER) 2 3 (MILD) 4 5 (MODERATE) 6 7 (SEVERE)

DSM III DIAGNOSIS (TRANSPOSE CODES FROM REVERSE SIDE):

PRIMARY ☐☐☐.☐☐ SECONDARY ☐☐☐.☐☐

ADDITIONAL COMMENTS:

PHYSICIAN'S LAST NAME (PRINT) _____ ☐☐☐-☐☐-☐☐☐☐ SOCIAL SECURITY NUMBER

H-01 Rev. 10/79

TRUCTIONS RECORD DIAGNOSES CODES ON REVERSE SIDE.

Indicate the patient's diagnosis by placing a heavy mark in the box next to the appropriate diagnosis.
n cases of multiple diagnoses, underscore the underlying diagnosis and circle the primary diagnosis (see DSM-II, Section 1, Page 2)
To use "Fifth Digit Qualifying Phrases" (see below), write the digit behind the diagnosis to be qualified.

MENTAL RETARDATION
310. Borderline
311. Mild
312. Moderate
313. Severe
314. Profound
315. Unspecified
each: Following or associated with
.0 Infection or intoxication
.1 Trauma or physical agent
.2 Disorders of metabolism, growth or nutrition
.3 Gross brain disease (postnatal)
.4 Unknown prenatal influence
.5 Chromosonal abnormality
.6 Prematurity
.7 Major psychiatric disorder
.8 Psycho-social (environmental) deprivation
.9 Other condition

ORGANIC BRAIN SYNDROMES (OBS)
SYCHOSES
le and pre-senile dementia
290.0 Senile dementia
290.1 Pre-senile dementia
holic psychosis
291.0 Delirium tremens
291.1 Korsakov's psychosis
291.2 Other alcoholic hallucinosis
291.3 Alcohol paranoid state
291.4* Acute alcohol intoxication*
291.5* Alcoholic deterioration*
291.6* Pathological intoxication*
291.9 Other alcoholic psychosis
hosis associated with intracranial infection
292.0 General paralysis
292.1 Syphilis of central nervous system
292.2 Epidemic encephalitis
292.3 Other and unspecified encephalitis
292.9 Other intracranial infection
hosis associated with other ral condition
293.0 Cerebral arteriosclerosis
293.1 Other cerebrovascular
293.2 Epilepsy
293.3 Intracranial neoplasm
293.4 Degenerative disease of the CNS
293.5 Brain trauma
293.9 Other cerebral condition
hosis associated with other ical condition
294.0 Endocrine disorder
294.1 Metabolic and nutritional disorder
294.2 Systemic infection
294.3 Drug or poison intoxication (other than alcohol)
294.4 Childbirth
294.8 Other and unspecified physical condition

ON-PSYCHOTIC OBS
309.0 Intracranial infection
309.13* Alcohol* simple drunkenness
309.14* Other drug, poison or systemic intoxication
309.2 Brain trauma
309.3 Circulatory disturbance
309.4 Epilepsy
309.5 Disturbance of metabolism, growth, or nutrition
309.6 Senile or pre-senile brain disease
309.7 Intracranial neoplasm
309.8 Degenerative disease of the CNS
309.9 Other physical condition

egories added to ICD-8 for use in the U.S. Only

III PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY

Schizophrenia
295.0 Simple
295.1 Hebephrenic
295.2 Catatonic
295.23* Catatonic type, excited*
295.24* Catatonic type, withdrawn*
295.3* Paranoid
295.4 Acute schizophrenic episode
295.5 Latent
295.6 Residual
295.7 Schizo-affective
295.73* Schizo-affective, excited*
295.74* Schizo-affective, depressed*
295.8* Childhood
295.90* Chronic undifferentiated*
295.99* Other schizophrenia*

Major affective disorders
296.0 Involutional melancholia
296.1 Manic-depressive illness, manic
296.2 Manic-depressive illness, depressed
296.3 Manic-depressive illness, circular
296.33* Manic-depressive, circular, manic*
296.34* Manic-depressive, circular, depressed*
296.8 Other major affective disorder

Paranoid states
297.0 Paranoia
297.1 Involutional paranoid state
297.9 Other paranoid state

Other psychosis
298.0 Psychotic depressive reaction

IV NEUROSES
300.0 Anxiety
300.1 Hysterical
300.13* Hysterical, conversion type*
300.14* Hysterical, dissociative type*
300.2 Phobic
300.3 Obsessive compulsive
300.4 Depressive
300.5 Neurasthenic
300.6 Depersonalization
300.7 Hypochondriacal
300.8 Other neurosis

V PERSONALITY DISORDERS AND CERTAIN OTHER NON-PSYCHOTIC MENTAL DISORDERS

Personality disorders
301.0 Paranoid
301.1 Cyclothymic
301.2 Schizoid
301.3 Explosive
301.4 Obsessive compulsive
301.5 Hysterical
301.6 Asthenic
301.7 Antisocial
301.81* Passive-aggressive*
301.82* Inadequate*
301.89* Other specified types*

Sexual deviation
302.0 Homosexuality
302.1 Fetishism
302.2 Pedophilia
302.3 Transvestitism
302.4 Exhibitionism
302.5* Voyeurism*
302.6* Sadism*
302.7* Masochism*
302.8 Other sexual deviation

Alcoholism
303.0 Episodic excessive drinking
303.1 Habitual excessive drinking
303.2 Alcohol addiction
303.9 Other alcoholism

Drug dependence
304.0 Opium, opium alkaloids and their derivatives
304.1 Synthetic analgesics with morphine-like effects
304.2 Barbiturates
304.3 Other hypnotics and sedatives or "tranquilizers"
304.4 Cocaine
304.5 Cannabis sativa (hashish, marihuana)
304.6 Other psycho-stimulants
304.7 Hallucinogens
304.8 Other drug dependence

VI PSYCHOPHYSIOLOGIC DISORDERS
305.0 Skin
305.1 Musculoskeletal
305.2 Respiratory
305.3 Cardiovascular
305.4 Hemic and lymphatic
305.5 Gastro - intestinal
305.6 Genito - urinary
305.7 Endocrine
305.8 Organ or special sense
305.9 Other type

VII SPECIAL SYMPTOMS
306.0 Speech disturbance
306.1 Specific learning disturbance
306.2 Tic
306.3 Other psychomotor disorder
306.4 Disorders of sleep
306.5 Feeding disturbance
306.6 Enuresis
306.7 Encopresis
306.8 Cephalalgia
306.9 Other special symptoms

VIII TRANSIENT SITUATIONAL DISTURBANCES
307.0* Adjustment reaction of infancy*
307.1* Adjustment reaction of childhood*
307.2* Adjustment reaction of adolescence*
307.3* Adjustment reaction of adult life*
307.4* Adjustment reaction of late life*

IX BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE
308.0* Hyperkinetic reaction*
308.1* Withdrawing reaction*
308.2* Overanxious reaction*
308.3* Runaway reaction*
308.4* Unsocialized aggressive reaction*
308.5* Group delinquent reaction*
308.9* Other reaction

X CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON-SPECIFIC CONDITIONS

Social maladjustment without manifest psychiatric disorder
316.0* Marital maladjustment*
316.1* Social maladjustment*
316.2* Occupational maladjustment*
316.3* Dyssocial behavior
316.9* Other social maladjustment*

Non-specific conditions
317* Non-specific conditions*

No Mental Disorders
318* No mental disorder*

XI NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE
319.0* Diagnosis deferred*

DX Limited To Five Digits

FIFTH DIGIT QUALIFYING PHRASES

SECTION II	SECTION III	SECTIONS IV THROUGH IX	ALL DISORDERS
1 Acute	6 Not psychotic now	6 Mild	5 In remission
2 Chronic		7 Moderate	
		8 Severe	

FULTON STATE HOSPITAL
FULTON, MISSOURI

SOCIAL HISTORY QUESTIONAIRE

IMPORTANT

In order to give your patient the best treatment possible, we urgently need your help in filling out this questionaire. Only you or another person close to the patient can give us this special help. The treatment for nervous or mental illness is different from that of other kinds of illnesses. The doctor needs to know all the ideas which go through the patients mind; how he felt about these ideas and feelings that have developed. He must look for his clues to these mental processes by learning something about the patients life history; the kind of person he has been, how he felt about people around him, toward his family and friends. An understanding of what the patient did, what he talked about and how he talked is also necessary. The doctor measures improvement in the patient by knowing the kind of person he was before he became mentally ill.

Please read through the entire form before beginning to write your information. The headings are only suggestions; anything else that you know about the patient may be added on extra. Perhaps some of the suggested points do not relate to this patient at all, but answer as many as possible. Perhaps you will wish to ask another family member, friend, doctor, or minister, to help you with some especially difficult questions, if you do, be sure to let us know which questions they have answered and give us their name and address. What you write is of value to the doctor and the patient, and will be considered confidential by the hospital.

Name of Patient: _____ Soc. Sec. No. _____

Address _____

Sex _____ Age _____ Birthdate _____ Marital Status _____ Religion _____

Highest School Grade completed _____ Usual Occupation _____

Has patient a legal guardian? _____ Name _____

Address of Guardian _____ Telephone _____

Who should be notified in case of emergency?

Name: _____ Relationship _____

Address _____ Telephone _____

Who has completed this form?

Name: _____ Relationship _____

Address _____ Telephone _____

Date _____

PRESENT MENTAL ILLNESS

This section is devoted to your story of the patient's illness. Please tell us why it was necessary for the patient to come to this hospital. Tell us what changes occurred in the patient's personality and behavior, that were different than normal.

When did these changes first occur?

Did the changes in behavior and personality occur gradually or suddenly?

Do you think any event or person could have caused this illness? What?

How did the patient feel about coming to this hospital?

Tell us which of the following words describe the patient as he is now.
Please check those which apply.

extremely happy _____ easily upset _____ withdrawn _____
violent _____ confused _____ goes thru certain actions _____
suspicious _____ noisy _____ paces floor _____
fearful _____ forgetful _____ refuses to eat _____
cries frequently _____ untidy _____ very worried _____
dangerous to others _____ unusually religious _____ threatening to kill
unable to sleep _____ messy in personal himself _____
habits _____ very quiet _____

Please explain very completely those which you check.

Tell uswhich of the following ideas are typical of the patient's thinking now.
Check those which apply.

Thinks he is always right _____ Feels worthless _____
Thinks that people are talking about him _____ Hears imaginary voices _____
Thinks wife (or husband) unfaithful _____ Sees imaginary things _____
Believes he has unusual powers _____ Tastes imaginary things _____
Thinks others plan to harm him _____ Believes he is someone other than himself _____

Please explain very completely those items which you have checked.

Do you believe the patient has a problem with alcohol? _____ If so, please answer:

What does he drink?
How much does he drink?
When does he drink. (daily, weekends, periodically, etc.)?
Does he drink alone or with friends?
Did he ever try to get help? _____ From Whom?
When did he first begin to drink?
How does drinking affect his personality?

Does the patient use drugs? _____ Is there a problem of addiction?
What kind of drugs does he take?
How much does he take?
When and why did he start?
Where did he get them?

Do you believe the patient has any unusual sexual habits or tendencies?
If so, please explain in detail:

Has the patient ever been arrested? _____ Jailed? _____ For how long?
When Where

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PAST MENTAL ILLNESS:

Were there any other periods in the patient's life (other than the present illness) when he did not appear normal?_____Please describe his behavior at those times:

Was he ever hospitalized for nervous or mental illness?_____If so, give names of doctors, hospitals, and dates.

Did he ever visit any Out-Patient Clinic or other agency about his problem?_____ Give names, dates:

Did he get better?

Were there times when the patient seemed normal and other times when he seemed sick again?_____Please explain:

PERSONAL HISTORY:

Here the doctor wants to know what kind of person the patient has been -- his interests and feelings toward people and toward himself. We will start at the beginning and continue through the patient's childhood into adult life:

Birth, Infancy, and Childhood:

Did the patient's mother have any sickness during pregnancy?

Were there any complications during the patient's birth?_____If yes, tell us about them:

Tell us about the patient's training:

Age first walked?_____Age first talked?_____Age weaned?_____
Age toilet trained?_____Any problems with weaning or toilet training?____
Were there any convulsions?_____Temper tantrumes?_____
Thumb sucking?_____Bedwetting after age 3?_____
Stuttering?_____Nightmares?_____
How were these situations handled?

How did the patient get along with other children? Did he play alone or with others?

Was the patient especially attached to his parents or other members of the family?

Were parents generally easy-going?

Were there any family difficulties such as death, illness, or finacial problems?

Adolescence:

How did the patient get along with other people during teen years?
Did he mix easily with others or did he stay alone?

At what age did the patient begin to show an interest in the opposite sex?
Did he have dates?_____How often?_____

Did he show an excessive interest in girls (boys), or was it normal?
Or do you think it might have been less than normal?

Education:

Age patient entered school?____ Country or town?_____
Age patient stopped going to school?_____

Grade?____ Reason for stopping school?

Repeat any grades?_____How did the patient like school?

How did patient get along with other students?

What were his grades like?

What sports, clubs, or other such activities did patient take part in?

How did patient get along with teachers?

Occupation:

Age patient first began full time work?____ What was patient's first work?

What has been patient's principal occupation most of his life?

When did he last work and at what?

How many jobs has patient had in the last three (3) years?

What reasons for change?

What sort of worker is he?

Has he had any special training for his work?

Does he have any problems in connection with his work?

Has he received public assistance?_____Does he now receive Social Security?____Or any other pension?_____What?_____Amount?_____

Adulthood:

How does the patient get along with other people?
As an adult, had he always made friends easily?
Or has he preferred to remain alone more?

How has the patient normally liked to spend his free time?

Is this the same since he became ill?_____If not, how is it different?

What lodges or clubs does he belong to?

Does he have any hobbies?_____What?
Does he enjoy sports?_____ Does he enjoy Music?
How often does he participate and to what extent?

Does the patient attend church?_____How does he feel about religion?

Marital status:

Date patient married?_____Age at marriage?_____

Give full name of patient's wife (or husband) and age at marriage?

Do you feel that this marriage has been a happy one?

How do the patient and wife (or husband) feel about each other?

What problems have there been in this marriage?

What is wife (or husband)'s occupation?

What is wife (or husband)'s highest grade completed in school?

If patient is divorced or separated from his wife (or husband), please give date of separation and reason. How did this affect the patient?

If wife (or husband) is deceased, please guve cause and date of death:

How did this affect the patient?

Has the patient remarried?_____Second wife (or husband)'s name:

Date of this marriage?_____Present age of wife (or husband)?_____

If there have been more than two marriages, please use this space to tell us about when they took place and to whom?

Parenthood:

Please give us the names of the patient's children, in order of birth. Tell us also about any miscarriages, stillborn babies or deaths:

Name	Age	Present address	Occupation	If dead cause and age

How does the patient get along with his children? If there are any problems, please explain in detail:

Family History:

Here, we are interested in knowing something about the people who make up the patient's own family. If there is anyone else to whom the patient has been close such as another relative or a very close friend, please tell us about them, also:

Father's name:_____ Birthdate:_____ Age_____
Address_____ Birthplace:_____
Occupation_____ Highest school grade completed:_____
If dead, please give cause and age at death:_____
How old was the patient?_____ Any affect on him?_____

Mother's name:_____ Birthdate:_____ Age:_____
Address:_____ Birthplace:_____
Occupation:_____ Highest school grade completed:_____
If dead, please give cause and age at death:_____
How old was the patient?_____ Any affect on him?_____

Tell us about the patient's brothers and sisters. (List in order of birth.)

Name	Age	Present Address	Occupation	If dead, cause and age

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Are there any other people to whom the patient was especially attached? Any grandparents, aunts, uncles, or cousins, or even friends. Tell us about them:

Which relations live with the patient at home? How does the patient get along with them?

What difficulty has the patient had with any members of the family? Please explain in detail.

Were the patient's parents ever separated or divorced? Tell us about what happened:

How old was the patient?
With whom did he live afterwards?
Did he have a chance to see the other parent?
Did either parent remarry?
How old was the patient when remarriage took place?
How did the patient get along with his step-parent?

Tell us any more that you can about the effects on the patient:

Were there any relatives on either side of the family who were mentally ill; mentally deficient, alcoholic, or had nervous trouble? If so, who were they and what was their illness? Were they hospitalized?_____Where?_____

Medical History:

Childhood diseases: (Check which diseases patient had and please give age.)

Measles_____ Whooping Cough_____ Mumps_____ Chicken Pox_____
Diptheria____ Scarlet Fever_____ Rheumatic Fever_____
Polio_____ Meninggitis_____ Sleeping Sickness (Encephalitis)_____
High Fever_____ Other_____

General Diseases:

Typhoid_____ Pneumonia_____ Influenza_____ Malaria_____
Small Pox____ Diabetes_____ Tuberculosis_____Cancer_____
Rheumatism____Ulcers_____ Jaundice_____ Asthma_____
Kidney Disease____ Veneral Disease_____ Heart Disease_____
Convulsions_____ Others_____

Any operations: (Please tell what kind of operation and give the patient's age at the time:

What hospital?
Who was the doctor?

Any serious injuries: (Please describe and tell us how old the patient was when it happened.)

Did patient lose consciousness?

Does patient complain of any pain or particular disease at this time?

For female patients: At what age did she begin to menstruate?_____
Are her periods regular?_____
Has she complained of pain or cramps while menstruating?___
Has she stopped menstruating?_____
How did this affect her behaviour?_____
Has she ever had any abortions?_____ When?_____
Has she ever had any miscarriages?_____When?_____

Has the patient ever had any seizures or fits?_____
How often did they occur?_____
How long did each seizure last?_____
What was his behavior immediately before and after a seizure?_____
What do you think caused them?_____
When did the first one occur?_____
Describe the seizure:

Does the patient take any medicine?_____What kind?_____
How long has he been taking it?_____

MILITARY HISTORY:

Was the patient in the military service?_____Which branch?_____
What was his job?_____
Date he entered service?_____ Date he left service?_____
Type of discharge?_____ Highest rank?_____
Has he ever applied for a pension based on his military service?_____
What is his identification number?_____Claim Number?_____
Does he receive a pension?_____

If patient was rejected for service, please give date and reason:

Please use the rest of this space to tell us anything else you know about the patient. Remember, the doctor measures improvement in the patient by knowing the kind of person he was before he became ill. So whatever you can tell us will be very important. It would be helpful if you could include your plans for the patient when he is ready to leave the hospital -- will he return to his home? What will he do? Will he work? -- because answers to these questions are often needed by the doctor as he moves toward his eventual goal of discharging the patient.

Thank you.

APPENDIX E

COMPETENCY SCREENING TEST

1. The lawyer told Bill that
2. When I go to court the lawyer will
3. Jack felt that the judge
4. When Phil was accused of the crime, he
5. When I prepare to go to court with my lawyer
6. If the jury finds me guilty, I
7. The way a court trial is decided
8. When the evidence in George's case was presented to the jury
9. When the lawyer questioned his client in court, the client said
10. If Jack has to try his own case, he
11. Each time the D.A. asked me a question, I
12. While listening to the witnesses testify against me, I
13. When the witness testifying against Harry gave incorrect evidence, he

APPENDIX F

CERTIFICATE

DATE

I CERTIFY THAT THIS IS A REPORT OF THE PSYCHIATRIC EXAMINATION PURSUANT TO THE PROVISIONS OF CHAPTER 552 RsMO AS ORDERED BY THE _____ COURT OF _____ (CITY OR COUNTY), CAUSE NO. _____ HONORABLE _____ _____ PRESIDING, IN THE CASE OF _____ _____, A ___ Y/O ___ (W-B) _____ (M-F), WHO WAS ADMITTED TO THE MAXIUM SECURITY UNIT OF FULTON STATE HOSPITAL ON

___ ___ ___

I REASON FOR ADMISSION: PRE-TRIAL EXAMINATION PURSUANT TO CHAPTER _____ AS ORDERED BY _____ ____ ____ (COURT). THE PATIENT IS CHARGED WITH _____

LEGAL STATUS

PERTINENT SOCIAL HISTORY (PLEASE TYPE IN)

II PHYSICAL STATUS

PHYSICAL EXAM VITAL SIGNS, PHYSICAL STATS AND ABNORMALITIES

LAB DATA

IF NOT ALL RESULTS OF TESTS ORDERED IN AT TIME OF DICTATION NOTE "IF ANY ABNORMALITIES ARE FOUND AN ADDENUM WILL BE MAILED TO THE COURT"

III MENTAL STATUS

_____ _____ WAS GIVEN A PSYCHIATRIC INTERVIEW ON __ __. PRIOR TO THE BEGINNING OF THE EXAMINATION _____ _____ WAS ADVISED OF HIS RIGHTS AND INFORMED THAT HE DID NOT HAVE TO DISCUSS ANY MATTERS PERTAINING TO THE ALLEGED CRIME IF HE SO DESIRED.

PATIENT (FULLY OR DID NOT FULLY) COMPREHEND(ED) WHAT WAS SAID TO HIM AND WAS (CO-OPERATIVE OR NOT CO-OPERATIVE) THROUGHOUT THE INTERVIEW, POLICE REPORTS WERE AVAILABLE AT THE TIME OF THIS CERTIFICATE (OR NOT AVAILABLE), AS WELL AS REPORTS FROM SOCIAL SVCES AND PSYCHOLOGY AND ALSO REPORTS OF THE PATIENT'S BEHAVIOR AS GIVEN BY EXPERIENCED PSYCHIATRIC AIDS.

ORIENTATION: P,T,P AND REASON FOR EXAM

APPEARANCE AND BEHAVIOR: STATED AGE, DRESS, HYGIENE

UNUSUAL OR BIZARRE MANNERISMS

MEMORY: (ALSO FOR ALLEGED CRIME)

SPEECH AND MENTAL ACTIVITY:

TONE, FLOW, RATE, MODULATION

ARE ANSWERS RELEVANT, LOGICAL AND COHERENT

ILLUSIONS, DELUSIONS, AND HALLUCINATIONS

CALCULATIONS

PROVERBS AND SIMILARITIES

EVIDENCE FOR DISORDER OF THOUGHT, CONTENT OR PROCESSING

MOOD AND AFFECT

INSIGHT AND JUDGEMENT

-IS PATIENT AWARE OF CHARGES AND POSSIBLE CONSEQUENCES SHOULD HE BE FOUND GUILTY

-DOES PATIENT FEEL HE HAS A MENTAL DISEASE

-DOES PATIENT UNDERSTAND

COURTROOM PROCEDURES

DUTIES OF JUDGE

PROSECUTING ATTORNEY

DEFENSE ATTORNEY

JURY

-WILL HE HELP HIS ATTORNEY IN PREPARATION OF HIS DEFENSE

PSYCHOLOGICAL TESTING PLEASE FILL IN

IV COURSE IN HOSPITAL

SINCE HOSPITALIZATION AT FULTON STATE HOSPITAL ___ ____

HAS (NOT) BEEN A MANAGEMENT PROBLEM

HE HAS (NOT) REQUIRED THE USE OF MEDS (PSYCHOACTIVE)

V CONDITION AT PRESENT

AT THE PRESENT TIME THE PATIENT IS IN THE MAXIMUM SECURITY UNIT AT FULTON STATE HOSPITAL OR PATIENT HAS BEEN DISCHARGED TO THE CUSTODY OF THE SHERIFF OF _____ _____

VI DIAGNOSIS

VII DISCUSSION

___ ____ IS A __ Y/O __ ___ WHO WAS ADMITTED TO THE MAXIMUM SECURITY UNIT OF FULTON STATE HOSPITAL ON ___ ___ BY ORDER OF ____ . _____ _____ (COURT) FOR PURPOSE OF PRE-TRIAL PSYCHIATRIC EXAMINATION ON THE CHARGE OF _____ _____ . SINCE ADMISSION ___ ____ HAS BEEN OBSERVED AND STUDIED AND THERE ARE (NO) INDICATIONS THAT THE PATIENT WAS SUFFERING FROM A MENTAL DISEASE OR DEFECT AT THE TIME OF THE ALLEGED OFFENSE OR SINCE HE HAS BEEN AT FULTON STATE HOSPITAL TO EXCLUDE HIM FROM RESPONSIBILITY. (IS THE PATIENT SUFFERING FROM MENTAL ILLNESS.) HIS ACTIONS ARE VOLITIONAL AND NOT A PRODUCT OF ONGOING PSYCHIATRIC ILLNESS.

-PATIENT HAS ADAQUATE KNOWLEDGE OF THE COURTROOM PROCEDURE AND THE CAPACITY TO ASSIST IN PREPARING HIS DEFENSE.

-IT IS MY OPINION ____ ____ IS (NOT) COMPETENT AND RESPONSIBLE.

VIII FINDINGS

1) THAT THE ACCUSED HAS (NO) MENTAL DISEASE OF DEFECT WITHIN THE MEANING OF SECTION _____

2) THAT THE PATIENT HAS (DOESN'T HAVE) THE CAPICITY TO UNDERSTAND THE PROCEEDINGS AGAINST HIM AND CAN (NOT) ASSIST IN THE PREPARATION OF HIS DEFENSE AT THIS TIME.

3) THAT THE ACCUSED DID (NOT) KNOW OR APPRECAIATE THE NATURE, QUALITY OR WRONGFULLNESS OF HIS ALLEGED CONDUCT AND WAS (IN) CAPABLE OF CONFORMING HIS CONDUCT TO THE REQUIREMENTS OF THE LAW.

4) THAT THE ACCUSED DOES (NOT) REQUIRE PSYCHIATRIC HOSPITAL-IZATION PENDING FURTHUR PROCEEDINGS.

IX RECOMMENDATIONS

IT IS RECOMMENDED THAT _____ _____ BE COMMITED TO THE MISSOURI DIVISION OF MENTAL HEALTH AS HAVING A MENTAL AS HAVING A MENTAL DISEASE OF DEFECT EXCLUDING RESPONSIBILITY PURSUANT TO CHAPTER (552.040)

IX RECOMD CONT'

IT IS RECOMMENDED THAT _____ _____ BE RETURNED TO THE COURT FOR ADJUDICATION OF THE CHARGES PENDING AGAINST HIM

APPENDIX G

DEPARTMENT OF MENTAL HEALTH
FORENSIC INFORMATION SYSTEM

Facility _____ Date Referral Notice Received _____

I. DEMOGRAPHIC INFORMATION

1. _____ Patient Number _____ Date First Staff Contact

2. _____ Patient Name (Last, First, M.I.) _____ Date Report Sent to Court

3. _____ Patient Alias(es) Patient Missed Appointments ____ Yes ____ No

4. D.O.B. _____ Month _____ Day _____ Year

5. Sex _____ M _____ F

6. Race _____Black
_____White
_____Am. Ind.
_____Hisp.
_____Other

7. Patient Status _____Bond
_____Jail

8. Patient Attorney _____ (Last, First, M.I.)

II. REFERRAL INFORMATION (From Court Order)

9. County of Referring Court _____

10. Judge _____ (Last, First, M.I.)

11. Offense(s) Charged

_____ _____
_____ _____
_____ _____

(Note: The "Offenses Charged" will be taken from the court orders until natural groupings appear at which time they will be lumped into a few categories. Until that time, we need only reserve several spaces in the computer for this category.)

12. Questions for Evaluation (Check applicable items)

_____ competency to stand trial

_____ whether hospitalization required pending determination of competency

_____ whether hospitalization required if found competent

_____ whether client has mental disease or defect

_____ whether client responsible at time of offense

_____ whether "diminished responsibility" exists

_____ recommendations for sentencing

III. HISTORIC INFORMATION

13. Grade Achieved _____

(Note: This will be taken from the educational categories DMH already uses.)

14. Psychiatric History

_____	in-patient	_____	most recent year
_____	out-patient	_____	most recent year
_____	alcohol/drug	_____	most recent year
_____	M.R. facility	_____	most recent year
_____	none		

15. Most Recent Diagnosis Prior to Current Evaluation.

_____

16. Number of Previous Felony Convictions

_____ 1
_____ 2 - 4
_____ more than 4
_____ none

17. Offense(s) for Which Convicted

_____ _____
_____ _____
_____ _____

18. Date of Most Recent Felony Conviction _____

19. Previous Misdemeanor Conviction _____ yes
_____ no

(Note: With reference to No. 17, see note after No. 11, above.)

IV. EVALUATION INFORMATION

20. Site of Evaluation _____ In-patient
_____ Out-patient
_____ Jail

21. Signatory of Report _____
(Last, First, M.I.)
_____
Profession (from DMH code)

_____
(Last, First, M.I.)
_____
Professions (from DMH code)

22. Client Competent to Stand Trial? _____ Yes
_____ No
_____ Deferred
_____ Not Asked

23. Client Sane at Time of Offense? _____ Yes
_____ No
_____ Deferred
_____ Not Asked

24. Diminished Capacity Available? _____ Yes
_____ No
_____ Deferred
_____ Not Asked

25. Hospitalization Pending Trial? _____ Necessary
_____ Unnecessary
_____ Not Asked

26. Medical Disease or Defect? _____ Yes
_____ No
_____ Deferred
_____ Not Asked

27. Diagnoses _____ Primary
_____ Secondary

28. Therapeutic Recommendations (check appropriate items)

_____ medication
_____ psychotherapy
_____ alcohol/drug rx
_____ in-patient rx
_____ out-patient rx
_____ other
_____ no recommendations

29. Sources of Information Available for Evaluation

_____ psychiatric interview
_____ social worker interview with client
_____ psychological testing
_____ written client statement
_____ police report
_____ autopsy
_____ confession
_____ interview(s) with family member(s)
_____ laboratory tests
_____ other

Addendum

Does the report predict that the client will engage again in the behavior which forms the underlying basis for the charged offense(s)?

_____ Yes _____ No

If such a prediction is made, what language is used? _____

_____

_____

Does the report predict behavior other than that which forms the underlying basis for the charged offense(s)?

_____ Yes _____ No

If so, what is the prediction? _____

_____

_____

APPENDIX H

FIVE DAY INITIAL TEMPORARY TREATMENT PLAN

NAME:

CASE NO:

ADMISSION DATE:

TYPE OF COMMITMENT:

PHYSICIAN'S SECTION: DATE

Admission Note Completed_____

History & Physical Completed_____

Routine Laboratory Workup Ordered_____

Routine Chest X-ray Ordered_____

Routine Psychologicals Ordered_____

If Applicable, Medication Ordered_____
Specify Drug(s) & Dosage:

Other Than Routine Consultations:

Example: EEG, Neurological, Skull X-rays, EKG, etc.

List Consult Type	Date Ordered
1)	_____
2)	_____
3)	_____
4)	_____

NURSING SECTION: DATE

Admission Nursing Notes Completed (SF-207 & SF-37)_

SOCIAL WORK SECTION: DATE

Social History Process Started_____

APPENDIX I

FOURTEEN DAY TREATMENT PLAN

NAME:

CASE NO:

ADMISSION DATE:

TYPE OF COMMITMENT:

DATE

SOCIAL HISTORY COMPLETED.....

PSYCHOLOGICAL TESTING COMPLETED.....

INITIAL CLINICAL STAFFING COMPLETED.....

PROGRAM REFERRAL MADE.....

TO WHOM 1 2 3 4

PROGRAM REFERRAL ACCEPTED.....

BY WHOM 1 2 3 4

ESTABLISHED CLINICAL DIAGNOSIS COMPLETED.....

DIAGNOSIS:

1.)
2.)
3.)

SPECIFY CURRENT MEDICATION AND DOSAGE, IF ANY:

1.)
2.)
3.)
4.)

TREATMENT REFERRALS COMPLETED DATE

RECREATION.....

OCCUPATIONAL THERAPY.....

MUSIC.....

ALCOHOLICS ANONYMOUS.....

OTHER:

LIST OF PROBLEMS IDENTIFIED

1.)

2.)

3.)

4.)

5.)

6.)

7.)

LIST OF STRENGTHS IDENTIFIED

1.)

2.)

3.)

4.)

5.)

6.)

7.)

NAME_____ TITLE_____

NAME_____ TITLE_____
(SIGNATURE AND TITLE OF TWO MENTAL HEALTH PROFESSIONALS WHO DEVELOPED THE PLAN)

NOTE: After the Program Referral Process has been completed, the program to which the referral was made assumes immediate responsibility for the development of the Goal Oriented Treatment Plan within 10 working days, as well as its maximum formal review of once every 90 days thereafter. This applies to the receiving program even if the patient temporarily remains on the Admission Ward for whatever reason.

