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FORENSIC MENTAL HEALTH
SCREENING AND EVALUATION
IN COMMUNITY AND REGIONAL
FORENSIC MENTAL HEALTH CENTERS

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FOREWORD

This monograph, "Forensic Mental Health Screening and Evaluation in Community and Regional Forensic Mental Health Centers," is the fourth in a series that explores the mental health forensic examination, a pivotal point in the criminal justice process that occurs when, at the direction of a judge or some other criminal justice authority, a mental health professional assesses a defendant's mental condition. The results of such forensic mental health evaluations can have profound effects on the destinies of persons charged with or convicted of crimes.

The first monograph in this series, "Forensic Mental Screening and Evaluation of Client-Offenders: An Overview," reflects the National Center's initial assessment of the state of knowledge about mental health screening and evaluation. It contains a general description of the screening and evaluation process, an operational definition of screening and evaluation, and discussions of the purposes, points of application, and manner of resource allocation for screening and evaluation in 121 selected programs throughout the country, which were surveyed in telephone interviews. Summary descriptions of the programs and an annotated listing of selected literature in the forensic mental health area are presented in appendices to this first monograph. Four additional papers and monographs, providing detailed descriptions of the day-to-day operations of screening and evaluation in court clinics, centralized state forensic units, jail mental health services, and community corrections programs complete the series on forensic mental health examinations in various settings. A listing of papers and monographs in the "Perspectives on Mental Health and the Law" series can be found at the end of this monograph.

The information presented in this and in the other papers and monographs in this series was gathered during the course of a research project conducted from October 1979 to June 1981 by the National Center for State Courts as part of the National Evaluation Program of the National Institute of Justice, United States Department of Justice. The preparation of these reports was supported by a grant (No. 79-NI-AX-0070) awarded to the National Center for State Courts from the National Institute of Justice. Points of view or opinions are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice, the National Center for State Courts, or the community and regional centers profiled in this monograph.

The authors owe thanks to Joel Zimmerman, our colleague at the National Center for State Courts, who reviewed and commented on earlier drafts of this monograph. In addition, we acknowledge the numerous individuals associated with the five forensic centers profiled in this monograph who graciously gave of their time during the authors' visits to the facilities, tolerated follow-up telephone calls, and reviewed earlier drafts of the sections describing their center. We are especially grateful to the following individuals for their assistance: Harold R. Bussey, Barbra Bergman, Eleanor Kent, Sharon Blyskun, Gary Noteboom, Frederick Pavelka, Pam Montag, and Joan Yalman, of the Dayton Area Forensic Psychiatry Services; Ronald J. Averbeck, Division of Forensic Psychiatry, Ohio Department of Mental Health and Mental Retardation; Jim

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1.0 INTRODUCTION

For many persons accused of crimes, a crucial point in the criminal justice process occurs when, at the direction of a judge or some other criminal justice authority, a mental health professional assesses a client-offender's mental condition (for reason explained later in this monograph, the term "client-offenders" is used to refer to persons who have gone afoul of the law and whose mental health has been questioned). It is estimated that one million forensic mental health screenings and evaluations are conducted in the United States each year (National Institute of Law Enforcement and Criminal Justice, 1979). Screening and evaluation may occur for various reasons at any of several points in the criminal justice process. It 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, 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.

This monograph describes forensic mental health screening and evaluation conducted by the arrangement of one type of collaboration between the mental health and criminal justice system: 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 (Monohan, 1976). The most significant and substantial portion of this monograph is the description of the operations of the following 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

These centers were visited and studied during the course of a research project conducted by the National Center for State Courts as part of the National Evaluation Programs (NEP) of the National Institute of Justice, United States Department of Justice. The National Center's study focused on the mental health system's most significant involvement in the criminal justice process: the forensic mental health screening and evaluation of offenders and alleged offenders performed by psychiatrists, psychologists, and social workers at the request of attorneys, the courts, or corrections agencies. In assessing forensic mental health screening and evaluation programs, National Center staff reviewed the literature relating to screening and evaluation, surveyed forensic screening and evaluation programs throughout the country, and visited 20 selected forensic programs in 17 states and the District of Columbia, including the six programs described in this paper. A number of conspicuous knowledge gaps were identified, and the likelihood of their being filled, as well as the nature and scope of sensible next steps, were assessed during field testing of several tentative program evaluation models in a number of forensic units throughout the country.

An earlier paper in this series (Keilitz, Fitch, and Marvell, 1981) describes the results of the National Center's initial assessment of the current state of knowledge about screening and evaluation. The NEP methodology, developed by the National Institute of Justice in response to the congressional mandate to evaluate the wide range of justice programs, is detailed by Nay, Barnes, Kay, Ratner, and Graham (Note 1); the NEP methodology conforms in all essential aspects to the program evaluation method coined "evaluability assessment" (see Wholey, 1977). The reader is referred to these writings for a complete description of the operational definition of screening and evaluation, state-of-the-knowledge assessment, and methods used in the National Center's study.

1.1 Community and Regional Forensic Mental Health Centers

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; Monohan, 1976).

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 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 marks a continued 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 monograph 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 (some may be community-based), and court clinics.

Perhaps the oldest element of the forensic mental health service system, with which the forensic community centers draw the sharpest contrast, 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 service is 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 client-offenders undergoing extensive observation and evaluation for their competency to stand trial or for criminal responsibility, those persons found incompetent to stand trial, persons committed under some "psychopath" statute, certain sexual offenders, 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).

State and local corrections agencies also may conduct forensic mental health screening and evaluation. 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. 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.

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 orientation (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.

1.2 Forensic Mental Health Screening and Evaluation: Definition and a Conceptual Framework

The general operational definition of screening and evaluation that served as a starting point for the National Center's study and guided the preparation of the descriptions of the six centers in this paper 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 useful for decision-making in the criminal justice systems.

The nine key elements of the definition are italicized. The elements are further defined and explained briefly as follows.

- o Process: A particular activity, directed towards a client-offender, subsuming many different methods and involving a number of steps or operations.
- o Information about mental status: Data concerning an individual's physical, emotional, and/or cognitive functioning, and social and behavioral history, including inferences drawn from this information about past, present, and future behavior.
- o Client-offenders: Convicted and accused offenders whose mental status has been questioned.
- o Mental health personnel: Professionals charged with the responsibility of conducting the process of screening and evaluation.

- o Delineating: The procedures involved in delimiting the information about the client-offender required by the criminal justice authorities and thereby determining the scope of the screening and evaluation process.
- o Obtaining: The procedures, techniques, and use of tests and data-gathering instruments involved in the collection of information about the mental status of client-offenders.
- o Providing: The procedures used to transfer information obtained by the mental health personnel to the criminal justice authorities.
- o Decision making in the criminal justice system: The process of choosing among the options available to the criminal justice authorities for dealing with suspected mentally disordered offenders.
- o Criminal justice authorities: Prosecutors, defense attorneys, judges, corrections officials, and their agents involved in decision making concerning client-offenders.

The foregoing definition and its nine key elements can be imposed on a simple conceptual framework of three processes characterizing the court's involvement in mental health screening and evaluation--delineation, acquisition, and provision. The delineation and provision of information subsume the bulk of the interaction of the criminal justice system and the mental health system in the screening and evaluation of client-offenders.

Delineation, as noted earlier in the definition, includes all activities, standards, rules, and established proceedings that serve to define and focus the legal-psychological 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, delineating and later providing mental health information necessitates communication between the two systems. The delineation and provision phases thus provide from the perspective of the courts the greatest opportunity for relatively inexpensive and expedient improvement of mental health screening and evaluation.

Raising the issue of mental health, making the referral, and using the information provided remain largely the domain of the criminal justice system. Acquisition, the activity of gathering the mental health information about a client-offender, on the other hand, is often viewed by criminal justice personnel as a black box whose inner workings are known only to mental health professionals. Instituting changes in the acquisition of mental health information is relatively difficult for court personnel, just as it is difficult for mental health workers to influence the delineation of the issue of mental health.

The foregoing definition and conceptual framework for forensic mental health screening and evaluation were used as guides in conducting the National Center's research project, including the study of the six centers profiled in this monograph. A more detailed description of the definition and conceptual framework is presented in Keilitz and Holmstrup (1981) and Keilitz, Fitch, and Marvell (1981).

1.3 Profiles of Six Community and Regional Centers

Mental health law as it pertains to forensic mental health screening and evaluation is, to be sure, an area where law departs sharply from theory.

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." (Perlin, 1980, p. 194).

In presenting the profiles of operating community and regional forensic units, it is hoped that it can be shown that the context and consequences of the application of mental health issues in criminal justice are of far greater practical importance--and interest--than the contents of the issues. Many of the salient aspects of the alliances between the systems of mental health and criminal justice are revealed in the descriptions of the operations in the six states represented.

Each of the program descriptions that follows contains a brief history of the center; a summary of the center's goals and objectives; an illustration of the flow of client-offenders into and through the center; discussions of how mental health information is delineated by the referral source, acquired by the center staff, and provided to the user; and a review of the systems used for feedback, quality control, and program evaluation.

Each center profile conforms, generally, to 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
 - Medical Examination
 - Interviews
 - Social History
 - Psychological Testing
 - Case Conferences
 - Report Preparation
 - Data Gathering Instruments
 - Legal Tests
 - Projective Tests
 - Objective Tests
- 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

2.0 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 3). 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 thorough discussion of the development of the Ohio community forensic center network).

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 the Dayton Center.

2.1. A Function Model of Psychological and Psychiatric Evaluations Conducted by the Dayton Center

Figures 1-3 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. These processes are summarized in the text below. Appendix A provides a key for the geometric shapes in the figures throughout this paper.

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 1 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 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 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.

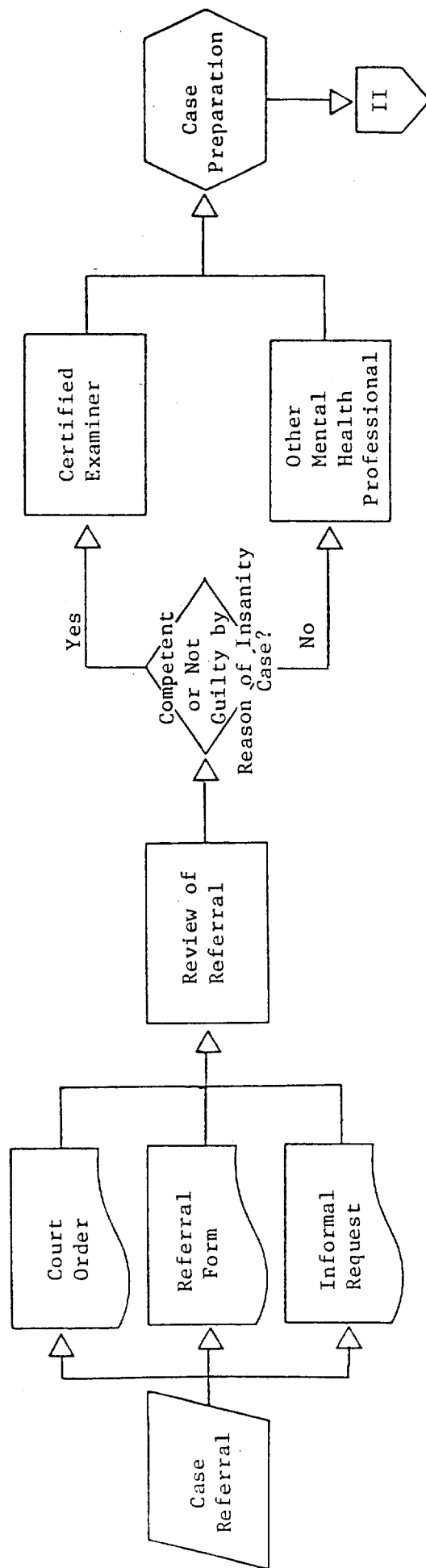


Figure 1. Case Processing Model of the Dayton Center, Delineation of Evaluation Information.

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 2 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.

The final stage, the provision of the evaluative information to the referral agents, is depicted in Figure 3. 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.