Chapter 8

COMMUNITY CORRECTIONS

This last chapter in Part II of this book describes forensic mental health screening and evaluation as it is conducted by collaboration between the mental health and criminal justice systems in community corrections programs. The chapter describes in detail the mental health screening and evaluation performed in two community corrections programs, the Larimer County Community Corrections in Fort Collins, Colorado, and the Island County District Court Probation Department in Oak Harbor, Washington.

Incarceration in closed penal institutions has been rapidly losing popularity among criminologists and lawmakers alike (cf. President's Commission on Law Enforcement and Administration of Justice, 1967; Klapmuts, 1976; Prison Research Education Action Project, 1976; Warren, 1972; see also Note 1). Although not without some criticism (see, for example, Comptroller General of the United States, 1980), community-based corrections programs have been extensively used since the 1960s as viable alternatives to institutionalization, perhaps influenced by the deinstitutionalization trend in mental health. Unfortunately, the phrase "community-based treatment" has come to describe a wide variety of programs in corrections, creating a confusion that has been described quite well by Shah (1972, p. iii):

> [L]argely as a function of overuse and also because it has become somewhat of a catchword, the phrase, "community-based treatment," has come to describe a rather wide assortment of correctional programs. Thus, almost any correctional program conducted outside the walls of traditional juvenile and adult correctional institutions has been lumped into this category. For example, probation, parole, halfway houses, noninstitutionalized boarding arrangements (such as foster and group homes), and even small institutions or residential facilities located in the community, have been included under the description "community-based correctional programs." Indeed, the impression is often obtained that the very fact of labeling or designating a program as "community-based" is supposed to connote that the effort is "innovative," "enlightened," and "progressive." The numerous conceptual and programmatic issues which need to be specified, and the process and outcome indexes required for ascertaining program effectiveness, have generally been neglected.

Offenders eligible for community-based programs include those who (1) have been released after serving their sentences or released pretrial under some type of supervision, (2) are on probation or parole, or (3) are serving their sentences in the community as part of a special program. The support and growth of community corrections programs has been advanced by such reasons as the following:

- Treatment of offenders in a less restrictive environment in the community is more humane than incarceration in a traditional penal institution (Prison Research Education Action Project, 1976; Comptroller General of the United States, 1980).

- Institutionalization itself has a derogatory effect upon a person committed to such a facility (Coffey, Eldefonso, and Hartinger, 1974, pp. 266-269; National Advisory Commission on Criminal Justice Standards and Goals, 1973).

- Successful reintegration of the offender into society can be most expeditiously accomplished in a community setting (Coffey et al., 1974; Comptroller General of the United States, 1980; Klapmuts, 1976).

- Community corrections helps to maintain stability in the family of the offender (Coffey, et al., 1974).

- Reintegration of the offender is less costly to society than incarceration (Coffey et al., 1974; Comptroller General of the United States, 1980; Klapmuts, 1976; Perry, Note 2).

Ideally, aside from pretrial examinations of competency to stand trial and criminal responsibility, the goal of mental health screening and evaluation conducted in community corrections programs is the appropriate matching of offender needs (psychological, emotional, social, vocational, etc.) with individual programs to meet those needs. But in practice, the evaluation of risk to the community (Will the offender constitute a threat to the community?) and inadequate community resources balance the needs of the offender (Roth, 1980).

This chapter was based on the premise that there is a lack of knowledge about the operation of community corrections facilities. When this lack of knowledge is coupled with heated debate in the area of mental health and the law, it may be best to first describe simply what is, rather than what might be. As Michael Perlin has stated, "[a]lthough thousands of words are written about the subtle points of a significant decision or statutory revision, usually limited analysis is given what can be termed the 'socialization of the law' (1980, p. 194)."

Together with other detailed descriptions of community-based corrections programs, such as the Des Moines (Iowa) program (see Boorkman, Fazio, Day, and Weinstein, 1976), it is hoped that this chapter provides the information base to stimulate improvement in community corrections. Also, it is hoped that it can be shown that the operational context and practical consequences of the application of mental health issues in community corrections are often of far greater importance and interest than the substance of the issues. Many of the salient aspects of the alliances among law enforcement, the courts, the mental health system, and corrections are revealed in the descriptions of the Larimer County Community Corrections and the Island County District Court Probation Department.

LARIMER COUNTY COMMUNITY CORRECTIONS

Although Larimer County Community Corrections (LCCC) in Fort Collins, Colorado, has changed considerably in its five-year history, two basic goals have remained constant: to encourage diversion of criminal defendants from prison and to provide "transition" services to inmates upon leaving prison (Perry and Kammerzell, Note 3). These goals have been accomplished primarily through two programs, one residential and the other non-residential.

In the nonresidential program, LCCC staff counsels defendants sentenced to community corrections and ex-inmates on parole. The residential program is a halfway house, which receives (a) defendants referred for community corrections instead of prison and (b) prison inmates released from state prison to spend the last months of their sentences in the halfway house. At any one time the non-residential program has about 75 clients and the residential about 12. The purposes of mental health evaluations conducted by LCCC are generally to determine (a) whether prospective clients have mental problems too severe for LCCC to handle and (b) what types of services should be provided to clients accepted.

The nonresidential program receives clients who are either sentenced directly to community corrections or who are required to use LCCC as a condition of probation. A "contract" establishes the clients' obligations and the services given them under the sentencing order. The services include general counseling by the non-residential staff, vocational and educational counseling by LCCC specialists, and group therapy under the guidance of consulting psychologists. Clients, in their part of the contract, often must attend counseling sessions regularly at LCCC, attend drug or alcohol therapy, maintain jobs, and pay restitution.

The residential program--i.e., the halfway house--has a capacity of 20 men and women, although that capacity is seldom reached (see Note 4). Clients remain three to four months, while they are given a variety of individual and group treatments. Most halfway house residents work during the day and pay much of the cost of their lodging.

The service area of the LCCC is limited to Larimer County, a ranch and farming district about 60 miles north of Denver. The county population is about 120,000. LCCC is located in the county seat, Fort Collins, a town of some 60,000, best known as the location of Colorado State University. There are two courts for criminal cases, the District and the County Courts; LCCC generally deals with the District Court, which has jurisdiction over felonies.

LCCC was established by the Larimer County government in August 1976, the first community correction program under new Colorado legislation encouraging such programs. The initial task of LCCC was to submit a funding proposal to the state planning agency, the Council on Criminal Justice, for a Law Enforcement Assistance Administration (LEAA)

block grant. The proposal was successful and LCCC received $93,854 for a one-year grant starting early in 1976. This grant marked the beginning of the community corrections operations. Its major goals, as described in the grant, were:

- o to provide an alternative to jail sentencing--that is, sentencing to community corrections with a wide range of services to the convicted defendants, including psychological testing;
- o in-jail inmate counseling and education; and
- o counseling and other services for inmates released from prison.

LCCC received two continuation grants of $96,600 and $60,000. With extensions, the grants continued until June 1979. The program, since then, has continued under state financing, although reduced from the initial level of funding.

In 1978 the LCCC received another LEAA grant, $115,200, to establish a halfway house. This was the origin of the LCCC's second major function, the residential program. The grant lasted for less than a year and was not continued when it terminated in September 1979, but the state and county continued much of the funding.

LCCC conducts several activities other than the residential and non-residential programs. It initiated a pretrial release program in January 1980; in this program, staff members evaluate inmates who are awaiting trial in jail because they cannot pay bond for possible pretrial release. LCCC also has a vocational counseling program and a project for educational diagnosis. These activities do not involve mental health screening, and will be discussed in this report only as they act upon clients referred for the residential or nonresidential programs.

The LCCC has had its ups and downs. During the first six months of operations under the original grant, there was discontent among the LCCC staff and county and state officials. After several government investigations, the LCCC director resigned. His replacement was able to maintain and expand the organization until he left at the beginning of a second troubled era, late in 1979. Federal grants terminated and were only partly replaced by state and local appropriations, requiring staff cutbacks. At this writing, however, LCCC has received sufficient money to build its staff to full strength, although a new director has not yet been appointed.

A major change over the years has been the reduction of services to Larimer County Jail inmates, which was originally one of its major functions. LCCC has discontinued educational classes in jail, and it no longer maintains an exercise room there. Inmate counseling is now limited to prisoners who are being screened for possible sentence to community corrections. A "workender" program (under which people sentenced for weekend jail are placed in work details rather than jail cells) was transferred from the LCCC to the sheriff's department.

The fortunes of LCCC are closely tied to overcrowding in the state prison and county jail. The more these institutions need relief, the more local and state governments seem willing to support LCCC community corrections programs that provide alternatives to imprisonment. Jail overcrowding has also deprived the LCCC staff of office space to counsel defendants in jail; this is a major reason given for cutbacks in LCCC counseling services to inmates. An important event, in November 1979, was a federal court consent decree ordering the Larimer County sheriff to limit jail population to the designed capacity of the jail, far below the traditional jail population.

LCCC is a county agency, directly under the Larimer County Board of Commissioners. It also has an advisory board, with some 20 members appointed by the Commissioners. The board members represent all major segments of the local criminal justice system, as well as a sampling of community members. In May 1980 the county and the LCCC board reorganized the agency, creating a separate division for special programs, which includes an evaluation specialist to screen all clients referred to the residential or non-residential programs.

The size of the LCCC staff fluctuates greatly. At the time of writing it numbered 17. LCCC also employs several student interns, and it has three consulting psychologists. Six of the staff are active in screening for the residential and non-residential programs. All are counselors, with college or master's level degrees in social work, counseling, or social sciences. One of the consulting psychologists participates in the screening decisions.

The LCCC is located in an old sorority house. Parts are used for counselors' rooms and parts for bedrooms, kitchen, and a commonroom for halfway house residents.

Process Flow

Figure 57 summarizes the procedures used in most LCCC mental health evaluations and gives the reader a broad picture of LCCC screening operations. Figure 57 leaves out many details and infrequent deviations from normal procedures; these will be described in the following sections. The diagram does not include LCCC's operations, such as treatment programs, that do not involve mental health screening.

LCCC receives three types of referrals for mental health screenings: defendants awaiting trial, inmates in the state penitentiary, and parolees. Figure 57 depicts the processing of the first, and most common, type. The other screenings, referrals from the penitentiary and from parole agents, will be summarized later, but these screenings are so uncomplicated that process flow diagrams would not be helpful.

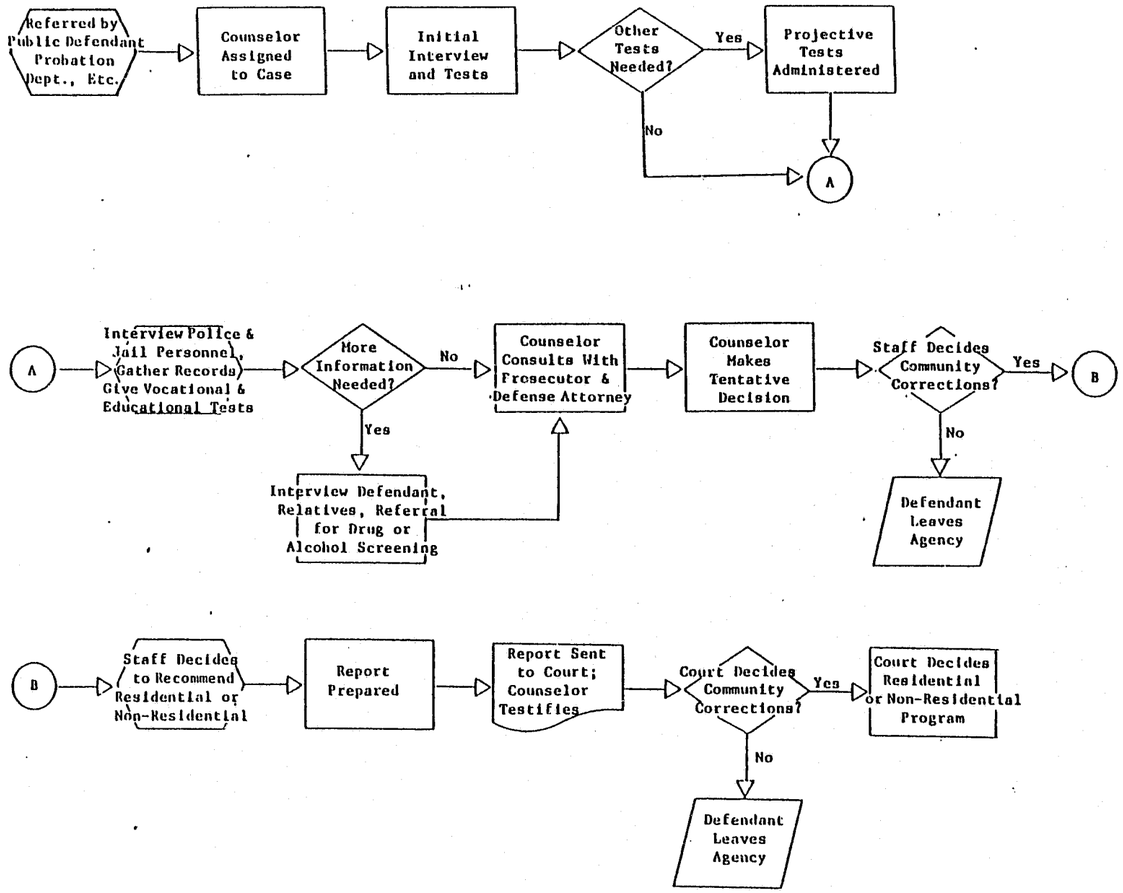

Figure 57. Larimer County Community Corrections, Flow of Defendants Referred Before Sentencing.

Screening Defendants Awaiting Trial

The most common referral agents for defendants awaiting trial are defense attorneys and the District Court probation department. The purpose of the referral is to have LCCC screen the defendant for possible community corrections, which would be administered by LCCC. The first action at LCCC after the referral is assigning the case to a counselor. The case is assigned to a residential or non-residential counselor depending on which type of community treatment appears the most likely for the defendant. The referral agent sometimes indicates whether the defendant is a candidate for the residential or the non-residential program, and the counselor is assigned accordingly. More often, however, the assignment is made solely on the basis of an initial estimate by the LCCC staff as to which program is more likely.

The assigned counselor both screens the defendant and provides counseling. The screening begins with an initial interview, where the counselor completes an intake form and administers a Minnesota Multiphasic Personality Inventory (MMPI). Other tests are given in later interviews. The Firo-B and the Incomplete Sentence Blank (ISB) are always given, but projective tests are optional. The defendant is given vocational and educational tests by other LCCC staff. The counselor also investigates the defendant by interviewing police and jail personnel, gathering crime records, and in some cases by interviewing defendant's relatives. Also, the counsel refers some defendants for drug or alcohol screenings. Meanwhile, for the three months or so between referral and the sentencing hearing, the counselor holds weekly meetings with the defendant; these meetings are counseling sessions as well as opportunities for staff to observe the defendant for screening purposes.

The counselor, after consulting with the prosecutor and defense attorney, reaches a tentative decision about whether LCCC should recommend to the court that the defendant be given community corrections, and if so, whether residential or non-residential corrections. The counselor's tentative decision is reviewed in a staff meeting, consisting of the counselor's colleagues in either the residential or non-residential staff. One of many factors entering the decision to accept the defendant or not is whether he or she may have severe mental problems that are beyond the resources of LCCC.

After the staff decision the counselor prepares a formal report for the court giving reasons for the LCCC recommendation and suggesting specific treatment if the defendant is referred to LCCC. The defense, prosecutor, and court generally follow the recommendation.

Screening Inmates and Parolees

The second and third types of referral are less frequent and involve less screening activity. First, the Department of Corrections refers inmates in state institutions to spend the last few months of their sentences in the LCCC residential program. Here the LCCC residential staff must decide whether to accept the referrals with what

they consider to be scanty information from the Department of Corrections. The final type of referrals are parolees referred to the non-residential program; here the parole agents' referrals are accepted without any actual screening.

Delineation of Mental Health Information Requirements

Time and Source of Referrals

Referrals to LCCC are made virtually at any stage of the criminal justice system after arrest. Most occur soon after arrest, others occur just before the trial date, between the time of trial and sentencing, after sentencing upon a petition for resentencing, and pending release from prison.

There seems to be little correlation between the time of referral and whether the client is a candidate for the residential or non-residential program. That is, both programs receive defendants referred to LCCC for screening prior to conviction as well as prison inmates and parolees referred to facilitate transition from prison to normal life.

The source of referral, however, does vary somewhat with the time and purpose of the referral. Referrals before the sentencing stage come from a great variety of referral agents. The most common are defense attorneys, especially public defenders, and the probation department of the District Court. A further, rapidly growing referral source is the staff psychologist in the Larimer County Jail, who was hired by the sheriff's department in late 1979 to screen and classify incoming inmates. Also, staff in the LCCC Pretrial Release Program may refer cases to LCCC residential and non-residential staff. Less frequent referral sources are judges, district attorneys, other jail staff, the community mental health center forensic psychologist who treats inmates, police officers, friends and relatives of the client, and the clients themselves.

These presentence referrals are made whenever it occurs to a potential referral agent to make the referral, usually fairly soon after arrest, but sometimes as late as a few days before sentencing (in which case, the LCCC obtains a continuance from the court so it will have sufficient time with the client). The local courts have substantial delays, so the LCCC staff usually has several months to make its screening decision when presentence referrals are made soon after arrest. The staff prefers to have at least 90 days; but a few decisions, especially those concerning the residential program, are made within a month.

Postsentencing referrals, unlike the presentence referrals, come from a limited number of sources. Referrals upon sentencing review (which take place within 90 days of the first sentence) are generally made by defense counsel. Like the early referrals, these can be aimed at either the residential or non-residential programs.

The final stage in the criminal process at which referrals to LCCC are made is near the end of a prison term or after release from prison. The Department of Corrections refers inmates to the halfway house to complete their sentence. The local state parole agent (or occasionally a federal parole agent) refers some parolees to the non-residential program.

Form of Referrals

Most referrals are made verbally, usually by telephone, with a statement that the defendant should be considered for community corrections and, sometimes, with a recommendation that the focus be on residential or non-residential services. Two major referral agents, however, typically use a referral form. The probation department uses a form (see Appendix A), and the state parole officer in Larimer County uses a similar form. The probation department generally gives only two referral reasons on the form, the first two entries, "Diagnostic Information for Presentence Report," and "Personality Inventory." LCCC does these routinely in any case, however. The parole officer varies requests from case to case. LCCC complies with these requests and often provides parolees additional services not requested. The parole officer may also specify psychological tests, and the LCCC may perform additional tests. The indication "psychiatric evaluation" in the form remains from prior years when, in contrast to recent years, such evaluations were performed occasionally. The form is four years old, and the staff plans to revise it and other LCCC forms.

Acquisition of Mental Health Information

Defendants referred to LCCC go through a lengthy and thorough review that culminates in a presentence report. The only exceptions are that, on rare occasions, the screening is summarily terminated because the defendant decides not to participate, or because the defendant's lawyer informs LCCC that the defendant will surely be incarcerated, rather than sentenced to community corrections. By and large, however, defendants prefer LCCC as the only alternative to prison, and lawyers seldom refer defendants who face certain prison terms. In contrast to the presentence screening, LCCC screening referrals from prison or parole officers are limited in scope. Screening procedures for the residential and non-residential programs of LCCC are quite similar.

Presentence Screening

Time of Referral and Assignment. The LCCC prefers that defendants be referred as soon after arrest as possible to allow sufficient time to observe the defendant before the sentencing hearing, when the LCCC must give the court a report recommending for or against LCCC placement. Most referrals are made soon after arrest. Because there is considerable court delay, the LCCC staff has at least three months to screen the defendant and make an appropriate placement decision. Occasionally, however, referrals are not made until just before sentencing, whereupon the LCCC asks the court for an extension, which is routinely granted, giving at least a month for the evaluation.

After the referral, the case is assigned to a staff member. Each case is informally screened and assigned to one of the six counselors (there are three counselors in the non-residential and three in the residential program), mainly according to availability of time. (Until late 1979, one LCCC staff member conducted almost all initial screening and assigned cases to individual counselors. LCCC staff plan to return soon to this procedure.) Clients likely to enter the halfway house are assigned to residential counselors; those likely to enter the non-residential program are assigned to non-residential counselors. Often this choice is made because the public defender or other referral agent suggests that one program or another will be more suitable. If it appears later that a client of a non-residential counselor may be recommended for placement in the halfway house, a counselor from the residential staff may also be assigned to the case during the screening stage.

Intake Form. The intake procedure is generally uniform from case to case. About a week to ten days after the referral, counselors in both the residential and non-residential programs first interview the client and complete a seven-page intake form (the "Client Information Form," see Appendix B). Like all LCCC interviews and counseling sessions, this interview is held in the jail unless the defendant is on bond or other pretrial release. The interview typically lasts about 90 minutes. The counselor reads the questions and items from the form and writes answers on it. The information requested in the form is wide ranging; most is biographical data, especially criminal, family, occupational, and educational history. Several questions directly address the defendant's mental health. One section (Section XI, Appendix B) asks about the defendant's emotional health and about whether the defendant is undergoing therapy or has been in a psychiatric hospital or mental health clinic. Another section (Section XII, Appendix B), listing symptoms of mental health problems, asks whether the defendant has experienced, among other things, suicidal ideas, delusions, paranoia, depression, or hallucinations.

Psychological Tests. On the same day, if the defendant can read, the counselor administers the MMPI in its entirety. (In the near future, the jail psychologist will probably administer the MMPI in the new inmate classification program described later in this section. LCCC counselors believe that this will relieve them from having to wait at the jail while the inmate takes the test.) The MMPI is never the sole basis for a recommendation to the court. Its main purpose is to highlight concerns that need to be addressed in the interviews and to indicate whether further tests are needed. The MMPI results are also placed in the report advising the court about the disposition of the defendant.

In a second visit about a week later, the counselor gives two personality tests, the Rotter Incomplete Sentence Blank and the Fundamental Interpersonal Relations Orientation--Behavior (FIRO-B). These are self-administered questionnaires, like the MMPI, and are also limited to literate defendants. A large minority of the clients are also given projective tests, the Thematic Apperception Test (TAT) and House-Tree-Person Drawing tests. The latter is used more often than the

TAT. Individual counselors determine whether these two additional tests will be given, and there are no uniform criteria. Common situations when the tests are given occur when the results of the Rotter, MMPI, and FIRO-B are contradictory; when the consulting psychologist cannot "get a handle" on the defendant from these three tests; when the MMPI is not considered valid (for example, because the validity scores indicate that the defendant may be misrepresenting information); or when the intake interview or the earlier three tests indicate that the defendant may have severe mental problems that would make the defendant inappropriate for referral to LCCC at sentencing. Some counselors decide to give projective tests much more frequently than other counselors. Counselors use the TAT test less frequently than they did in the past, largely because it takes a relatively long time to administer.

The Consulting Psychologist. Although administered by LCCC counselors, all these tests are interpreted primarily by a consulting psychologist, a Ph.D. in clinical psychology. He is employed by the Larimer County Mental Health Center and spends approximately five hours per week consulting with LCCC. The mental health center (at this writing) pays for most of his time at the LCCC, but has announced that it will soon require reimbursement. The psychologist uses the test scores mainly to suggest to LCCC staff the general type of personality revealed by the results. That is, his advice is generally limited to interpretation of the tests, especially the various MMPI scores; it is usually based on direct contact with the defendant.

The psychologist may use the test results to advise staff about intake decisions, what further information should be acquired, and possible treatment approaches that LCCC should use with the individual. On rare occasions, especially when LCCC staff suspects severe mental problems that are beyond LCCC treatment capability, the psychologist goes beyond test interpretation. He may study the defendant's social history, review other material in the file, observe the defendant's interview with a social worker, or conduct an independent interview.

Other Information Gathered. The intake form and the results are only part of the information acquired about each client. A very important basis for recommendations to the court is the counselor's impression gained during weekly one-hour meetings with the defendant, usually for at least three months. Often another counselor sits in on one or more of these sessions. It should be noted that these sessions are used not only for screening but also for counseling.

The counselor gathers any additional feasible information that may help in the decision process. Sometimes a limited amount of information arrives with the referral, but seldom is this more than a statement of the crime charged and the defendant's record received from the defense attorney. Often the counselor gets no case information from the referral agencies. The counselor ordinarily acquires the following information:

- Copies of police reports of the crime and arrest.
- The arresting officer's description of the defendant and the offense, obtained from interviews by the counselor.

- Information about how the client has been acting in jail, obtained in interviews with jail personnel, particularly the jail psychologist.

- A copy of the defendant's criminal record. This is often obtained from the district attorney pursuant to an agreement between the district attorney and LCCC under which the district attorney has promised to supply defendants' records and the LCCC has promised to keep the district attorney informed of the progress of each LCCC client.

- Results of testing by the LCCC vocational counselor to determine the client's job history and vocational needs.

- Results of testing obtained by LCCC staff to determine educational achievements and needs.

Other information, obtained less frequently:

- An intake interview form completed by the jail psychologist. (The jail psychologist has recently begun intake screening and classification of prisoners; the LCCC staff obtains a copy of the intake interview form if the defendant signs a waiver.)

- Prison or mental hospital records. If there is any indication that the client has been in a prison or mental hospital, the counselor asks for a release and requests records. Institutions, however, frequently fail to send their records.

- Information obtained in interviews with the client's relatives and friends.

- An evaluation by a drug abuse counselor in the local community mental health center, the Larimer County Mental Health Center.

- An evaluation by a local non-profit alcohol center.

Finally, the counselor typically consults with the defense and prosecuting attorneys about possible disposition of the case. Here, the LCCC staff sometimes plays an active role in plea bargaining.

Transition Screening

The LCCC screens clients referred for "transition" services (transition between prison and outside life) much less thoroughly than defendants referred for possible sentence to community corrections. LCCC receives two types of transition clients, parolees referred by the federal or state parole agency for non-residential services, and inmates sent from the state prison to spend the last months of their term in the halfway house.

Counselors give the parolees far fewer interviews and tests than they give defendants who are being screened, as described in the past few pages. But the referring parole officer usually sends considerable information about the parolee, such as prison and arrest records. A counselor interviews the parolee, completes the intake form (see Appendix B), and administers an MMPI. Other psychological tests are given if the parole officer specifically requests them or if the counselor decides further testing is needed. The interview and tests are used to determine the parolee's treatment needs. In contrast to other referrals, parole referrals are routinely accepted by LCCC, although it has authority to reject them. (This practice might not continue. The state now refuses to pay for services not mandated by court order; and parole officers, not courts, send parolees to LCCC.)

The second category of transition referrals consists of inmates referred by the Department of Corrections for placement in the halfway house during the last part of their prison terms. The Department sends a lengthy report, which the LCCC staff considers largely uninformative. A major part of the report, for example, is a summary report from the Colorado prison intake screening and classification unit; this report is often several years old and typically gives only general conclusions. Psychological test results and interview notes for the prison intake screening are not available. Because LCCC cannot accommodate inmates with severe mental problems, it often refuses to accept referrals when the limited information available suggests the possibility of such problems. The Department of Corrections gives LCCC only seven days to decide whether to accept referrals; the staff believes this is not enough time to gather sufficient information for proper screening. Also, LCCC cannot afford trips by counselors to interview inmates at prison; the staff feels that these interviews are needed for decisions in many cases, and LCCC is seeking funds to pay for the trips.

Provision and Use of Mental Health Information

Mental health information obtained in the screening process is used by the LCCC staff to determine whether to recommend community corrections to the court or (in the case of transition clients) to accept or reject the clients. This section will emphasize the former, more common provision and use of mental health information, the recommendations to the court. The LCCC staff meets every Wednesday morning to make these determinations. There are usually three separate meetings: a meeting of residential program staff members, a meeting of non-residential program staff members, and a combined programs meeting. Some five to seven staff members attend the separate program meetings, and about twice as many attend the combined meetings.

Most discussion at the meetings concerns treatment of clients, although considerable time is also devoted to questions about whether the LCCC should accept specific clients referred to it. Whenever client admission issues are discussed, the consulting psychologist joins the meeting and expresses his opinion, based mainly on the psychological tests results, about whether LCCC should accept the client. The staff

discusses each case for 15 to 60 minutes before reaching a decision. They generally enter the meetings with considerable knowledge of the case gained from prior staff meeting discussions. The staff at the meetings decides by majority vote whether a client should be accepted into LCCC, and if so, for the residential or non-residential program.

Criteria for Accepting Clients

Criteria for accepting defendants in LCCC programs include the following:

- Whether LCCC has the resources and facilities to deal with the defendant's problems. (This criterion will be discussed further below.)
- Whether the defendant sincerely wishes to improve. Staff members feel that many defendants not unjustifiably view community corrections as their only possible escape from a prison term, so they often fear that defendants are not "leveling" with them when expressing a desire to enter the program and to improve their conduct.
- Whether the defendant is likely to commit a violent crime while in the program. LCCC, whenever possible, avoids the risk of accepting a person who may commit a violent assault, rape, armed robbery, or similar crime while assigned to LCCC. On the other hand, LCCC will accept the risk that a client may well commit a non-violent crime during treatment.
- Whether the crime is such that community standards prohibit the use of community corrections. If the staff feels that the community's desire for retribution would demand prison, they will not recommend community corrections.
- Whether the defendant would actually be sentenced to prison if not accepted by LCCC. At least some staff members are less likely to recommend community corrections if they think that the defendant will be placed on probation. They are particularly likely to recommend "two-time losers," who would automatically be given a lengthy prison sentence if not sentenced to community corrections.

The first criterion constitutes the major facet of mental health screening by the LCCC. Among the several reasons why the staff may not consider a defendant a good candidate for community corrections is the presence of mental problems that LCCC is ill-equipped to handle. The staff believes that most defendants referred have mental problems that can be addressed by LCCC counseling and group therapy. However, LCCC does not have the expertise, resources, and facilities to deal with more severe mental problems. The staff members thus reject the few candidates they believe have such problems. The advice of the consulting psychologist is important in discerning which defendants may present

these risks of severe mental problems. The LCCC also rejects defendants with severe alcohol or drug problems for the same reasons of limited resources. Clients with "moderate" alcohol or drug problems are often accepted, and counseling in local drug or alcohol programs is combined with LCCC services.

Report to the Court and Court Decision

After the staff vote and decision, the counselor assigned to the case prepares a formal report to the court, setting forth recommendations and supporting reasons. The length and thoroughness of reports vary considerably. The report is generally short if the prosecutor and defense attorney agree with the recommendation (the counselor discusses the recommendations with the two lawyers before LCCC makes a recommendation) and if the counselor believes from past experience with the judge that he will concur. If, on the other hand, an objection is expected, the report is typically longer and more thorough. Reports typically are very complete (even if the prosecutor agrees with the recommendation) when the defendant has had two prior felony convictions and LCCC staff is attempting to secure a sentence to community corrections instead of the otherwise mandatory prison term.

The typical full report is about two pages, single-spaced and legal sized. It is submitted to the court as an adjunct to the probation department's presentence report; hence, LCCC does not include background information that would duplicate information routinely put in presentence reports. The LCCC report contains a brief description of the defendant's criminal history and the offense, the defendant's social history, results of the psychological tests, the defendant's participation and progress in counseling, and LCCC's recommendations. The major recommentions are whether the defendant should be sent to LCCC and, if so, to the residential or non-residential program. If the report recommends the LCCC, it lists the types and length of treatments the defendant should receive. LCCC attaches to the report a proposed contract to become part of the sentencing requirement should the court refer the defendant to LCCC. The contract specifies the defendant's obligations and the services to be provided. Finally, the defendant's counselor usually testifies at the sentencing hearing.

Most services specified in the contract are not directly related to mental health problems. For example, it may stipulate that the defendant pay restitution or participate in a drug program. One common type of service contracted, however, is group therapy at the LCCC conducted by a consulting psychologist. Less often, defendants are referred to the community mental health center for individual psychological counseling. (These referrals have decreased because the Larimer County Mental Health Center now charges LCCC for the services.)

The court accepts LCCC's recommendation for community corrections in the great majority of cases; staff members estimate 70 to 80 percent of the cases, although this figure varies from judge to judge. The court seldom modifies the terms of the contract. The acceptance of the LCCC

recommendations, however, is largely because LCCC counselors typically discuss cases with the prosecutor and defense attorney before preparing reports and usually obtain prior agreement on the recommendations. The counselor, that is, often enters the plea bargaining process. The court can send a defendant to LCCC by two mechanisms: (a) by means of sentencing directly to LCCC residential or non-residential programs, or (b) by means of probation, with a stipulation that the defendant participate in the LCCC non-residential program.

When LCCC informs the court that it will not accept a client, the court, of course, does not sentence the defendant to LCCC. The report may include a recommendation for referral to treatment and on a few occasions LCCC has recommended specific treatment programs for clients rejected on the basis of severe mental problems. LCCC, however, does not make recommendations with respect to competency to stand trial or sanity at the time of the offense.

Transition Cases

No report to the court is prepared in transition cases. The LCCC alone determines whether to accept a referral. The mental health information, often quite limited, generated in the screening process is used solely for in-house decisions. LCCC, as was said earlier, automatically accepts transition referrals from parole officers (for the non-residential treatment). It rejects a substantial proportion of the referrals (for residential treatment) from the Department of Corrections, frequently making such rejection decisions on the basis of less information than staff would like to have. There is a two-week initiation period for transition clients, during which they are examined to determine appropriate treatment services. This process involves much the same psychological testing, employment and educational screening, and referral for drug and alcohol problems as is provided to "diversion" clients in the screening stage before their acceptance by LCCC.

Feedback, Monitoring, and Evaluation

At the broadest level, LCCC has often studied its internal procedures and organization. For example, it was recently reorganized, and the staff is in the process of writing an organization manual.

LCCC prepared periodic reports for its non-residential and the residential programs when they were funded by federal monies. For the non-residential program, the LCCC project reports from 1976 to 1979 provide statistics for the following:

1) the number of offenders placed in community corrections by court order;

2) the number of prisoners referred by the parole officer (number of parolees given transition services);

3) number of defendants in jail given counseling services;

4) the number of clients screened and found to have alcohol, drug, psychological, and family problems;

5) the number of "positive terminations" (has job or is in school, well adjusted, has made restitution), "marginal terminations" (difficulty in job, school, daily living patterns, or in making restitution; but no further criminal behavior), and "negative terminations" (arrested or institutionalized for any reason); and

6) the number of felony charges in the local courts (for evidence that community corrections has decreased repeat offenders).

The first few project reports contained information that was not continued in later reports. This included the referral sources, personal data about clients, and the offenses charged. The one project report of the residential program (which was federally funded for only one year, 1979) contained essentially the same information as the earlier reports of the non-residential program.

The LCCC files have a substantial amount of information about individual clients. Each file contains at least

1) a complete intake form;

2) MMPI results;

3) the client's contract (if there is one);

4) police rap sheet;

5) vocational evaluation results;

6) the court order sending the person to the project (if there is one);

7) case notes from counseling sessions;

8) notes of vocational progress (e.g., whether the client is working); and

9) progress notes from referral agencies.

The LCCC files on the clients are, of course, confidential. Staff is permitted to review the files, but must place them under locked storage during the night. The files have been used for research purposes: a student volunteer working at LCCC was given permission, after signing a release, to study the files for a masters thesis.

THE ISLAND COUNTY DISTRICT COURT PROBATION DEPARTMENT

Washington state law requires that probation services be available for all felony and juvenile cases in the state. Felony cases are handled by the Department of Social Services, and juvenile cases by the probation departments in each county. The provision of probation services for misdemeanor cases, however, is optional by the county. The Island County District Court Probation Department (hereinafter referred to as the Probation Department or, simply, the Department) was established in September 1975, to provide probation services for persons charged with or convicted of misdemeanors in Island County. The establishment of the Department was made possible by a grant from the Law Enforcement Assistance Administration (LEAA); LEAA provided 90 percent of the Department's funding for the first two years of its operation and 75 percent for the third year. The county provided the balance during those years and, with the exception of one part-time probation officer paid by means of a Comprehensive Employment Training Act (CETA) grant, funds the entire operation at this writing. Monies are generated by fines, fees, and forfeitures collected in the Island County District Court. The Department's budget is determined annually by the Island County county commissioners.

The primary user of Probation Department services is the Island County District Court. The District Court has limited civil jurisdiction and concurrent criminal jurisdiction with the Island County Superior Court over most misdemeanors. The District Court sits in three locations in Island County (Oak Harbor, Camano Island, and Langley) and is served by two judges, whom it shares with the Oak Harbor and Langley Municipal Courts. In 1978, the court disposed of 4,211 traffic cases and 580 misdemeanor cases. In addition to the District Court, the Probation Department serves the Oak Harbor Municipal Court (which has jurisdiction over municipal ordinance violations, and disposed of 1,124 traffic and 19 misdemeanor cases in 1978), and on rare occasions it provides services for misdemeanor cases within the jurisdiction of the Island County Superior Court (which receives all felony cases and some misdemeanor cases). Island County has a population of approximately 40,000, including 12,000 military personnel stationed at the Whidbey Naval Air Station in Oak Harbor.

The Probation Department's general purpose is to assist the court in selecting and carrying out the disposition of misdemeanor cases. To this end, the Department may be called upon to provide any of the following services:

- o presentence investigations to assist the court in sentencing (entails mental health screening and referral for evaluation);
- o postsentence investigations to assist the court in reconsidering sentences already imposed (entails screening and referral for evaluation);

- o supervision of offenders placed on probation (entails screening, referral for evaluation, and arrangement and coordination of treatment); and
- o monitoring offenders' compliance with court-ordered community service, work release, restitution, or alcohol, drug, or mental health treatment.

The final service noted above, offender monitoring, entails no screening and evaluation and will not be described directly in this section.

The Probation Department's offices are located in the Island County District Court courthouse in Oak Harbor. The Department's staff consists of a director (who also serves as a probation officer) with a Master of Arts degree in public administration, one half-time Bachelor of Arts level probation officer funded by a Comprehensive Employment Training Act (CETA) grant, and one half-time secretary. Statistics compiled by the Department indicate that in 1979 the Department staff conducted 81 presentence and 5 postsentence investigations, supervised 170 offenders placed on probation, and monitored 204 offenders for compliance with court orders (concerning service or treatment) issued in 1979.

A Function Model

Figures 58 and 59 illustrate the "flow" of cases, operations, and processes relating to the evaluation of criminal offenders by the Island County District Court Probation Department. Figure 58 depicts pre- and post-sentence investigations, and Figure 59 depicts supervised probation.

Pre- and Post-sentence Investigations

Figure 58 depicts the process by which the Probation Department receives referrals, collects information, and reports its findings concerning the background, behavior, and special needs of offenders awaiting sentence determination or reconsideration.

Upon a finding of guilty, a court may order the Department to conduct a presentence investigation of an offender. Similarly, any time after sentencing, a post-sentence investigation may be ordered. The court order may be sua sponte or at the request of the offender, his or her attorney, or the prosecutor. The order is sent by the court to the director of the Probation Department along with copies of the police citation and the bailiff's notes from the trial. The director reviews the referral, determines whether he or the part-time probation officer will handle the case, and sends the offender a letter requesting that contact be made with the Department for an interview appointment (or, if the offender is in jail, arrangements to visit there). Prior to the interview, the Department conducts a record search for previous criminal records.

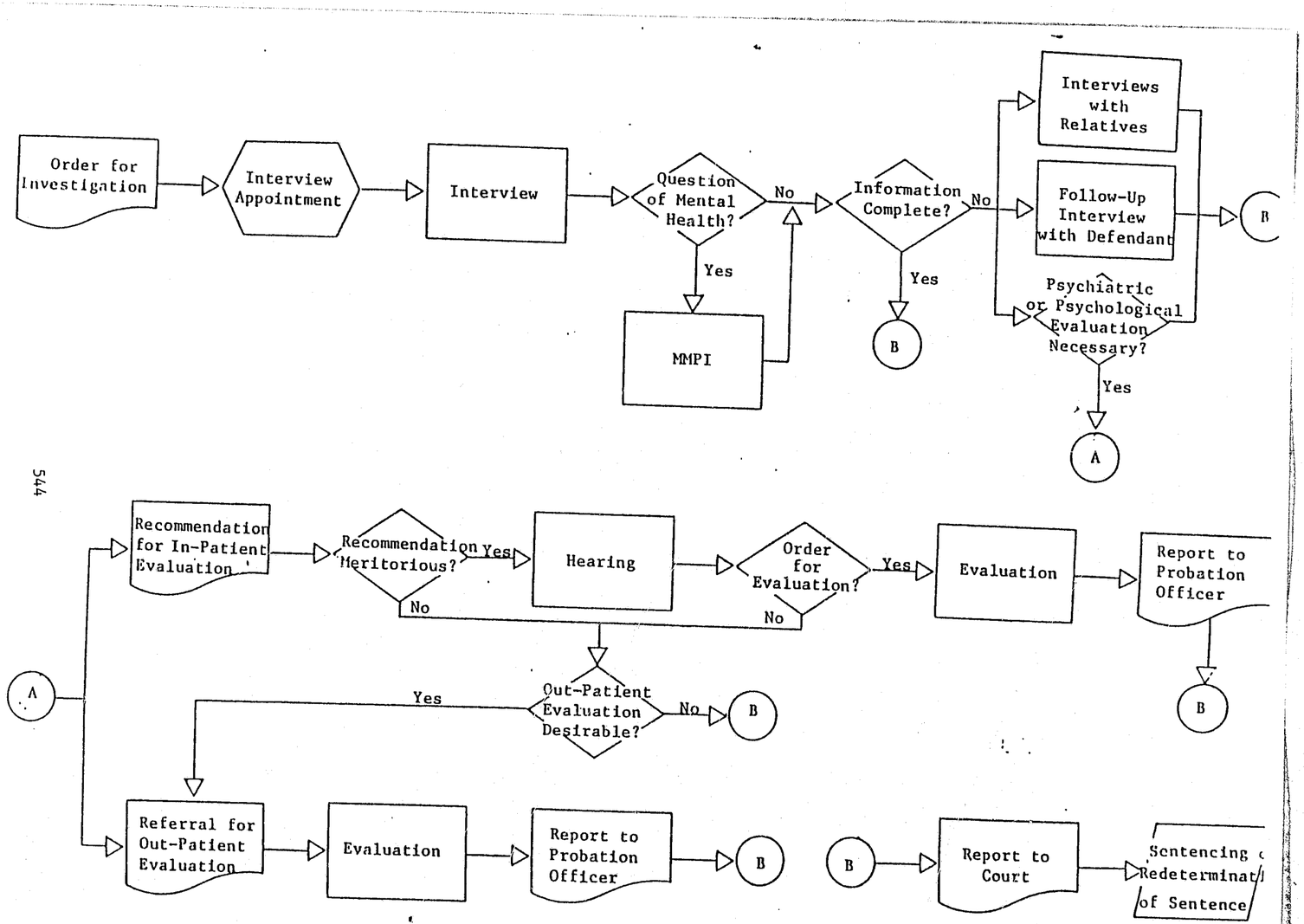

Figure 58. Case Process Flow of Pre-Sentence and Post-Sentence Investigations by the Island County District Court

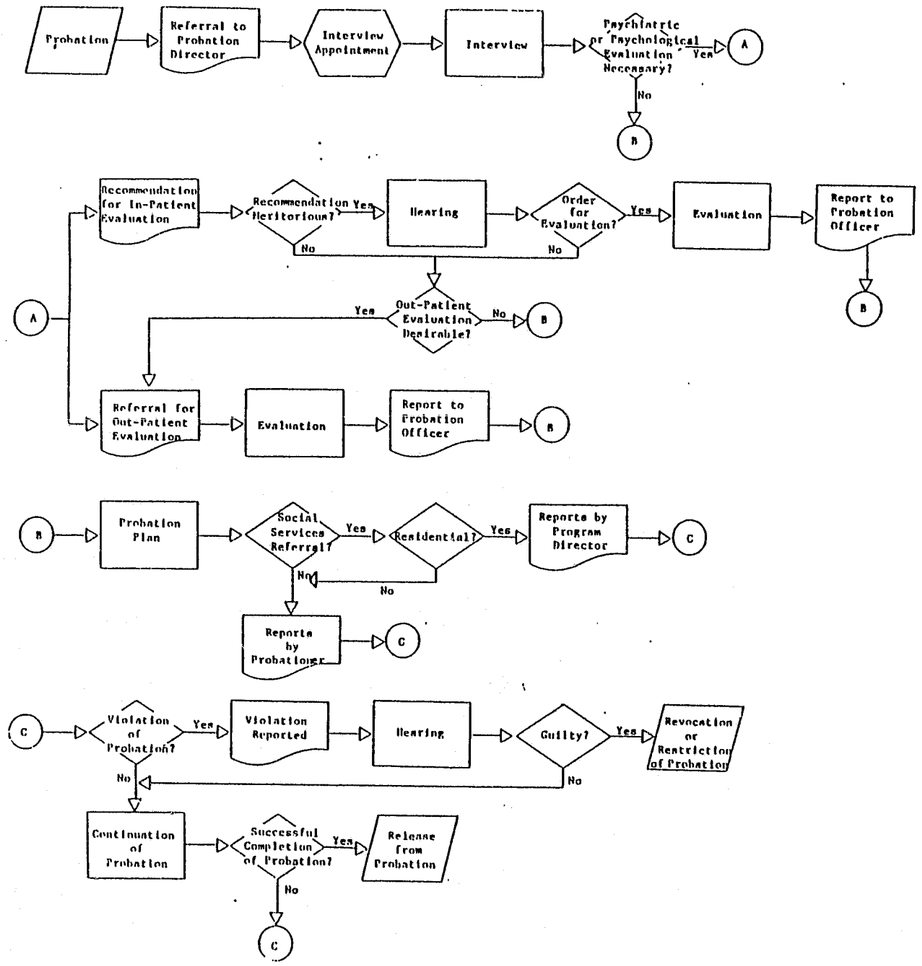

Figure 59. Case Process Flow of Probation Supervision by the Island County District Court Probation Department.

The probation officer conducts the interview and may administer the Minnesota Multiphasic Personality Inventory (MMPI) if he has some question concerning the offender's mental status. Following the interview, the probation officer may arrange to speak with relatives or friends of the offender mentioned during the interview. Additionally, he may conduct a follow-up interview with the offender at the offender's home.

If the probation officer believes that a psychiatric or psychological evaluation is indicated, he may refer the offender (if released in community) for an outpatient examination at the Island County Mental Health Center, the Counseling and Assistance Center at the Naval Air Station (if the offender is stationed at the base), or the local office of a private psychologist or psychiatrist. If the probation officer believes that an offender requires evaluation in a hospital setting, he may prepare a preliminary probation report for the court recommending a 90-day commitment to the Western Washington State Hospital for evaluation. If the court believes the recommendation has merit, it will schedule a hearing to determine whether to commit the offender for an evaluation.

The information contained in evaluation reports prepared by any of these mental health agencies is integrated into the pre- or post-sentence report prepared by the probation officer. However, the probation officer's report is submitted to the court along with copies of any mental health evaluation reports prepared. The court uses presentence reports to assist in determining sentencing. Post-sentence reports are used to determine whether an offender previously sentenced to jail should be reconsidered for probation.

Supervised Probation

Figure 59 shows the process by which the Probation Department receives and manages misdemeanants referred for supervision of probation. When an offender is sentenced to a period of probation, the court issues an order instructing the offender to report to the director of the Probation Department upon notification. A copy of the order is sent to the director, along with copies of the police citation and the bailiff's notes from the trial. The director reviews the referral and sends the offender a letter requesting him or her to contact the Probation Department for an interview apppointment. Upon the probationer's arrival, the interview is conducted; the MMPI may be administered; and a probation plan is formulated, written, and signed by the probationer.

If the probation officer believes the offender may have mental or emotional difficulties, he may refer the offender for an outpatient evaluation at the Island County Mental Health Center, the Counseling and Assistance Center at the Naval Air Station (if the offender is stationed at the base), or the office of a private psychologist or psychiatrist. If the probation officer believes the offender requires evaluation in a hospital setting, he may recommend to the court that the offender be

committed to Western Washington State Hospital for evaluation for up to 90 days. The court may schedule a hearing to determine whether to so commit the offender. In addition to making mental health referrals, a probation officer may refer an offender to any of a number of social service programs for rehabilitation.

Each month, the probationer (or the director of any program with which the probationer is placed on a live-in basis) submits a progress report to the probation officer. The probation officer provides the court with a monthly "activities report" indicating the status of current probationers. No other reports are submitted for the probationer in compliance with the terms of his probation. If the offender violates the terms of his probation, the probation officer reports that fact to the court; a hearing is held, and probation may be revoked or restricted.

Delineation of Mental Health Information Requirements

As indicated earlier, the Probation Department receives referrals from the Island County District Court, the Oak Harbor Municipal Court, and the Island County Superior Court. The director estimates that 75 percent of the referrals are from the District Court, 25 percent from the Municipal Court, and fewer than 1 percent from the Superior Court. (Superior Court referrals are made only when an offender initially charged with a felony in the Superior Court is convicted of a misdemeanor and is placed on, or is being considered for, probation). Referrals for pre- or post-sentence investigations are made if the judge feels he or she needs more information on an offender before ordering (or denying) probation; referrals for supervision of probation are made whenever an offender is placed on probation.

The court rarely explicitly requests particular information concerning the mental health of offenders referred for probation services. Typically, a referral for a pre- or post-sentence investigation comes by written court order (Appendix C) indicating merely that an offender apparently meets the basic requirements for probation and ordering that a pre- or post-sentence investigation be conducted and that the results of such investigation be reported by a specified date (usually within 4 to 5 weeks). Accompanying the order are a copy of the police citation (indicating the charges) and a copy of the bailiff's trial notes (indicating essentially the evidence presented at trial). The director of the Probation Department considers it implied that pre- and post-sentence investigations include an assessment of the offender's mental health needs.

Referrals for probation supervision also come by court order (Appendix D) accompanied by copies of the police citation and the bailiff's trial notes. The order indicates the charge, the conviction, and the terms of probation. Ordinarily, the terms consist of instructions to the offender to conduct himself "as a decent, upright, law-abiding citizen;" report to the director of the Probation Department as the director instructs; comply with all rules and regulations issued by the Probation Department; and pay any relevant court costs, fines, or

restitution. Occasionally, the order specifies special terms such as participation in a particular drug, alcohol, or mental health treatment program.

Acquisition of Mental Health Information

The director of the Probation Department reviews each referral within 24 hours of its receipt and determines whether he or the half-time probation officer will be responsible for handling the case. The director ordinarily assigns himself the more serious cases. Whether the referral is for a pre-sentence investigation, a post-sentence investigation, or supervised probation, an initial interview is arranged. Interviews ordinarily are scheduled for weekdays; however, the director is available on the first Saturday of each month to meet with offenders who would have difficulty visiting the Probation Department during the week. The interview is conducted in the Probation Department's offices unless the offender is incarcerated, in which case the offender is interviewed in the jail.

The interview typically lasts 45 minutes to one hour. During the course of the interview, the probation officer inquires in the following areas:

- biographic data (name, address, age, previous addresses);
- employment history and other sources of income;
- military history;
- medical history;
- educational history;
- marital history;
- driving history (accidents, license suspensions, etc.);
- criminal history;
- drug and alcohol history;
- mental health history; and
- offender's account of the circumstances that resulted in arrest.

In addition, if the probation officer has any question about the offender's mental orientation, he may administer the MMPI; however, the test is not scored unless the offender subsequently is referred for a mental health evaluation, in which case the scoring is performed by the individual or agency conducting the evaluation.

Pre- and post-sentence investigations often continue beyond the initial interview and may include interviews with family members or friends of the offender mentioned during the interview. Occasionally, the probation officer conducts a second interview with the offender in his home. According to the director of the Department, these interviews are designed to enable the probation officer to gain a better sense for the family and community support systems operating on behalf of the offender in his day-to-day existence; they bear heavily on recommendations concerning the offender's suitability for probation.

If after interviewing the offender the probation officer suspects (in view of the offender's behavior during the interview or his mental health history) that the offender may be mentally or emotionally disordered, he may refer the offender for an outpatient mental health evaluation at the Island County Mental Health Center (provided as a service of the Center), the Counseling and Assistance Center at the Naval Air Station (provided at no cost for personnel stationed at the Air Station), or the office of a private psychologist or psychiatrist (paid for by the Probation Department). (According to the Department director, referrals to private mental health professionals are made primarily to obtain "second opinions" regarding the mental condition of offenders already evaluated by the County Mental Health Center or the Air Station's Counseling and Assistance Center.) Referrals for outpatient evaluations are made by letter from the probation officer to the mental health agency indicating the reasons for the referral, background information on the offender, a copy of the unscored MMPI, and the date by which the information sought is required. If the probation officer believes that the offender is grossly psychotic or otherwise seriously mentally disordered, he may recommend to the court that the offender be committed to Western Washington State Hospital for up to 90 days for evaluation. If the court believes the recommendation has merit, it will conduct a hearing to determine whether to so commit the offender. A sample commitment order is attached as Appendix E. The agency's or hospital's report back to the probation officer typically indicates the results of any psychological testing administered, mental status information, diagnosis, and treatment recommendations.

The probation officer may refer persons whose probation he is supervising to local social service agencies or programs providing rehabilitation services in specialized areas. Frequently used services include the Washington Department of Social and Health Services (vocational rehabilitation), the Tri-County Counsel Community Alcohol Center (alcohol rehabilitation), and the "New Leaf" program (counseling and treatment for the mentally retarded).

During the course of an offender's period of probation, the offender (or the director of the program with which the offender has been placed on a live-in basis) is required to submit monthly reports to the probation officer indicating "what has happened in your/the offender's life since you last reported." If problems are noted in a monthly report, the probation officer may re-interview the offender to assess changes in his needs.

Provision and Use of Mental Health Information

The information collected during a pre- or post-sentence investigation is distilled into a report for the court. The report ordinarily is submitted within four or five weeks of the order directing its preparation. Copies are provided to the prosecutor and the offender (or his attorney). The report typically summarizes the biographic data collected, compares the offender's version of the circumstances leading to arrest with the official version, discusses the results of any mental

health evaluations conducted (and includes copies of any evaluation reports), and presents case recommendations that may take the form of a suggested probation plan for the offender. The court uses the information provided in a presentence report to determine an appropriate sentence to impose. Post-sentence reports are used to determine whether a jail sentence previously imposed should be changed to probation. The court usually rules in accordance with the Department's recommendations concerning probation.

The only reports prepared by the Probation Department concerning offenders on probation are a monthly "activities report" and an "affidavit of probation violation and motion for issuance of a bench warrant." The activities report indicates the current status of all offenders on supervised probation. The report identifies current probationers (and the dates on which their probation periods expire); persons placed on probation that month; persons successfully completing probation that month; probationers referred for probation revocation; those referred for mental health examination; and those currently assigned to community or military alcohol or drug rehabilitation programs. The court uses this information to track cases involving offenders placed on supervised probation. No independent report is sent to the court when a person completes his probation. Affidavits of probation violation and motion for bench warrants (Appendix F) are submitted when, in the opinion of the probation officer, a probationer has violated the terms of his probation. The document describes the alleged violation and requests the court to revoke or restrict probation. The court conducts a probation revocation hearing to determine the matter.

Feedback, Monitoring, and Evaluation

There is no formal, ongoing feedback, monitoring, or evaluation mechanism operating in the Island County District Court Probation Department. However, there are a number of mechanisms functioning informally to provide a measure of quality assurance.

In 1975, the Northwest Regional Counsel of the Washington State Law and Judicial Planning Office conducted an evaluation of the Probation Department pursuant to LEAA requirements. The Probation Department director reported that the evaluation was comprehensive; however, copies of the evaluation report were not available at the Probation Department, and the nature and extent of the evaluation will not be assessed in this report.

Two state organizations, the Washington Corrections Association and the Washington Misdemeanant Corrections Association, collect statistics, prepare annual reports, and conduct training sessions for Probation Departments and other corrections agencies throughout the state. Statistics collected by the Island County District Court Probation Department for the Misdemeanant Corrections Association include: number of cases handled, by type (presentence investigation, post-sentence investigation, probation supervision); crimes charged to

offenders referred; number of probationers referred to social service or mental health agencies or programs for treatment or evaluation; number of probation revocations; hours of staff training; and Department budget. In 1979, the Misdemeanant Corrections Association conducted a statewide survey of District Court judges to ascertain what information they found most helpful in presentence reports. The results of the survey were presented in a two-day training session for Probation Department personnel throughout the state. Although the survey results were not available for review at the Probation Department, the Department director noted that a major finding was that judges are not particularly interested in biographical information on offenders. To accommodate the judges, the director indicated, Department reports now are designed to emphasize the offender's current situation.

The Probation Department must apply each year to the Island County county commissioners for funding. Case statistics similar to those submitted to the Misdemeanant Corrections Association are presented annually to the commissioners. Additionally, the recidivism rate of offenders served by the Probation Department is calculated and reported.

Finally, the Probation Department receives feedback on an informal basis from the judges of the courts it serves. Because of the small size of the Department and of the judiciary, a close working relationship is maintained, and problems with Department procedures or particular cases are freely discussed.

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3. Perry M., and Kammerzell, J. Larimer County Community Corrections Project: Final Report, 1979. Project No. 76-11A-2-C2-90. Law Enforcement Assistance Administration, August 1979.

4. Perry, M., and Kammerzell, J. Final Report: LEAA Halfway House Grant (Larimer County Community Corrections). Project No. 77-AGE-11A-2-C2-110. Law Enforcement Assistance Administration, October 1979.

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Warren, M.Q. Correctional treatment in community settings. Rockville, Md.: National Institute of Mental Health, 1972.

REFERRAL PROCEDURES

ADULT PROBATION -- COMMUNITY CORRECTIONS

If the probation officer determines that his/her client should be referred to the Community Corrections Project for services outlined on the preceeding pages, he/she will complete a REFERRAL FORM and send it with the client to the Community Corrections office.

SAMPLE FORM: Date:_____

(Name of Client) has been referred to the Community Corrections Project by (Name of Probation Officer) for the purpose of:

___Diagnostic information for presentence report

___Personality inventory

___Psychiatric evaluation

___Sexuality counseling

___Individual counseling

___Group counseling

___Family counseling/assistance

___GED tutoring/testing

___Vocational training information

___Employment counseling

OTHER:

NOTES:

.....

APPENDIX B

LARIMER COUNTY COMMUNITY CORRECTIONS PROJECT

CLIENT INFORMATION FORM

Date_____

SECTION I - INTAKE

I. General Data

Client's Name_____ Soc. Sec. # _____

Home Address _____ DOB _____

_____ Age _____

_____ Sex _____

Home Phone _____ Race (W, B, S, I, O) _____

Work Phone _____ Religion _____

List any vehicles owned or driven:

1. Make_____ Model_____ Year_____ Color_____

   Lic. # and State_____ Owner's Name_____

2. Make_____ Model_____ Year_____ Color_____

   Lic. # and State_____ Owner's Name_____

II. Referral Data

In-Jail _____ Diversion _____

Referral _____ Reintegration _____

Who referred you to Community Corrections?_____

Reason for referral _____

Have you ever participated in this program before? ( ) Yes ( ) No If yes, give dates:_____

III. Criminal History

List all juvenile offenses:

Charge	Date	Place	Disposition

Number of juvenile felony convictions _____

Age at first offense_____ Charge - first offense _____

_____

III. Criminal History (continued)

List all adult offenses:

Charge	Date	Place	Disposition

Number of adult felony convictions _____ Misdemeanor convictions _____

Number of adult prison sentences _____ Total number of times arrested _____

Have you ever been on probation or parole? ( ) Yes ( ) No

Are you currently on probation or parole? ( ) Yes ( ) No

Have you ever violated probation or parole? ( ) Yes ( ) No

IV. Present Legal Status

Date incarcerated_____ Date released _____

Current charge(s)_____

_____

Disposition(s)/Sentence(s) _____

_____

Arresting agency _____ Officer _____

Judge _____ Attorney _____

DA _____ Parole/Prob. Officer _____

V. Residential Data

Type of residence: ( ) House ( ) Apartment ( ) Room
( ) Rented ( ) Owned ( ) No cost

With whom are you living? ( ) Alone ( ) With spouse ( ) Parents
( ) With friends ( ) With children ( ) With relatives
( ) Institutional ( ) No stable arrangements

How long have you resided in Larimer County? _____

How long have you resided in Colorado? _____

In what county and state were you born? _____

If foreign-born, date of arrival in USA _____

Name and address of nearest relative or friend _____

_____ Phone _____

V. Residential Data (continued)

List last five addresses (please give dates):

1. _____
2. _____
3. _____
4. _____
5. _____

VI. Marital Status

Current marital status: ( ) Never Married ( ) Married ( ) Separated
( ) Common Law ( ) Divorced ( ) Widowed

Name of spouse _____ Occupation _____

Address of spouse _____

Date and place of marriage _____

Date and place of termination of marriage _____

Previous marriages (give name of spouse, dates and reasons for termination) _____

_____

Children:

Name	Age	Address	Occupation

VII. Family History

Father's name _____ Age _____

Address _____

Employed? ( ) Yes ( ) No Occupation _____

Mother's name _____ Age _____

Address _____

Employed? ( ) Yes ( ) No Occupation _____

Parent's current marital status: ( ) Living together ( ) Separated
( ) Divorced ( ) Remarried ( ) Deceased ( ) Unknown

Brothers and sisters:

Name	Age	Address	Occupation

VII. Family History (continued)

Has any member of your family been on probation, or in a correctional or mental institution? ( ) Yes ( ) No

Name	Age	Type of Institution	Location	Cause

VIII. Military Service

Branch of service _____ From _____ to _____

Type of discharge _____

Do you receive any disability compensation? ( ) Yes ( ) No

Rank at discharge _____ M.O.S. _____

IX. Occupational Data

Employment status: ( ) Full Time ( ) Part Time
( ) Unemployed ( ) Unable to work

Present employer _____

Address _____ Phone _____

Job title _____ Earnings _____

Date started _____ Can you return to work? ( ) Yes ( ) No

List previous occupations and give dates:

_____

_____

_____

_____

_____

How many jobs have you had in the last 12 months? _____

List any and all job skills _____

_____

_____

Describe your occupational goals and list any further training/education that you desire:

_____

_____

_____

IX. Occupational Data (continued)

Does your present or last job satisfy you? If not, in what ways are (were) you dissatisfied? _____

_____

_____

List all sources of income:

Source	Amount

Number of persons supported on the above income _____

Is income sufficient to meet financial need? _____

Can you provide your own transportation? _____

Do you own a car? ( ) Yes ( ) No Driver's license? ( ) Yes ( ) No

X. Educational Data

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

If higher, indicate _____

Schools attended:

Name	Location	Dates	Degree or Certificate

Reason for quitting school (if applicable) _____

_____

Do you wish to return to school? ( ) Yes ( ) No

If yes, what do you want to study? _____

_____

_____

Do you wish to obtain a GED? ( ) Yes ( ) No

XI. Clinical Data

How would you describe your health (excellent, good, fair, poor)?

1. Physical _____
2. Emotional _____

When was your last examination by a physician? _____

For what condition? _____

XI. Clinical Data (continued)

Name of your physician _____

Address _____

List any medications that you are currently taking _____

_____

Are you currently seeing anyone for therapy or counseling? ( ) Yes ( ) No

If yes, give name and address _____

_____

Enter the number of months spent in any of the following institutions:

( ) Jail ( ) Reformatory ( ) Prison ( ) Medical Hospital
( ) Psychiatric Hospital ( ) Mental Health Clinic
( ) Residential Drug Program ( ) Juvenile Correctional Facility
( ) Other - Specify _____

Do you make Friends easily? ( ) Yes ( ) No

Do you keep them? ( ) Yes ( ) No

Are most of your friends of one sex? If so, which? _____

Can you confide in your friends? ( ) Yes ( ) No

How is most of your free time occupied? _____

List your favorite hobbies _____

List all organizations and clubs of which you are a member _____

_____

XII. Problem Checklist Check any of the following that apply to you:

( ) Headaches	( ) Dizziness	( ) Fainting spells
( ) Palpitations	( ) Stomach trouble	( ) No appetite
( ) Bowel disturbances	( ) Fatigue	( ) Insomnia
( ) Nightmares	( ) Take sedatives	( ) Alcoholism
( ) Drug Abuse	( ) Flashbacks	( ) Feel tense
( ) Feel panicky	( ) Tremors	( ) Depressed
( ) Suicidal ideas	( ) Always worried	( ) Unable to relax
( ) Unable to have a good time	( ) Don't like weekends or vacations	
( ) Over-ambitious	( ) Sexual problems	( ) Shy with people
( ) Can't make friends	( ) Can't make decisions	( ) Can't keep a job
( ) Inferiority feelings	( ) Home conditions bad	( ) Superiority feelings
( ) Financial problems	( ) Convulsions	( ) Epilepsy
( ) Heart trouble	( ) Diabetes	( ) Cancer
( ) Hernia	( ) Missing limbs	( ) Hallucinations
( ) Delusions	( ) Controlling self	( ) Phobias
( ) Obsessions	( ) Paranoia	( ) Other - specify

_____

_____

XIII. Program Interests And Objectives

_____

_____

_____

_____

_____

IX. Estimated Termination Date _____

IN THE DISTRICT COURT OF THE STATE OF WASHINGTON FOR ISLAND COUNTY

STATE OF WASHINGTON,)
)
Plaintiff,) NO.
)
vs.) ORDER FOR PRESENTENCE INVESTIGATION
)
)
Defendant.)
)

It appearing from the files and records and evidence presented in this case that there is a need for a presentence investigation and,

It appearing that the defendant_____ meets the basic intake requirements of the Island County District Court Probation Program.