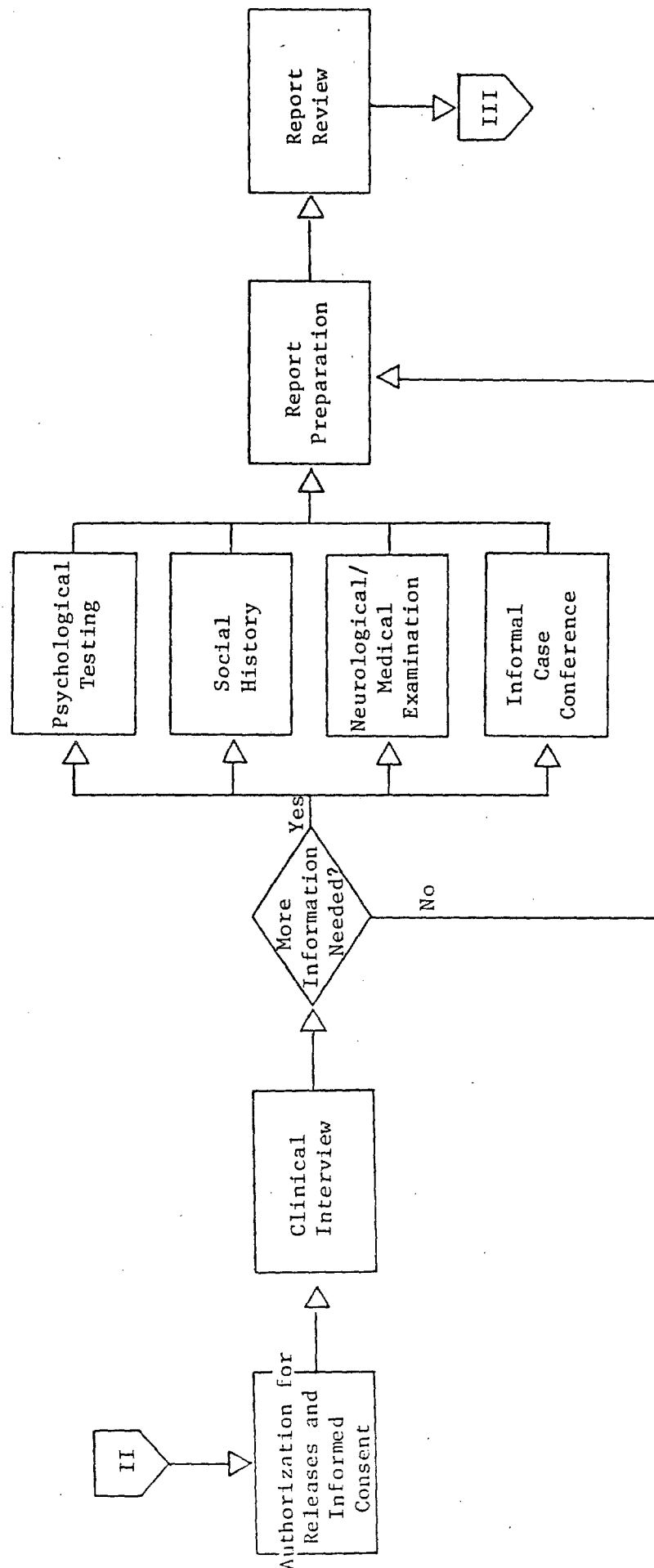


Figure 2. Case Processing Model of the Dayton Center, Acquisition of Case Information.

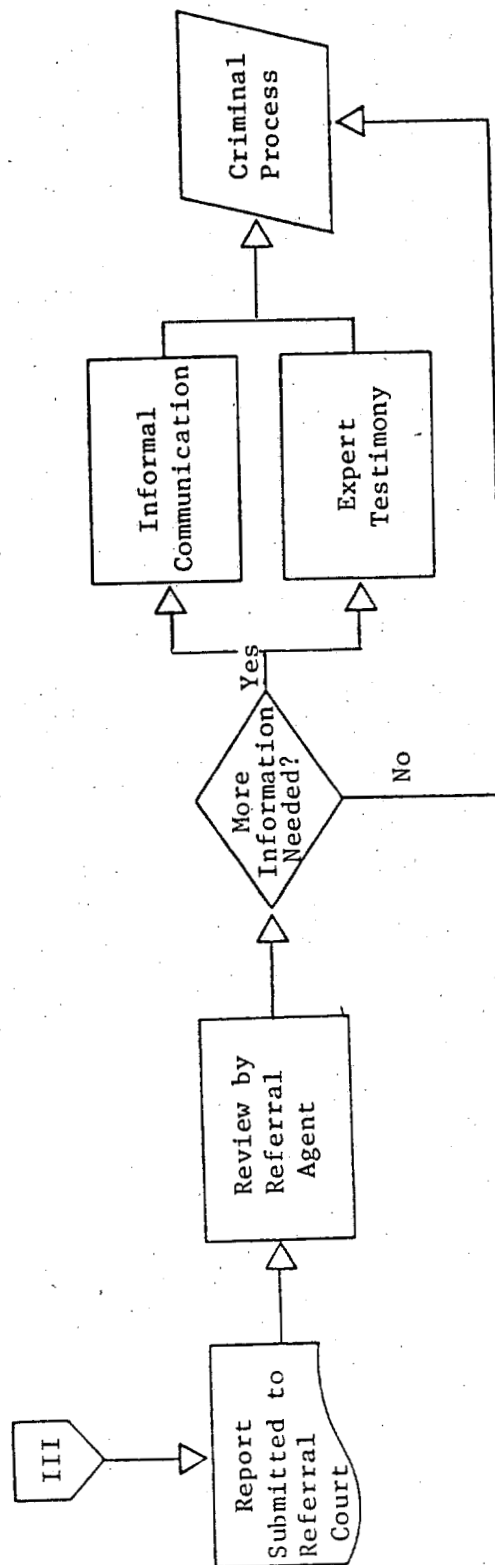


Figure 3. Case Processing Model of the Dayton Center, Provision of Evaluation Information.

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

2.2 The Delineation of Evaluation Requirements

2.2.1 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 process. The Dayton Center pays close attention to statutory authority. 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 10) 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:

2.2.1.1 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)

2.2.1.2 Insanity. Insanity was legally defined by the Ohio Supreme Court in 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 10).

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 10, 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 NGRI 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.

2.2.1.3 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)

2.2.1.4 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 10, 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)

2.2.1.5 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)

2.2.1.6 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).

2.2.2 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.

2.2.3 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 12).

(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 (Lima, Dayton Mental Health Center, C.M.H.C.)
- (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.

2.3 Acquisition of Mental Health Information

2.3.1 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.

2.3.2 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, Note 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 clinical interview, the defendant is asked to read and sign a form (see Appendix B) 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 C).

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.

2.3.2.1 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 13) suggested that the following aspects and issues of competency be covered to guide examiners in competency evaluations:

- a) Assessment of present mental condition
 - o Are there signs of mental disorder--psychosis, mental deficiency, organic cerebral disorder?
 - o Does the mental disorder cause defect in judgment?
 - o 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?

- o Who is your lawyer now?
- o Have you had any other lawyers in this case?
- o How did you get them?
- o What is your lawyer's job?
- o What is the purpose of the judge?
- o What does the jury do?
- o What does the prosecutor do?
- o Since arrest, have you spent time in jail? How long?
- o Have you been questioned by the police? When?
- o Where? Did they tell you what rights you have in this case?
- o What are the charges against you?
- o What do they mean to you?
- o Why were they made against you?
- o When is your trial going to take place?
- o In which court?
- o Can the judge or prosecutor make you take the witness stand in court and make you answer questions?
- o 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?
- o What is the difference between guilty and not guilty?
- o If you are found guilty, what are the possible sentences?
- o What do you think will happen? Why?
- o What is a suspended sentence?
- o What is probation?

c) Can the person assist his or her attorney in the defense?

- o What is your plea at this time?
- o What alibi or defense do you think you have at this time?
- o Does your lawyer agree with this?
- o Why are you going to use this alibi/defense?
- o Have you and your lawyer discussed any other defense you might use? Why not using?
- o What does incompetent to stand trial mean to you?
- o Do you think there is any reason why you should be found incompetent to stand trial?
- o Would you want to be found incompetent? Why?
- o Will there be any witnesses against you?
- o Do you think you know what they might say?
- o If one of them lies or makes a mistake, what would you do?
- o Will there be any witnesses for you?
- o What have you done to contact them to make sure they'll be at your trial?
- o Has your lawyer been helpful in letting you know about your rights (and other things to do) in this case?
- o Has there been anything you thought your lawyer could do to help your case that you have been reluctant to ask him to do?

- o Are you able to work with your lawyer?
- o Have you ever testified before? Describe.
- o Do you think you will have to testify at your trial?
- o How do you feel about testifying?
- o What will you do if you are asked a question you don't want to answer?

2.3.2.2 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.

2.3.2.3 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 10, pp. 27-29)

2.3.2.4 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.

2.4 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. Very infrequently, judges may require an examining social worker to testify at a presentence hearing.

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.

2.4.1 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.

- o Give the length of time spent with client (this information may prove to be valuable for program monitoring and evaluation at some future time).
- o State the factors adversely affecting the evaluation (e.g., lack of privacy, interruption, etc.).
- o Describe how the purpose of evaluation and the limits of the evaluation's confidentiality were explained to the defendant.
- o Limit the report's content to information directly relevant to the requested legal question necessary to substantiate conclusions and recommendations.
- o Subdivide report--client's account of the crime, mental health history, and family history.
- o Avoid technical mental health terms and/or jargon.

- o Use objective statements instead of subjective or interpretative statements (e.g., "client stated he consumed 'no' alcohol" instead of "client denied using alcohol").
- o 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 10, p. 31, emphasis added).

2.4.1.1 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.

2.4.1.2 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.

2.4.1.3 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.

2.4.1.4 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

2.4.1.5 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

2.4.2 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.

2.4.3 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 3, p. 29).

2.5 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.

2.5.1 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 11) 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 10).

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 10), 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 G, "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 11) 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 set in this rule include the following:

- (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.

2.5.2 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 (see Appendix D);
- (b) Forensic Psychiatry Admission Report (see Appendix E); and,
- (c) Forensic Psychiatry Termination Report (see Appendix F).

Also, on a biennial basis, the Dayton Center reports routine statistics and responses relevant to certification standards on an application for certification (Appendix G).

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.

2.5.3 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 Delinquency. The purposes, methods, and results of this evaluation research project are documented in detail in a series of eight monographs (see Notes 2-9) 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 3), 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:

- o Perceptions of working relations among participants (judges, probation officers, Dayton Center staff, etc.) in the system.
- o Perceptions of Dayton Center influence on criminal justice decisionmaking.
- o Demographic characteristics of the Dayton Center sample, including sex, age, race, marital status, occupation, and education.
- o Prior criminal record of defendants.
- o Number of years incarcerated.
- o Convictions by offense type and "currentness."
- o History of mental health institutionalizations of clients, including civil residency and criminal residency.
- o Reason for referral.
- o Current court status of referred cases.
- o Current offense.
- o Type of psychometric testing conducted.
- o Mean evaluation time in hours.
- o Mean evaluation time in hours for various types of evaluations.
- o Types of diagnoses.
- o Positive/negative evaluation results according to type of evaluation.

- o Agreement between recommendations and court decisions according to type of evaluation.
- o Recommendations according to type of evaluation.
- o Type of court disposition.
- o Mean number of days between referral and admission, admission and report, and report and disposition.
- o Current offense according to age of defendant.
- o Current offense according to race.
- o Reason for referral according to current offense.
- o Reason for referral according to criminal record.
- o Current offense according to treatment received.
- o Recommendation according to court decision.
- o Professional staff time and costs in evaluation and treatment.
- o Evaluation and treatment costs per day.
- o Costs according to evaluation type.

3.0 THE SAN MATEO COUNTY 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 disassociated with 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:

- o evaluation of offenders or alleged offenders for recommendations concerning their disposition or management;
- o consultation with courts or corrections personnel regarding particular cases without direct contact with the offender or alleged offender involved;
- o consultation with agency personnel regarding aspects of an agency's work not necessarily related to a particular case; and
- o training for personnel of courts and corrections agencies having contact with offenders or alleged offenders.

One particularly intriguing 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 an orientation 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 (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.

3.1 Process Flow

The flow of cases into, through, and out of the Courts and Corrections Unit is illustrated in Figures 4-7.

3.1.1 Jail Services

Figure 4 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.

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 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.

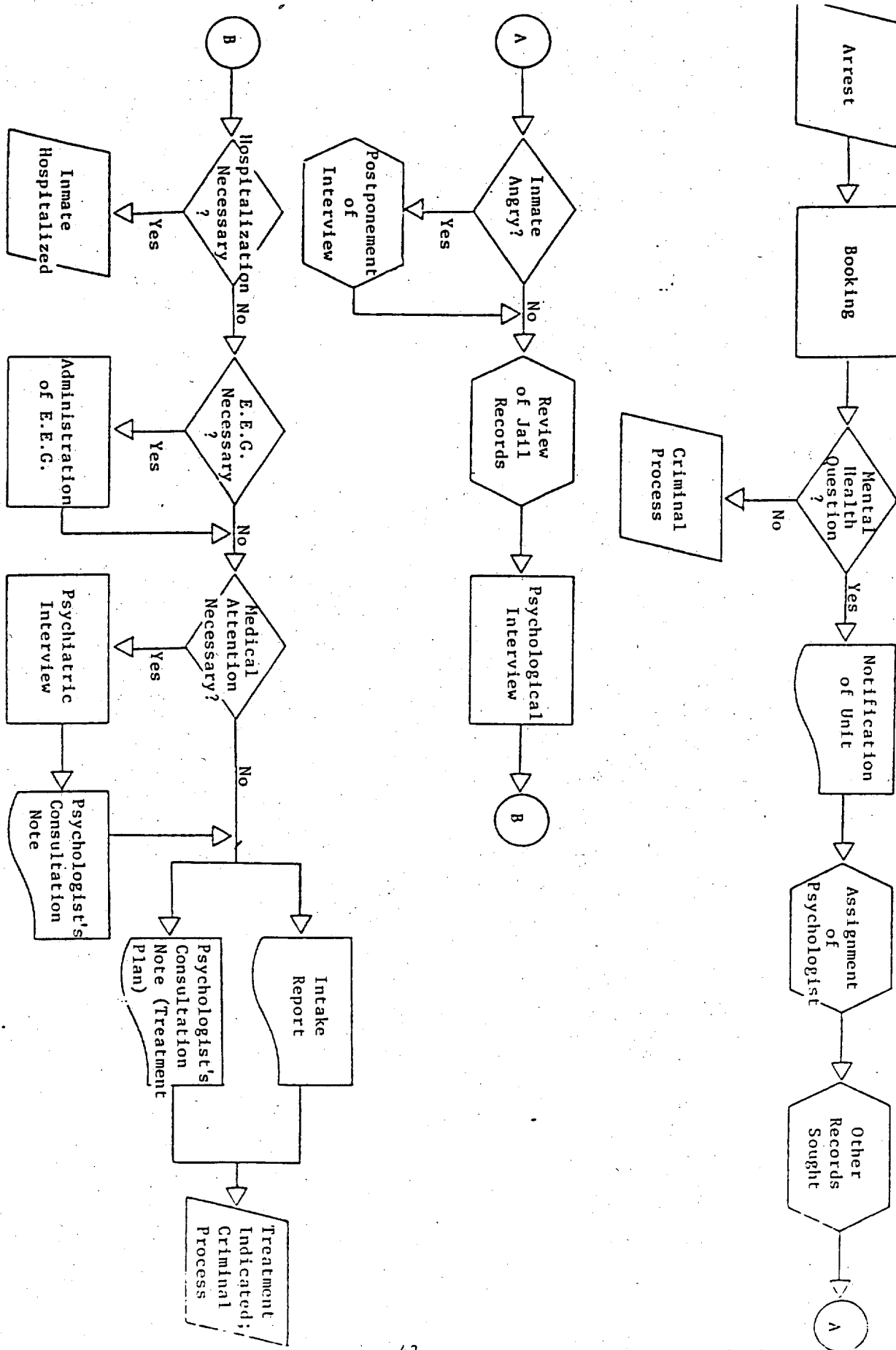


Figure 4. Process Flow of Jail Services Provided by the San Mateo Courts and Corrections Unit

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.