IT IS HEREBY ORDERED that a presentence investigation be carried out by the Island County District Court Probation Services and that the results of said investigation be reported back to the Court by_____.

DONE in open court this _____day of _____ 19_____.

_____
JUDGE

ORDER FOR PRESENTENCE INVESTIGATION

APPENDIX D

IN THE DISTRICT COURT AT LANGLEY
ISLAND COUNTY, STATE OF WASHINGTON

STATE OF WASHINGTON,)
Plaintiff,)
)
vs.) Case No. TRU 289 ORDER SUSPENDING SENTENCE AND PLACING DEFENDANT ON PROBATION
)
)
Defendant.)

This matter having come on for hearing in open Court on the 8th day of May, 19 80, the defendant, _____, being present in person ~~XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX~~, the defendant having been heretofore served with a copy of the citation, charging the defendant with: driving over the centerline and driving while intoxicated, and the defendant having been arraigned and having entered a plea of guilty, or having been found guilty after trial, and the Court having inquired of the defendant if he or she has any reason why judgement and sentence should not be entered against him or her in this cause, and the defendant not having any such reason, and the Court having advised the defendant of his or her rights as required by law, pursuant to RCW 9.95.200 and 9.95.210,

NOW THEREFORE, ORDERS, ADJUDGES and DECREES,

That the defendant, _____, is guilty of the crimes of driving while intoxicated

as charged in the citation, and, pursuant to RCW 9.95.200 and 9.95.210, is placed on probation and the execution of sentence is suspended, as follows: $50 fine suspended; 7 days in jail suspended on condition that defendant attend Alcohol Information School and remain on probation for a period of one year.

The TERMS and CONDITIONS of the SUSPENSION and PROBATION shall be as follows:

1. The defendant shall conduct himself or herself as a decent, upright, law-abiding citizen at all times and comply with all laws.
2. The defendant shall report to the Director of the Island County District Court Probation Service, _____, once each month or as instructed by the Director and shall comply with all rules and regulations applicable to the defendant issued by the Director.
3. The defendant shall pay, through the office of the Deputy Clerk of the District Court at Langley, the sum of $ 36.25, until the items below are paid in full:

a. Court costs	$ 4.00
b. Restitution	$
c. Reimbursement to Island County toward fee of court-appointed attorney	$
d. Fine	$ 32.25

4. Defendant's duty to make the payments pursuant to item 3 above shall exist only so long as defendant has the present financial ability to pay without causing undue hardship to himself or herself or dependants. Revocation of this probation for non-payment shall occur only if defendant wilfully fails to make payment having the financial ability to do so or for wilful failure to make a good faith reasonable effort to acquire the means to make payment. Defendant may petition the Court to adjust the amount of any installment payment or the total amount due to fit his or her changing financial situation.

UPON FULFILLMENT of the terms and conditions of this Probation, the defendant may apply to this Court, or the Probation Officer may request this Court, to release the defendant from Probation.

APPENDIX D (Continued)

UPON FAILURE of the defendant to comply with the terms of this Probation, defendant will be ordered to show cause why the suspended sentence should not be withdrawn and the full sentence imposed on the defendant.

This ORDER placing defendant on Probation and Suspending the sentence in whole or in part, signed this 9th day of May, 19 80, in the presence of defendant [redacted].

Court Commissioner

APPENDIX E

IN THE DISTRICT COURT OF ISLAND COUNTY, STATE OF WASHINGTON

STATE OF WASHINGTON,
Plaintiff,
vs.
Defendant.

No. 7238

O R D E R

This matter having come on regularly for hearing before the undersigned Judge for consideration and for sentencing and the Court having received the reports of Oak Harbor Police Department, the Island County Sheriff's Office, and , Assistant Probation Officer, and the Court having considered the matter fully, hereby

FINDS:

1. That is guilty of violation of his probation in the above-entitled case and is awaiting sentencing.

2. That it appears likely he has severe emotional problems requiring treatment.

3. That the Court has probable cause to believe needs treatment and further evaluation of his mental problems.

4. That the Court needs such information as will be generated by an evaluation in order to properly sentence the defendant.

5. That since being placed on probation, defendant has attempted to take his own life on two different occasions.

Based on these Findings and Conclusions, it is hereby

ORDERED:

1. That be committed to Western Washington State Hospital for treatment and evaluation for a period not to exceed ninety days, and that there he is to be held in custody until completion of said evaluation and treatment.

2. That Western Washington State Hospital shall furnish to the Court an evaluation of the mental and emotional condition of and a prognosis for his treatment.

3. That upon completion of the evaluation and treatment by Western Washington State Hospital shall be returned to the custody of the Island County Jail and then to be brought as soon as possible before this Court for sentencing.

DONE IN OPEN COURT this 26 day of October, 1977.

District Court Island County

ISLAND COUNTY DISTRICT COURT

STATE OF WASHINGTON, Plaintiff,

vs.

Defendant.

NO.

AFFIDAVIT OF PROBATION VIOLATION AND MOTION FOR ISSUANCE OF BENCH WARRANT

STATE OF WASHINGTON)
COUNTY OF ISLAND) ss.

being first duly sworn, deposes and says:

That he is and was at all times mentioned herein a duly appointed, qualified and acting Probation Officer of the Island County District Court;

That defendant was convicted in the above-entitled court, on the _____ day of _____, 19____, of the crime of _____ _____ and on the _____ day of _____, 19____, was admitted to probation by order of the above-entitled court for a period of _____, on certain terms and conditions as contained in the Order Granting Probation filed herein;

That the said defendant has violated the terms of h___ probation herein imposed upon h____ in that:

WHEREFORE, Affiant hereby prays and respectfully moves this Court to revoke the probation hereinbefore granted and to issue a Bench Warrant for the arrest of said defendant.

Executed at _____, Washington, on _____.

I declare under penalty of perjury that the foregoing is true.

_____
DISTRICT COURT PROBATION OFFICER

DPS-21

PART III

ISSUES IN DESIGNING AND EVALUATING A MODEL PROCESS

Craig Haney has stated that academic psychologists, among other social scientists, "who are trained to value the creative aspect of their science and who expect courts to be impressed with especially innovative approaches to problem solving, for example, are likely to be disappointed" (1980, p. 171). He suggests that the conservative nature of legalism rejects criteria imported from "outside the law."

Our experiences in collecting the descriptive data in Part II of this book did nothing to dispel Haney's notion of realism. We make the propositions and recommendation for change in Part III as realists, recognizing that our major audience is not the chapters of legal reformers, but administrators, program managers, planners, and evaluators who are more apt to accommodate changes in forensic mental health services to the law as it exists. The model forensic examination process and propositions presented should not be conceived as tested hypotheses. They are not. Rather they are hypotheses that we "discovered" in the conduct of our evaluability assessment of the forensic examination process (cf. Glaser and Strauss, 1967, for a discussion of the distinction between hypothesis discovery and hypothesis testing). Our hope is that the propositions, together with the model process of forensic screening and evaluation, contributes to a more testable and "evaluable" process.

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Chapter 9

A MODEL PROCESS OF FORENSIC MENTAL HEALTH SCREENING AND EVALUATION

The definitions, framework of inquiry, and descriptive research reflected in the first two parts of this book are the basis for the model process of forensic mental health screening and evaluation presented in this chapter. The model is consistent with the definition of the process of forensic mental health screening and evaluation in Chapter 2 insofar as it is in generalized form applicable to all types of forensic screening and evaluation (e.g., competency examinations as well as determinations of amenability to treatment). Recommendations implied by the steps of the model center on those changes involving little in the way of legal reform, and very little in the way of legalistic reasoning. As we discussed in Chapter 1, and in the foregoing introduction to Part III, our concern is not with what <u>should</u> be--as expressed by the substance of the law--but with the reordering of what <u>is</u>--the procedures of forensic mental health screening and evaluation.

The chapter is divided into three parts, consistent with the conceptualization of the forensic mental health screening and evaluation process used throughout this book: delineation, acquisition, and provision. The model process incorporates 14 steps. Figure 60 presents the model process in schematic form.

Delineation

While it is axiomatic that the form of a question determines in large part the answer, a major deficiency in the operations of forensic screening and evaluation is in the formation and communication of the psycholegal question to be addressed. Our analysis of the typical requests and orders for screening and evaluation indicated that they are largely reflexive and routine (often citing no more than a state's law by code number), and almost totally devoid of specific information relevant to the screening and evaluation process.

The four steps (Figure 60, Points 1 through 4) in the delineation component of the model address this deficiency. We propose that the screening and evaluation process be initiated by means of the thoughtful creation of a referral request (Point 1). A <u>written</u> statement including the following information should document the request: (a) specific behaviors observed (or documented in records of past mental health interventions) that have led the initiating referral agent to consider forensic mental health screening and evaluation of the client-offender; and, (b) how these behaviors are linked to the psycholegal concept (competency to stand trial, insanity, or amenability of treatment, and so forth) statutorily applicable to the case. This should be done regardless of whether the request is made before, during, or after trial, and what the legal considerations may be (i.e., competency to stand trial, sentencing alternatives, and so forth). The written statement should be executed by the individual initiating the request for

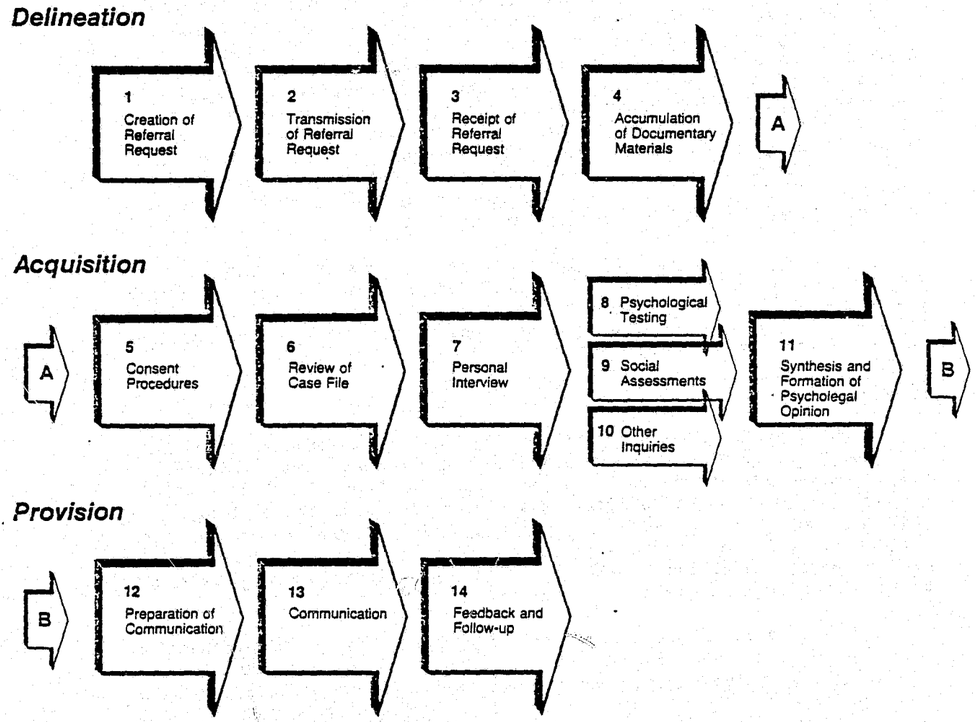

Figure 60. A Model Forensic Mental Health Examination Process.

examination; presumably, the individual with the information about the client-offender's behavior and the justification for invoking action by the forensic mental health system.

The degree of judicial review and relevance of the adversarial process, following the creation of the referral request, on arguable from legal and practical bases. The judicial rejection of a requst, or the denial of a motion for mental health examination, for example, may cause a case to be overturned on appeal. Or, a formal adversarial hearing after conviction (but before sentencing) to consider the mental health of the client-offender may have significant consequences for the sentence. Also, the demand that all referrals be in the form of written motions may in itself reduce frivolous and unnecessary requests for forensic mental health examinations (cf. Roesch and Golding, 1980; also, Chapter 10 in this volume). Although we deal briefly with the question of judicial review of motions in the next chapter, we leave the issue of the judicial and adversarial scrutiny of referral requests largely unresolved.

Our proposition discussed in Chapter 10 that requests for screening and evaluation be in the form of written motions is practical in intent. The wishes of the actors in the legal setting are customarily conveyed by motions and court orders. As we have seen in Part II, the court order in most jurisdictions does not lend itself well to the full communication of the psycholegal question in the request for forensic examinations: it is an order to initiate a process, not an instrument for delineating the examination process itself. The formal motion, on the other hand, assumes judicial review or scrutiny by opposing parties of the facts and circumstances prompting the referral. Importantly, all other things being equal, the criminal justice system also seems more receptive to the accomodation to existing legal procedures for communicating its wishes than it is to adoption of unfamiliar (albeit eminently reasonable to non-lawyers) extra-legal procedures such as telephone or face-to-face contacts between referral agents and mental health professionals, or the submission of nonlegal referral instruments. While the written motion may not have been executed primarily with the forensic mental health professional's need-to-know in mind (see Chapter 10), it has the effect of providing the examiner with the necessary information to answer the specific psycholegal question before the court. We, thus, propose that the transmission of the referral request to the forensic examiner be in the form of a formal motion, containing the facts and circumstances defining the specific psycholegal question (see Figure 60, Point 2). The formal court order, if accompanying the motion, simply authorizes the initiation of the process of screening and evaluation.

Once the referral request has been created by the criminal justice system and transmitted to a forensic mental health facility by means of a motion, court order, or some other more informal means, the jurisdiction of the forensic mental health system is invoked. The mental health personnel's responsibilities begin. The receipt of the referral request by mental health personnel (Point 3) is a critical feature of the model

process signalling that the individual has now become a client, as well as being a defendant or convict. Formal acknowledgement of receipt of the referral request should be made by mental health personnel. The court of record, defense counsel, prosecuting attorney, and those law enforcement officials likely to be called upon to transport the client-offender to the place of examination, should be informed of the date of receipt of the referral and the date, time, and place of the examination. The defense and prosecuting attorneys should not only be reasonably well informed about the circumstances surrounding the referral request, but should be given the opportunity to avail themselves of information relating to the details of the screening and evaluation process. Notice of the receipt of the referral request should serve this purpose. Similarly, notice should be sent to the court to allow for accomodation of any hearing or trial schedules to timing the screening and evaluation process. The importance of this step in the delineation of the referral question (Figure 60, Point 3) lies in the need for coordination of the criminal justice system and the mental health system, at the earliest possible moment, to serve the best interests of the client-offender, the court, and others affected by the examination process.

Following the receipt of the referral request and acknowledgement thereof, the forensic mental health facility receiving the request begins the accumulation of documentary materials relevant to the case and the psycholegal question asked (Point 4). The appropriate delineation of the screening and evaluation process to this point, should greatly facilitate the selective accumulation of information relevant to the acquisition phase of the process. For example, police records of the alleged offense are of questionable value in the evaluation of present and future fitness to stand trial. Also, the accumulation and review of such records may entail unnecessary costs as well as the threat of prejudicial evaluation of client-offenders on such circumscribed psycholegal questions. The model process suggests (at Point 4) the informed and selective accumulation of documentary materials specifically relevant to the case and the presenting psycholegal question.

Acquisition

Ethical guidelines for the practice of psychology (American Psychological Association, 1981), psychiatry (American Psychiatric Association, 1973), and social work (National Association of Social Workers, 1967), as well as emerging case law that broadens defendants' pretrial rights (cf. Estelle v. Smith, 1981), suggest that client-offenders be informed of the likely consequences of their participation in the forensic screening and evaluation process. While the use of deception, coercion, and the administration of drugs to obtain a confession, without the client-offender's consent, is considered clearly unethical conduct for mental health professionals (cf. Curran, 1980), neither law (cf. Bonnie and Slobogin 1980, 496-503) or practice specifies the necessary preliminary communications explaining how the information obtained will be used.

A common-sense of fairness dictates that a client-offender be given the opportunity to be cautious about the information he or she reveals, i.e., to inhibit full disclosure and thereby limit the state's access to information. Even in cases of legally compelled examinations (where the state is entitled to an independent evaluation after the client-offender has given notice of the intent to assert a defense based on mental aberration), a forewarning that leads to cautious participation by the client-offender does not necessarily constitute a complete refusal to cooperate with the state examiner (such refusal may block any mental testimony on the client-offenders behalf [cf. Bonnie and Slobogin, 1980, Note 215]). If the state is entitled to compel an examination, argue Bonnie and Slobogin (1980, p. 501-502), such warnings may be "superfluous" serving "only to complicate the data collection process." We disagree. Theirs may be the correct legal analysis of unresolved legal questions, but it does not take into account the professional ethics of the examiner, who must choose between an honest explanation of the process to the client-offender, or a course of omission close to deceit.

We propose (Figure 60, Point 5) that the acquisition component of the screening and evaluation process begin with a clear and honest explanation of the likely consequences of participation in the process. Jonas Rappeport, a psychiatrist and Medical Director of the Baltimore Court Clinic (see Chapter 4 in this volume), has proposed to the American Academy of Psychiatry and the Law that the following information be provided to a client-offender before a forensic mental health evaluation by a psychiatrist (Rappeport, 1981):

(a) the goal of the examination is not treatment;

(b) the examiner, although a psychiatrist, should not be considered the client-offender's physician, i.e., the patient-doctor shield does not apply;

(c) for whom the examination is conducted (i.e., who the client is);

(d) what is to become of the information acquired; and,

(e) what might result from full disclosure of the information.

An additional consideration at this point in the model process is the client-offender's authorization to release or transfer of confidential information. As cumbersome as it may be to the screening and evaluation process from an administrative point of view, such authorization only makes sense if it occurs after the client-offender has been informed that full cooperation and honest disclosure might not be in his or her best interest.

Assuming that the accumulation of documentary materials (Point 4) relevant to the case has gone well, the next critical feature of the acquisition component of the model process is the thorough review of the

client-offender's case file (Point 6). Our observations of practice suggested that the review of case files typically was cursory, often completed only moments before (or even during) the clinical interview of the client-offender. At the minimum, we suggest that the accumulation of collateral information from sources other than the client-offender (at Point 4 of the model process) be balanced against a forensic facility's resources to review (Point 6) and use such information in the formation of the psycholegal opinion (Point 11). Background information accumulated in the client-offender's file, but unused may prove prejudicial to the client-offender at some future time. Information gathered for one purpose may be used inappropriately for another purpose (for example, records accumulated to support a pretrial examination of competency may provide investigatory leads during the trial and at the time of sentencing). It does not seem unreasonable to propose that the mental health professional who is to conduct the personal clinical interview with the client-offender spend at least one hour reviewing the case file. Further, in many cases, especially those involving questions about the client-offenders competency to assist his defense attorney, review of the case file would include contact with the attorney or referral agent.

The centerpiece of the acquisition component of the screening and evaluation process is the personal interview of the client-offender by a mental health professional (Figure 60, Point 7). The interview should not precede the delineation of the forensic mental health examination (Points 1-4), should only be initiated after the consent procedures (Point 5) have been disposed of appropriately, and, finally, should only occur after the examiner has had adequate time to review the case file (Point 6). While there was great variability among the twenty forensic facilities described in Part II of this volume, and between individual examiners in the use of psychological tests, social assessments, and other inquiries (e.g., competency screening instruments, interviews of individuals other than the client-offender, neurological examination, and other more exotic investigative devices such as the administration of sodium amytal [truth serum], hypnosis, or a polygraph), all the facilities studied and examiners we queried used the personal clinical interview to reach a psychological opinion in all cases.

Of course, the specific content, format, style, and length of the personal interview will be dictated by the overt and latent reasons for the referral for examination, the nature and specificity of the psycholegal question posed, the policies and resources of the forensic facility, the nature of the case, the behavior of the client-offender at the time of the examination, and importantly, the background, experiences, and preferences of the examiner. But generally, a personal interview begins with preliminary questions and statements by the examiner designed to build rapport and allay any anxieties that the client-offender may harbor; this may include discussion ensuring that the consent procedures (Point 5) have been dealt with adequately. The interview may then proceed to a "mental status examination," a generic phrase generally referring to the evaluation of the client-offenders general appearance, speech, mood or affect, thought content,

intelligence, insight, judgment and any abnormal mental trends (cf. Gerard, 1974; Lawrence, 1980). Questions are then asked which address the specific psycholegal question such as competency, insanity at the time of the alleged offense, or sentencing alternatives. One Ohio social worker typically asks a client-offender, "Tell me about the offense," during presentence evaluations. Personal interviews may include the use of questions adapted from standard instruments such as the MMPI and the Competency Screening Test (McGarry et. al., 1973), although such tests are rarely administered in full during an interview.

Only when and if the examiner is unable to reach an opinion regarding the psycholegal question at the conclusion of the personal interview are other inquiries initiated. Of course, the examiner may be able to reach an opinion, but it may not necessarily be conclusive. For example, an examiner may be unable to determine conclusively that a client-offender was legally insane or sane at the time of the alleged offense, but yet be of the firm opinion that a conclusive determination of sanity is not forthcoming, even after additional evaluation procedures are brought to bear on the question. Following the model process would thus preclude psychological testing, social assessments, and other types of inquiries (Figure 60, Point 8 through 10) in all but controversial or very complex cases, and in extraordinary settings (e.g., facilities such as the Forensic Psychiatry Clinic, at the University of Virginia, which fulfills an educational as well as a service function).

We estimate that all but a small percentage of competency evaluations and presentence evaluations that are performed in the twenty forensic mental health facilities described in Part II would require further data collection directly from the client-offender or "third party" sources following the personal interview with the model process in place; similarly, more than one-half of the insanity evaluations would likely lead to psycholegal opinions without further psychological testing, additional interviews, social assessments, and other inquiries. Indeed, in some of the forensic facilities we visited, data acquisition beyond the personal interview was largely routine and pro forma and only rarely actually used to reach an opinion, except when the need for further inquiry arose during the personal interview and was specifically requested by the examiner. A conservative estimate of 30 percent of the cases handled by the Medical Service of the Supreme Bench of Baltimore City (see Chapter 4, pp. 69-71) are concluded after only the clinical interview, yet the routine administration of a standard battery of tests and interviews with the client-offender's family may still be performed prior to, simultaneous with, or after the interview.

Restricting the use of inquiry beyond the personal interview with the offender to after the personal interview has occurred, and only upon the urging of the examiner, has a number of advantages. The model process comports with the judgments of examiners, if not practice, on this point. Most of the psychiatrists, psychologists, and social workers we interviewed expressed confidence in their ability to reach a psycholegal opinion based solely on the review of the case file (Figure 60, Point 6), containing accumulated documentary materials (Point 4), and

the personal interview of the client-offender in most cases. The need for further data collection, they said, arose from uncertainty or unanswered questions during the interview. Suspecting mental retardation from the responses of a client-offender during a personal interview, for example, the examiner may request the administration of an intelligence test to support the hunch. Or, suspecting malingering by the client-offender, the examiner may administer portions of MMPI or conduct another interview. But the routine administration of psychological tests and other inquiries in the absence of questions or uncertainty arising in the interview seems unjustified. An exception to this restriction in the model process of the use of inquiries beyond the interview might be when the case is extremely controversial, complex, or publicized, or involves a particularly bizarre alleged crime. But even in such cases where a neurological examination, and the administration of an intelligence test, the MMPI, and the Rorschach, for example, may have been prompted by a fear of adverse publicity (and not uncertainty about the psycholegal referral question) the data acquisition does comport with the model process. That is, the use of psychological testing (Point 8), interviews with family members of the client-offender and others (Point 9), and other inquiries including such procedures as neurological examination (Point 10) is purposive and not pro forma.

It is interesting to note what seemed a universal assumption among the psychiatrists, psychologists, and social workers we interviewed, namely that examinations of sanity at the time of the alleged offense were far more complex and almost always demanded more data collection and analysis, as well as being more controversial, than examinations of competency or presentence examinations. Without fail, the examiners we queried stated that competency examinations required shorter personal interviews and fewer additional inquiries than insanity examinations. While this discrepancy in practice is understandable, and even justifiable, on the basis of the greater public attention afforded the insanity examination, it is questionable whether the determination of insanity at the time of the offense necessarily demands more data acquisition and analyses than competency determinations. Psychiatrist Walter Bromberg, for example, contends that the competency examination "involves many more psychiatric combinations and permutations than appear to confront the examiner in estimating the presence of insanity and the capacity to appreciate the criminality of the accused's conduct" (1979, pp. 89-90). We contend that much of the data collection in the acquisition component of the forensic mental health evaluation process beyond the personal interview is pro forma, often unnecessary, and based upon unexamined assumptions. The model process would preclude such pro forma allocation of more data acquisition to insanity determinations, for example. At the least, compliance with the model might force examiners to question the basis of such differential allocation of resources. And, importantly, purposive and sequential data acquisition according to the model process may have the advantage of providing an opportunity for research of the differential bases for and use of data acquisition to the various psycholegal questions. (See Chapter 13 for a further discussion of this last point.)

The synthesis of the information gathered and the formation of the psycholegal opinion is the last, yet crucial, step in the acquisition component of the model process (Figure 60, Point 11). The examiner may have reached a psycholegal opinion ("client-offender is competent") before this step, but yet have not anchored the determination in the specific legal context of the case. Addressing themselves specifically to determinations of competency, Roesch and Golding (1980) concluded that "[p]sychiatrists and psychologists, while competent to judge some aspects of behavioral and psychological processes, are . . . not sufficiently conversant with legal matters to be able to judges, within the Dusky criteria, whether or not this defendant, facing these charges, in light of existing evidence, will be able to assist his attorney in a rational matter" (pp. 18-19, emphasis in original). Our own observations comport, generally, with those of Roesch and Golding. A deliberate effort by the examiner to link the psycholegal opinion to the investigation conducted, the facts of the case, and, especially, the general framework of applicable statutes and case law, would go far in making subsequent reports provided to the criminal justice system more useful.

Provision

As operationally defined in Chapter 2, the provision component of the evaluation process includes all the procedures involved in the creation, transmittal, receipt of the message containing information that is acquired by the examiner. In our view, it is an important component of the evaluation process that has not received the attention that it deserves. The model process envisions three important steps in the provision of information acquired: the actual preparation of the communication between the examiner and the referral agent, the communication process itself, and the exchange of information about the consequences of that communication. A contention underlying the recommended steps for the provision of mental health information is that the written reports and other communications to the criminal justice system should accomodate, as much as possible, the practical needs of that system.

Because the communication in response to the referral question as delineated (Figure 60, Points 1-4), is the sine qua non of the entire examination process, the provision component should begin with a thoughtful preparation of the communication to the criminal justice system (Point 12). Although standard forms have procedural advantages, stereotyped forms of communications should be avoided. Considerations of the following should be given to preparation of each individual communication:

(1) Medium of the communication. Should the psycholegal opinion and supporting reasons and evidence be conveyed in a written report, informal messages, expert testimony, or some combination thereof?

(2) Description of facts, delineation and data acquisition components of examination performed, and reasoning underlying

the opinion of the examiner. Are these adequately communicated in a legally non-conclusory manner in language understandable and useful to the particular referral agent?

(3) Format and length of communication. Are they in accord with the desires of the recipients of the communication?

(4) Confidentiality. Has consideration been given to the confidentiality rights of the client-offender, and is the communication consistent with the explanation of the evaluation process and its likely consequences given to the client offender at the beginning of the data acquisition process?

(5) Identity and authority of examiner(s). Does the communication describe the identity and qualifications of the examiner?

(6) Timing and recipients of communication. Do they comply with applicable statutes and caselaw governing the transmission of the mental health communication, and a common-sense appreciation of the context-dependent nature of the communication?

We propose that the actual transmission and receipt of the communication (Figure 60, Point 13) be accorded more attention by the mental health professionals actually conducting the delineation and acquisition of the screening and evaluation process. Who receives the information and psycholegal opinion, when, and how are questions that should not be left to be answered totally by clerical staff, although this is often the case especially in situations where examiners are employed as part-time consultants to forensic mental health facilities. Ideally, such questions should be considered generally in discussions between criminal justice personnel making the referrals for mental health evaluation, and the mental health personnel conducting the process; in specific instances, questions about who, when, and how, should be answered by the primary examiner.

The final step recommended in the model process is follow-up and feedback (Point 14), i.e., procedures employed to ensure that the consequences of the communications to the criminal justice system have an effect on the improvement of the delineation, acquisition, and provision of forensic mental health screening and evaluation. That the consequences of the evaluation process, as reflected in the communication provided criminal justice referral agents, should govern the conduct of the process evaluation in a deliberate, planned, and continuous manner seems to make eminent sense. However, with only a few exceptions (e.g., the case disposition follow-up routinely conducted by the Pima County Court Clinic; see pp. 150-151), follow-up and feedback procedures in evidence in the forensic facilities we studied were largely informal, "hit-and-miss," and seemingly ineffectual in promoting improvements in the evaluation process. Special research studies or program evaluation efforts, in the judgments of the psychologists, psychiatrists, and social

workers we interviewed, made little or no impact on the conduct of the evaluation process (see the concluding subsections describing quality control, feedback, monitoring, and program evaluation in each of the twenty forensic facilities in Chapters 4 through 8 in Part II of this volume).

Conclusion

The model process presented in this chapter is a synthesis of our perceptions of good practices in the twenty forensic mental health facilities described in Part II of this book, the judgments of many of the criminal justice and mental health personnel we interviewed, as well as an integration of the observations of others described in relevant literature. The model describes what we consider the major components of the evaluation process--delineation, acquisition, and provision--in a manner that we hope places the process in the functional context of the legal system. Fourteen major sequential steps are proposed.

A major aim of the model process is to balance the importance of the acquisition component, what we referred to in Chapter 1 as the mystique-producing "black box" of the forensic examination process, with that of the delineation and the provision components in which the criminal justice system and mental health system are most likely to interact. The steps and the components of the model process are broadly conceived and are described in a degree of detail that we hope is helpful to those who design and plan the resources for forensic mental health screening and evaluation primarily at a systems level. The model does not include a detailed set of recommendation of specific psychological and psychiatric assessments to follow the personal interview, for example, although some recommendations will be presented later in Chapter 11. Nor does the model, for example, prescribe the form of the communication (see Figure 60, Point 12) to be provided to the referral agent.

The next four chapters will expand the presentation of the model forensic mental health screening and evaluation process in this chapter. Chapters 10, 11, and 12 will describe the delineation, acquisition, and provision components, respectively, in greater detail. These chapters will also present a number of specific propositions relevant to the performance of specific steps in the model process. The final chapter will attempt to place the forensic examination process in the context of public policy. It will also propose specific strategies for the program evaluation of the forensic mental health examination process.

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Chapter 10

DELINEATION: DEFINING THE PSYCHOLEGAL QUESTION

The scene is a courtroom. Before the court is a client-offender who exhibits, or has in the past exhibited, aberrant psychological functioning which has come to the attention of the court. In preparation for a possible defense based upon mental dysfunction, pursuant to a delay in the criminal proceedings to determine his or her client's fitness to stand trial, or as a legal strategy unconnected to any legitimate concern for the mental health of the client-offender, the defense attorney makes a motion to the court for a mental health examination of his or her client. Thus starts a chain of communications suggestive of the party game in which a short message is whispered to one individual, who in turn whispers the message to another, and so on, until the last person has received a whispered message. Predictably, the outcome of the game, announced aloud by the last person in line, is a garbled message bearing little relationship to the original message.