3.1.2 Court-Requested Evaluations

Figure 5 indicates the manner in which the Court and Corrections Unit receives and processes court referrals for evaluation.

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.

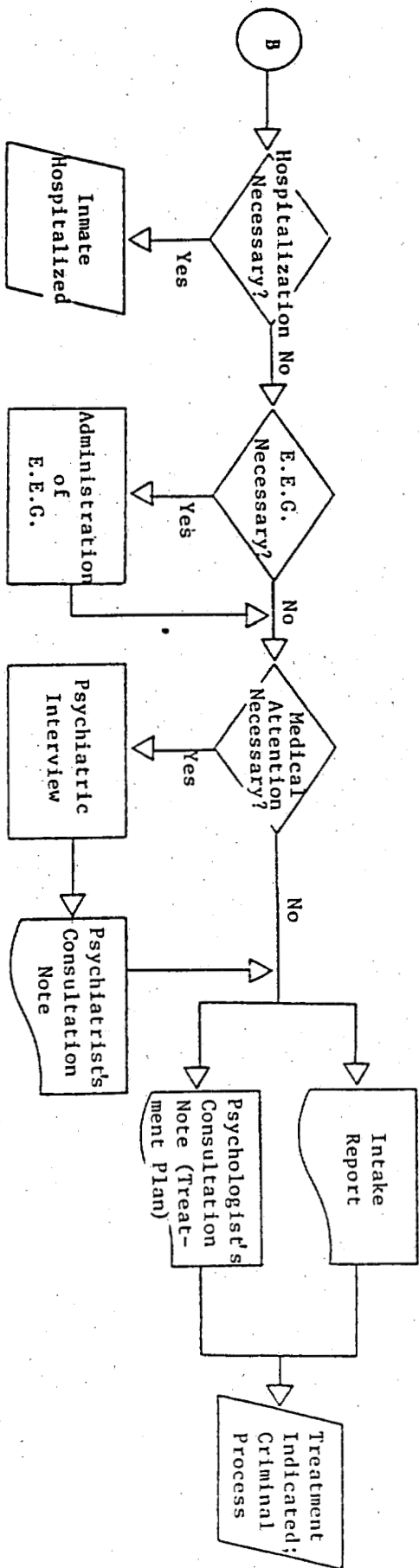
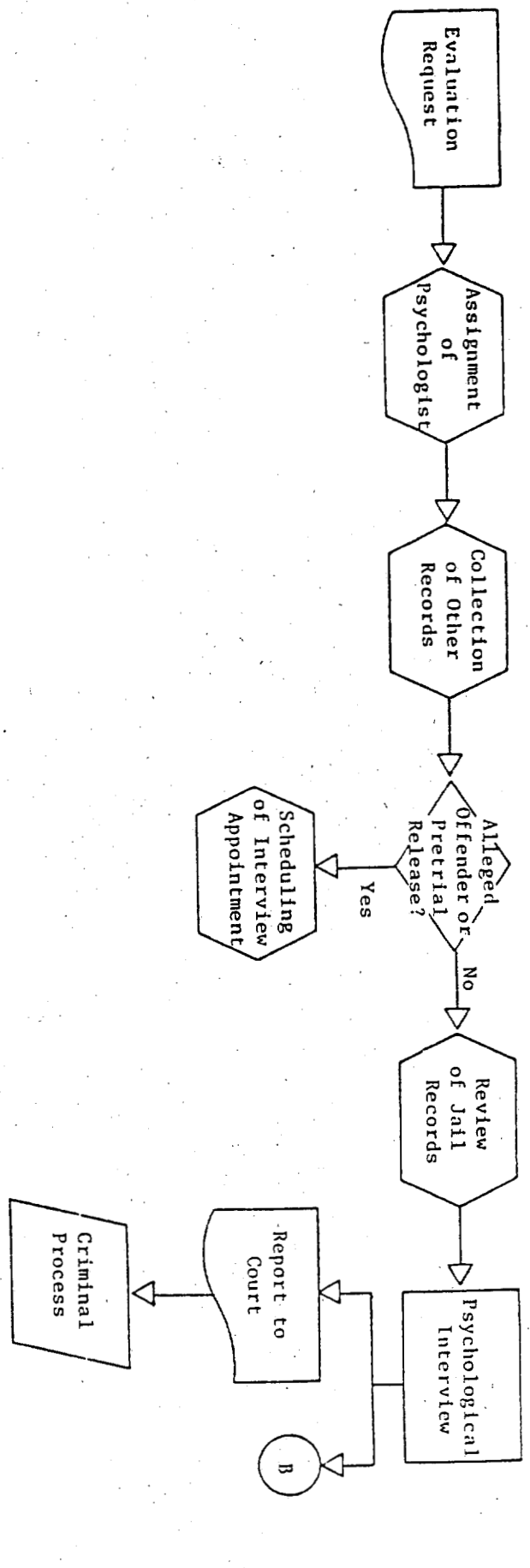


Figure 5. Process Flow of Court-requested Evaluations Conducted by the San Mateo Courts and Corrections Unit.

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 (see section 3.4, below).

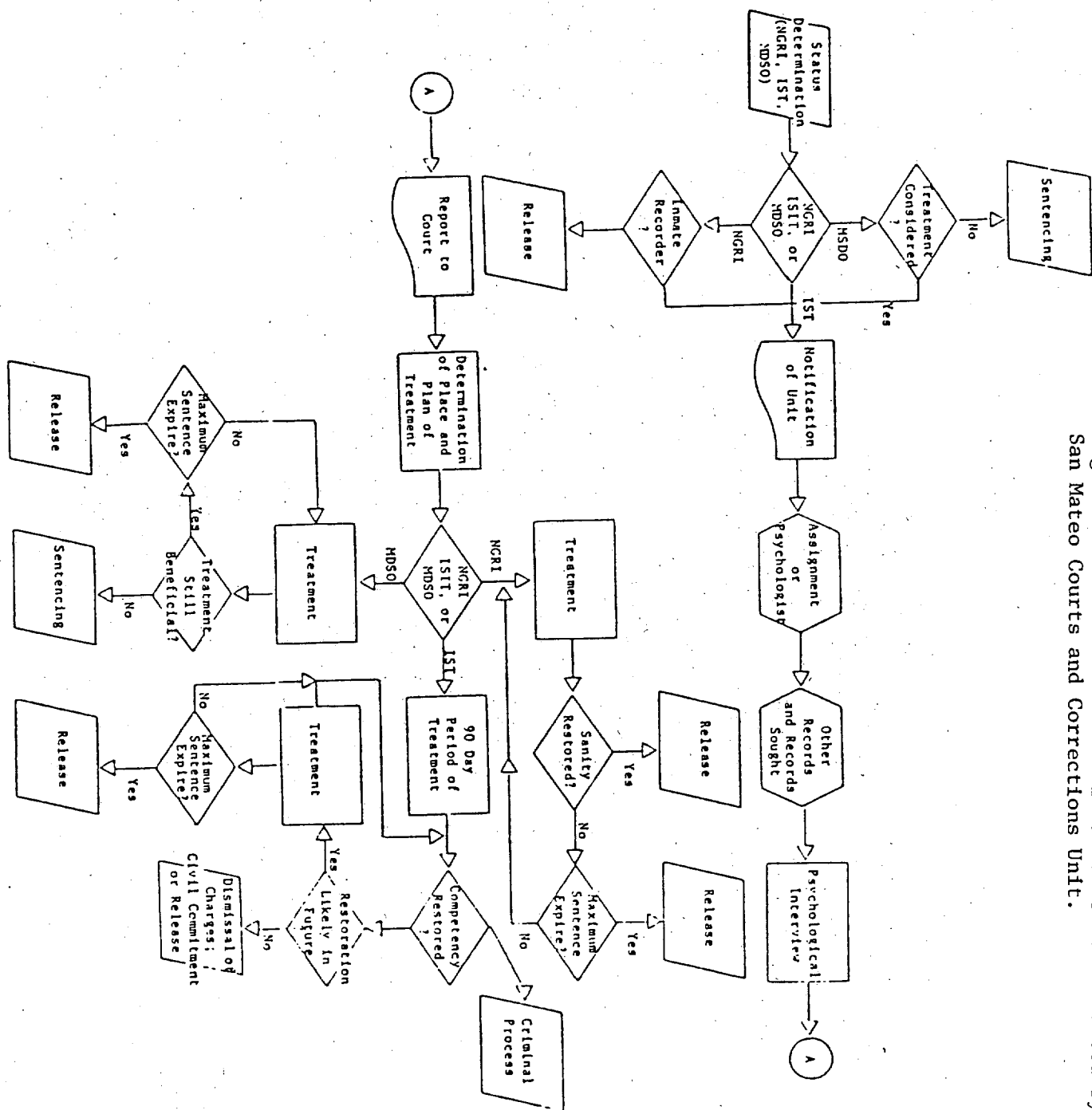
3.1.3 "1229" Program Coordination

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 6 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 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

Figure 6. Process Flow of "1229" Cases Coordinated by the San Mateo Courts and Corrections Unit.



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.

3.1.4 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 7 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 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.

3.2 Delineation of Mental Health Information Requirements

3.2.1 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.

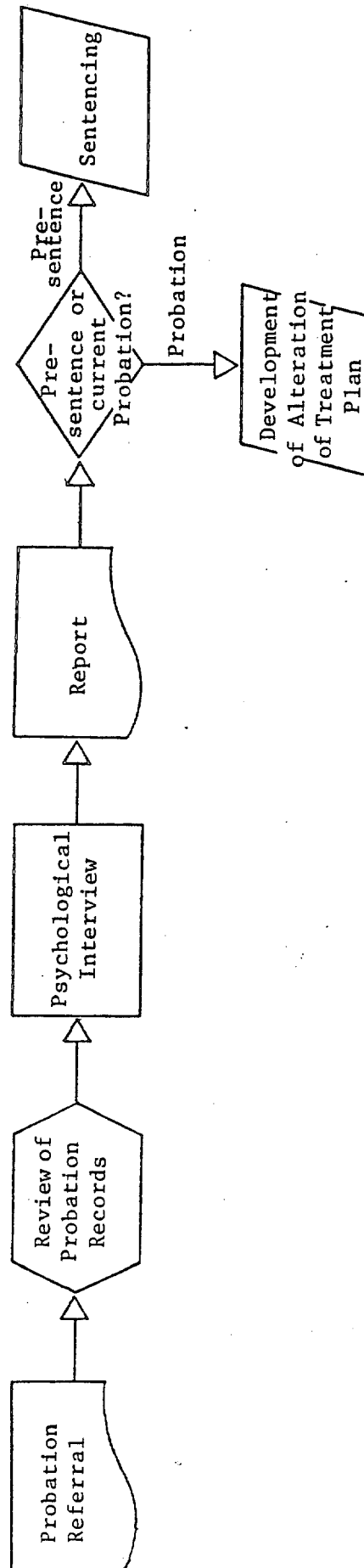


Figure 7. Process Flow of Probation Consultation Provided by the San Mateo Courts and Corrections Unit.

3.2.2 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.

3.2.3 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.

3.2.4 "1229" Program Coordination

California Penal Code §§1026 and 1370 and California Welfare and Institutions Code §6316, all as amended by 1975 California assembly bill 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 in section 3.1.3, above, bill 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 in section 3.1.3, 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).

3.2.5 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.

3.3 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 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.

3.4 Provision and Use of Mental Health Information

3.4.1 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.

3.4.2 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.

3.4.3 "1229" Program Coordination

Evaluations for placement of client-offenders under the 1229 program result in reports typically containing:

- o a summary of the offender's legal status (including reason for referral);
- o an account of the offender's mental health history, if any;
- o an assessment of the offender's current mental status (including an opinion regarding the dangerousness of the offender to the community);
- o a description of the offender's family and community support systems; and
- o 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).

3.4.4 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 in section 3.1.4, 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.

3.5 Feedback, Monitoring, and Evaluation

There is no major program evaluation mechanism functioning with respect to the Courts and Corrections Unit. However, a number of the Unit's activities serve to some extent to monitor its 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:

- o "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;
- o "The Quality Control of Community Caretakers: A Study of Mental Health Screening in a Sheriff's Office" (McDonough and Monohan, 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;
- o "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,
- o "The Psychiatrization of Criminal Behavior: A Reply" (Monohan, 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.