A Hypothetical Example

Consider a hypothetical, yet typical series of communications that serve to shape the psycholegal referral question that sets into action the data acquisition component of the forensic examination process. A defendant's possible mental dysfunction first comes to the attention of the defense attorney, who after some consideration conveys the request for a mental health examination to the court in the form of a petition or motion, which may be a formal written notice or, more typically, a simple statement in open court. A judge reviews the motion, and if he or she believes that there are reasonable grounds to believe that the accused has some mental dysfunction to warrant mental health examination, conveys his request for a forensic examination of the client-offender to an agent of the court in the form of a court order. It is this agent, typically a secretary to the judge, clerk, or bailiff, who transmits the intents and desires of the court to the mental health system. Note that in this hypothetical, yet not atypical example, the creation of the psycholegal question has involved at least three representatives of the criminal justice system (attorney, judge, and a secretary, clerk, or bailiff). Yet, the court's request for assistance in resolving a psycholegal question has not yet been constructed into a message, nor has it been transmitted to the mental health system. (See the model process in the previous chapter, especially Figure 60.)

At this stage, the court clerk prepares a formal court order for mental health examination. The standard form used for this purpose has spaces for the defendant's name, case number or numbers, names of two psychiatrists to be drawn from a list of court-appointed experts, the date of the order, and the judge's signature. The standard order, written in formal language similar to that of the state's statutes, specifies the sections of the statute authorizing the raising of the

competency issue, appointments of psychiatric experts, and provisions for conducting the examination. The order also contains a short checklist of items relating to the perceived reasons for referral, headed by a sentence requesting that an official of the referring court check the appropriate items. The checklist includes such items as the nature of the offense, unusual or dangerous behavior seen in court, and disposition recommendations. Since this last portion of the order was added at the request of researchers at the local university a few years ago, and has rarely been used by the judges except for a short time immediately following the researchers' request, the clerk completes all but this portion of the court order and passes it to the judge for signature. Once signed by the judge, the clerk mails the court order to the forensic mental health unit of the county hospital with which the court-appointed psychiatrists are affiliated and where most of the court-ordered mental health examinations take place. Copies of the order are also sent to the county attorney and sheriff.

The agent of the mental health system who first receives the formal order is unlikely to be the individual who actually conducts the examination. In his hypothetical example, the secretary of the hospital's forensic unit, upon receipt of the court order, telephones the clerk of the court for further information about the client-offender such as date of birth, age, race, marital status, charge, whether the individual is in custody, and if so, where, and the name and telephone number of the defense attorney. A second call is made to the county attorney's office to request the client-offender's file containing police reports and other information (e.g., Medical and psychiatric reports). Finally, a third call is made to the defense attorney to request information that may be helpful in the examination of the defendant. The actual procedures followed by the Pima County Court Clinic in Tucson, Arizona (see Chapter 4), in response to requests for examinations of competency to proceed to trial or criminal responsibility, includes a telephone call to the client-offender's attorney made by a secretary to obtain the following information, recorded on a standard form by the secretary: the client-offender's prior offenses, prior mental health treatment, history of substance abuse, history of behavior, family, or marital problems, educational background, and any "bizarre" behavior noted by the attorney or judge that might have prompted the request for a forensic mental health examination.

At this stage of the hypothetical example, the secretary of the forensic unit (1) schedules an appointment time when the psychiatrist is available to conduct a personal interview with the client-offender, (2) makes arrangements with the sheriff for transportation (if the client-offender is in custody by law enforcement authorities) to the forensic unit and, (3) prepares a case file, containing all information acquired by the secretary, for review by the examining psychiatrist immediately prior to the scheduled time for the personal interview. Thus ends the typical process of delineation that serves to define the psycholegal question.

Beginning with the client-offender, this chain of communication between the criminal justice system and the mental health system has linked the defense attorney who petitioned the court for a halt in the proceedings to consider the defendant's mental condition, the judge, the judge's agent who executed the request of the court, the mental health worker who received the request and compiled the necessary documentary materials, and finally, the mental health professional conducting the examination. Of course, once a psycholegal opinion is reached by the examiner, the links in this chain of communication are retraced in order to provide the court with the information requested (see Chapter 12).

Inattention to Delineation of the Examination Process

Proposition 1: Far more attention should be paid, and professional resources allocated to the delineation component of the forensic screening and evaluation process.

Our aim in presenting the above hypothetical example is to emphasize the importance of the delineation component of the process of forensic mental health screening and evaluation. While its importance has been acknowledged by some observers (e.g., Lawrence, 1980; McGarry, 1980; Roesch and Golding, 1980, pp. 191-200), the operational aspects of the delineation component tend to be largely overlooked in the writings of forensic psychiatry and psychology.

In a recent review, for example, Richard Bonnie and Christopher Slobogin (1980), law professors at the University of Virginia, make a thoughtful and well balanced presentation of general principles for improving the quality of forensic evaluations. They begin their discussion, however, with the data acquisition component process (see Figure 60, Chapter 9) largely skipping any mention of the operational aspects of delineation of the psycholegal question. Though they acknowledge that an "ideal" forensic evaluation "should afford the evaluator maximum access to relevant, reliable information about the subject and his alleged behavior" (p. 496), their focus is on "clinical methodology" and the law, and they thus shed little light on the manner in which the forensic evaluation is delineated operationally to become an effective instrument of the legal system. A. Louis McGarry, a professor of psychiatry who has written extensively in the area of forensic psychiatry, gives more attention to the delineation of the elements that should be covered in a forensic examination and in the preparation of reports to the court (McGarry, 1980). He cites practical examples of reports addressing the question of competency, and describes very clearly the circumstances and purposes of the evaluation as he sees them. But the operations whereby a "clear understanding on the part of the examiners of what legal questions are being asked" (McGarry, 1980, p. 739) is obtained are left unexplored. Finally, in an article discussing psychological testing in legal settings, George Parker, a practicing psychologist, barely acknowledges the role of such testing as an instrument of the criminal justice system, and makes no mention of the

delineation of the psycholegal question to which that instrument might be addressed (Parker, 1980).

Few professional resources seem to be allocated to the delineation component in practice. Delineation of the psycholegal question seems particularly problematic in jail-mental health relationship. The Mental Health Diagnostic Services for Jail Inmates in the Nashville Sheriff's Office, for example, receives very little information or formal instructions from the Metropolitan Jail when a client-offender is referred. The only referral information available to mental health personnel is contained in a "bound-over docket" list, which gives only the client-offender's jail identification number, the court docket number, and the pretrial release status of the client-offender (see Chapter 5).

This inattention to the delineation component of the forensic evaluation process in the writings of lawyers, psychiatrists, and psychologists in the area of mental health and law is understandable when one considers what might be the functional role of these individuals in the hypothetical delineation process described above. The lawyers might be preoccupied with trial tactics and the language of the legal tests, together with locally relevant law, applicable to the case at hand. The psychiatrist might concern himself or herself primarily with the case file presented to him by the secretary of the forensic unit and his preparation for the client-offender scheduled for a personal interview less than an hour away. For the psychologist, the smooth administration of the instruments of his or her trade to difficult subjects, and the accurate and reliable interpretation of the client-offenders' test responses, in support of the opinion-formation process, would most likely be the central concern. Indeed, given the traditional roles of the lawyer, psychiatrist, and psychologist in forensic mental health evaluation, it is unlikely that they would be much involved in the delineation process depicted in the hypothetical example. The operations of delineation would most likely fall to administrative or other support personnel in the mental health and criminal justice systems. Such is the case in the Pima County Court Clinic in Tucson, for example, where administrative personnel of the clinic have recently created detailed operational guidelines for the delineation process specifically for each of its referral sources (see Chapter 7).

To what extent, then, is the fidelity of the defense attorney's and the judge's initial concern for the client-offender's mental condition maintained and transmitted to the examiner? (We are reminded of the party game of successive whispered messages.) Considering that the procedures involved in the delineation component, including the accumulation of documentary and research material, are largely accomplished by criminal justice and mental health personnel other than attorneys, judges, psychiatrists, psychologists, and social workers, without formal licensure or certification, to what extent should their role in the opinion-formation process of certified examiners be acknowledged? Should individual examiners, or the administrators of

forensic evaluation programs, be made aware of factors other than psycholegal considerations (e.g., pretrial detention of a troublesome defendant) prompting the mental health evaluation referral, factors probably better known to the persons engaged in the steps of the delineation component? And, if so, how should this knowledge affect the process of forensic mental health screening and evaluation? These questions address concerns central to the delineation component and will be discussed later in this chapter. They address not the issues raised by the written rules of substance and procedure in mental health law, but in the "socialization of the law" (cf. Perlin, 1980) reflected in operations that abound in the interactions of the mental health and criminal justice systems.

In the remainder of this chapter, we turn to a discussion of procedures and issues in the delineation of the forensic evaluation process, including the construction of the presenting problem, as informal motions for forensic examination, and the creation of the referral request; the source and transmission of the referral request; the receipt and translation of the referral request for mental health examination; and the potential for misuse of the examination process. Interspersed in the remaining text of this chapter (as well as the following three chapters) will be tersely stated propositions relevant to the discussion at hand. We hope that the propositions and the discussion will serve to better articulate the model process presented in the previous chapter and contribute to a better understanding of the various screening and evaluation processes described in Part II of the book.

We first turn our attention to a legal mechanism for delineation that was conspicuous by its absence in the twenty jurisdictions we studied.

Motions for Mental Health Evaluation

An attorney or judge, alerted to the possibility of mental dysfunction in a defendant by some observed event or fact (e.g., strange behavior on the part of the client-offender), must link this observed fact with one or more of the legal constructs that make up the fabric of mental health law. Typically, referred to as the "reasons for referral" in court orders for mental health examination, these constructs include competency to stand trial (broadly conceived to include competency to participate in the entire criminal proceedings, including the entering of a plea and to waive the right to counsel), insanity, criminal responsibility, dangerousness, and amenability to treatment, to name the most frequent. It is the articulation of these psycholegal constructs, termed "open concepts" or "concept with open texture" whose meaning "can never be fully reduced to a set of concrete operations and observational terms" (cf. Roesch and Golding, 1980, p. 12, writing specifically about competency to stand trial), that has drawn the attention of the legal and forensic mental health literature. Raising the issue of mental health in the legal contexts by a formal motion or petition for examination necessitates the use of these constructs, even though their meaning or connection to the observed events may be poorly understood, and even

though they may be misused by defense attorneys for reasons other than a legitimate concern for their client's mental health.

Given the costs of a mental health examination and the concomitant delay in the judicial proceedings, it does not seem unreasonable to recommend the drafting of written motions or petitions by attorneys for the defense or prosecution, specifically detailing the connections between observed fact and psycholegal constructs, for pretrial evaluation of present competency and mental state at the time of the offense, as well as presentence and postsentence evaluations. Of course, as noted by Roesch and Golding (1980, p. 202), for such detailed motions to be worthwhile and effective, the court must exercise its authority by denying motions that are unsubstantiated.

Is the question of whether or not to evaluate a defendant's mental condition exclusively a judicial concern, a mental health concern, or is this threshhold question one to be addressed by the interaction of the criminal justice system and the mental health system? Courts in the jurisdictions we visited seemed reluctant to exercise their judicial authority in screening legitimate requests for mental health examination from those that may be unsubstantiated, preferring instead: (1) to defer completely to mental health professions in this first screening; (2) to acquire an assessment by mental health professionals of the viability of the written motion for mental health examination, i.e., assist the court in determining whether a sufficient doubt exists to grant the examination request; or (3) most typically, to require only formal oral motions for mental health examinations by prosecution and defense attorneys.

In Wyandotte County, Kansas, for example, all defendants detained in the county jail are interviewed in the jail by staff of the Pretrial Services Project (see Chapter 5, pp. 228-236). The initial interview may be followed by another interview and psychological testing by a clinical psychologist. These procedures are usually not initiated by the judge, or by prosecution or defense attorneys. In another example, the response to a continued high rate for findings of competency and sanity in defendants evaluated by private psychiatrists (at great expense to the court), the Pima County Superior Court in Tucson recently directed their Court Clinic to conduct mental health screenings to assist the court in assessing the grounds of motions for "full scale" pretrial examinations by court-appointed psychiatrist in the private sector. Prior to the institution of this screening procedure (prompted by economy measures), upon which the court grants or rejects motions for "full scale" evaluations, the Pima County Court Clinic restricted its work to postconviction, presentence evaluations. The court, in essence, conducts a mental health examination in order to determine whether such an examination would be warranted in the first instance. Interestingly, although this specific procedure has yet to be put to a test, one judge in Pima County informed us of his intentions for granting motions for further mental health examination even after the court clinic found a defendant competent and criminally responsible, but in such a situation the court would refuse to shoulder the cost of such an evaluation (see Chapter 4, pp. 151-153).

Judges' deference to mental health experts in answering the threshhold question of whether to grant motions for mental health evaluation is understandable on several grounds: (1) complex case law which gives trial judges very little latitude in denying all but the most frivolous motions for mental health evaluation, e.g., Pate v. Robinson (1966), People v. Pennington (1967), People v. Laudermilk (1967), Moore v. United States (1972), Drope v. Missouri (1975), and deKaplany v. Enomoto (1977), addressing the issue of competency (see also Roesch and Golding, 1980, pp. 24-33); (2) judges' fear of reversal on appeals based on denial of due process, or denial of sixth amendment rights entitling a defendant to a mental health examination allowing the full exploration of the possibilities of a defense based on mental aberration (see Bonnie and Slobogin, 1980, pp. 497-503); (3) judges' general uncomfortableness with psycholegal constructs and their unfamiliarity with the specialized and technical aspects of psychology and psychiatry; and (4) the court's general reliance on "mental health experts." Yet, it seems unlikely that the courts will move to the extreme of granting all defendants court-ordered evaluations, or even granting such evaluations in all cases where motions have been made to such effect (although Pate v. Robinson [1966] has been so misinterpreted with reference to the issue of competency [Roesch and Golding, 1980, p. 29]). Nor would they move to the opposite, almost absurd extreme characterized by Judge David Bazelon's comments in Mitchell v. United States (1963, p. 360) where insanity or incompetency must be demonstrated before the motion for examination is approved: "It cannot reasonably be supposed that Congress intended to require the accused to produce, in order to get a mental examination, enough evidence to prove that he is incompetent or irresponsible. That is what the examination itself may, or may not, produce. If the accused already had such evidence, there would be little need for the examination" (cited in Roesch and Golding, 1980, p. 28).

From a practical standpoint, the socialization of the unsettled law seems to have devalued the attorney's and judge's role in delineating the presenting problem for mental health examination of client-offenders and communicating the basis of the request to the mental health examiner. In the few courts we studied where the motion for an examination even reached the attention of the mental health examiner (in most of the courts, they did not) the language of the motion merely parroted statutory language. As noted above, the Pima County Superior Court in Tucson is a peculiar exception to this. It requires the submission of written motions for "mental condition examination and stay of proceedings" which detail the facts upon which the examination is first sought, but then directs its Court Clinic to conduct such an examination in all such cases. The factual basis of the request for mental health examination in most jurisdictions typically remains a mystery to the mental health professional conducting the examination, unless he or she directly questions the referring attorney or judge following the formal court order. Formal petitions, if they existed at all, rarely became part of the documentary base for mental health evaluation in the jurisdictions we studied.

Proposition 2: Formal written motions or petitions to the court should initiate all requests for mental health examination. In cases in which the court, sua sponte, request a forensic mental health examination, judges should draft and submit the equivalent of a written motion.

We concur with the recommendation made by Roesch and Golding (1980) that motions be written in a manner that makes the perceived connection between the facts observed or known by the attorney, and the psycholegal construct explicit. (It should be noted that Eizenstat's proposed model statute for competency to stand trial [quoted in Brooks, 1974, pp. 385-388] recommends that no special motion be necessary in raising the issue of competency.) Roesch and Golding propose that the following information be detailed in motions of competency so that the court could curtail inappropriate uses of mental health examination and deny motions which are not supported by relevant observed events (pp. 201-202):

(a) The behaviors actually observed (including verbal behavior) by the defense or prosecuting attorney that led to the motion for mental health.

(b) The specific events, linked to this behavior, that have occurred, or are likely to occur, that might hinder the preparation of a defense.

Similar documentation of the presenting problem can reasonably be proposed for pretrial questions of criminal responsibility, as well as presentence and postsentence questions. A motion detailing the psychologically aberrant behaviors that the client-offender is alleged to have exhibited, and explaining how those behaviors might relate to a relevant psycholegal construct would have several advantages (notwithstanding the sticky legal issues concerning the appropriate standards or evidence required to initiate mental health evaluation). The mere notice to attorneys that a proper motion must do more than parrot statutory language might decrease motions made frivolously or without reasonable grounds. Also, such motions would provide the documentary support upon which to base the decision to grant or deny the motion (and to appeal such a decision). But more central to the operational concern of this chapter, such detailed motions would provide the mental health examiner (assuming the motion was granted) with a clear statement of the presenting problem as viewed by the criminal justice system. Written motions may reduce the need for mental health professionals to query attorneys by telephone once they have received a court order to examine a client-offender--a procedure that may prejudice the examination. In most jurisdictions, the mental health examiner or agent must reconstruct the presenting problem in the absence of such a clear statement of the presenting problem. As one Virginia psychiatrist lamented, "I often don't know whether to look first in the attic or the basement when I get an order for mental health evaluation."

But, should mental health personnel contribute to the threshhold decision to grant or deny motions for court ordered mental health evaluation? Our contention is that unless such contribution is based on observation and examination of possible mental aberration of the client-offender, the decisional strategies are highly suspect. (Of course, if such contribution is based on actual examination then we have moved close to the absurd extreme requirement, rejected by Judge Bazelon in Mitchell v. United States (1963), where an evaluation is conducted to determine if an evaluation is warranted).

Considering the construct of competency to stand trial, for example, the mental health professional assisting the court decides whether or not to grant an evaluation, must consider if a "bona fide doubt" of the client-offender's competency has been established by the court's own evidence or that presented by the prosecution or defense. This legal standard was set by the Supreme Court in Pate v. Robinson (1966). Whether the evidence before the court is "substantial" enough to raise a "bona fide doubt" is arguably a judicial consideration--not a mental health consideration. It is a matter of weighing all the evidence before the court. The court in deKaplany v. Enomoto (1977, p. 982, cited by Roesch and Golding, 1980, p. 31) characterized the necessary doubt that forces an evaluation in this way: "Genuine doubt, not a synthetic doubt or constructive doubt, is the measuring rod. The emergence of genuine doubt in the mind of a trial judge necessarily is the consequence of his total experience and his evaluation of the testimony and events of the trial." Few mental health professionals have the opportunity to evaluate the "testimony and events of the trial" from the perspective of the "total experience" of the trial judge. Moreover, leading authors in forensic psychiatry and psychology assume that any testimony by a clinician about the mental condition of a client-offender must always be based on a face-to-face interview with the client-offender (see, e.g., Sadoff, 1975; MacDonald, 1975; Pollack, 1973). Bonnie and Slobogin (1980, p. 496) conclude that "[n]either the factual predicates of hypothetical questions, nor observation of courtroom behavior or testimony, nor review of the interview records of other clinicians can provide an adequate clinical base for formulation of an expert opinion about a person's mental condition."

The threshhold decision to grant or deny a mental health examination seems to fall even more squarely to the role of a judge when one considers that many motions for examinations are prompted by defense or prosecution motives at best indirectly related to the psycholegal constructs invoked in the motion (e.g., assistance in plea bargaining, delay in the proceedings until negative publicity dissipates, testing the court's receptivity to an insanity, preventive detention, and exploration of mental aberrations at the pretrial phase which become relevant only at the sentencing stage). Mental health professionals generally have not the knowledge of statutory law, case law, nor a working familiarity with attorneys making the motion, and the peculiarities of the case in question to be able to distinguish frivolous motions, unsubstantiated motions, motions that appear to have multiple purposes including delay, from motions that clearly present sufficient legal grounds for a mental

health examination. We know of no advocate for the position that mental health professionals should have a legitimate role to play in this decisionmaking.

The Law and the Creation of the Referral Request

What are the important and essential elements of a mental health referral that must be communicated (should be communicated) to the mental health system by the criminal justice referral agent or agency? Whatever the message that reaches the mental health examiner, it is borne by the initial psycholegal question posed by the court. Communication between the judge, the attorney, or probation department official and the mental health personnel should be lucid and complete, but is often incomplete and flawed. The precision with which the court poses the psycholegal question for the mental health personnel, noting specifically what information is needed and for what purpose, is crucial to the success of the screening and evaluation process. But, too little information may render the screening and evaluation process to be imprecise, irrelevant, and useless. Too much information, however, may lead mental health personnel to inappropriate predictions, or perhaps, unduly prejudice the examination.

Proposition 3: More because of its ambiguity, incompleteness, and potential for confusion than its prescriptive or descriptive informativeness, statutory language should be scrutinized carefully by mental health personnel.

Given the fact that the process of forensic mental health evaluation and screening is an instrument of the legal system, one might think that the law would delineate its use by mental health professionals. But state statutes are written in language that has broad and flexible applicability at the cost of ambiguity and considerable confusion.

Consider, for example, the legal standards defining competency to stand trial in the statutes of several states in which we studied the forensic examination process. In Colorado, "'[i]ncompetent to proceed' means the defendant is suffering from a mental disease or defect which renders him incapable of understanding the nature and course of the proceedings against him or of participating or assisting in his defense" (Colo. Rev. Stat. § 16-8-102(3)). The Colorado statute, as the statutes in most states, adopted the "rationally consult, assist, and comprehend" standard for competency set by the Supreme Court of the United States in Dusky v. United States (1960). As part of the forensic examination, the Colorado statute permits the use of "confessions and admissions of the defendant and any other evidence of the circumstances surrounding the commission of the offense" and the medical and social history of the defendant. It also permits administration of "sodium amytal, sodium pentathol, metrazol and like drugs" and the use of polygraph examinations (Colo. Rev. Stat. § 16-8-106(3)). In Kansas, a client-offender is incompetent to stand trial if "because of mental illness or defect is unable: to understand the nature and purpose of the proceedings against

him; or to make or assist in making his defense" (Kan. Crim. Code & Code of Crim. Proc. § 22-3301(a)). The Kansas statute does not describe the particulars of the examination process. In Michigan, a defendant is incompetent to stand trial "only if he is incapable because of his mental condition of understanding the nature and object of the proceedings against him or of assisting in his defense in a rational manner" (Mich. Comp. Laws § 330.020(1)). The fact that a client-offender may be using psychotropic drugs or other medication does not render him or her incompetent in Michigan, even if he would be considered incompetent if he was not using the medication (Mich. Comp. Laws § 330.2020(2)). A mental health professional, specifically, a "certified or licensed examiner of the Center for Forensic Psychiatry or other facility officially certified by the Department of Mental Health" (Mich. Gen. Ct. R. 786.3(a)), is to "examine the defendant and consult with defense counsel" and may consult with the prosecutor or any other person "for the purpose of gathering psychiatric and other information pertinent to the issue of" incompetency (Mich. Comp. Laws § 330.2028(1)). Most states have statutes with similar language defining the standards for competency to stand trial, and include similarly brief statements, if any at all, delineating the examination process.

A little more definition of the scope and conduct of the evaluation process can, however, be inferred from statutory specification of the content of the written reports which are to be provided to the court following an examination. The Missouri statute is typical, specifying that a written report to the court must contain

> an opinion as to whether the accused, as a result of a mental disease or defect, lacks capacity to understand the proceedings against him or to assist in his own defense; a recommendation as to whether the accused should be held in custody in a suitable hospital facility for treatment pending determination by the court of the issue of mental fitness to proceed; and a recommendation as to whether the accused, if found by the court mentally fit to proceed, should be detained in such hospital facility pending further proceedings" (Mo. Rev. Stat. § 552.020.3).

Among the states we studied, only California, Kansas, Tennessee, and the District of Columbia had no such statutory language describing the content of the written reports to the court, following an examination of competency to stand trial.

State statutes are generally much less clear and informative concerning the evaluation of criminal responsibility. The responsibility standard in most states is derived from the case of Daniel M'Naghten, decided in England in 1843. The M'Naghten rule, or "right and wrong test," as it came to be dubbed, held

> that to establish a defense on the ground of insanity, it must be clearly proved that at the time of the committing of the act, the party accused was labouring under such defect of reason, from disease of the mind, as not to know the nature and quality of the

act he was doing, or if he did know it, that he did not know he was doing what was wrong (cited in Bromberg, 1979, p. 44).

Modern state statutes reflect broadened applications of the M'Naghten test including emotional or volitional components ("irresistable impulse") and elements of causation (the "product test" of the Durham v. United States [1954] decision). The American Law Institute's Model Penal Code "substantial capacity" test (see Brooks, 1974, pp. 165-171) has been enacted into the statutes of Connecticut, Illinois, Kentucky, Maryland, Michigan, Missouri, and New York, among the states in which we studied the forensic evaluation process. The New York statute reads: "A person is not criminally responsible for conduct if at the time of such conduct, as a result of mental disease or defect, he lacks substantial capacity to know or appreciate either: the nature and consequence of such conduct; or that such conduct was wrong" (N.Y. Penal Law § 30.05). In sum, state statutes are brief and ambiguous in describing the operations that may be performed by examiners in evaluating criminal responsibility. The Massachusetts statute is illustrative: "Examiners may give physiological and psychological examinations as they deem necessary" (Mass. R. Crim. P. § 14(b)(2)(B)).

Forensic mental health evaluations, conducted after a defendant has been convicted, but not yet sentenced, in order to assist a trial judge in fashioning an appropriate sentence (including, e.g., rehabilitative options), receive even less attention in state statutes than do the examinations for competency and criminal responsibility. A mental health professional looking for guidance in delineating the scope and conduct of such evaluation would find little. In California, for example, the court may order a presentence mental examination or treatment in any criminal case punishable by imprisonment in the state penitentiary (Penal Code § 1203.03); the examination is required if the defendant is convicted of an offense involving child abuse or neglect (Cal. Penal Code § 1203h). The statute specifies only that the examination entail "such diagnosis and treatment services as can be provided at a diagnostic facility of the Department of Corrections . . . ." The examination must be completed within 90 days of the referral (Cal. Penal Code § 1203.03). A mandatory examination in child abuse and neglect cases requires "a psychological evaluation to determine the extent of counseling necessary for successful rehabilitation and which may be mandated by the court during the term of probation" (Cal. Penal Code § 1203h). As uninformative as the California statute may be about the scope and conduct of presentence mental health examination, it is atypical only in its breadth of coverage of the subject.

To make matters worse for the examiners looking to state law for a delineation of the forensic examination process, the statutes of many states reflect and contribute to a confusion between competency, criminal responsibility, and mental illness (Rosenberg, 1970; Roesch and Golding, 1980). For example, the Florida Rules of Criminal Procedure, in effect in 1977, did not define competency to stand trial in terms of the defendant's ability to understand the nature of the charges or capability to assist counsel, following the general framework of the decision in

Dusky v. United States (1960), but instead used the terms "sanity" and "insanity." Another peculiarity of this 1977 Florida law, sure to have bewildered mental health personnel, was the requirement of a NGRI (not guilty by reason of insanity) adjudication following the finding that there is no substantial probability that a defendant will become fit to stand trial in the foreseeable future (cf. Williams and Miller, in press). The United States Supreme Court in its landmark decision in Jackson v. Indiana (1972) noted a similar confusion in the Indiana statutes at the time of the decision. "The [statute] section refers at several points to the defendant's 'sanity.' This term is nowhere defined. In context, and in the absence of a contrary statutory construction by the state courts, it appears that the term is intended to be synonymous with competence to stand trial" (Note 2). Although it is certainly arguable whether much would be accomplished by more operational specificity in states' laws pertaining to the forensic evaluation process, the point of the foregoing is that statutes are presently uninformative, are often imprecise, and may even cause confusion in both the criminal justice system and the mental health system.

The Referral Source and the Potential Misuse of the Process

> . . . [V]arious incentives (fiscal or otherwise) that are purposely or often intentionally built into the criminal commitment system, and the consequences that flow from those incentive patterns, are generally of far more interest and importance than are the tests for determining whether one is incompetent to stand trial, not guilty by reason of insanity, and so forth (Wexler, 1981, p. 118).

What is the significance of the source of the referral for forensic mental health screening and evaluation? Requests for mental health examination may come from a variety of referral sources. First, the client-offender may possess the resources to request and finance the examination himself or herself. Second, the defense attorney may make the referral. This may occur, for example, in federal criminal prosecutions where counsel for an indigent defendant is provided the sum of $300 for such purposes (18 U.S.C. § 3006A [1976]). Third, the prosecution may request the evaluation in the first instance or in response to a defense motion of incompetency to stand trial or mental health related defenses. Finally, the court may order the evaluation on its own initiative. Each of these referral sources presents differing legal implications and potential problems for the examiner and the examination process.

When the client-offender has made the request, a statutory therapist-patient privilege may pertain that protects the confidentiality of the process. This privilege, however, does not exist in every jurisdiction (see Pratt v. State, 1978, for one court's struggle with privilege in this context). If the client-offender's counsel initiates the evaluation as a part of his defense preparation, the disclosures made to the therapist are also protected, this time by the attorney-client privilege.

This protection is acknowledged in the ethical guidelines for confidentiality proposed by the American Academy of Psychiatry and the Law (AAPL) which states, in part, that a psychiatrist "has an absolute obligation of confidentiality with the hiring attorney and may not discuss the case with anyone of the adverse party without proper permission" (Rappeport, 1981). Further, according to another guideline termed "institutional treatment role" the AAPL proposed that

> it is the psychiatrist's responsibility to clarify in writing with his employers, exactly what his role is with reference to confidentiality, and other responsibilities, and to see that anyone who confides in him is aware of any limitations to the relationship (Rappeport, 1981).

Unlike the therapist-patient privilege, the attorney-client privilege is in the common law and, thus, exists in every jurisdiction in the nation unless expressly repealed. Privileges, however, are afforded to the client-offender and not to the attorney or therapist. Should the client-offender waive the privilege, the therapist could not rely on the privilege to refuse to testify.

When the examination is ordered by an arm of the state or federal government, such as the prosecution attorney, probation department, or the court, a constitutional privilege against compelled self-incrimination may be raised (U.S. Const., Ams. 5 & 14). In this situation, the therapist, as an agent of the state, may be required to give the client-offender a Miranda-type warning. Fifth and fourteenth amendment rights, like privileges, are subject to waiver by the client-offender. The different sources of referral for forensic mental health examination also have different practical consequences for the acquisition of information from the client-offender directly, as well as from "third party" sources, and for the distribution and provision of the acquired information. Some of these consequences are discussed further in the next chapter.

Proposition 4: The conduct of the forensic mental health screening and evaluation process should be geared to both the explicit and latent purposes of the evaluation referral.

The examination process may be used by defense and prosecution attorneys for reasons other than a legitimate concern about a client-offender's mental condition (cf. Brooks, 1974, p. 332; Roesch and Golding, pp. 191-200). Legal criteria may be distorted to achieve a preferred disposition of a client-offender (Roth, 1980; Steadman and Braff, 1975). Pretrial commitment for screening and evaluation, for example, may be prompted by considerations of legal strategy, preventive detention, financial factors, or a lack of other clear alternatives and not necessarily a legitimate concern for possible mental aberration. The hospitalization of criminal defendants before trial, for another example, may be formally invoked to evaluate competency to stand trial, yet in practice hospitalization for the purpose of assessing competency may be used as an expedient temporary diversion of a troublesome defendant. The

violent but not mentally ill inmate may be labelled "mentally ill" to rid the jail or prison of him. Perhaps less ominous is the motion for a competency-to-stand-trial evaluation used as the only available legal device whereby a court can obtain mental health care for some defendants. Finally, the request for testing for mental retardation may be prompted by a probation officer seeking to reduce his or her caseload by a commitment to a department for mental retardation.

The precision with which the referral agents pose the psycholegal question to be addressed by forensic mental health personnel, making note in the motion of the types of information needed and for what purposes, is crucial to the success of the examination process. We contend in this chapter that the nature and purpose of a forensic mental health evaluation requested by a court, for example, may not be clearly delineated when a legitimate concern about a client-offender's mental health actually exists. But what of the situation, for example, where a defense attorney's sole, but latent, purpose in requesting a competency examination is to delay the proceedings and explore the possibility of an insanity defense in the future? Assuming that the evidence in a formal motion for competency examination has met the Pate standard and the motion is granted, how should the examiner who has knowledge of the "real" reason for the referral proceed?

On the one hand, probing the psycholegal questions of insanity and criminal responsibility within the context of a competency examination, and thus responding to the explicit and latent purposes of the referral, has both serious legal implications (as we will discuss in the next chapter) and practical implications for the conduct of the examination. What is said to the client-offender prior to the examination, how it is said, and when (see the previous chapter, Figure 60, Point 5; also Chapter 11)? Should he or she be told that there is a good likelihood that the information gained might be used to establish guilt or innocence, given the examiners' knowledge of the latent goals of the examination? How much time and effort should the examiner expend on addressing an issue (i.e., criminal responsibility in our example) not formally and explicitly raised by the court? On the other hand, restricting the process to the exploration of the competency issue, without acknowledgement and consideration of the hidden agendas of the referral agents may constitute a complete denial by the examiner of the philosophy and socialization of the law, and a denial that the examination process is an instrument of the legal system. Consider Judge Henry Friendly: "Under our adversary system the role of counsel is not to make sure the truth is ascertained but to advance his client's cause by any ethical means. Within the limits of propriety, causing delay and sowing confusion not only are his right but may be his duty" (quoted in Haney, 1981, p. 162).

With Proposition 4, above, we suggest a "necessary but cautious alliance" (cf. Haney, 1981) between the examiner and referral agent which acknowledges, within the bounds of legal and professional propriety, both the explicit and latent purposes of the evaluation referral. To do otherwise, in our minds, would be to encourage hypocrisy in the

interaction of the criminal justice and mental health system. In the next chapter, we discuss the related issues of warnings, consents, and confidentiality before and during the data acquisition component of the examination process.

Notification and Communication Requirements

Proposition 5: Written court orders for mental health examination, following successful motions or petitions, should be prepared in all cases.

Proposition 6: Copies of court orders and motions for mental health examination should be transmitted to defense, prosecution attorneys, and other criminal justice agents, as appropriate, at the same time as their transmittal to forensic mental health authorities.

Proposition 7: Only the receipt of a formal court order for forensic mental health examination should initiate the acquisition of information from the client-offender and third party sources.

As has already been discussed in the previous chapter, and early in this one, the formal court order invokes the authority of the law and initiates the examination process. It is not an instrument for delineating the process, it merely sets it into action in a general direction only vaguely charted in statutes. The written motion, as we have recommended its execution, however, serves to delineate the concerns and wishes of criminal justice referral agents. With the three propositions stated above we recommend the minimum notification and communication requirements for the delineation component of the evaluation process. The defense and prosecuting attorneys should thus be adequately informed of the fact that a forensic examination has been legally authorized and when it can be initiated, by whom the referral was made, and the basis of the referral. We have already argued strongly for the necessity of an adequate delineation of the examination for the purposes of the mental health system responsible for data acquisition; such delineation is typically not present in practice. With the foregoing three propositions we emphasize the need for notification and communication to the actors in the adversarial process as well. The last proposition presented in this chapter concerns itself with the important matter of timing.

Proposition 8: Defense attorneys should be notified by mental health personnel in advance of a scheduled forensic mental health examination to allow ample time for counselling with and preparation of their clients.

Conclusion

In practice, how can the delineation of the forensic screening and evaluation process be improved? The hypothesis that mental health personnel will have difficulty in working with criminal justice

authorities in direct proportion to the distance they perceive between the criminal justice system and the mental health system, has led to the proposal for training programs that stress knowledge of both systems by all personnel (cf. Beigel, 1976, p. 148). Professional jargon, the lack of common language, unclear role definition, and the fear of abrogation of traditional disciplines impede the development of such training programs. We have made in this chapter a number of propositions that may facilitate the design and subsequent evaluation (that is, program evaluation) of the forensic mental health examination process, in general, and the delineation component in particular. There are, of course, a number of much more mundane recommendations for procedures to improve the process, procedures that may entail little accomodation to new ways of doing things. The delineation of screening and evaluation can be facilitated, if not significantly improved, by an exchange of memoranda or by a face-to-face meeting between referral agents (judges, probation officers and attorneys) and mental health examiners. These meetings could serve to specify, for example: (1) factors (type of offense, psychological history, age, race, history of substance abuse, current behavior, etc.) most salient in the decision to request mental health services; (2) aspects of written evaluation reports (personal and family history of defendant, general description of intellectual functioning, psychological test scores, recommendations for treatment, conclusory statements regarding specific legal questions, etc.) most helpful in addressing various legal-psychological questions; (3) standard mechanisms for conveying the request for evaluation (court order, referral form, telephone conversation, etc.); (4) identification of referral agents (court clerks, bailiffs, etc.) and recipients of those referrals; (5) time frames for completion of the screening and evaluation process; and, finally, (6) the general communication processes between referral agents and mental health examiners. This list of suggestions for improving the delineation process is certainly not exhaustive. It is, however, illustrative of the simple efforts for which the net gain seems to greatly exceed the cost.

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Chapter 11

THE DATA ACQUISITION COMPONENT OF THE EXAMINATION PROCESS

Our discussion in this chapter follows the earlier description of the steps in the data acquisition component of the model process of forensic mental health examination which was presented in Chapter 9 (see, especially, Figure 60, Points 5 through 11). Briefly, the recommended seven steps in acquiring information directly from the client-offender, and from other sources, are:

(1) the administration of warnings or informed consent procedures that initiate (or terminate) the forensic examination process;

(2) a thorough review of the client-offender's case file which was selectively compiled to provide background information addressing a specific psycholegal question;

(3) the personal interview of the client-offender by a mental health professional;

(4) psychological testing, if warranted by knowledge gaps remaining after the personal interview;

(5) social assessments;

(6) other inquiries, including additional interviews with the client-offender, physical and neurological examinations, and electroencephalograph recordings, to name just a few; and finally,

(7) the formation of the opinion regarding the specific psycholegal question.

This chapter will describe these steps in greater detail than that provided in Chapter 9, highlight practical and legal problems that might arise when taking these steps , and present a number of propositions specific to the acquisition component of the forensic examination process. As we pointed out earlier, and emphasize here, the propositions presented in the last three chapters of Part III of this book are not conclusions based on empirically tested hypotheses, but instead are yet to be verified hypotheses, "discovered" and developed on the basis of the descriptive research reflected in Part II. We hope these propositions will be demonstrated in practice, and thoroughly evaluated in the future.

Hospitalization versus Outpatient Examination

Is it necessary to hospitalize a client-offender for the purpose of a forensic mental health examination?

Proposition 9: The forensic mental health screening and evaluation process does not require the hospitalization of a client offender.

Although some states (e.g., Virginia) may still adhere to a model wherein client-offenders are hospitalized solely for the purpose of forensic mental health examination (see Chapter 7 in this volume), and notwithstanding Eizenstadt's recommendations for such hospitalization for pretrial examination (proposed model statute cited in Brooks, 1974, pp. 385-388), there are strong national trends toward community-based outpatient examinations in court clinics, mental health units in jails, community and regional mental health centers, and community corrections programs (Chapters 4, 5, 6, and 8 in this volume). The decentralization of the forensic mental health evaluation process is an accomplished fact in most of the states we studied. Connecticut, for example, decentralized the process in 1975, the year the Courts Diagnostic Clinic in Hartford was established (see Chapter 4, p. 99).

The traditional approach requiring client-offenders to be transported many miles to the place where the mental health personnel are located is reversed in the Cambridge Court Clinic, where mental health personnel are on "court call". When questions of competency to stand trial or criminally responsibility arise at arraignment, this court clinic in Massachusetts immediately dispatches a psychologist or psychiatrist to the courtroom where they typically speak with the defense attorney and other court officials, and then interview the client-offender in an interview room adjacent to the courtroom. The resulting opinion and recommendation is presented verbally to the court. The court either finds the client-offender competent and proceeds with arraignment or orders further mental health evaluation (see Chapter 4). The Mental Health Diagnostic Services for Jail Inmates in the Nashville Sheriff's Office (see Chapter 5) have very recently instituted similar rearrangements whereby mental health personnel go to where the client-offenders are located in the jail, rather than transporting them to a forensic mental facility for examination. This rearrangement was prompted by several reasons:

(a) the security problems and logistic difficulties of transferring client-offenders;

(b) lack of feedback about the client-offender after mental health examination; and

(c) the related problem of the inability to monitor improvements or deterioration of client-offender's condition (see Chapter 5).

Thus, Proposition 9 is supported in practice, i.e., the mere fact that outpatient forensic examination is the preferred procedure in many jurisdictions demonstrates that the examination process does not necessarily require hospitalization of a client-offender. Conceivably, Proposition 9 also receives constitutional support from the principle of

due process requiring that any state action bear a reasonable relationship to some legitimate state purpose (the United States Supreme Court applied this principle to involuntary civil commitment proceedings in Jackson v. Indiana [1972]). Unless an initial forensic examination, performed on an outpatient (see Proposition 17 later in this chapter), establishes the need for subsequent examinations including, perhaps, prolonged observations of a client-offender in a hospital setting, the need for hospitalization cannot be simply presumed. Although there seemed to be no consensus on the specific minimum criteria for an adequate forensic mental health examination among the mental health workers we interviewed, hospitalization was never mentioned as a necessary requirement for an initial examination. Even in very controversial cases such as that of John Hinckley (see Chapter 1), who underwent several months of forensic mental health examinations while confined in a federal mental health correctional institution in Butner, North Carolina (Kiernan, 1981), hospitalization seemed prompted by security concerns and not demanded by requirements of the examination process itself.

Given the trend toward outpatient forensic mental health examination, who bears the responsibility for bringing the examiner and the client-offender together at a designated time and place?

Proposition 10: The criminal justice system should have the responsibility for assuring that the client-offender is present at the time and place of scheduled forensic mental health screenings and evaluation.

A client-offender subject to forensic mental health examination is either in the custody of law enforcement agencies (e.g., in jail) or has been released in the community under some legal restrictions (e.g., the posting of bail or release on his or her recognizance). Forensic mental health facilities do not have the initial opportunity, personnel, and resources to:

(a) determine whether a client-offender in custody, all things considered, should not be removed from incarceration to be transported to the site of the examination because of a threat to the safety of the client-offender or others;

(b) determine and make the most secure and safe arrangements, if the examination is to take place in a jail, prison, or other secure facility;

(c) arrange transportation and safety precautions for client-offenders in custody in the case of examinations in sites distant from the place of custody;

(d) arrange and enforce compliance with appointments for examinations scheduled for client-offenders released in the community; and, finally,

(e) make the initial determination of the client-offenders' capabilities for arranging transportation and meeting scheduled appointments for examination.

Although the admission procedures for inpatient mental health examination in centralized facilities specifically acknowledge safety and security concerns (see, for example, the delineation procedures at the Fulton State Hospital, Biggs Unit, described in Chapter 7), similar formal acknowledgement is conspicuously absent in community-based outpatient examinations. An exception may be the procedures used by the Riverside Hospital Community Mental Health Center in Virginia (see Chapter 6). The Riverside Center is not responsible for ensuring that a client-offender is present for examination. At the time an examination is ordered by the court, the judge determines the client-offender's responsibility for presenting himself or herself for examination.

Warnings, Consents, and Confidentiality

What are the legal and ethical implications of acquiring information from a client-offender during forensic mental examinations? As we discussed earlier in Chapter 9, ethical guidelines for mental health workers conducting forensic mental health examinations, a growing (albeit confusing) body of case law, and a number of commentators (see, generally, Bonnie and Slobogin, 1980; also, "Fifth Amendment Protections in Criminal Psychiatric Evaluations," 1981) suggest that the acquisition component of the screening and evaluation process begin with a clear explanation to the client-offender of the likely consequences of participation in the process. Considering the potential importance to a client-offender of the clinical opinion rendered following examination, the therapeutic power that is wielded by the examiner in the criminal process, and the absence of an appeal from a bad, inappropriate, or improper mental health examination, a sense of fairness suggests informing the client-offender (or his or her counsel) what he or she has to gain or lose from participation in the examination process. One psychiatrist, suggesting a thought-provoking metaphor for the court-ordered examination, concluded that psychiatry, like sex, is best conducted between two consenting adults (Note 1).

Proposition 11: An examiner shall inform the client-offender, before initiating the examination process, orally and in writing, of the likely consequences of the examination process and the right to refuse to cooperate in any portion thereof.

Under the heading of "consent," ethical guidelines for forensic psychiatry proposed by the American Academy of Psychiatry and the Law state that the following information be provided to a client-offender before an examination:

(a) that the goal of the examination is not treatment;

(b) that the examiner is indeed a psychiatrist, but should not be considered as the client-offender's "doctor";

(c) for whom the evaluation is conducted (who is the client?);

(d) what is to be done with the information gained; and

(e) what could result from disclosure from the information.

Further, according to the guideline of confidentiality, "it is the psychiatrist's responsibility to see that none of the information he receives falls into the hands of unauthorized persons" (Rappeport, 1981).

The American Psychological Association's Task Force on the Role of Psychology in the Criminal Justice System (1980) similarly addresses the ethical dilemna presented by the question of an examiners loyalties in criminal justice settings:

> Psychologists in criminal justice settings, as elsewhere, should inform all parties to a given service of the level of confidentiality that applies and should specify any circumstances that would constitute an exception to confidentiality. This should be done in advance of service, preferably in writing.
>
> The ideal level of confidentiality of therapeutic services in criminal justice settings should be the same as the level of confidentiality that exists in voluntary noninstitutional settings.

Thus, the likely consequences of the examination process that are communicated to the client-offender should not be restricted to those formally delineated in law but should include those suggested by ethical practice. If, for example, the results of a preliminary mental health screening conducted before trial are likely to find their way into plea bargaining agreements or sentencing hearings (as they are in Bartow, Florida; see Chapter 6), this should be clearly explained to the client-offender.Indeed, it seems antithetical to the purposes of the criminal justice system in enlisting the aid of mental heath professionals and requiring certification of their professional status (e.g., only licensed psychiatrists can perform certain duties in some states), for the system not to support their professional integrity and ethics in the matter of warnings before examinations.

Practically speaking, the question reduces to: Who tells the client-offender what, how, and when? What is actually said to the client-offender has claimed most of the limited attention to this question. And, it is doubtful that the issue of proper content of an informed consent statement, including the familiar warnings required by Miranda v. Arizona (1966) before a forensic examination is initiated, will be resolved without considerable debate. Still, the issues of how the message is conveyed, by whom, and when are far from trival.

In the Pima County Clinic in Tucson, Arizona, upon arrival for examination a client-offender is greeted by an administrative aide or secretary who briefly and informally explains the reasons for the

referral (see Chapter 4 in this volume). Quite apart from possible deficiencies in the content of the message conveyed to the client-offenders in the Pima County Court Clinic, questions can be raised about the appropriateness of the person(s) giving the message, as well as how and when it is conveyed.

At the Dayton (Ohio) Area Forensic Psychiatry Center, client-offenders are asked to read and sign a form (see Appendix, Chapter 6) indicating informed consent. The form contains information on the purpose of the examination, the referral agent, the lack of confidentiality, and the public nature of the report of the interview. The form is administered prior to the initiation of the clinical interview. At the Psychiatric Services of the Cook County Correctional Complex, all detainees are interviewed using an Intake Screening and Evaluation Form. The examinee is asked to sign a statement indicating his or her acquiescence in the examination for diagnostic and treatment purposes. Both the examiner and the psychiatric caseworker sign the form. The authorization for release of information used at the Cook County complex is unique in that the client-offender is given the right to inspect and copy any information disclosed (see Appendix, Chapter 5). The consent-for-disclosure form used by Pierce County Jail in Tacoma, Washington (see Appendix, Chapter 5) is also unique in several respects. The release is only operative for 90 days or until the final disposition of criminal charges, and is revocable in writing at any time. The federal confidentiality regulations are cited on the prohibition on redisclosure. Another form used by the same facility contains check-off boxes for both the types of information to be released and the purposes for which the information is to be released.

Notification-of-rights forms are used in some forensic facilities. The Center for Forensic Psychiatry at Ann Arbor, for example, uses such a form (see Appendix, Chapter 7) for client-offenders undergoing evaluations of their competency to stand trial and criminal responsibility. The form reveals the purpose of the evaluation and the clinical report to the court, the possibility of court testimony, and the nonconfidentiality of any psychological testing. Space is provided for the client's response to the question: "Do you understand what I have told you and is it alright to proceed with the interview?" The form is signed by the client and a witness.

The Sixth Amendment to the federal Constitution guarantees a criminal defendant the right "to have the Assistance of Counsel for his defense." The landmark decision of Gideon v. Wainwright (1963) interpreted this guarantee as requiring publicly provided counsel for indigent defendants. Today, it is generally conceded that the Sixth Amendment also guarantees an indigent defendant the right to thorough mental health examination to investigate competency to stand trial and explore defenses based on mental abberration (Louisiana v. Bennett, 1977); and that "extraordinary" safeguards may be necessary in cases of incompetency (United States v. Masthers, 1976). In some states this right is guaranteed by statute as well (see Bonnie and Slobogin, 1980, pp. 497-98). The utility of this Sixth Amendment right for an indigent client-offender is vitiated severely by the the tremendous uncertainty

surrounding his or her ability to keep disclosures to the examiner from the court and prosecution. Bonnie and Slobogin state that "the most powerful legal disincentive to full disclosure is the defendant's fear that what he says during the forensic evaluation will be used against him in court." (1980, p. 487)

There is great difference between the mere recognition of a constitutionally grounded right and the realization of such rights in practice. And that is the rub here. Despite the clear relevance of the defendant's Fifth Amendment freedom from self-incrimination, the courts and commentators are in hopeless disagreement over the proper application of Fifth Amendment jurisprudence in forensic mental health screening and evaluation. Four possible uses (or misuses) of the defendant's statements could implicate the Fifth Amendment:

> (1) defendant's statements and admissions may implicate him in the crime charged;
>
> (2) they may implicate him in other crimes;
>
> (3) evidence of his mental condition may assist the prosecution in building its prima facie case by establishing the mens rea element (whether or not the defendant raises an insanity defense);
>
> (4) if the defendant does raise an insanity defense, the examination has forced him to provide the prosecution with evidence that might defeat it. (Meister, 1975, p. 419)

A fifth candidate for this list is the use of defendant's statements in a subsequent hearing to determine whether the death penalty should be imposed in a capital murder case. In Estelle v. Smith (1981) a case where this last scenario occurred, the United States Supreme Court made its first ruling on any of these uses. The suit was brought by a Texas death row inmate, Ernest Benjamin Smith, who challenged a court-ordered examination of competency, performed by the infamous Psychiatrist James Grigson ("They call him Dr. Death," 1981), because the true purpose of the examinations were not disclosed to him. The Supreme Court ruled that defendants subject to the death penalty, when undergoing forensic mental health examination, need protections similar to those granted during police interrogations established in the court's 1966 Miranda decision. The court found that the Fifth Amendment applied because although Dr. Grigson's evaluation had been conducted for the limited purpose of determining Smith's competency to stand trial, "the results of that inquiry were used by the State for a much broader objective that was plainly adverse to the respondent." Under the present state of the law, an indigent defendant seemingly is in a situation where he or she

> must choose between his fifth and sixth amendment rights. If he remains silent, or is cautious about the information he reveals, he may forfeit the adequate evaluation necessary to determine whether he can successfully raise a clinically based defense (Bonnie and Slobogin, 1980, p. 499).

Although the law precludes the use of mental health information obtained in pretrial court-ordered examinations to establish guilt or set the death penalty (cf. Estelle v. Smith 1981), it seems to be conventional practice for attorneys to use information gained in such pretrial examinations in plea bargain discussion and in sentencing hearings. The Forensic Unit of the Peace River Center for Personal Development in Bartow, Florida (see Chapter 6), for example, conducts "preliminary mental screening" for two purposes:

(a) to determine whether more extensive, "full mental examination of incompetency to stand trial or criminal responsibility at the time of the alleged crime might be warranted; or,

(b) to detect mental health problems and recommend treatment.

The public defenders in Bartow often use the latter to acquire information for use in plea bargaining or sentence hearing, even though the information was acquired at pretrial proceedings. Even when a "full" examination of the client-offender's competency or sanity is ordered by the court before trial, the court virtually always follows the recommendation of the examiner (which with few exception is that the client-offender is competent to proceed with trial and was sane at the time of the alleged offense), but uses the information in the extensive written reports only if the client-offender is convicted in the sentencing stage (see Chapter 6).

The possibility of Fifth Amendment implications in court ordered pretrial mental health examinations raises serious and presently unresolved issues for the examiner. As an employer or agent of the court, does the practitioner have to give the defendant the familiar Miranda warnings? And, if so, how is this warning to be given to individuals likely to be unreceptive to a communication due to mental problems? Does the defendant have the right to counsel present during the examination? At least one court, in Gibson v. Zahradnick (1978), has implied that the warnings required by Miranda before police interrogations might also be required before forensic mental health examination (see Bonnie and Slobogin, 1980, Note 210).

Some courts have attempted to avoid these issues by employing a "constructive waiver" or estoppel theory, i.e., that the defendant has waived any Fifth Amendment rights through his act of requesting the examination (see Meister, 1975, 431-38; also, Judge David Bazelon's dissent in United States v. Byers [quoted in Mental Disability Law Reporter, 1981, 5(4), 267]), although at least one recent decision has held that a defendant may not easily waive the privilege against self-incrimination (People v. Parker, 1975). The Supreme Court has set a high standard for any waiver, repeatedly admonishing that the defendant make such waiver knowingly and intelligently. Furthermore, in a Miranda setting, the defendant has the continuing right to revoke his waiver at any time (Miranda v. Arizona, 1966), a point seldom acknowledged in the practice of mental health examination.

This raises several intriguing questions. How does a defendant who may be later found to be incompetent to stand trial make a knowing and intelligent waiver? Similarly, how does any defendant who is ignorant of forensic mental health examination procedures, and thus unaware of the import of his responses, make such a waiver? Finally, how can a defendant under medication or hypnosis revoke his waiver?

Not surprisingly, protection of the defendant's rights vary according to the economics involved. An affluent defendant's statements to a private psychologist retained by counsel are protected by the attorney-client privilege until such time as counsel chooses to submit clinical evidence (see Bonnie and Slobogin, 1980, pp. 497-503; Saltzburg, 1980). Indigent defendants, evaluated by mental health professionals in state forensic units, are offered fewer protections against the prosecution's use of incriminating disclosures of information acquired during the evaluation. This state of the law may very well violate the Constitution's equal protection mandates. Although distinctions based solely on wealth have failed to elicit strict scrutiny by the Supreme Court, when fundamental interests like the Fifth and Sixth amendments are implicated, the state must meet an extremely high burden of persuasion to justify such a legal rule.

As a postscript to the foregoing, one might ask whether there is much of a strawman in the discussion of this issue. Writing, presumably, about all of the Massachusetts clinics established since 1956, Devlin and Russell (Note 2) claimed that "[d]uring the 16 years of court clinics operation there have been no instances of legal issues being raised about the examinations or the reports."

From a broader perspective, one might ask how much the "rule of law" can intrude into the domain of psychiatry, psychology, and sociology in the conduct of the forensic examination process without diluting its effectiveness for the intended purposes. In his widely-read critique of the decision in Tarasoff (Tarasoff v. Regents of the University of California, 1976), Stone (1976), a psychiatrist, warns that "a duty to warn threatened third parties, will imperil the therapeutic alliance and destroy the patient's expectations of confidentiality, thereby thwarting effective treatment and ultimately reducing public safety." Rather than sharing Stone's fear of the destructive nature of the Tarasoff decision, Wexler (1981) strongly hails Tarasoff's "victimological virtues" that may force therapists from an "individual pathology model" to one that focuses on relationships, including that between patient and potential victim.

> In the Structure of Scientific Revolutions,[199] Thomas Kuhn teaches that the toppling of old scientific paradigms, and their replacement by new ones, is often far from a tidy process.[200] If a Tarasoff-type obligation is widely recognized[201] and adhered to seriously, we may experience a particularly unusual process where a rule of law prompts a paradigmatic (or at least a pragmatic) shift in the treatment of interpersonal violence from an intrapsychic model to a model more interactionist in perspective. Perhaps more precisely, Tarasoff may lead mental health professionals to

> practice the paradigm currently resisted but already accepted and preached by the bulk of the scientific and clinical literature. In terms of its overall impact, then, Tarasoff may help rather than hinder therapy, and may well constitute a major victimological victory.202 (Wexler, 1981, p. 176.)

Review and Control of the Case File

Effective mental health diagnoses and the formation of clinical opinions in criminal justice settings depend on the ability of the examiner to acquire information from sources other than the client-offender himself or herself. Bonnie and Slobogin (1980, p. 508) maintain that

> [i]t is impossible to base a reliable reconstructive or predictive opinion solely on an interview with the subject.240 The thorough forensic clinician seeks out additional information on the alleged offense and data on the subject's previous antisocial behavior, together with general "historical" information on the defendant, relevant medical and psychiatric history, and pertinent information in the clinical and criminological literature. To verify what the defendant tells him about these subjects and to obtain information unknown to the defendant, the clinician must consult, and rely upon, sources other than the defendant.

Statutes or court rules may require the transmission of certain documents (i.e., police reports) to the mental health evaluator prior to initiating the examination. Alternatively, legal pronouncements may merely authorize the exchange of documents without mandating receipt prior to an examination. Although disclosure of information gathered pursuant to a court-ordered forensic mental health examination is generally permitted without the consent of the client-offender (see "Model Law on Confidentiality Proposed by APA," 1979), the accumulation of documentary materials unnecessary for addressing the psycholegal question may prove embarrassing or damaging to both examiner and client-offender.

In most states, the use of a client-offender's utterances made during pretrial forensic mental health examinations are generally restricted by the psycholegal question (e.g., competency) at issue , and to the pretrial stages of the proceedings (see the preceding section of this chapter; also, Bonnie and Slobogin, 1980, 497-503). However, similar restrictions are not placed on an examiners access and use of available information about the client-offender and his or her alleged anti-social behavior. Nor are such restrictions, typically, imposed by the examiner himself or herself before the initiation of the examination process. For example, psychiatrist James Grigson, who had evaluated Ernest Smith for the limited purpose of determining his competency in the recent celebrated Estelle v. Smith (1981) case, apparently had no misgivings about applying the knowledge gained for a much broader objective adverse to Smith (i.e., whether Smith met the "dangerous" criteria for a mandatory death sentence).

As we mentioned in the previous chapter and suggested in the model examination process in Chapter 9, too little information available to the examiner before the examination may render the entire process to be imprecise, irrelevant, and useless. But may not too much information lead mental health personnel to inappropriate psycholegal opinions or predictions, or perhaps, unduly prejudice the examination process?

> Proposition 12: Upon receipt of a court order for forensic mental health examination, and before the personal interview with the client-offender, mental health personnel should compile a case file.
>
> Proposition 13: The accumulation of documentary materials and information about the client-offender and his or her alleged criminal behavior should be controlled by the specific psycholegal question. Gathering of unnecessary or irrelevant information (regardless of its reliability and validity) should be prohibited.

Materials compiled in a client-offender's case file may be of various types from various sources. The following listing is illustrative, not exhaustive.

(1) Police reports of precipitating incident.

(2) Arresting officer's description of incident.

(3) Witnesses' statements.

(4) Autopsy reports.

(5) Past arrest records.

(6) Arraignment sheets.

(7) Information forms completed by counselors, intake or admissions officers.

(8) Previous medical, psychiatric, psychological, and social reports.

(9) Reports of penal institutions where client-offender was previously incarcerated.

(10) Booking sheets.

(11) Notes of discussions with referral agents.

(12) Report of emergency room examination.

(13) Previous records held by examining agency.

(14) Financial statements.

(15) Employment records.

(16) School records.

(17) Report of probation officer.

(18) Background information sheet completed by moving attorney.

(19) Notes of discussions with defense attorney.

(20) Reports by other staff members who have previously examined the client-offender.

(21) Notes of consultation with other mental health personnel.

(22) Newspaper accounts of incidents and circumstances involving the client-offender.

It is highly unlikely that all but the most controversial and complex cases would involve the accumulation of all the listed types of information. The typical psycholegal questions do not require access, accumulation, and review of such an extensive file of information. Moreover, the limited resources of most forensic mental health facilitiess do not permit it. Our study of the forensic facilities highlighted in Part III of this book indicated that selective attention to various documentary materials was more likely to be dictated by past practices and convenience than a specific psycholegal question about the client-offender.

Proposition 14: Before the review of the case file by the primary examiner, a mental health professional other than the examiner should inspect and screen all file materials for relevance to the specific psycholegal question, threats to reaching a non-prejudicial opinion on the question, possible embarrassment to the client-offender and examiner, breaches of actual or expected confidentiality, and a betrayal of trust that may need to be established in the personal interview.

At the Forensic Psychiatry Clinic in Charlottesville,

> [o]n the day of the interview, a staff conference is held in order to consult the material compiled by the social worker, the psychologist, and other staff members. The participants identify and explore the range of working hypotheses about the case, and decide what data should be obtained during the interview to exclude or refine these hypotheses. An additional function of this pre-interview conference is the selection of interviewers,261 based on the issues involved in the case and on the social worker's impressions of the client's probable reactions to different types of individuals. (Bonnie and Slobogin, 1980, pp. 515-516)

While it may be difficult, if not impossible, to set general rules for implementing Propositions 12, 13, and 14, it may not be so difficult to make a purposive selection of information to be contained in a case file on a case-by-case basis. Past arrest records, witnesses' statements, and police reports, for example, may have only limited relevance to the question of the client-offender's competency to voluntarily and intelligently enter a plea of guilty. Conversely, school records may be extremely valuable in supportng a psycholegal opinion in response to that question.

The Dayton Center (see Chapter 6) comes close to compliance with Propositions 13 and 14 by requesting via memoranda that referral agents include specific documentary materials according to the type of examination (i.e., competency, advisability of treatment for probation, and so forth) authorized by Ohio statutes. While the accumulation and review of documentary materials is not controlled by the specific psycholegal question(s), the gathering of supplementary information according to evaluation type minimizes grossly irrelevant and unnecessary data in the case file, data that may be used later for other objectives plainly adverse to the client-offender.

Thus far, we have considered only the restriction of access to and accumulation of information in a client-offender's case file before a review of that file by the examiner. Objections were raised earlier to the general practice of unrestricted, often ritualistic and pointless accumulation of information about the client-offender. If nothing else such work seems wasteful, and potentially frustrating to the staff. Of course, on the other side of the coin, the inability of the examiner to acquire relevant information about the examiner from third party sources on balance may be equally frustrating to the forensic mental health examination process.

Proposition 15: Failure in the access to and accumulation of necessary, relevant documentary materials from "third" party sources, before the scheduled personal interview with the client-offender, should be known to the referral agents initiating the request for forensic mental health examination.

It is in the best interests of both the examiner and the criminal justice referral agent to communicate difficulties in acquiring important information about the client offender. Notifications of failure in access to information can initiate assistance from the court and its allied agency, under direct authority of court. Such notification may also allow the court to make appropriate allowances for a continuance of a court date in order to get the needed information. In New York City's Forensic Psychiatry Clinic, collatoral information not already in the files of the clinic or the referring court (e.g., hospitalization or employment records) must be obtained by subpeona. This is a time-consuming process that typically requires a continuance of the court date in order to allow mental health personnel to receive the subpoenead information (see Chapter 4).

Some forensic mental health facilities have instituted procedures that cause the examination process to come to halt when documentary materials relevant and necessary to the case have not been received. New York City's Forensic Psychiatry Clinic will not initiate presentence (probation) evaluations without receipt of a preliminary probation report. The Pima County Court Clinic in Tucson, Arizona will not proceed with an assignment of an examiner to a case, and proceed with the personal interview of the client-offender, until pertinent supporting documents have been submitted by the referral agent. Apparently this procedure is successful in prompting requested documentary materials to be submitted at least one day prior to the scheduled personal interview in over nine out of ten cases (see Chapter 4). The Center for Forensic Psychiatry in Ann Arbor, Michigan will proceed without a police record of the alleged crime, but will not send a report of the results of the examination until such time as the police report is received and reviewed for consistency with the Center's competency report (see Chapter 7).