4.0 FORENSIC UNIT OF THE BARREN RIVER MENTAL HEALTH-MENTAL RETARDATION BOARD (BOWLING GREEN, KENTUCKY)

4.1 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. 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 5th 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. That was the end of the LEAA funding, although the Comprehensive Care Center still performs some forensic services.

4.1.1 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.

4.1.2 Forensic Unit Staff

When the Unit was created, early in 1977, three people 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.

4.1.3 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.

4.2 Process Flow

This section of the report is an introductory outline of the Forensic Unit's screening and evaluation activities. A more complete description is given in the Sections 4.3, 4.4, and 4.5. Figure 8 shows the Unit's process for court-ordered mental examinations. (Appendix A explains the symbols used in Figure 8.) 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.

4.2.1 Court Referrals for Mental Examinations

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

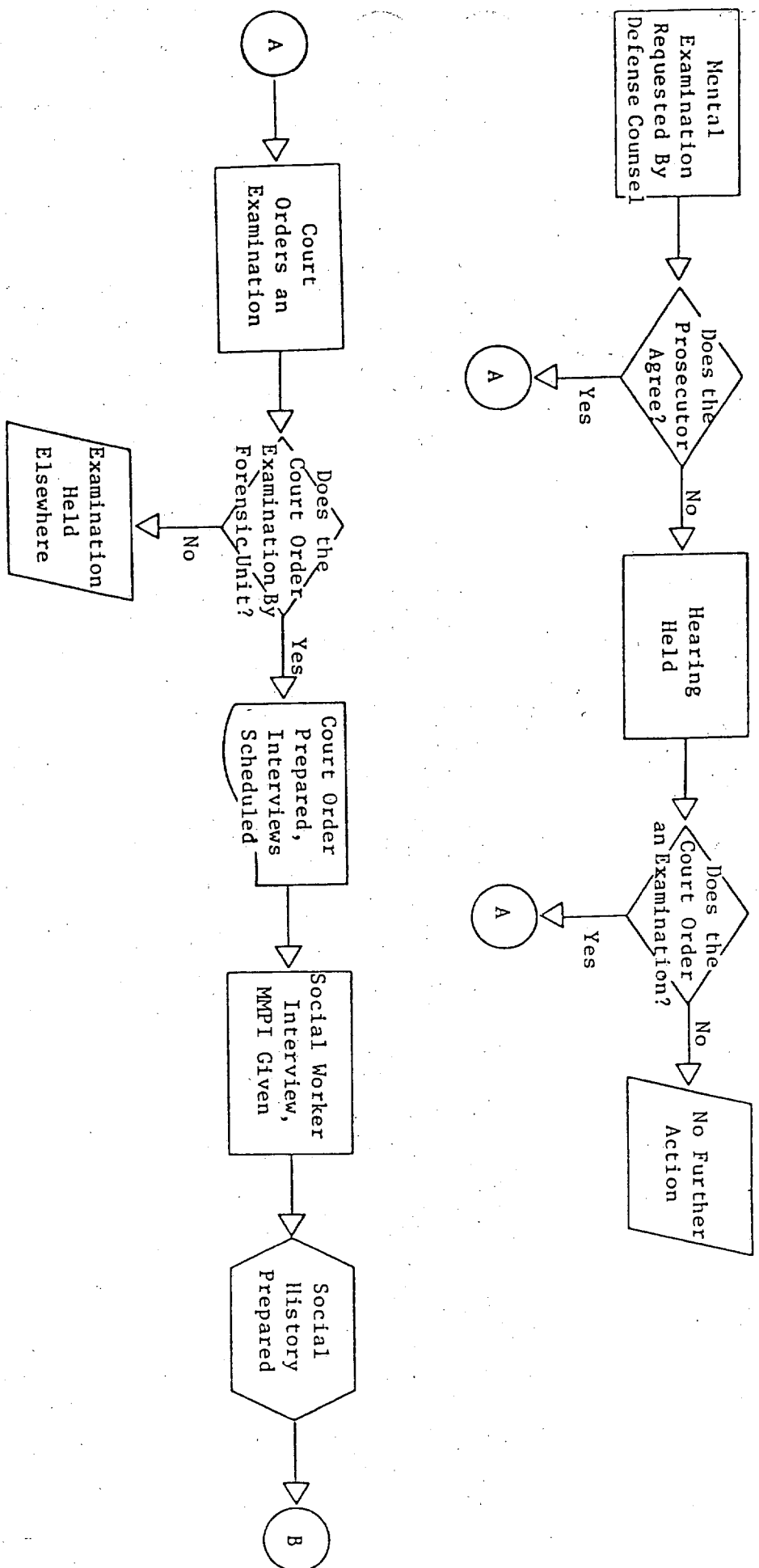


Figure 8. Barren River Forensic Unit.

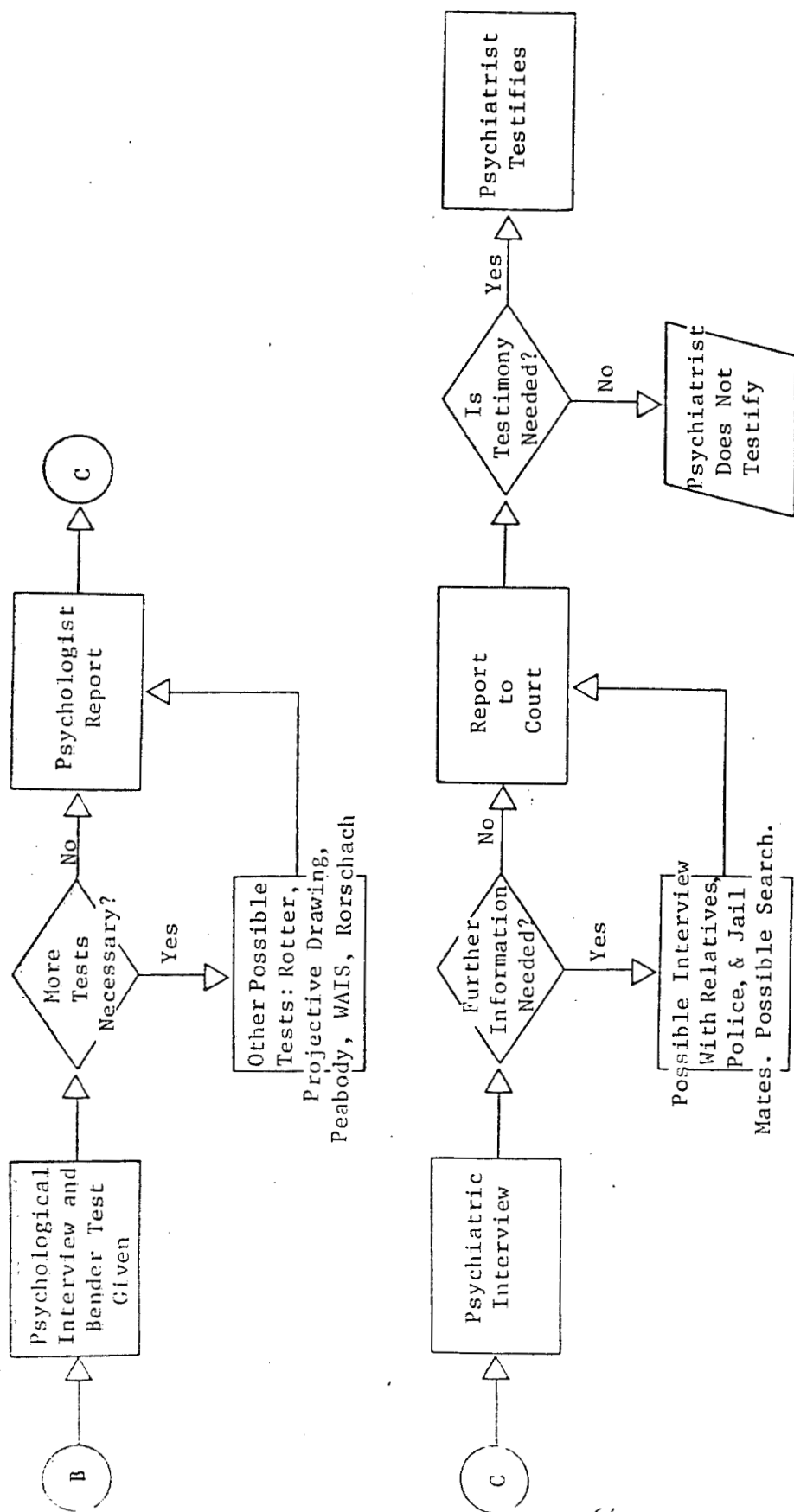


Figure 8. (Continued) Barren River Forensic Unit.

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.

4.2.2 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 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.

4.3 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.

4.3.1 Court Referrals

The Forensic Unit receives 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. (The Forensic Unit form is in Appendix H.) 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.)

4.3.2 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.

4.3.2.1 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).

4.3.2.2 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.

4.3.2.3 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, 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.

4.4 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 in Section 4.3.2 above. This section presents a detailed account of the procedures used in the Forensic Unit when conducting mental examinations, and Section 4.5 describes the psychiatrist's report and its use by the courts.

4.4.1 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 sent. 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 jailor 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.)

4.4.2 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 I). 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.)

4.4.3 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 hygiene, 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; used to help determine if the client is malingering).

The psychologist does not conduct an outside investigation for facts; for example, he relies on defendants for accounts of their prior record.

The psychologist's report, placed on the form shown in Appendix J, 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.

4.4.4 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.

4.5 Provision and Use of Mental Health Information

The psychiatrist's report is prepared on a form (see Appendix K), 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:

- o 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).
- o The results of the MMPI and other tests, and interpretations of the results.
- o The psychiatrist's assessment of the defendant, sometimes drawn from the psychologist's assessment.
- o The diagnosis, often expressed in psychiatric terms.
- o 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, unless the defense attorney gives a copy of his.

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.

4.6 Feedback, Monitoring, and Program Evaluation

4.6.1 Management, Monitoring, and Informal Feedback to Staff

Management and monitoring within the Forensic Unit is generally informal. The project director under the 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.

4.6.2 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 biographical 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.

4.6.3 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.

5.0 THE FORENSIC SERVICES OF MALCOLM BLISS MENTAL HEALTH CENTER (ST. LOUIS, MISSOURI)

In the 1930's, 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 14).

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.

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 14). 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 Services 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, one full-time social worker who is also an attorney, and one 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.

5.1 A Function Model of the Forensic Services

Figures 9-13 depict the flow of cases, operations, and processes characterizing the evaluation of client-offenders at Forensic Services. Figure 9 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 outlined in Figures 10, 11, and 12. Each of the latter figures depicts 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 13 provides a 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 9. 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 logged in and evaluations 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 12) 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 10. As Figure 11 illustrates, a jailed client-offender is evaluated on the basis of a psychiatric interview and the information obtained from a family member or other outside informant. The Bliss Forensic Services director may

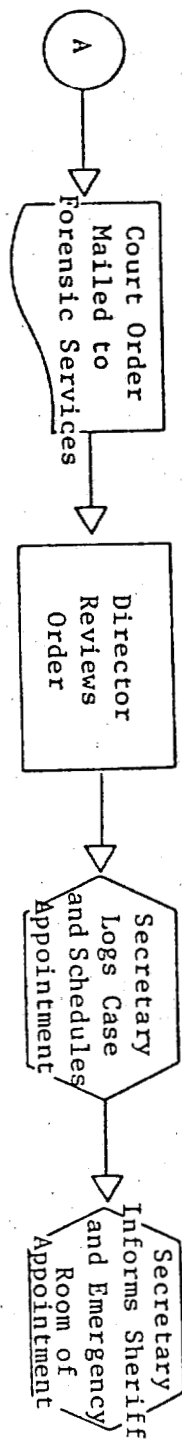
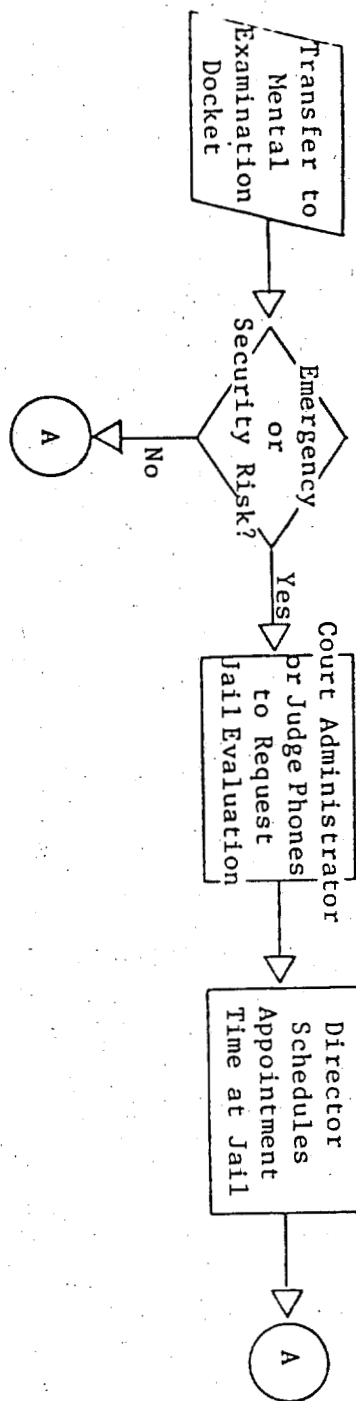


Figure 9. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center. Delination of Evaluation Information.

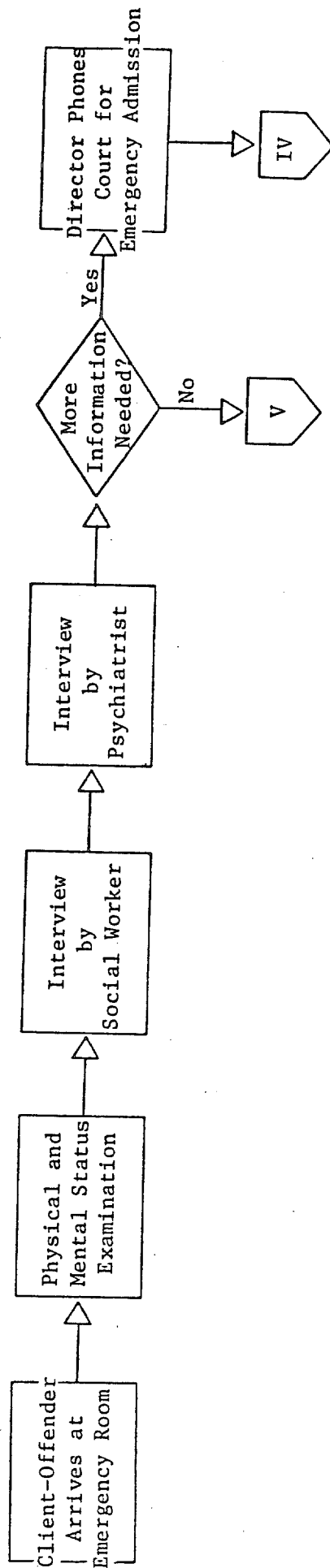


Figure 10. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Acquisition of Case Information for Outpatients..

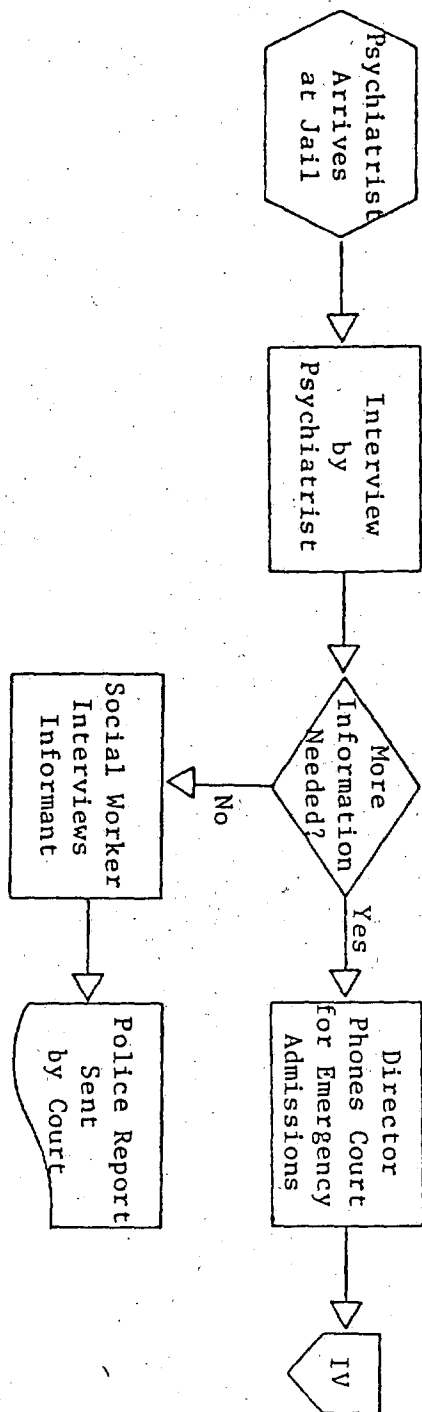


Figure 11. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Acquisition of Case Information for Client-Offenders at St. Louis City Jail.

need to request the referring court's permission to admit the client-offender to the Center to gather further information or to provide emergency mental health services.

The final phase of this evaluative sequence, depicted in Figure 13, is the provision of the mental health information to the court. Irrespective of the client-offender's status as an inpatient or an outpatient, the psychiatrist composes a letter to the court. The letter follows statutory guidelines (see Section 5.2.1) and includes an introduction, detailed findings, diagnosis, competency assessment, opinion as to criminal responsibility and recommendation as to treatment and hospitalization needs. Three copies of each report are mailed to the city court administrator or county judges.

Further elaboration of these processes follows in Sections 5.2, 5.3 and 5.4.

5.2 Delineation of Mental Health Information Requirements

5.2.1 Statutes

In early 1980 the Missouri General Assembly passed H.B. 1724, a comprehensive revision of the state's mental health code. Statutory changes governing pretrial examinations are effective August 13, 1980. Several changes are detailed below:

- 1) 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.
- 2) Pretrial exams must be completed within 60 days of the court order unless there is "good cause" to increase the examination period.
- 3) The examination is narrowed to allow a court to request only an evaluation of competency to stand trial; whereas formerly an evaluation of competency and criminal responsibility were inseparable.
- 4) The criminal sexual psychopath law is repealed (Note 16).
- 5) The Director of the Missouri Department of Mental Health or a designated agent is now empowered to determine the "time, place and conditions" of the examination. Under the previous statute, this determination was left to the court's discretion.

The revised code provides specific instructions for the content of court orders and court reports by the mental health evaluators (see Section 5.4.1). The Director of Forensic Services for the State of Missouri has offered a suggested format for an "Order for Mental

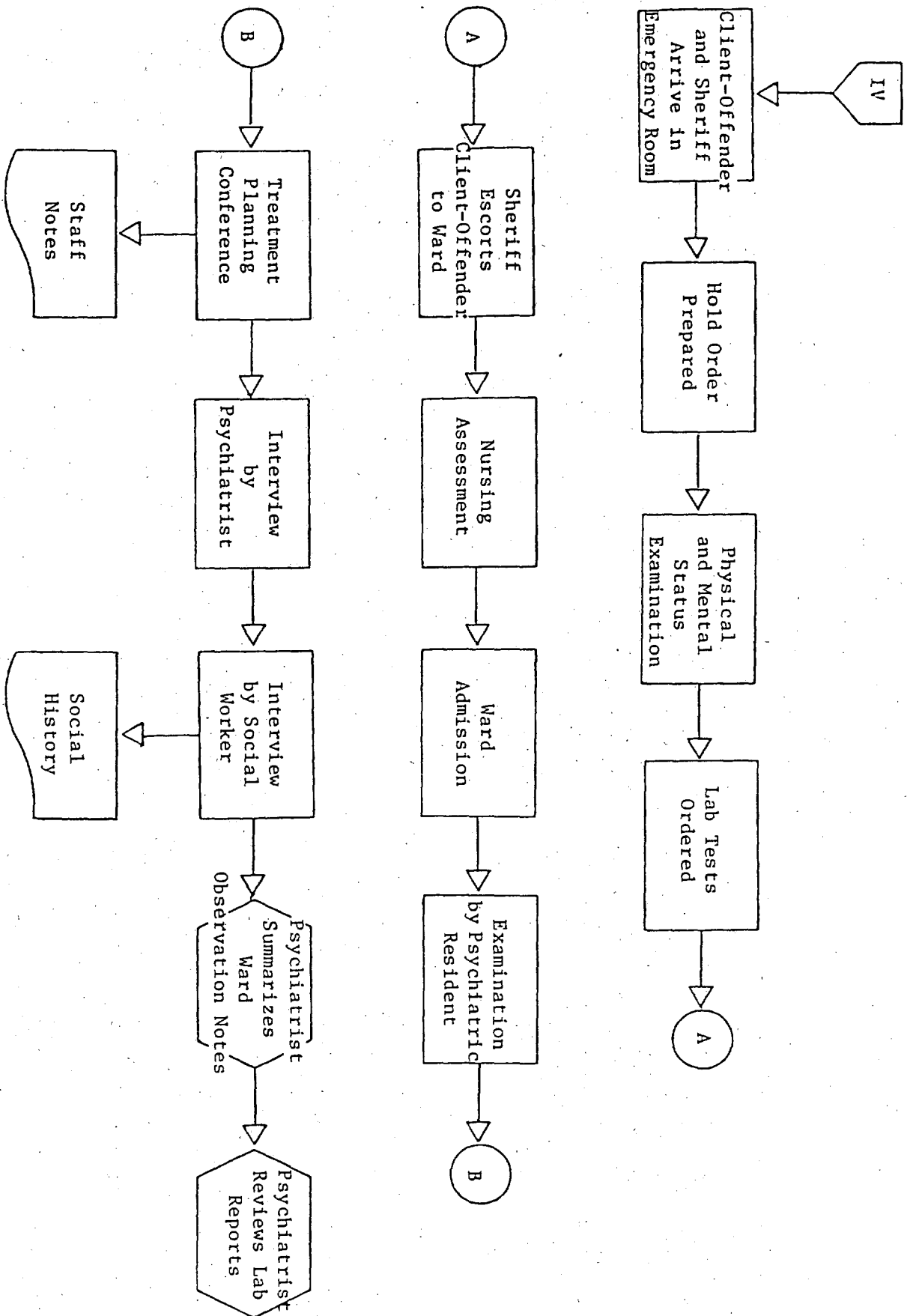


Figure 12. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Acquisition of Case Information for Inpatients.

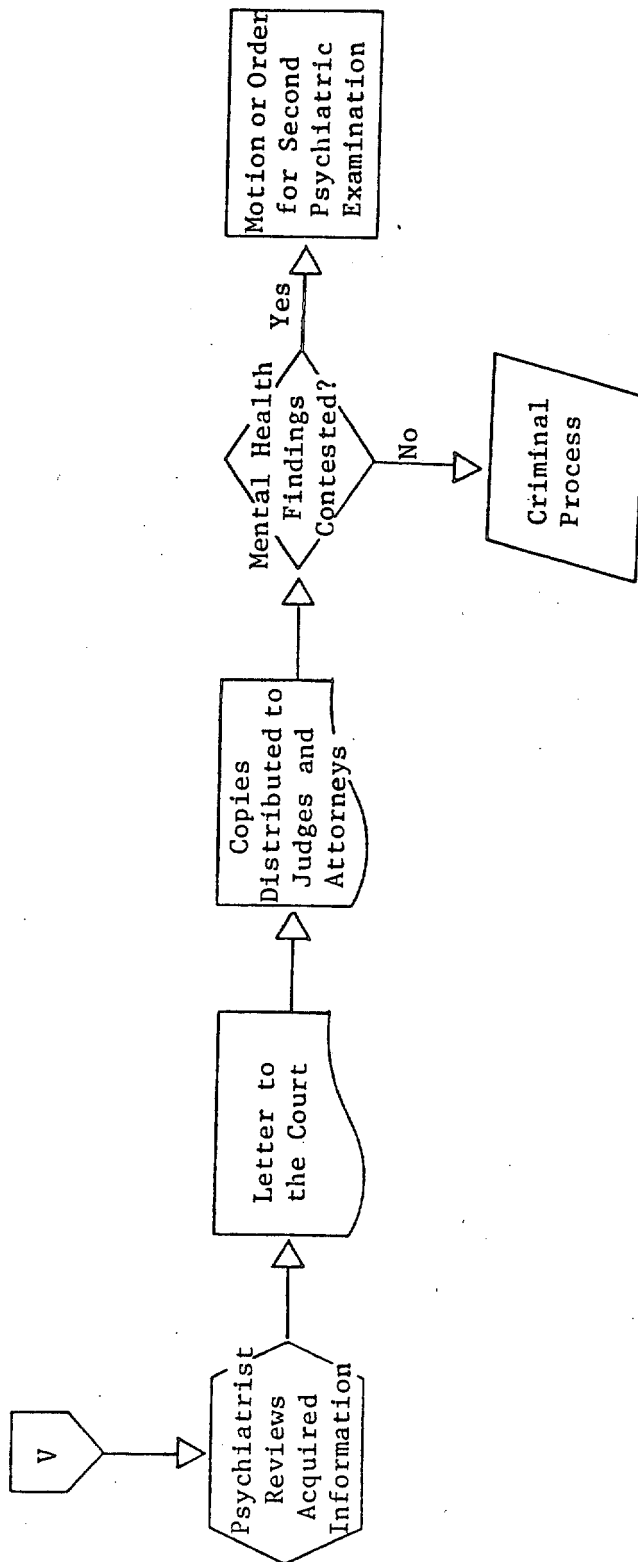


Figure 13. Case Processing Function Model of Forensic Services of Malcolm Bliss Mental Health Center, Provision of Evaluation Information.

Examination" (Appendix L). The State Director has also proposed the use of a "Background Information Sheet" (Appendix M). 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 15). 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)

5.2.2 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 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 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 paid bail and 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.

5.2.3 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.

5.3 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.

5.3.1 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.

5.3.1.1 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 verbalizations indicating the need for suicidal or elopement precautions. The physician or resident then conducts an emergency room examination with the client-offender to determine if there is an urgent medical or mental problem. Past medical history such as allergies to various medications is elicited. 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 N) is used to record 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.

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.

5.3.1.2 Ward Admission. The sheriff's deputy escorts the client-offender to the ward, where the client-offender is given pajamas and 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 (Appendix O) is very complete. 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. An ending 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.

5.3.1.3 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 Miranda 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.

5.3.1.4 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 P) 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, emuresis 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.

5.3.1.5 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.

5.3.1.6 Final Data Collection. As 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.

5.3.2 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, as 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.