The Personal Interview

Although it is the least standardized method (cf. Meister, 1975) used in the data acquisition component of the examination process, the personal interview of the client-offender is the mainstay of the process. And, even though the psychiatrists, psychologists, and social workers we interviewed disagreed about the use of psychological tests, social assessments, and other inquiries (see the next section in this chapter), all the examiners we queried indicated that the personal interview is a necessary minimum in all forensic mental health examinations. Most commentators and authors of leading texts on forensic psychiatry and psychology assume that examiners have interviewed a client-offender before testifying about the case (see generally, Bonnie and Slobogin, 1980, Note 204). However, in practice the courts are often willing to accept expert testimony about a client-offender who has never been personally interviewed (see, for example, People v. Bassett, 1968, cited in Bonnie and Slobogin, 1980, Note 204; also, Estelle v. Smith, 1981; "Fifth Amendment Protections in Criminal Psychiatric Evaluations," 1981). Consistent with the model presented in Chapter 9 and with general practice in the twenty forensic facilities described in Part II of this book, the interview should not precede the proper delineation of the psycholegal question, should only be begun after the proper warnings and consents, and should only occur after the examiner has had adequate time to review the case file (see Figure 60, Chapter 9).

Proposition 16: A single one-hour interview with the client-offender, supplemented by a review of the case file, is a sufficient base for reaching a psycholegal opinion in the majority of cases.

Proposition 17: The use of psychological testing, social assessments, and other inquiries beyond the personal interview should be restricted to those cases where a psycholegal opinion cannot be rendered following a personal interview with the client-offender, and only when the examiner has a clear rationale for their chosen focus in that specific case.

The forensic mental health interview differs from the typical "therapeutic" interview in intent and scope, if not in form (see generally, Bonnie and Slobogin, 1980, Notes 220 and 230; Matarazzo and Wiens, 1972; Kahn and Cannell, 1957; Fear, 1973). That is, the forensic interview is an instrument of the criminal justice system; the scope of the forensic interview is also narrowly defined by the legal criteria in the psycholegal question; finally, while the "therapeutic" interview typically results from a voluntary arrangement between the interviewer and patient, the client-offenders who are interviewed are usually not voluntary interviewees in the strictest sense (see Bonnie and Slobogin, 1980, pp 502-508).

As already noted in the previous chapter and in the commentary on the meanings of the terms "process" and "acquiring" in the operational definition in Chapter 2, the specific content, format, style, and length of the personal interview will be dictated by the overt and latent reasons for the referral for examination, the nature and specificity of the psycholegal question posed, the policies and resources of the forensic facility, the nature of the case, the behavior of the client-offender at the time of the examination, and importantly, the background, experiences, and preferences of the examiner. Interviews may vary from highly structured (representing little more than the oral administration of portions of a standardized questionnaire) to nondirective interviews in which the examiner merely encourages the client-offender to talk as freely as possible. As is true, generally, of all clinical interviews, the forensic interview affords the examiner an opportunity for direct observation of behavior manifested during the interview, as well as eliciting the client-offender's rendition of life-history information and the circumstances of important events. The forensic examiner is required to focus his inquiry into one or more of the following areas of the client-offenders mental health: (1) mental functioning and capacity at the time of the examination (primarily relevant to the determination of competency to stand trial); (2) mental state at the time of the alleged offense, including the developmental, psychological, and social history; and (3) potential for engaging in antisocial behavior in the future under various conditions of treatment and confinement (relevant to presentence examinations in the context of disposition decisions).

The typical forensic interview may begin with a few questions and informal discussion designed to build rapport and to allay any noticeable anxieties that the client-offender may harbor. This initial period of the interview may include Miranda-type warnings and consent procedures initiated by the examiner. The interview proper may then continue with a mental status examination, including behavioral observations of the client-observers general appearance, stream of talk, affect, thought content, "sensorium" (orientation, memory, intelligence), insight, and judgement (cf. Gerard, 1974; Lawrence, 1980). The mental status examination is considered a standard part of the psychiatric examination of all mental health patients (American Psychiatric Association, 1980), although its implementation may differ widely across examiners. In addition to the time for building rapport and the mental status examination, the typical interview then proceeds with a series of

questions addressing specific psycholegal questions such as fitness to proceed with trial, criminal responsibility, and sentencing options. The questions may be a part of, one and the same, or interspersed with questions focused on aspects of the mental status examination. The questions set the stage for and encourages the client-offender to tell his or her own account of the alleged crime, for example, in examinations of sanity at the time of the offense. Again, depending on the psycholegal question posed, the examiner's attention may be focused on the client-offender's understanding of the alleged crime and the events surrounding it, present ability to assist an attorney in preparing a defense, or on the potential threats of harm posed by client-offender with or without treatment. The interview may include a number of pointed questions (Why are you here? What happened in the past? When? Are you on medication?) that prompt responses, discussion, and more questions, such as the following posed in one presentence psychiatric evaluation observed by one of the authors in the Pima County Court Clinic (see Chapter 4).

- You know, of course, that you will be sent to prison or placed on probation? What will you do while on probation?
- Are you having problems in jail? Sleeping? Are you hearing voices?
- How is your health?
- Did you have trouble in court?
- Do you know today's date? Time?
- What does "No use crying over spilled milk" mean?
- Where are your folks now?
- How far did you go in school?
- Have you been able to work? What do you like to do?

Although the formal administration of psychological tests is generally shunned by most psychiatrists, and many other mental health personnel, critical questions from the Minnesota Multiphasic Personality Inventory (MMPI) (i.e., those framing problem areas such as depression, suicide, persecution, family discord, and alcohol problems) are sometimes used in the interview. When the referral question concerns competency to stand trial, the clinical interview may include the administration of checklists, tests, or sections of instruments designed to assess competency to stand trial (e.g., the Competency Screening Test). The examiner is also sensitive to special problems that may bear directly on the psycholegal question raised. For example, in determinations of insanity at the time of the alleged crime, the examiner may be particularly alert to voluntary (person was "dead drunk" at the time) or involuntary (punch was spiked with LSD) intoxication with may rule out specific intent to commit the act (mens rea). Delirium tremens, an acute

brain disorder caused by withdrawal from excessive alcohol intake; the Wernicke-Korsakoff syndrome, another alcohol psychosis associated with brain damage and poisoning from alcohol; amnesia; and malingering, the deliberate simulation or exaggeration of mental illness by the client-offender, are other examples of problems the examiner is alert to during the determinations of insanity.

A forensic interview should utilize the amount of time required to formulate a conpetent psycholegal opinion (Rappeport, 1981). However, when asked about the minimum time required for a competent interview the psychiatrists, psychologists, and social workers we queried responded within a range of 10 minutes to two hours, with the modal response being 60 minutes. One prominent forensic psychiatrist indicated that 30 minutes is a sufficient minimum for reaching a psycholegal opinion in 80 percent of pretrial and presentence examinations.

Generally speaking, the time, examiner's effort, and supplementary resources devoted to personal interviews seemed to vary according to the complexity or controversy surrounding the case, the professional discipline of the examiner, and the various professional and academic persuasions of the examiner. Not surprisingly, psychiatrists, psychologists, and social workers, alike, spent more time, effort, and resources in controversial cases. More than one interview with the client-offender, psychological testing, social assessments, and other inquiries (see further in this chapter) were not uncommon in such cases. Resource allocation seemed to vary directly according to the likelihood that the examiner would be required to provide oral testimony in open court, rather than simply submit a written report. As a practical matter, most psychiatrists tended to shun psychological testing, social assessments, and other inquiries to support their conclusions, based on the personal interview with the client-offender and corroborating evidence accumulated in the case file. Understandably, psychologist relied more heavily on psychological testing to support the personal interview. Finally, social workers depended on social history interviews and evaluation of family members, witnesses, and friends of the client-offender to conform inferences drawn from the interveiw (see, generally, Bonnie and Slobogin, 1980, pp. 496-520, and further in this chapter for a discussion of assessments and inquiries supporting the interview.)

Again, generally speaking, examinations of sanity of the client-offender at the time of the alleged crime consistently commanded more time, effort, and resources than examinations focused on other psycholegal questions such as competency to stand trial. The Dayton Center, for example, often required two clinical interviews of a client-offender to evaluate sanity, whereas the issue of competency to stand trial and presentence evaluations rarely required more than a single interview (see Chapter 6). But the differences in the perceived demands posed by the questions of competency and insanity seem to stem less from methodological concerns logically raised by the question, than historical precedence and the varying professional persuasions of the examiners. As we noted briefly in Chapter 9, it may be that greater resource demands are made by the question of insanity because of (1) the

relatively rich history of the insanity defense, (2) the great public interest in exculpation based on mental abberation, and (3) the comfortable fit between the insanity question's focus on past events and the backward-looking approach that may be taken by examiners trained in depth psychology and dynamic psychiatry. On the last point, Bonnie and Slobogin (1980, p. 512-415) state that a "person trained in psychoanalytic theory, for example, may be attuned to different symptoms and may interpret the same symptoms differently than a behaviorist." At least one commentator has questioned the differential professional attention paid to the competency and insanity issues.

> The question of competency to stand trial has grown out of the common law. The three-pronged test encompasses the accused's capacity (1) to understand the nature and purpose of the proceedings against him, (2) to comprehend his condition in reference to such proceedings, and (3) to assist counsel in preparing his defense.[4] This determination involves many more psychiatric combinations and permutations than appear to confront the examiner in estimating the presence of insanity and the capacity to appreciate the criminality of the accused's conduct. In the competency determinations, for example, a gradation of emotional reactions occurs, ranging from a minor depression to catatonic regression. In insanity examinations, one may find a continued mental illness, paranoid schizophrenia, a paranoid state, organic brain syndrome, or mental deficiency. On the other hand, the conditions that bring about incompetency to stand trial usually are briefer episodes, thus illustrating the ego stresses attending the prospect of imminent conviction and eventual punishment. Since such ego pressures are often related to guilt feelings of which the accused is not aware, these emotional states may cover the whole scale of human reactions. (Bomberg, 1979, pp. 89-90)

Psychological Testing, Social Assessments, and Other Inquiries

The model forensic examination proposed earlier in Chapter 9, as well as Proposition 17 in the preceding section of this chapter, restricts the use of psychological testing, social assessment, and other supplementary inquiries to after an initial personal interview has been completed, and to circumstances where the examiner is unable to reach a psycholegal opinion without such inquiries. We contend that the examiner should be able to present rationale justifying such additional inquiries that clearly links the chosen inquiry method to the unresolved psycholegal issues impeding the formulation of a psycholegal opinion. This proposition is consistent with Recommendation 3 and the supporting reasoning of the Task Force on the Role of Psychology in the Criminal Justice System (1980):

> Other than for legitimate research purposes, psychological assessments of offenders should be performed only when the psychologist has a reasonable expectation that such assessment will serve a useful therapeutic or dispositional function. . .

> Such assessment-without-disposition-function, when not done for legitimate research purposes . . . constitute an unethical intrusion into the lives of offenders and an unprofessional squandering of limited psychological resources and limited public funds. Perhaps most objectionably, they give the illusion that psychological services are being provided to offenders and thus serve to legitimate aspects of the criminal justice system that are in serious need of reform.(pp. 7-8, emphasis deleted)

In the same document in which the above recommendation appeared, Brodsky (1980) put the matter more colorfully:

> When they exist for their own sake, such psychological assessments can be ritualistic and pointless. In (prison) reception and diagnostic centers, these assessments have been described as boring, repetitive and frustrating to the staff, an Edsel-like flop for the system and a disservice and waste of resources for all involved. (p. 65)

In the forensic mental health facilities we studied, psychological testing, social assessments, and other inquiries, when they were used at all, were always used to confirm inferences made on the basis of a personal interview. We never actually observed, nor were we informed of, the use of such inquiries to reach a psycholegal opinion in the absence of a personal interview. Given this primary support function for these inquiry methods, their highly questionable validity for making legal determinations (see further in this section), and the use of the interview as the centerpiece in general pracatice, it seems wasteful (at the least) to use these methods before and in the absence of justifications bases on the personal interview with the client-offender.

This may seem obvious, but it was not so in our observation of practice. In several of the facilities we studied the timing and rationale of use of inquiries other than the interview suggested by Proposition 17 were not followed. For example, upon arrival at the place for examination in the Nashville, Tennessee Sheriff's Office (see Chapter 5), a psychometrician (masters-level psychologist) first administers the Minnesota Multiphasic Personality Inventory (MMPI), the Wechsler Adult Intelligence Scale (WAIS), and, frequently, other instruments such as the Rotter Incomplete Sentence Blank and the House- Tree-Person Drawing Technique. A personal interview conducted by a consulting psychologist followed the administration of the psychological tests; and, this interview may have prompted another interview (in about 15 to 20 percent of the cases) with a consulting psychiatrist. For another example, shortly after arrival at the Pima County Court Clinic (see Chapter 4), and before a scheduled personal interview, client- offenders scheduled for forensic mental health examination are routinely given several psychological tests and are asked to complete a 40-question form eliciting biographical information. In both of these cases, there seemed to be little evidence of a systematic reliance on, and a clear rationale for, psychological test results in the formation of the psycholegal opinions. (See Chapter 9 for further discussion of this point.)

Psychological tests are used primarily for determination and analysis of individual differences in general intelligence, specific aptitudes, vocational fitness or preference, and personality traits (see, generally, Anastasi, 1976; Freeman, 1962). The value of psychological testing in legal settings has long been recognized by mental health workers and criminal justice practitioners alike (cf. Parker, 1980). Generally speaking, a battery of psychological tests may be administered to assess intelligence, cognitive, and perceptual functioning, as well as to confirm judgments based on the information in the case file and the personal interview. Frequently used tests in legal settings include the Wechsler Adult Intelligence Scale (WAIS), the Bender-Visual Motor Gestalt Test, the Rorschach Test and projective drawing techniques, the Color-Form Sort, and the Thematic Apperception Test (TAT); also used may be the Minnesota Multiphasic Personality Inventory (MMPI), the Rotter Sentence Completion Test, the Quick Test of Verbal Ability, the Object Relations Technique, the House-Tree-Person Test, the Draw-a-Person Test, the Lawrence Mental Competency Test, the Legal Dangerousness Scale, and the Competency Assessment Instrument. Vocational tests may also be administered. Finally, staff conferences may be held to integrate the information obtained. The forensic examinations in court clinics, jail mental health services, and most other forensic facilities typically includes the use of psychological in testing in terms of policy; our impressions are, however, that the policy was far from being implemented in practice in the forensic facilities we studied.

Table 10 lists the psychological tests that were noted by mental health personnel to be in use in their facilities. Unfortunately, we were unable to observe the actual administration of these instruments except in a few instances, much less make a reliable assessment of frequency of use. However, on the basis of interviews with the mental health personnel in the forensic facilities, and a review of available documentary materials, we came to the impression that psychological testing was much more a matter of policy than practice. When it did occur, it was often ritualistic and pointless (to use Brodsky's words, see above), serving no legitimate psycholegal determination.

The tests in Table 10 are listed roughly according to the frequency with which they were represented in policy statements, mentioned by mental health personnel during interviews, or seen by us during our study of the twenty forensic mental health facilities described in detail in Part II of this book. The MMPI was by far the most popular test, represented in fourteen of the twenty facilities, reflecting a general popularity enjoyed by the MMPI in classifying criminal offenders for some time (see Megargee and Bohn, 1979). The Bender, the WAIS, and inkblot tests were represented in half of the facilities studied. Figure drawing techniques, the TAT, and incomplete sentences techniques were in evidence in a quarter to one half of the facilities. The remainder of instruments listed in Table 10 were noted in no more than two of the facilities we studied.

Some forensic mental health facilities rarely administered psychological tests as part of their forensic examination procedures, relying totally on the clinical interview, notwithstanding those

Table 10

Psychological Tests Used in Forensic Mental Health Facilities

Minnesota Multiphasic Personality Inventory (MMPI)
Bender Visual-Motor Gestalt Test
Figure Drawing Tests[a]
Thematic Apperception Test (TAT)
Inkblot Techniques[b]
Incomplete Sentences Techniques[c]
Wechsler Adult Intelligence Scale (WAIS)[d]
Wechsler Intelligence Scale for Children (WICS)
General Aptitude Test Battery (GATB)
Revised Beta Examination
Stanford-Binet Test
Raven Progressive Matrices Test
Slossen Intelligence Test
Wide Range Achievement Test
Quick Test of Verbal Ability
Peabody Picture Vocabulary Test
Memory-for-Designs Test
Goldman Memory Test
Benton Visual Retention Test
Halstead-Reitan Neuropsychological Battery
Luria-Nebraska Neuropsychological Assessment
Mooney Problem Check List
Sixteen Personality Factor Questionnaire (16PF)
Fundamental Interpersonal Relations Orientation-Behavior

a Includes a variety of projective tests in which client-offenders' produce drawings on blank sheets of paper (see Parker, 1980; Anastasi, 1976); e.g., Draw-A-Person, Draw-A-Family, House Tree, and Goodenough Draw-A-Person.

b Includes the Rorschach and the Holtzman Inkblot techniques.

c Includes both projective methods (e.g., the Rotter Incomplete Sentences Blank) and the Competency Screening Test (Lipsitt, Lelos, and McGarry, 1971).

d Includes use of abbreviated scales (see Anastasi, 1976, p. 249).

psychiatrists and legal scholars that argue that it is extremely difficult, if not impossible, to base a reconstructive or predictive clinical opinion solely on an interview with the client-offender (see, for example, Sadoff, 1975; Pollack, 1975; and Bonnie and Slobogin, 1980). The policy of the Center for Forensic Psychiatry is that psychological testing is rarely essential to formulating an opinion about a client-offenders competency to stand trial. Although such psychological consultation is not discouraged in the course of evaluations to assess criminal responsibility or diminished capacity (see Chapter 7). Other facilities either routinely administered a battery of tests, or did not discourage extensive psychological testing in their policies. The Pretrial Branch of St. Elizabeths' Division of Forensic Program (see Chapter 7) may include any of fourteen tests in their forensic examinations. Similarly, the Dayton Center (Chapter 6) and the Pima County Court Clinic (Chapter 4) each use ten or more of the tests listed in Table 10, according to their policy statements and statements by their staff.

However, as we indicated in Chapter 9, most of the mental health personnel we interviewed expressed confidence in their ability to reach a psycholegal opinion based solely on the review of the case file, containing accumulated documentary materials, and their personal interview of the client-offender in most cases. The need for further data collection, they said, arose from uncertainty or unanswered questions during the interview. Suspecting mental retardation from the responses of a client-offender during a personal interview, for example, the examiner may request the administration of an intelligence test to support the hunch. Or, suspecting malingering by the client-offender, the examiner may administer the validity scales of the MMPI which assess malingering or faking (see Anastasi, 1975, p. 498), or the examiner may ask a colleague to do another interview. But, in sum, the routine administration of psychological tests and other inquries in the absence of questions or uncertainty arising in the personal interview seems to be an unjustified misuse and waste of resources. Even if the testing results are actually used, efficiency that may be gained by routine psychological testing hardly seems to outweigh the intrusion into the lives of those client-offenders whose test results are not used, and the squandering of professional resources (see Task Force on the Role of Psychology in the Criminal Justice System, 1980, Recommendation 3, pp. 7-8).

In addition to the personal interview and psychological testing, assessments of the social history of the client-offender are frequently part of the forensic mental health examination. Such assessments are typically initiated in the delineation component of the examination process, as historical information about the client-offender is accumulated (see Figure 60, Point 4, p. 576); they are continued as the examiner reviews the case file (Figure 60, Point 6) in the acquisition component. Also, but only when conducted before sentencing for the purpose of assisting the sentencing and disposition process (and not pretrial examinations), interviews of the client-offender typically conducted by a social worker become central to the examination process; i.e., they take the place of the personal interview of the

client-offender by a psychiatrist or psychologist. Perhaps, the restriction of presentence evaluation to where a personal interview with a client-offender by a social worker is the centerpiece of the examination process, is due to statutory limitations on social workers' expert testimony in adversary proceedings and a tradition of social worker involvement in probation departments (see Roth, 1980). In cases in which it <u>is</u> the centerpiece, the earlier discussions about the personal interview apply, we believe. In the case where social assessments are only supportive of the inferences based on the personal interview, and not necessarily based on evidence already in the client-offender's case file, they should probably be restricted in the same manner as that proposed for psychological testing.

Social assessments in the criminal setting are fairly standard, and similar to the social histories compiled in other mental health and social services settings. The major difference between forensic mental social assessments and those assessments conducted in other settings are the inquiries into the following areas:

(1) alleged offense;
(2) legal history;
(3) criminal record; and
(4) childhood anomalies (e.g., cruelty to animals, enuresis, and arson)

Typically conducted by a social worker, a social assessment compiles a variety of psychosocial data on the client-offender. A personal interview conducted by a social worker is usually one to two hours in length. During the interview, the client-offender is often asked to name one or two persons who the social worker could contact to corroborate the social history told by the client-offender. ("They are not," stated one New York psychiatrist, "the world's greatest historians.") The contacts are usually family members, but may also be a family, doctor, minister, or friend. This verification is usually done by telephone, but the social worker may elect to meet with the persons in his or her office or the person's home.

While the personal interview, psychological testing and social assessments are the most common elements of the acquisition component of the examination process, other inquiries are sometimes undertaken. Such additional data collection raises the following questions: To what extent are these additional inquiries necessary to answer the psycholegal questions delineated by the court? Do the added resources justify the additional cost? How long do these additional procedures take? Will they delay the criminal proceedings? Is it necessary to place the client-offender in an inpatient facility to complete all the testing?

<u>Validity, Reliability, and Ethics</u>

In practice, what are the assurances of validity, reliability, and ethics of data acquisition and the formation of the psycholegal opinion in the forensic examination process? The mental health workers we interviewed seemed to be in general agreement (implicitly, if not

expressly) with the following proposition which relies greatly on the theoretical and empirical analysis of competency to stand trial by Roesch and Golding (1980, see especially, p. 11-12).

> Proposition 18: To infer competency, sanity, amenability to treatment, or any other psycholegal condition is to engage in complex judgements that are dependent upon the facts and context of the particular case, but are not completely reducible to a set of rules about those facts and context.

Jurisdictions differ with regard to the specific legal tests for insanity, incompetency, diminished capacity, bail risk, and so forth. These tests are designed to specify what type (and in some sense, severity) of mental condition that needs to be shown to render the person insane, incompetent, diminished, or constituting risk. The most important purpose of psychological tests, personal interviews, and the other evaluation procedures is to show the presence of the mental aberration in sufficient degree, to meet the legal tests. The elasticity of the terms used in defining the legal tests and the laws interpreting the legal concepts involved, make it difficult for mental health workers to achieve a goodness of fit between legal and psychological tests. In a footnote to their analysis of competency to stand trial, Roesch and Golding (1980) equate the examination of competency to stand trial with construct validation in testing (see Anastasi, 1976). Their analysis, we think, applies equally well to the determination of other psycholegal questions.

> [T]he very assessment techniques employed by the courts and their agents must mirror steps involved in the establishment of "construct validity." Briefly, this means that multiple sources of consistent and converging evidence must be sought to assert a defendant's incompetency. Thus incompetency could not be equated with amnesia per se, or a particular conclusory statement, or a low score on a particular test. Furthermore, given the functional nature of the construct of competency, the "facts to be sought" will be highly dependent upon the particular case. (1980, p. 43, Note 4; emphasis in original)

Typically, examiners can cite an extensive catalog of historical facts, scores, and impressions they deem important in whatever assessment and instruments they use, but they are consistently unable to give clear rationales for their chosen focus. One might argue that not only should the acquisition component be scrutinized in terms of its technical measurement characteristics but also in terms of its potential social consequences (see Messick, 1980).

No doubt, in the day-to-day practice of forensic mental health the technical and ethical questions interact. Robert Michaels, Barlie McKee Henry Professor and Chairman of the Department of Psychiatry at the Cornell University Medical Center, spoke to this issue in characterizing how psychiatrists and lawyers are trained (see Note 3). He claimed that psychiatrists (and lawyers, one can assume, although he did restrict this portion of his commentary to psychiatry) operate on the principle of

"professional consensual validation"; that is, they operate not from the question "what is the truth here" but from "how does this follow the profession's rules for practice?" Professions make the moral and ethical decisions--the professionals only make the decisions regarding whether the thing examined can be placed in the category bounded by the profession. That is, the issue for the professional is one of reliability within the profession, not validity.

The issue turns on the answers to two simple questions: First, is the test, procedure, or technique any good as a measure of the characteristics (competency, culpability, and so forth) it is interpreted to assess? Second, should it be used for the proposed reasons in the proposed way? The first question is a technical one, the second an ethical one.

We discovered very little evidence of any attention to the first question in the twenty forensic facilities we studied. Our impression is that those responsible for administering psychological tests, for example, seemed to make the tacit assumption that, while few of the tests were validated for legal determinations, they may be helpful in corroborating the determinations made during the personal interview. The reliability, validity, and ethics of determinations based on the personal interview seemed beyond questioning, except as discussed earlier in this chapter under "Warnings, Consents, and Confidentiality." The attitude of those psychologists, psychiatrists, social workers, and other mental health workers we interviewed toward the concern addressed by the second question--the importance of taking into account the ethics and value implications of the assessment techniques used--maybe (albeit, somewhat harshly) reflected in the cynicism of one psychologist's proposal for a model forensic examination process: "If he knows his Zip code he's competent. And, depending on the place corresponding to the Zip code, he's sane."

The Qualifications of Forensic Mental Health Personnel

Which of the traditional forensic mental health disciplines--psychology, psychiatry, and social work--and which combination of training experiences best equips a forensic mental health worker to conduct the forensic examination process? This chapter concludes with a brief discussion addressing this question of staff qualification. (For the working definition of "mental personnel" see Chapter 2.)

Although there has been and continues to be much debate on the issue, there appears to be no clear script for the roles of mental health professionals in the criminal process (see, generally, Perlin, 1980; Saltzburg, 1980; Halleck, 1980). In concluding their article on the role of mental professionals in the criminal process, Bonnie and Slobogin share the concern of critics of the forensic mental health specialist (e.g., Morse, 1978a, b).

> [W]e are troubled by the poor quality of much clinical testimony which seems to rely more heavily on the assertion of

> Aesculapian authority than on proven expertise. If clinical testimony, in the aggregate, is to enlighten rather than confuse or obstruct the administration of criminal justice, the courts will need to pay greater attention to the qualification of expert witnesses than is now ordinarily the case. In doing so, they can be much benefited by the developing efforts of the mental health professions to clarify the requirements of forensic specialization and to formulate specific methodological and ethical requirements for the forensic discipline (Bonnie and Slobogin, 1980, p. 494).

The task force of the American Bar Association's Standing Committee on Association Standards for Criminal Justice has taken up the issue in a provisional outline containing the following components: the proper role of mental health professionals, the assessment of adequacy of interdisciplinary intercommunication, and interaction, the assessment of responsibilities of mental health institutions, the professional responsibility in performance standards, interdisciplinary training/problem solving, and finally, joint ventures to promote understanding, achieve fiscal support and legislative reform (see Note 4).

> Proposition 19: Although compliance with statutory regulation is obviously necessary, the most important consideration in the assignment of mental health personnel to steps and components of the process of forensic mental health examination is the fit between staff expertise and specific task requirements.

As was reported in Chapter 3 (p. 40), psychiatrists, psychologists, and social workers are the professional groups predominantly involved in the forensic examination process. Traditionally, the law has welcomed participation first and foremost by psychiatrists, second and more recently by clinical psychologists, and third, by social workers but only on a limited basis usually in determining sentencing alternatives.

The laws of most states have traditionally, however, bestowed their invitation largely with regard to expert testimony in open court and not participation in the examination process short of testimony. The thrust of the foregoing proposition is to encourage those responsible for hiring decisions and allocation of staff resources to be less thwarted by legal requirements and more creative in their interpretation of those legal requirements, and the subsequent assignment of staff. Would the courts balk, for example, at the receipt of a competent evaluation report signed by two examiners, only one of whom was legally qualified to perform the evaluation, assuming close and conscientious supervision by the formally qualified examiner of the other who did most, if not all, of the work? We think not, given a high quality in the reporting process and the availability of qualified examiner for testimony, if he or she were called. It may be that the legal system is less receptive to such a procedure when instituted by "outsiders" (see Haney, 1981). However, the precedents for such a distinction between those relatively invisible individuals who do much of the work, and those visible individuals accountable for its application, clearly exist in the preparation of cases in law firms and in the drafting of judicial opinions in the courts.

Notes

1. Comment made by William Tucker during a panel discussion entitled "Ethics of the Court-Ordered Psychiatric Examination." Summarized in the Newsletter (1981, Vol. 6, No. 1, p. 7) of the American Academy of Psychiatry and the Law (AAPL).

2. Devlin, J.M. and Russell, D.H. All About the Massachusetts Courts Clinic Program. The Commonwealth of Massachusetts Department of Mental Health. Division of Legal Medicine (190 Portland Street, Boston, Massachusetts, 02114), 1972.

3. Michaels, R. Professional Education and the Resolution of Ethical Conflicts—How We Train Psychiatrists and Lawyers to Avoid Good and Evil. Presentation at a Conference of the American Academy of Psychiatry and the Law (Tri-State Chapter), New York City, January 17, 1981.

4. Criminal Justice Mental Health Standards Projects. Provisional outline of task force: Substantive issues. American Bar Association Standing Committee on Association Standard for Criminal Justice, February 1981. The Criminal Justice Mental Health Standards Project is an American Bar Association Criminal Justice Improvement Project begun in January 1981 and funded by the John D. and Catherine P. MacArthur Foundation.

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Chapter 12

PROVISION OF INFORMATION

For every fifteen minutes psychiatrists, psychologists, and social workers testify as expert witnesses in open court, they may spend an hour or more in preparation and review of a written report that documents the content, conduct, and consequences of a forensic examination of a client-offender. The courtroom testimony is only the visible tip of the iceberg that constitutes the provision to criminal justice authorities of information gained by mental health personnel as a result of the forensic mental health examination process. No doubt, it is the courtroom presentation that attracts newspaper headlines, especially when the outcome of a controversial case--for example, that of Dan White who was exculpated for the execution-style slaying of San Francisco Mayor George Moscone and Supervisor Harvey Milk--turns on the dramatic testimony of several mental health experts. But in most cases, testimony is, or should be (cf. McGarry and Curran, 1980), based on a written report. In fact, most involvement of mental health personnel in legal proceedings ends with the provision of a written report to one of the adversaries in the dispute, the court, a law enforcement or corrections agency (cf. McGarry, 1980). This chapter will expand on the definition of "provision" in Chapter 2 and the representation of the steps of the provision component in the model forensic examination in Chapter 9. Additionally, a number of propositions specific to the provision of information to criminal justice referral agents will be presented.

The Medium and Timing of Communications

Information acquired about a client-offender by mental health personnel can be communicated to criminal justice authorities in a formal written report, by informal messages conveyed in writing or by telephone, by courtroom testimony, or some combination of these. The timing of testimony is typically controlled by legal proceedings, i.e., mental health workers appear in court when asked. Our focus in this section will be on the timing of the provision of written reports and informal messages about client-offenders.

Proposition 20: The provision of psycholegal information to the criminal justice system should accommodate legal proceedings, not impede them.

Having received a request for the forensic mental health examination of a client-offender, the facilities we studied usually accomplished the steps required for examination, including the provision of information back to the referral agent or agency, within a timeframe controlled by policy or practice. Of course, whatever timeframes were used, they could be altered to suit the peculiarities of a particular case, e.g., an unanticipated hearing scheduled at the last minute or a delay in receipt of results of laboratory tests. Nonetheless, the general timeframes for the accomplishment of the steps of the examination process from receipt

of the referral request (see Figure 60, Point 4) to the provision of information (Point 13) varied considerably across forensic facilities, even among similar types of facilities. The Pima County Court Clinic in Tucson, for example, accommodates the examination process within a five-day timeframe; the Medical Service of the Supreme Bench of Baltimore City, on the other hand, allows 30 days for completion of the process (see Chapter 4). Our impressions are that neither the differences in the steps of the examination process, nor the rigour with which the steps are taken (we did not evaluate the latter) in these court clinics, justify the different timeframes. Given that most forensic examinations, at least that portion encompassed by the acquisition component as we conceive it, rarely takes more than an hour or two, excluding preparation, dictation, and review of a report (cf. McGarry, 1980, p. 740), one might question whether differences in the timeframes are not more a matter of administrative convenience than concerns for completeness and quality. One New York judge we interviewed who was concerned with just this issue contended that the psychiatrists to whom he made referrals for mental health examination raised havoc with his case calendar because they had a "fetish for quality."