5.3.3 Jail Evaluation

A very small number of evaluations are conducted at the St. Louis city jail. The Bliss Forensic Services Director 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 assigned 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.

5.4 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.

5.4.1 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 hospitalization indicated pending further legal proceedings?

The letter to the court is signed by the psychiatrist. (See Note 16)

5.4.2 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).

5.5 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 empirically 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 data sheet on each forensic client-offender in the state. His staff will complete a standard data sheet (Appendix Q) 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 17)

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.

Periodic research is conducted also. Currently, the Forensic staff psychologist is engaged with the Bliss Forensic Services director in studies in the areas of hostility and prediction of dangerousness. The psychologist was to begin performing examinations on August 13, 1980, under the new law authorizing persons other than licensed physicians to be designated as qualified examiners. The courts' receptivity to this psychologist's new role will be monitored.

6.0 FORENSIC UNIT OF THE PEACE RIVER CENTER FOR PERSONAL DEVELOPMENT (BARTOW, FLORIDA)

The Forensic Unit 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. With 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 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 against him. 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.

6.1 History of the Forensic Unit

The Forensic Unit began in July 1975 under a Law Enforcement Assistance Association (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. These and other changes will be described later in this report.

6.2 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 report 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 the present study. These will be summarized in the next section of the report 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 has 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.

6.3 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" in this report. 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.

6.4 Case Process Flow

The process flow diagrams, Figures 14, 15 and 16, 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.

6.4.1 Treatment Screening

Treatment screening is depicted in Figure 14. 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 referral to Wing E, an inpatient mental facility; referral to a psychiatrist for possible medication; or 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.

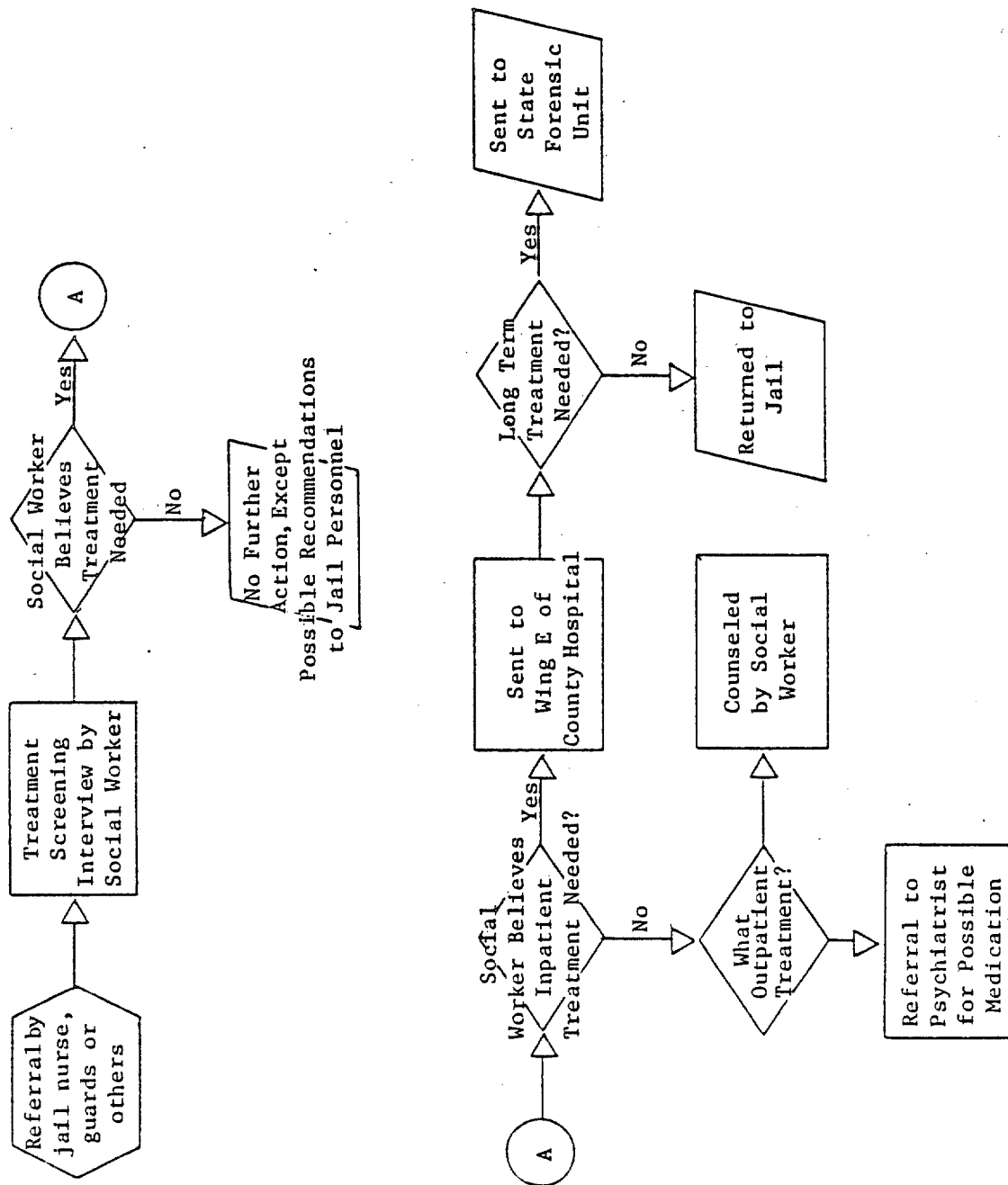


Figure 14. Forensic Unit, screening of jail inmates for possible mental health treatment.

6.4.2 Preliminary Mental Screening

As shown in Figure 15, a social worker screens defendants with possible mental health problems, usually at the request of the public defender. These pretrial screenings have two purposes: to determine whether a full mental examination for incompetency and insanity is warranted; and 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.

6.4.3 Mental Examinations

Mental examinations, which are the topic of Figure 16, 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 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

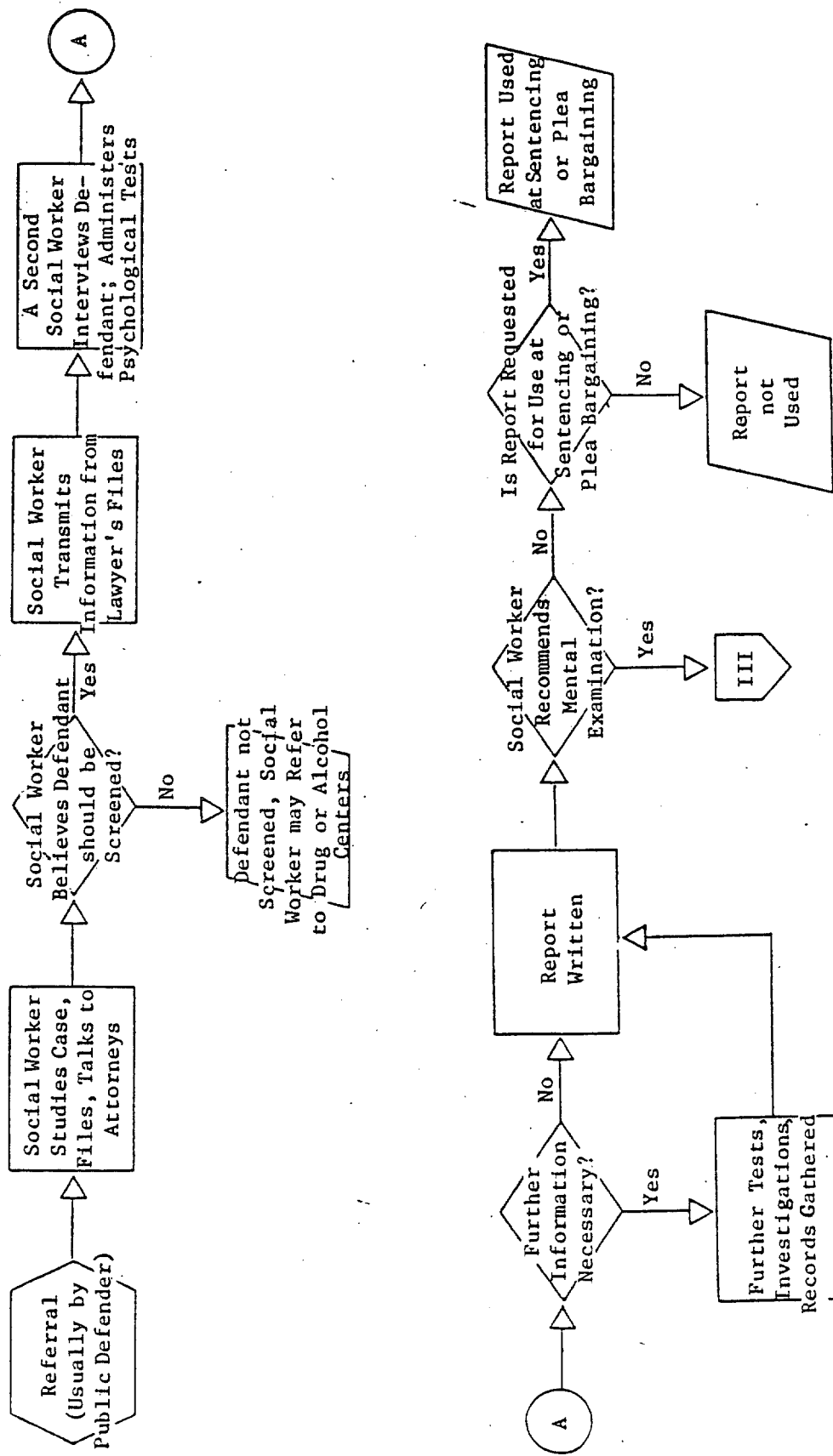


Figure 15. Forensic Unit, preliminary mental screening for possible mental examinations.

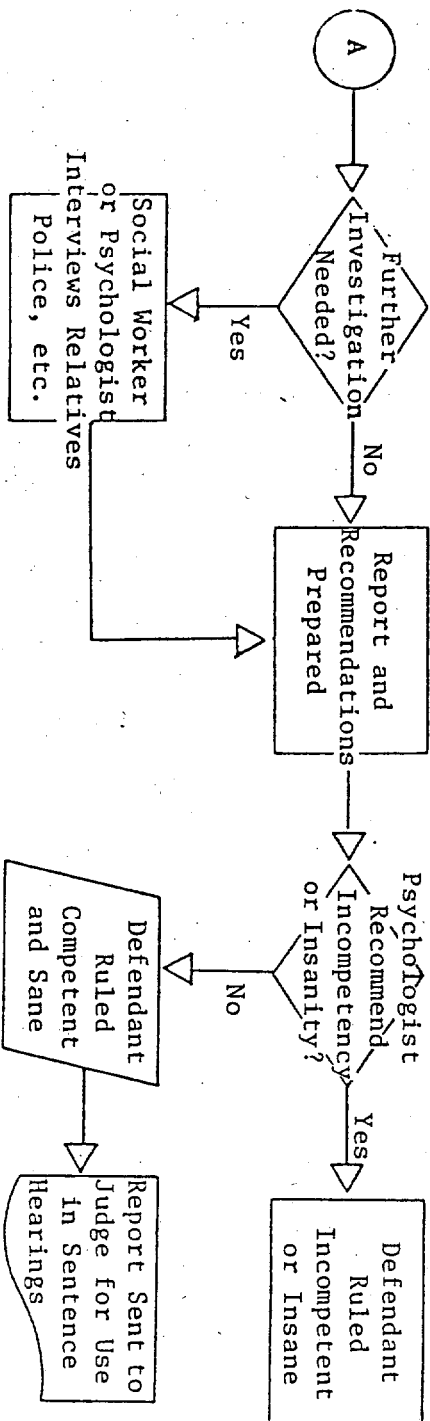
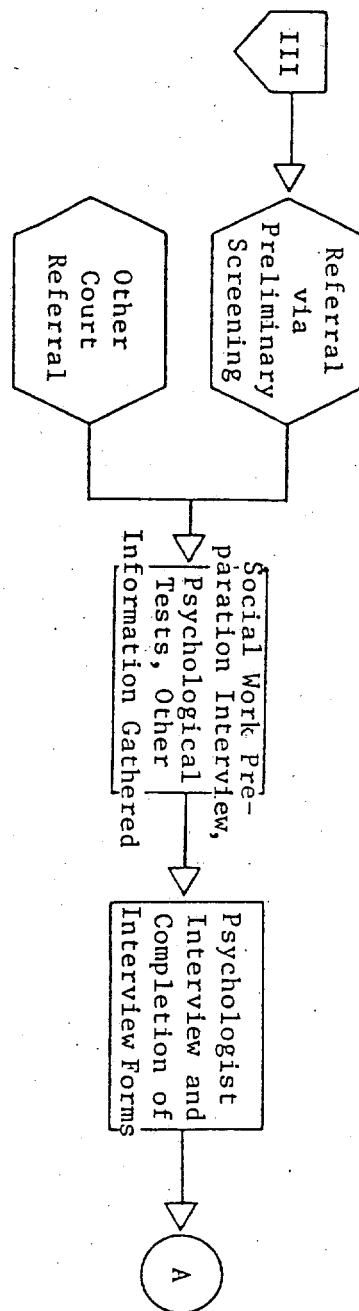


Figure 16. Forensic Unit, mental examinations to determine competency or sanity.

fills out two forms developed by the Unit, an Adult Evaluation form and a Competency Interview form (see Appendix U). 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.

6.5 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.

6.5.1 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.)

6.5.2 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 (see Appendix R). 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 report, 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 (See Appendix R). 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.)