The timing of informal communications between the examiner and criminal justice authorities bears brief discussion. In the preceding chapter we touched upon the necessary attention that must be paid to the content of communications bearing on issues of privacy, confidentiality, and the rights of the client-offender. These issues arise in the timing of informal communications as well. In most of the facilities we studied, mental health personnel frequently communicated informally with criminal justice referral agents long before a formal report was submitted. This may occur, especially, during the accumulation of documentary materials in the delineation of the psycholegal question (see Chapter 10) and during the review of the case file (see the previous chapter), but may occur as readily as someone picking up a telephone at any point in the examination process.

How much access should criminal justice agents have to psycholegal information about client-offenders before the completion of the examination process and before the submission of a written report? To what extent do such communications preempt the written report? To what extent do such communications accommodate the latent purposes of a referral, e.g., acquistion of information for plea bargaining (see Chapter 10, p. 599)?

These are not easy questions. There is no substitute for intelligence, clinical competence, and knowledge of the law and legal proceedings on the part of the examiner. Obviously, inappropriate questions raised by a prosecution attorney long before the examination is completed (e.g., "Is he crazy, Doc?" "They're not going to be able to raise the insanity defense, are they?") are easy to ward off. More difficult, are legitimate questions raised by attorneys, judges, probation officers, and other criminal justice referral agents during the course of the examination process; for example, subtle questions about the viability of an insanity defense that may be raised by the client-offender's defense attorney during a telephone conversation which

was initiated by an examiner in preparation for an examination of competence to stand trial.

Either extreme, i.e., the prohibition or total allowance of all informal communications between mental health personnel and criminal justice authorities, seems indefensible on logical and practical grounds. Unfortunately, we cannot offer viable alternatives between those extremes except to urge an awareness of the importance of such informal communication among those involved with the examination process.

Accommodation to the Legal System

Proposition 21: Written reports and other communicatins to the court should accommodate the practical needs of the criminal justice system in content and form.

Ten to twenty years ago, many commentators were less than charitable in their appraisal of mental health professionals' participation in the legal process (Hess and Thomas, 1963; Vann and Morganroth, 1965; McGarry, 1965; Wexler and Scoville, 1971; Rosenberg and McGarry, 1972). Much of their criticism was based on a negative assessment of the testimony and the written reports of psychiatrists and other mental health personnel. They found that mental health personnel were very often ignorant of or inattentive to legal criteria or tests; they confused mental health and legal terms; they failed to address the psycholegal questions raised by the referral agents; and, they explained behavior and motives in psychodynamic language largely irrelevant to criminal justice. Years later, our impressions are that such criticism, leveled at the written reports produced by the facilities we studied, would be less justified. In our interviews with hundreds of forensic mental health personnel, we were positively impressed with the overall knowledge among psychiatrists, psychologists, and social workers. No one we spoke with, who was closely involved in the examination process, for example, confused competency and insanity--something that could not be said of the legislators who drafted some of the states' mental health laws (see Chapter 10).

In general, the many reports we were able to review in twenty forensic facilities conformed fairly well to the guidelines for preparing formal reports that have been outlined for mental health personnel in recent commercial publications (e.g., Bromberg, 1979, pp. 33-37; Lawrence, 1980; McGarry, 1980), unpublished manuals (e.g., the "Report Writing guide" distributed to Ohio's Community forensic mental health centers by the Association of Ohio Forensic Psychiatric Centers Directors [see Chapter 6, pp. 269-277]), and in regional and national conferences. Reports typically contained the required elements of identifying information, circumstances of the referral and psycholegal question as understood by the examiner, the client-offender's family and personal history up to and including the time of the offense, psychiatric and psychological data, findings, and psychological conclusions or recommendations.

The following common "errors" were found in many reports but not to the degree and frequency we had expected to find them: irrelevant,

extraneous information; conflicting information; unsupported conclusions; equation of psychosis and insanity; seeking a "just outcome" rather than applying specific legal tests; and, use of jargon. In sum, major shortcomings in the provision component's accommodation to the legal system were generally not in the content of written reports. One would like to think that the rivers of ink, mountains of printer's lead, and forests of paper that Morris and Hawkins (1970) complained of being used in writings on mental health and the law recently have had a positive effect on this.

In our view, difficulties in the provision component of the examination process were not in the content of the messages but in the format, length, language, style, mode of transmission of the messages, and in the seemingly legitimate differences in interpretations of such issues as what constitutes conclusory language. We will touch upon these difficulties briefly.

Should evaluation reports be written in conclusory legal terms or be limited to the terms and language of the mental health professions? Some critics of clinical methodology in the criminal process take the extreme position that mental health personnel should not be permitted to offer clinical opinions as expert witnesses at all. Although they do not believe that the participation of mental health professionals in the criminal process should be curtailed--in fact, they believe that the well-trained clinician has much to offer, Bonnie and Slobogin (1980, p. 429) characterize the position critical of the mental health professional as an expert witness as follows:

> The essence of the claim is that reconstructive and predictive issues can be decided by laymen on the basis of common experience, and that the "expert" has so little "knowledge" reaching beyond every day experience that his participation in the adjudication is highly misleading and should be circumscribed severely.

Morse (1978) has proposed the exclusion of clinical opinion altoghether, leaving the clinical expert only a descriptive role. Morse would exclude any testimony by diagnoses, contending that the diagnostic concepts are not reliable or accurate.

In response to Thomas Szasz's comments about psychiatry's intrusions into criminal process (see September 1980 Newsletter of the American Academy of Psychiatry and the Law), Seymour Halleck agreed with Szasz that psychiatrists should not give opinions in conclusory terms during testimony in court.

> By this I mean that the standards for determining most of the issues psychiatrists testify about are legal ones. A psychiatrist cannot determine scientifically if anyone knows right from wrong, if anyone is capable of maturely and meaningfully reflecting on his acts or if anyone knows his obligations to society, other people, and the law. These, as well as issues of competency, and issues of dangerousness under

> commitment statutes are issues of law, and the psychiatrist's only function in the courtroom should be to provide information which the judge and jury might wish to use or not use in making a legal decision.

Conclusory allegations by nonjudicial personnel have long been legally taboo (Aguilar v. Texas, 1964; Spinelli v. United States, 1969). An expert witness is prohibited from giving his or her opinion on applicable law because the definition and interpretation of the law is the exclusive responsibility of a trial judge. A mental health examiner can offer his or her opinion on the mental condition of the client-offender, and thus embrace the ultimate legal issue (i.e., criminal responsibility, competency, and diminished capacity), but is prohibited from explaining the meeting of legal standards. The Michigan Court of Appeals held in People v. Drossart (1979) that ". . . a witness' legal opinion on the issue of insanity is both incompetent and irrelevant. It is incompetent because the opinion of a medical expert on the correct legal standards of criminal responsibility is outside the range of the witness' expertise in the field of mental diseases. It is irrelevant because it is not 'otherwise admissable' under our rules of evidence." Further, in the words of the Court in the same opinion,

> A witness may not give his opinion as to what law is applicable in a given case but may, of course, testify to the facts relevant to the applicable legal principles. Also, where the legal criteria are adequately defined by the questioner or the trial court . . . so as to be correctly understood by the jury, the witness may properly phrase his opinion in terms of some familiar legal standard. McCormick, Evidence § 12, pp. 28-29. Generally, the witness should state his opinion of the defendant's mental condition in his own language and by such ordinary and professional forms of expression as will best convey his own ideas of the matter. Still, if, in expressing his ideas and opinion on the matter, the witness refers to legal standards properly explained by the trial court or examining attorney, there can be no danger of usurping the role of the trial judge to deal with questions of law.

In Washington v. United States (1967), Judge David Bazelon prohibited psychiatrists from testifying in conclusory terms about whether an alleged act or acts were a "product" of mental illness in the Durham-McDonald test for insanity. Such conclusory testimony would usurp the jury's function.

While the letter of the law does not seem crystal clear on this matter, the advice to mental health workers providing expert testimony seems to be clear, if not easily heeded in practice: Phrase opinions in such a way that the jump to legal conclusion is a short one, without making the jump yourself. The Forensic Psychiatric Clinic in Virginia seems to heed such advice when they recommend in their "Guidelines for Written Report" (unpublished) that a conclusion such as, "The defendant is presently competent," is a judicial determination of fact and should not be made in a report. But, if the same phrase is preceded by "In our professional opinion" it becomes non-conclusory and permissable.

Although the complexities of the interactions between the mental health and criminal justice systems often seem overwhelming, significant improvements in forensic mental health screening and evaluation need not await major reforms in mental health law. Nor do attempts at improvement necessarily need to confront head-on the idealogical or theoretical differences between the legal profession and the helping professions.

Proposition 22: A quality assurance review board consisting of mental health and criminal justice personnel should make periodic evaluations of forensic mental health reports, as well as other matters pertaining to communication between the two systems.

The provision component of the forensic examination process can be improved in similar fashion as that described earlier in Chapter 10 with reference to delineation of the process. In many jurisdictions it is only by chance that mental health examiners successfuly respond to the referring agents' specific needs. Mental health personnel can easily convey to judges, attorneys, and probation officers the nature, capabilities, and limitations of the screening and evaluation process, thereby developing a common set of expectations for the production of the written report. Format, length, language, style, and mode of transmission of the report all become negotiable once the expectations are set. A simple reorganization of the paragraphs in a typical report such that the examiner's pithy conclusions and recommendations are presented first, rather that at the end of lengthy report, for example, may make the difference between a report judged to be thorough, and one judged to be verbose and one providing information overkill.

To what extent, and under what circumstances, could and should written mental health evaluation reports supplant courtroom testimony by evaluators? Mental health personel, researchers and practitioners alike, are relatively uninformed about how criminal justice authorities utilize evaluation reports in practice. It seems that the two groups of professionals rarely communicate about the services they exchange, except for perhaps an occasional, informal telephone call from a judge seeking clarification of a written report. The more thorough and understandable the written evaluation report provided to the court is, the less likely it may be that the evaluator is subpoenaed to testify. In fact, a measure of the effectiveness of forensic mental health evaluation may be the ratio of written reports acceptable to the court to the number of requests for courtroom testimony by psychologists and psychiatrists. Laban, Kashgarian, Nessa, and Spencer (1977) discuss such a measure in their assessment of mental health evaluations of competency to stand trial.

Feedback and Quality Control of the Provision of Information

As we will discuss in the final chapter, the most effective regulation of the flow of information and feedback regarding quality of the provision component, in our judgement, is that initiated internally by the forensic mental health facilities--first on an individual basis and then, perhaps, on an agency-wide basis. Regulation, program

monitoring, and program evaluation from the top down and from external sources seems less likely to offer substantive and practical guidance. The results of the telephone survey described in Chapter 3 (see especially pp. 44-48), confirmed in on-site interviews, indicate that most mental health personnel are totally unaware of program evaluation efforts that may have been conducted by individuals outside of the core of forensic health personnel who are directly involved with examinations of the client offenders on a regular basis, despite the existence of a considerable number of relevant program evaluation efforts, albeit in the "fugitive" literature (see Chapter 3, p. 45). When the existence of program evaluations was known, the results were typically not accessible or, if accessible, not used. (See, also, the last section of each of the twenty descriptions of forensic mental health facilities in Part II.) The type of program quality review by committee, suggested in Proposition 21, that is initiated internally and involves immediate, direct feedback to both criminal justice authorities and mental health personnel, was as conspicuously absent in the facilities we studied as its intent (i.e., to bring the involved individuals together to talk about improvement) seems simple and obvious. One New York social worker, responsible for the administration of the forensic exaination process in a court clinic, who accompanied one of the authors to an interview with two judges who make frequent referrals to the clinic, remarked that the interview had been the first time that she had met with the judges to discuss quality of services.

Procedural manuals or policy statements, when available, reflect administrative philosophy and approach. The absence of such guidelines often foretell potential management inadequacies (cf. Clements, 1979). We conclude this chapter by touching briefly on the need for a practical procedures manual specific to each forensic mental health facility, covering the components of delineation, acquisition, and provision. This issue overlaps the topics of feedback and quality control of this section and the discussion of the general topic of program evaluation in Chapter 13 which follows.

Proposition 22: The process of forensic mental health examination (including the components of delineation, acquisition, and delineation) conducted in each forensic mental health facility should be fully described and documented in a procedures and policy manual available to all staff.

While the majority of the forensic facilities we studied had some documentation available to staff that was useful in day-to-day operations (the Baltimore Court Clinic; Psychiatric Services in Chicago, the St. Elizabeths Hospital Pretrial (Forensic) Branch, and the Center for Forensic Psychiatry have developed relatively comprehensive procedures manuals), written procedure and policy manuals to guide operations did not seem to be in widespread use. Alhough there are some disadvantages to model written reports for various types of examinations to the court, for example, (e.g., the relaxation of attentions to unique characteristics and the homogonization of communications to the criminal justice system), the inclusion of such models in a procedures manual seems beneficial for guiding appropriate content (or exclusion of

inappropriate material), format, language, and length. The psychiatric staff of the Biggs Unit of Fulton State (Missouri) Hospital has developed such a model report (a copy of which is included in Chapter 6, Appendix F.). One clear benefit of such model report is that it can be subjected to periodic review without threat or embarassment to the referral agent, recipient, and author of an actual report.

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Chapter 13

HUMAN SERVICE PROGRAM EVALUATION AND SOCIAL POLICY

> [O]ur criminal justice system is predicated upon tensions and conflicts between the goals of the system and the values underlying it. Evaluation depends on the clear, empirical specification of the process or outcome goals of the program under investigation. The clear, empirical specification of goals necessary for good evaluation is particularly difficult in a system that is committed to conflicting goals and values, some of which, such as fairness or justice, are probably impossible to quantify in a sensible fashion. (Morse, 1980, p. 331)

The extent to which any human service is amenable to program evaluation, indeed to improvement, is compromised by a host of operational, legal, ethical, political, and organizational factors. In the first twelve chapters of this book, we discussed the operational, ethical, and legal aspects of the delineation, acquisition, and provision components of the forensic mental health examination without regard to the contexts of the political and organizational realities. In this final chapter, we address the issue of the evaluability of forensic mental health examinations, as we have defined and described them within the contexts of criminal justice, organizations, and social policy.

As we discussed in Chapter 3, the basic purpose of the present evaluability assessment is expressed in three questions: What is the nature and scope of the mental health examination process? How does it operate in practice? How should it be evaluated as a program of human service, if at all? The first two parts of this book have addressed the first two questions. The preceding four chapters in Part III constitute the prologue to this concluding chapter, which attempts to answer the third question.

Enhancing Program Evaluability

A successful program evaluation requires at least two major requirements: a workable evaluation design and a definable, comprehensible, and measurable program. In this section, we will discuss the latter requirement.

> Proposition 23: The program evaluability of the forensic mental health examination process will be enhanced to the degree that the process is referenced to a general model of human service delivery.

It would be most difficult to make judgements of worth or value of a program without a good understanding of that program. The generalized model of the forensic mental health examination process in

Chapter 9 provides a standard for description and understanding, not necessarily a standard of quality worthy of imitation. We do not claim that a program of service delivery implemented to the specification of the model examination process in Chapter 9, and following the propositions in Chapters 10, 11 and 12, will necessarily be judged superior to any of the forensic mental health examinations described in Part II of this book. That is not the point, even if it were generally shown to be so after large-scale program evaluation (an approach we do not recommend; see discussion later in this chapter). However, we do propose that the forensic examination process will become more understandable, and hence more evaluable, with reference to the generalized model.

Consider, for example, any of the forensic examination processes operating in the twenty facilities described in Part II, with particular reference to Step 7 and Step 8 (the personal interview and psychological testing) of the model process (see Figure 60, p. 576), and the propositions relevant to the data acquisition component of the process in Chapter 11. In brief, the model and supporting propositions set the following standards for this portion of the process:

a) A single one-hour personal interview with the client-offender (Proposition 16),

b) conducted on an out-patient basis (Proposition 9), by a

c) a competent examiner (Proposition 19),

d) preceded by a thorough review of the case file (Propositions 12, 13, and 14), and

e) appropriate warnings given to the client-offender (Proposition 11);

f) no administration of psychological tests (Proposition 17), unless the examiner expresses,

g) a clearly articulated need and rationale for their application in the specific case following the interview (Proposition 17).

Given these standards, a unique forensic examination process could be described in a manner to make it understandable and comparable to other programs. Descriptive measures would be derived from answers to questions based on the standards. Is the interview longer or shorter than one hour? Are there more than one? Is the client-offender hospitalized? Are warnings given? And so forth. Further, given the discrepancy from the model as a general variable, a rudimentary measurement approach including inferential measures could be developed. For example, a process that includes the routine administration of a complete battery of tests might be judged high on efficiency but low on equity for the client-offender.

The breadth of the model and the propositions in the previous chapters precludes the full explication of such a descriptive and inferential measurement approach here. Suffice it to say, in sum, that the description of a forensic examination process with reference to the model will enhance its evaluability. As suggested with Proposition 22, in the previous chapter, such a description could also serve purposes other than program evaluation (e.g., staff training) when developed into a procedures manual. For a more detailed discussion of the advantages of program models derived from evaluability assessments see, generally, Schmidt, Scanlon, and Bell (1979), Wholey (1979), and Rutman (1980).

Developing Internal Evaluation Capabilities

Proposition 24: As a first step, determinations of the ultimate worth or value of programs of forensic mental health examinations are best served by development of the internal program evaluation capabilities of those programs.

Proposition 25: Until such time as a viable program of forensic mental health examination has been successfully and reliably demonstrated and implemented, large-sclae outcome evaluations of such programs will not be worth their costs.

For the program evaluator and decision-maker who may be planning program evaluation efforts, Proposition 24 and Proposition 25 are most relevant. The central point of this section is this: not until a program of forensic examinations has been sufficiently developed, demonstrated, and implemented will determinations of worth or value be of practical and policy relevance; until such time, program evaluation efforts aimed at program improvement are most beneficial.

One rationale for the above proposition is based in the observation of two related trends: the general difficulty faced by this nation's mental health policies in general, and the developing nature of forensic mental health programs under those general mental health policies. Together, these trends suggest program evaluation which stresses program development rather than program verification or assessment, formative (developmental, process) evaluation rather than impact (summative, outcome, effectiveness) evaluation.

According to a recent study by the Institute for Social Research of this nation's mental health policies, the expectations of the 1963 Community Mental Health Act--a dramatic reduction of the numbers of persons in mental institutions--have not been met.

> Mental health programs are in deep trouble at both the state and national level. While they have successfully gotten away from the custodial approach to treatment, they are still lacking in the policies and programs that would make a community based approach to mental health really feasible. ("Mental Health Programs in Trouble," 1980)

The study revealed several recurrent problems that dominated current mental health policies. Definitional problems still plague policy, having an impact on funding and development of programs. Whether those who receive services are called "mentally ill," "patients," "clients," "consumers," or "mentally disabled," is still a matter of debate. The fragmentation of efforts and short term goals of mental health is another problem. Mental health programs vary widely from state to state and city to city, depending to a large degree on the size and type of funding available to them. A related problem is the over-emphasis on cost-effectiveness and efficiency which has tended to overshadow innovation and initiative. Finally, mental health programs are plagued with some complex economic consequences of deinstitutionalization. For example, the emptying of mental hospitals has threatened the job stability of a large number of employed mental health workers who are skeptical about the worth of deinstitutionalization.

As a growing component of the mental health system, forensic mental health programs do not only share the problems of mental health programs in general, but also show the growing pains of their own relatively new development. This development is not made easier by its necessary relationship with the criminal justice system.

Some categories of program evaluation are better associated with some program contexts and settings than others. Some evaluation activities are more appropriate <u>prior</u> to the installation of a program to confirm, ascertain, or estimate needs, adequacy of conception, operational feasibility and sources of financial support. A major purpose of such activities might include the testing or appraising of a particular process or processes of an ongoing program in order to make immediate modifications and improvements. Other types of program evaluations are more appropriate <u>after</u> the installation of a program, after some time of program implementation or even program institutionalization. Given the developmental nature and contexts of the programs of forensic mental health examination, it seems that the former type of program evaluation--that aimed at program modification and improvement--is most appropriately applied to forensic mental health programs at this time. An internal evaluation approach, in which the evaluator is likely to work quite closely with program designers or administrators and participate directly in decisions to make program modifications, is a program evaluation model falling in this category.

A second rationale for our preference (for now) of building the internal evaluation capabilities of forensic mental health programs, instead of planning large scale outcome evaluations, lies in the very difficult nature of the beast to be evaluated, i.e., a program involving the interaction of two very different systems, mental health and criminal justice, each with their own conflicting goals and values. Consider the example of the evaluation of a newly instituted program of determinations of insanity at the time of the alleged offense. Assume, further, the description of the program along the lines

suggested in Proposition 23 in the previous section. How should outcome be measured? It could be broadly conceived in terms of effectiveness, efficiency, equity (justice?), or satisfaction, or all of these based on the relevant questions posed by an outcome evaluation. If we are interested primarily in measures of effectiveness and equity, for example, we might determine the agreement among mental health recommendations for insanity determinations, judicial determinations, and disposition (i.e., release versus involuntary civil commitment). But, how would high agreement be interpreted? Would the program be equitable and effective? Would it be any more equitable and effective than a comparable program with low agreement? Putting aside for the moment the problem of different criteria burdens of proof and fora operating in the criminal and civil systems, might one not argue that <u>low</u> agreement among mental health judgement of the degree of criminal responsibility, judicial determination, and disposition, indicates a vigorous, vigilant adversary system? From such a perspective, is a program of forensic examinations that demonstrates a high frequency of "reversals" at the judicial level (i.e., low agreement), necessarily a "poor" program in terms of equity and effectiveness? We know of no compelling answers to such questions that would not be countered by equally compelling, opposing interpretations.

We must empahsize that we are not suggesting the abandonment of all program evaluation efforts addressing the examination process, just the postponment of large-scale program impact evaluation until some time in the future. We are proposing that relatively modest internal evaluation efforts aimed at program improvement, initiated and conducted by program personnel and, perhaps, reviewed by a quality assurance committee (see Proposition 22, p. 642), be considered on a first priority basis. The model process and propositions in Part III of this volume might provide adequate bases for program description, program analysis, and evaluation for program improvement.

<u>Program Evaluation and the Adversary Model</u>

But is the initial building of an internal evaluation capability, followed later by outcome evaluation of the process of forensic examination really necessary at all? One might argue that the outcome of forensic mental health screening and evaluation--written reports and expert testimonies, in particular--hardly need to be evaluated by program evaluation efforts since the adversary process already involves methods of scrutinizing the evidence and arriving at truth. Does not the scrutiny of evaluation reports, and the testing of experts by means of skillful cross-examination and by the presentation of opposing testimony constitute a form of program evaluation?

A few program evaluators have not only acknowledged the possibility that the adversary process may reach the truth or determine the value of a program, but have suggested an adversary model of program evaluation applied outside of the legal arena (<u>cf</u>. Anderson, Ball, Murphy, and Associates, 1975, pp. 21-22; Levine, 1974, House, 1980, pp. 37-39). Challenging the framework of the scientific method as the exclusive approach to the truth, they have suggested that we try out the legal system's appraoch, i.e., presentation

of evidence by two opposing groups to a decision maker (judge), or decision makers (jury), according to a complex set of investigative and evidence rules.

Rather than pitting the scientific method of the mental health system against the adversary model of the legal system in the search for the truth, it may be that both can be accommodated and developed in program evaluation efforts. In Ballew v. Georgia (1978), the United States Supreme Court apparently made such an accommodation to form a part of its opinion in that case. In ruling that the trial of Claude Ballew, the manager of the Paris Adult Theater in Atlanta convicted of violating Georgia's obscentiy law, by a five-person jury was unconstitutional, the Supreme Court made extensive use of behavioral science data obtained by scientific experimentation. Justice Powell, concurring in the opinion of the Court written by Justice Blackmun, may have been making the point of the following proposition for us, when he suggested that behavioral science data may become more useful if it were "subjected to the traditional testing mechanisms of the adversary process."

Proposition 26: The designs of program evaluations of the forensic mental health process should include and encourage the naturally occurring inquiry methods of the legal system where possible.

The incorporation of legal checks, reviews, and other inquiry methods into program evaluation designs is not restricted to the last step in the provision component of the forensic examination process, i.e., feedback and follow-up focused on adversarial scrutiny of written reports and courtroom presentation. Indeed, Proposition 2 (p. 494) advocates the drafting of formal motions to the court requesting mental health examinations, and judicial review of the legitimacy of those motions, as part of the proper delineation of the forensic examination process.

Interagency Arrangements and the Social Context

The organizational and social contexts in which a human service delivery program of forensic mental health examination occurs, has a profound influence on its goals, characteristics, operations, service improvement (existence?), and its accountability to administrative agencies and the public. What is the best interagency (intersystem) arrangement, under what situation, between the criminal justice system and the mental health system for the accomplishment of forensic mental health screening and evaluation?

One Ohio judge responded to this question by asserting that an adequate answer will most likely have to await resolution of the fundamental issues in the way society views crime, punishment, and rehabilitation. Unfortunately (or fortunately), the practice of forensic mental examinations proceeds even in the absence of adequate answers. In fact, it is quite conceivable that the examination of practice in this

area may force the clarifying and reformulating of theory (see Chapter 1). The complex relationships and alliances formed by the mental health system, law enforcement, and the judicial system are shaped by a number of factors related both directly to the client-offender and his or her entanglements with the law, and other factors only indirectly related to the individual, the crime (or alleged offense), and his or her mental health. Among these factors are:

(a) The nature and severity of the offense or alleged offense;

(b) the nature and severity of the suspected or diagnosed mental problem;

(c) the stage in the criminal proceedings (e.g., pretrial or after conviction);

(d) the type of defense contemplated by the client-offender, or his counsel;

(e) the financial means of the client-offender;

(f) the mental health law issues involved (e.g., competency to stand trial, criminal responsibility, and mitigating circumstances affecting the sentence);

(g) the availability of viable options (e.g., jail-mental health program, court clinic, or community mental health center);

(h) the cooperative and competitive strategies in most interorganizational relationships (see Steadman and Morrissey, Note 1);

(i) the movement toward community mental health programs and away from institutionalization (cf. Monahan, 1976);

(j) budget arrangements and the various fiscal incentives operating between agencies;

(k) the tensions between applications of the medical model and the legal model to client-offenders (see generally, Wexler, 1981; Miller, 1980); and, finally,

(l) the political climate, especially in an austere economy (cf. "Summary and Analysis," pp. 299-300, and Breslin, 1980, pp. 345-355)

(See also the general descriptions of court clinics, jails, community and regional mental health programs, centralized forensic mental health facilities, and community corrections programs at the beginnings of the chapters in Part II of this volume).

Two issues were the interactive effect of social policy and practice seem clear are the decentralization of mental health care and the proper role of the adversary process in mental health issues. Forensic mental health screening and evaluation services can be distinguished according to the degree of centralization or decentralization of those services. Many states (Ohio, Tennessee, and Missouri, to name three) are moving away from a system in which one or two centrally located, maximum security facilities provide all forensic services (Petrila, 1981). Instead, states are adopting a system in which forensic mental health screening and evaluation will occur, at least initially, in the community. Ohio began developing community forensic mental health centers in 1972 to reduce in-patient evaluation referrals to its maximum security facility, Lima State Hospital. Today, there are 18 out-patient community forensic mental health centers in Ohio, including four basic types of community facilities: (1) a branch of a community mental health center; (2) a freestanding entity with its own Board of Directors; (3) a division of a general out-patient mental health facility of a university; and (4) an agency of a court or probation department (see Beran and Toomey, 1979).

But decentralizing of forensic mental health services can be seen as running counter to the proponents of unified service systems. At least one observer (Wexler, 1981, p. 118) has witnessed the situation, feared by these proponents, of "jurisdictional jockeying generated by fiscal considerations that are irrelevant to the patient's needs" (Note 2).

To what extent mental health services are to be included within the adversary process varies according to geography? In Maryland, staff of the Medical Service of the Supreme Bench of Baltimore routinely conduct pretrial evaluations involving questions of insanity and incompetency. Across the country in Tucson, Arizona, the Pima County Court Clinic, which is under the jurisdiction of the Superior Court of Pima County, performs primarily presentence and post-conviction evaluations. The Clinic seldom performs evaluations to determine competency to stand trial or sanity at the time of the offense. These pretrial evaluations requested by the Pima County Superior Court are referred to psychiatrists and clinical psychologists in the private sector on a fee basis. Allen Beigel (1976), a professor of psychiatry at the nearby University of Arizona, College of Medicine, contends that

> . . . [T]he mental health system should restrict its role to being a friend of the court in keeping with the treatment relationship outside the adversary process . . . [W]e believe [competency] examinations are an appropriate function of the mental health system because they are directly a part of the adversary process (pp. 146-147).

Miller (1980) goes a step further in arguing that mental health services should not be organizationally affiliated with the courts at all, and

when mental health professionals <u>are</u> involved in court procedures it should be totally within the adversary process. The major court functions of the mental health system should be totally eliminated, especially determinations of competency to stand trial, criminal responsibility, and future dangerousness. Clearly, the side on which the issue is decided will dictate the alliances formed between the mental health criminal justice system.

A series of fundamental questions, related to the alliance of the mental health and judicial system, concerns the function of government in this alliance. Should the administration of forensic screening and evaluation at the state, regional and community levels be a part of the executive or judicial branch of government? What are the implications of the differing administrative structures on the day-to-day operations of forensic mental health units?

Forensic mental health facilities have one foot in the mental health camp, the other in the criminal justice camp. But whose side are they really on? The perception, regardless of official stances, of a forensic center's affiliation may have some practical consequences for the services that are provided. A court clinic providing screening and evaluation services in competency and criminal responsibility issues, under the jurisdiction and funding of the courts, for example, may be viewed not as neutral "friends of the court" but as biased pro-prosecution arms of the state. Such a view may be seen in a clearer light when the forensic center provides pre-sentence mental health examinations as part of a probation department, the examination results being routinely incorporated into a probation officer's post-conviction, pre-sentence report to the court. On the other hand, forensic centers funded by state and/or community mental health centers may be perceived as havens of soft-headed liberals that coddle criminals under the guise of constitutionally guaranteed rights involving mental health examination and treatment.

The real or imagined affiliation of a forensic center may foster a view of forensic units as pro-defense, pro-prosecution, pro-competency, anti-responsibility, anti-incarceration, etc. While a forensic unit may be able to survive such a view when it is focused on an individual mental health worker, for an entire forensic unit, or system, to be viewed as siding with particular criminal justice dispositions may have dire consequences for the referrals for services and quality control. Informed neutrality, perceived or actual, seems essential to quality service provided by forensic centers. At the least, partial autonomy from both systems seems part of the answer to "informed neutrality."

Finally, in an austere economy, it is inevitable that courts will become more mindful of their partnership with mental health professionals. For example, an executive committee of the Los Angeles County Superior Court recently balked at raising the fee paid to court-appointed examiners for a psychiatric or psychological report from $135 to the $250 requested by a group of psychiatrists on the court-approved list of experts (Granelli, 1981).

Conclusion

The operations and organizational arrangements constituting programs of forensic mental health examination are presently not sufficiently developed, demonstrated, or implemented to justify a full-scale program impact evaluation. Ironically, even if it were otherwise, the virtual demise of the National Institute of Justice's National Evaluation Program (NEP) within the last year would have precluded adequate funding of such an effort. As outlined in Chapter 2, the first phase of NEP studies--the equivalent of evaluability assessments--involved the collection, synthesis, and determination of what is already known about a program, followed by recommendations for further, more intensive program evaluation to be conducted in a second-phase NEP study. The lowered expectations and dictates of an austerity economy seem to be, in this case, consistent with the recommendations resulting from the evaluability assessment of forensic mental health screening.

An enhancement of the evaluability of forensic mental health examination is proposed by developing the internal program evaluation capabilities of programs of such forensic examinations. This may begin with the description and the analysis of the program with reference to the model process and the 26 propositions in Part III of this book. It may be aimed at the primary purposes of program modification and improvement but produce program evaluability enhancement as an important side-product.

Notes

1. N.J. Steadman and J.P. Morrissey, Interfacing Local Jails with the Mental Health System. Grant application submitted to the National Institute for Mental Health, Public Health Services by the Research Foundation for Mental Hygiene, Inc. (44 Holland Avenue, Albany, New York, 12229). 1980.

2. Testimony entitled, "The Need for Unified Services Amendments," presented on behalf of June Jackson Christmas, M.D., Commissioner, New York City Department of Mental Health and Mental Retardation Services, to the Select Committee on Mental and Physical Handicap, Albany, New York (December 3, 1974, p. 1), cited in Wexler (1981, p. 131, Note 1).

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