6.5.3 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 ten or fifteen examinations per month. This number was 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 report 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 S) 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'Naughton 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.

6.6 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.

6.6.1 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. (These three forms are in Appendix T).

The basic purpose of the interview is to gather the information required for the "Competency Interview" form and an "Adult Evaluation" form (see Appendix U). 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, 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 in Section 6.7.

6.6.2 Mental Examinations

6.6.2.1 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.

6.6.2.2 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.

6.6.2.3 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 (see Appendix U). 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.

6.6.2.4 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.

6.7 Provision and Use of Mental Health Information

This section will describe 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.

6.7.1 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 at the Forensic Unit. (Appendix V is a recent example of a preliminary screening report.) 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.

6.7.2 Mental Examinations

6.5.2.1 Mental Examinations Report. The mental examination report is typically issued about two weeks after the interview is conducted. An example of a report can be found in Appendix X. 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).

6.7.2.2 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.)

6.7.2.3 Confidentialness 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 public defenders' formal order for mental examinations (see Appendix S) 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 (see the form letter in Appendix X). 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 (see Appendix X) 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.

6.7.2.4 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.

6.8 Feedback, Monitoring, and Program Evaluation

Except for general praise from the criminal justice community, (routinely evidenced in interviews), the Forensic Unit receives limited feedback about its operations. The Unit's primary clients, the judges and the public defenders, in interviews often express 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. In all, feedback mechanisms or formal evaluations, 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:

- o number of competency evaluations;
- o percentage of evaluations completed within fifteen working days;
- o number of psychological evaluations of juveniles;
- o treatment sessions with jail inmates; and
- o 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 T), which contain basic demographic information about clients;
- o "General Mental Health Service Ticket" forms (Appendix Y), which contain the time, length, and type of service for each client contact, and the staff involved; and
- o "Discharge Summary" forms (Appendix AA), 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.

7.0 THE RIVERSIDE HOSPITAL COMMUNITY MENTAL HEALTH CENTER

The present operation 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 Mental Health and Mental Retardation Services Board (Chapter 10).

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 18). 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 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 persons at Level 3 of 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 report will focus 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.

7.1 A Function Model of RHCMHC Evaluations and Pre-screenings

7.1.1 Organization

Figures 17 and 18 depict the flow of cases, operations and processes which characterize court-initiated evaluations and pre-screenings for civil commitment. Each figure represents the entire process for one type of evaluation, with Figure 17 emphasizing court-ordered evaluations and Figure 18 describing the pre-screenings for civil commitment.

7.1.2 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 supporting information. The verbal report of the escort forms the sole basis of the intake process. By 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. This delineation process is further discussed in Section 7.2 of this report.

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 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 18. Additional details of this phase are discussed in Section 7.3 of this report.

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

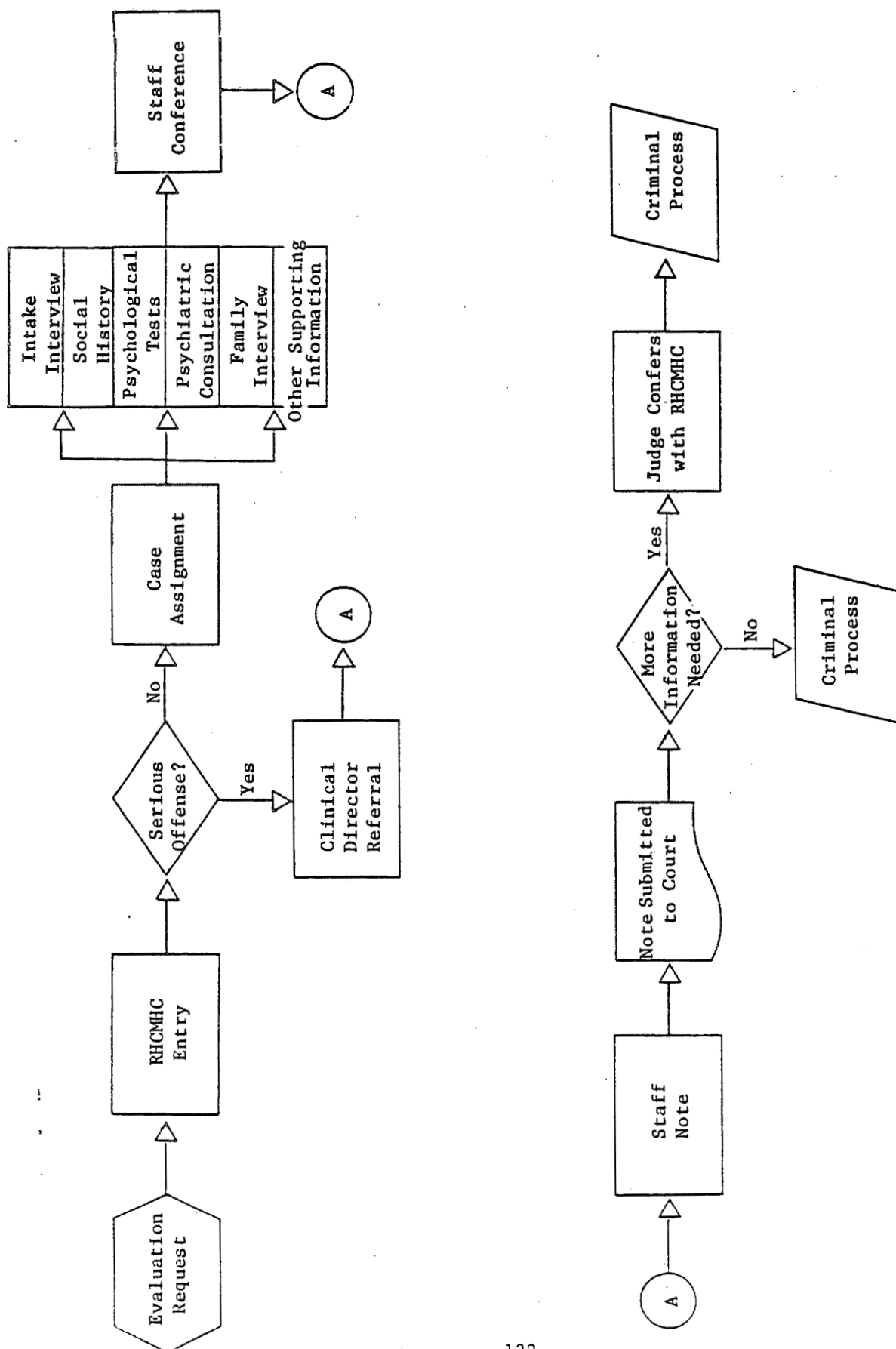


Figure 17. Case processing function model of the Riverside Hospital Community Mental Health Center for court-initiated evaluations.

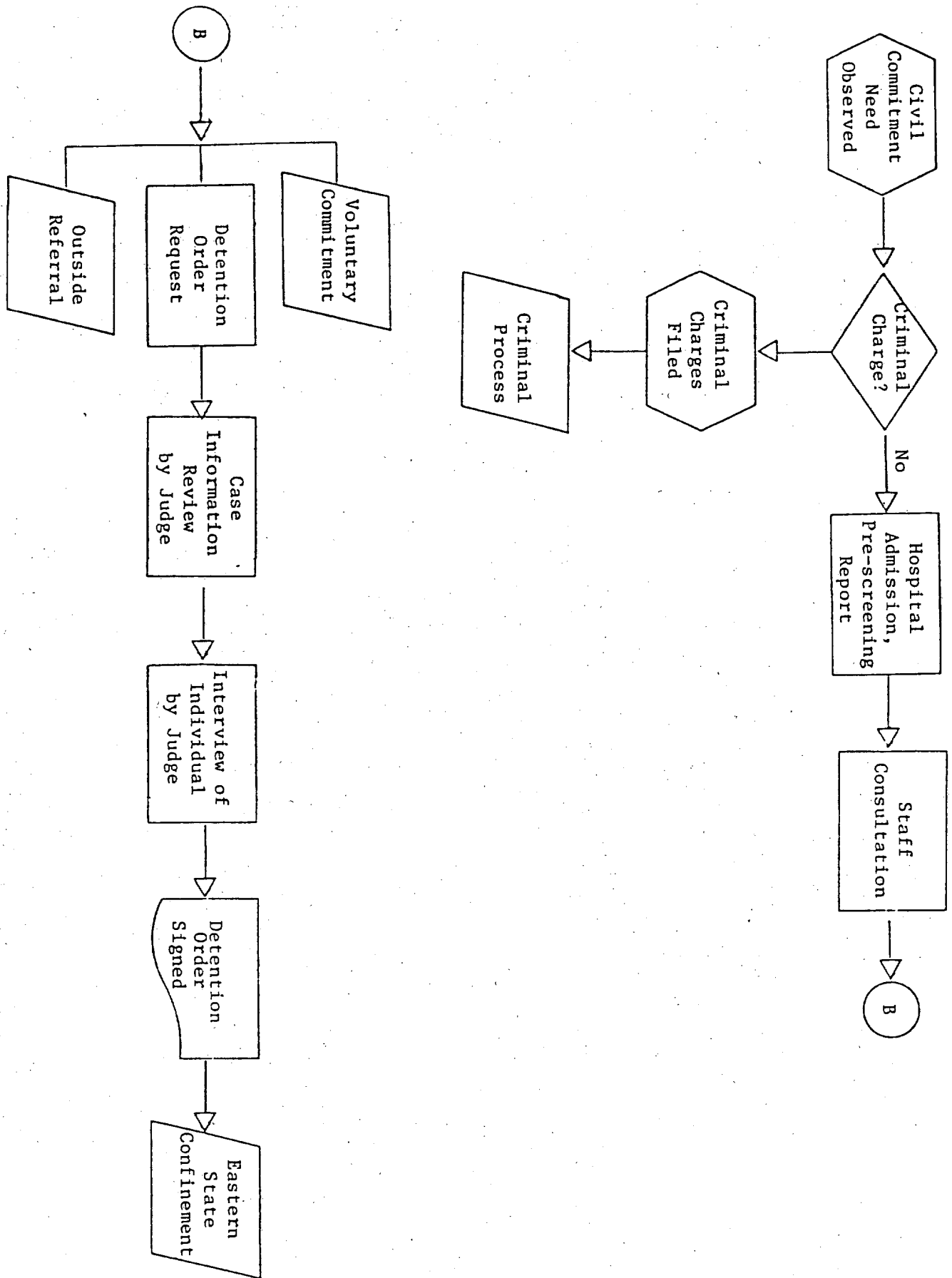


Figure 18. Case processing function model of the Riverside Hospital Community Mental Health Center
Pre-screening for Civil Commitment

needed. In rare instances, RHCMHC staff may be subpoenaed 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 18. Section 7.4 discusses in further detail the provision of information and the possible outcomes of a pre-screening for civil commitment.

7.2 Delineation of Mental Health Information

7.2.1 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 19).

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 "Dr. Lassen [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 shrouded in mystery. All that is known is that the Clinic Director conducts a psychiatric interview and communicates his findings to the court.

RHCMHC utilizes the M'Naughten 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 RHC/MHC 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 RHC/MHC 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 RHC/MHC. A family member or attorney may try to make the appointment, but the alleged offender must initiate the process. RHC/MHC is not responsible for notifying the court that a defendant has failed to make contact with the clinic; however, RHC/MHC 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 RHC/MHC 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 sheet (Appendix DD). The green sheet includes basic descriptive data, name of attorney, other RHC/MHC 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.

7.2.2 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.

7.3 Acquisition of Mental Health Information

7.3.1 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.

7.3.2 Procedures and Techniques

Movement of a client through the system begins when an appointment is scheduled. The intake worker completes the green referral sheet (Appendix DD) and gives it to the receptionist. She attaches a Log Sheet (Appendix EE) and a Staffing Note (Appendix FF) to the referral sheet 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 GG). 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 sheet, 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 worker's 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 HH) 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 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.

7.3.3 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 BB). 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 CC). RHC/MHC staff indicate that the judge always concurs with staff recommendations on the issuance of detention orders.

7.4 Provision and Use of Mental Health Information

7.4.1 Court-Ordered Mental Health Evaluation

The staff note (Appendix FF) 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 RHC/MHC and confer with the psychologist or psychiatrist. This happens only rarely, about once a year. The court may request RHC/MHC 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, RHC/MHC's involvement ceases.

7.4.2 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 an indefinite time up to 180 days, but the case must be reviewed every six weeks by Eastern State personnel.

7.5 Quality Control and Overall Program Evaluation

7.5.1 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.

7.5.2 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 pulled 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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14. A Case Study of the Malcolm Bliss Mental Health Center, St. Louis, Missouri, No Author, Draft, September 14, 1972.
15. 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])
16. Co, B.T., How Medical Reports Are Done. Speech to the Missouri Bar Association, April 24, 1980.
17. Forensic Service Procedure Manual, Malcolm Bliss Mental Health Center, St. Louis, Missouri, May, 1980.
18. Riverside Hospital Community Mental Health Center. Program Summary. Newport News, Virginia: author (no date, unpublished manuscript).
19. From a court order on file with RHCMHC.

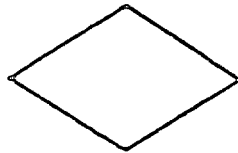
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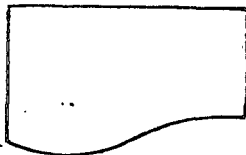
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Key to Figures

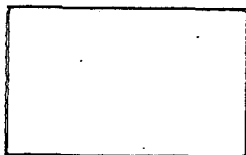
Operations, events, and decision points are portrayed in figures by geometric shapes, viz:



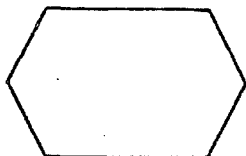
= Decision to make
regarding the defendant.



= Information received or
transmitted, usually in
document form.



= Implementation of a process
involving the client-defendant.



= Preparation for a process or
decision involving the client-
defendant.



= Exit or entry of the client-
defendant 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.

FORENSIC PSYCHIATRY

SERVICES

R. Bussey, ACSW, Coordinator

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. _____

A Certified Forensic Center Serving 7 Counties

Champaign • Darke • Greene • Logan • Miami • Montgomery • Shelby

A Component of EASTWAY COMMUNITY MENTAL HEALTH CENTER Dayton, Ohio



DAYTON AREA

APPENDIX C

FORENSIC PSYCHIATRY

SERVICES

Harold R. Bussey, ACSW, Coordinator

Talbot Tower • 131 N. Ludlow Street • Suite 268 • Dayton, Ohio 45402

Telephone 513/253-3988 or 223-0081

AUTHORIZATION FOR RELEASE OF INFORMATION

DAYTON AREA FORENSIC 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 dis-
closed: _____

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 re-
tain this copy for your records.

Revised 10-1-78

F-7

FC-3

Bureau of Statistics
Ohio Department of Mental Health and Mental Retardation

MONTHLY STATISTICAL SUMMARY REPORT COMMUNITY MENTAL HEALTH FACILITY

DMH&MR BOS 648-701
Revised 7-77

Report For:

Month Year

Agency No.

Agency Name

SECTION I - UNDUPLICATED COUNT of Clients by Total and Program, for Whom DMH&MR BOS 648-702 Admission and/or Termination Reports have Been Completed.

MOVEMENT OF CLIENTS	TOTAL (1)	TYPE OF SERVICE ENVIRONMENT							
		INPATIENTS (24 hour) (2)	EMERGENCY (Extensive Program) (3)	OUTPATIENTS (4)	INTERMEDIATE DIRECT CARE PROGRAMS				
					Residential Care (5)	Day Treatment (8)	Sheltered Workshop (7)	Halfway House (6)	Other (9)
A. Clients (patients) in the Caseload at the Beginning of the Month.									
+ B. Admissions during the Month - TOTAL									
C. Transfers between Service Categories (within the Organization) + C ₁ . Transfers TO:									
- C ₂ . Transfers FROM:									
- D. Terminations during the Month - TOTAL									
- E. Clients (patients) in the Caseload at the End of the Month									
TOTAL DIRECT CARE - hours									
STAFF - hours									
VOLUNTEER - hours									
TOTAL UNITS OF SERVICE					days	hours	hours	days	days

NOTES: 1. The Number of Admission Reports and the Number of Termination Reports sent to the Bureau of Statistics MUST EQUAL their respective totals shown in this Section.

2. In column (4) "Total" Line C, must equal line C, because all transfers are within the facility. Initially, ()

3. If the facility provides non treatment supportive services on a continuing basis in a residential facility, use Section II on the back.

SECTION II - Supportive Services

Page 2

Non-Treatment supportive services on a regular or intermittent basis to enable independent living for an established caseload of clients. The client data needed and collected by the agency are not applicable to the clinical data required by the mental health client reporting system of the State of Ohio.

Number of Clients Served

SECTION III - Non-client-service Staff Activity

SUB-PROGRAMS	TOTAL HOURS	STAFF HOURS	VOLUNTEER HOURS
A. ADMINISTRATIVE SERVICES - TOTAL			
1. Administration/Support			
2. Staff Training			
3. Research/Evaluation			
B. COMMUNITY SERVICES - TOTAL			
1. Public Info. & Education			
2. Consultations			
3. Community Planning			
4. One-Time Services			

SECTION IV - Output Measures

OUTPUT MEASURES:	Public Information & Education	Consultations	One-Time	Community Planning
A. Number of Single Presentations (Lectures, Talks)				
B. Number of Workshops or Institutes				
C. Number of Radio, Television, etc., spots				
D. Number of pamphlets, flyers, etc., distributed				
E. Telephone Contacts				
F. Number of School Consultations				
G. Consultations with Courts, Police, Parole, etc.				
H. Consultations with Social/ Welfare Agencies				
I. Consultations with Mental Health Agencies				
J. Number of Walk-ins (Face to Face contacts)				
K. Number of Sessions				
L. Number of Other Contacts Not in Above				

APPENDIX E FORENSIC PSYCHIATRY ADMISSION REPORT

Form 10-73
Revised 10-73

A - Identification - Required of all agencies.

Agency Name:	Agency Number:
State Case Number:	
(Assigned by the Agency from a block of numbers provided by the Bureau of Statistics of the Bureau of Support. See instructions.)	
Admission Date: (First contact resulting in a date work-up under the supervision of a professional.)	12 month day year
County of Ohio Residence: (TY-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
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
2 Sex: M - Male F - Female	22
3 Ethnic Group: 1 - white 2 - black 3 - Oriental 4 - American Indian 5 - Puerto Rican 6 - Mexican American 7 - Other 8 - Unknown	23
Marital Status: 1 - Never married 2 - Married 3 - Widowed 4 - Divorced 5 - Separated 6 - Remarried 7 - Other 8 - Unknown	24
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	25
Normal Occupation: (Name the usual occupation even if unemployed or underemployed now)	26
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	27
Annual Family Income (in dollars): (TTTTT-Unknown)	28
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)	29
10 Military Service: Y - Unknown 0 - None 1 - Veteran 2 - Reservist 4 - Active Duty Now Total	30
Prior Mental Health Evaluation, Counseling, or Treatment: This FY Prior FYs This Fiscal Year Prior Fiscal Years	31
TY - 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	32

D - Administrative Data - Required of all agencies.

1 Source of Referral: (See Source Code on the back of this sheet.)	49
2 Presenting Problem Admitting Diagnosis: (See Diagnosis Code on the back of this sheet.)	51
3 Type of Service Environment: (Choose only the primary type) 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	52
4 Agency Program: (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	53

F - Administrative Data - Required of all forensic agencies.

1 Date of Receipt of Referral:	34
2 Type of Evaluation Requested: 1 - Pretrial: Expert Witness (2945.40) 2 - After Conviction, before sentencing (2947.25, Ascherman Act) 3 - Probation for Treatment of Drug Dependence (3719.51) 4 - Adult Probation 5 - Adult Parole Authority 9 - Other	60
3 County Where Charged:	61
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.)	70
5 Ohio Correction Institution Inmate Number: Institution Code: (See Institution Code on the back of this sheet)	71
This block for state use only:	72
1 - Admission 2 - Delete this Record from the file	73

If you need help with this form call: (614) 466-2342
Out-patient Section/Bureau of Statistics

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 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)
- Y - 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, Child, & 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 8-83 608-702779
Revised 10-79

G - Identification - Required of all agencies.

1 Agency Name:	Agency Number:
2 State Case Number:	
(Assigned by the Agency from a block of numbers provided by the Bureau of Statistics or the Bureau of Support. Use the one number previously assigned to the Client.)	
3 Admission Date:	
(Put in the same date shown to the Client's Admission Report.)	
4 Date of Birth:	
(Put in the same date shown to the Client's Admission Report.)	

H - Administrative Data - Required of all agencies.

1 Agency Classification:	
(See code on back of this sheet)	
2 Date of Final Interview:	
3 Date of Termination:	

I - Clinical Data - Required of all agencies.

1 Number of Service Units Provided to the Client:	
Number of interviews with or about the Client:	
Number of days of Inpatient Care:	
Number of days of Residential Care:	
Number of days of Partial Care (Day care, Night care):	
Number of other Service Units (Specify the Units):	

2 Diagnoses:

Primary Diagnosis - APA Code:

APA Description:

Secondary Diagnosis (if any) - APA Code:

APA Description:

3 Types of Service:

General:

- 1 - Intake only
2 - Evaluation
4 - Referral to other service
Total

Psychotherapy:

- 1 - Individual therapy
2 - Family therapy
4 - Group therapy
Total

Social Therapy:

- 1 - Therapy thru Collateral
2 - Rehabilitative therapy
4 - Educational therapy
Total

Physical Therapy:

- 1 - Chemotherapy
2 - Somatic therapy
4 - Rehabilitative
Total

Miscellaneous Service:

- 1 - Work related (vocational)
2 - Telephone
4 - Home visits
8 - Advocacy
16 - Other
Total

K - Identification - Required of State Operative Agencies, otherwise optional.

1 Agency File Number on the patient: (if any)
2 Patient or Client:
Name: Last First Middle Initial
3 Social Security Number:

L - Personal History - Required of all Forensic agencies.

1 Military Service:	
1 - Unknown	
2 - None	
3 - Wars before 1929	
4 - World War II	
5 - Korean War	
6 - Viet Nam	
10 - Peacetime only	
32 - Other	
Total	
Status:	
1 - Unknown	
2 - Honorable Discharge	
3 - General Discharge (Without Honor)	
4 - Dishonorable Discharge	
2 Prior Incarceration for Convictions:	
1 - Unknown	
2 - None	
3 - Adult Correction Institutions	
4 - Juvenile Correction Institutions	
5 - Local Jails, Workhouses	
6 - Other	
Total	
3 Into Correction Institution Inmate No. (if any)	
Institution Code:	
(See code on the back of this sheet)	

M - Administrative Data - Required of all Forensic agencies.

1 Response to the Requesting Authority:	
0 - None	
1 - Testimony	
2 - Consultation	
4 - Written Report	
Total	
2 Types of Evaluation Performed:	
0 - None	
1 - Psychiatric evaluation	
2 - Psychological evaluation	
4 - Social evaluation	
8 - Physical evaluation	
16 - Other	
Total	
3 Recommended Treatment Disposition:	
1 - Inpatient (24 hour)	
2 - Intermediate Residential Care	
3 - Partial Care (day care, night care)	
4 - Outpatient (workshop, School)	
5 - Outpatient	
6 - Custodial Confinement with Treatment	
7 - No Treatment Recommended	
9 - Other	
4 Actual Treatment Disposition:	
1 - Inpatient (24 hour)	
2 - Intermediate Residential Care	
3 - Partial Care (day care, night care)	
4 - Outpatient (workshop, School)	
5 - Outpatient	
6 - Custodial Confinement with Treatment	
7 - No Treatment Recommended	
9 - Other	
5 Legal Disposition by Requesting Authority:	
1 - Case dismissed	
2 - Found innocent	
3 - Acquitted	
4 - Probation	
5 - Rehabilitation and Correction-Incarceration	
6 - Reprimand of Mental Health and Mental Retardation (Commitment or Probation)	
7 - Rehabilitation and Correction-Parole	
8 - Disposition open because of escape	
9 - Other (includes death)	
10 - Unknown	
6 Defense Committee of (most extreme penalty):	
Ohio Revised Code	
Number of other charges committed of:	
(If more than 9, enter 9)	

N - This Block for State Use Only.

1 - Termination Card 1	
2 - Delete	

O - This Block for State Use Only.

1 - Termination Card 2	
2 - Delete	

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 | 70 - Court, correctional institution, police, probation and parole service, attorney |
| 22 - Public mental hospital (federal, state, county, city) | 71 - Common Pleas Court |
| 23 - Psychiatric service of general hospital | 72 - Municipal Court |
| 24 - Residential treatment center for children | 73 - County Court |
| 25 - Training school for mental retardation, epilepsy or other disabilities | 74 - Prosecutor's Office |
| 26 - Psychiatric nursing home | 75 - Client's Attorney |
| 29 - Other psychiatric inpatient facility | 76 - Police, Sheriff |
| 31 - Private psychiatrist | 77 - Common Pleas Probation Department |
| 32 - Outpatient psychiatric clinic | 78 - Municipal Court Probation Department |
| 33 - Psychiatric day care center | 79 - County Court Probation Department |
| 41 - Private physician | 7A - Correctional Facility |
| 42 - Local health department | 7B - Adult Parole Authority - Parole |
| 43 - General hospital | 7C - Adult Parole Authority - Probation |
| 44 - Nursing home (skilled nursing and related medical service) | 7D - Re-referral for Ascherman Act |
| 49 - Other medical or health agency, nurse | 80 - School (elementary, high school, etc.) |
| 51 - Private psychologist | 91 - Clergy |
| 59 - Other psychological services (e.g., psychological counseling service) | 92 - Alcoholics Anonymous |
| 60 - Social service agency (as in family service agency, public welfare agency, settlement house, child placement agency, marriage counseling, private welfare agency) | 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 | B - Marion Correctional Institution |
| 4 - Ohio Women's Reformatory | A - Lebanon Correctional Institution |
| 5 - London Correctional Institution | F - Chillicothe Correctional Institute |
| 6 - Ohio Penitentiary | S - Southern Ohio Correctional Facility |

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}

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 base 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.

C. 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.)

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 relevant to these certification standards on a semi-annual basis on designated forms?

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.}

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 H

WARREN CIRCUIT COURT

INDICTMENT NUMBER _____

DIVISION NUMBER _____

COMMONWEALTH OF KENTUCKY

PLAINTIFF

S: 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:

ATTY. FOR THE COMMONWEALTH

1st Appointment: _____

TENDERED BY:

2nd. Appointment: _____

ATTY. FOR DEFENDANT

3rd. Appointment: _____

DEFENDANT'S STATUS:

IN JAIL _____

LEGAL DATE

OUT ON BOND _____

AS OF _____

APPENDIX I

COMPREHENSIVE CARE CENTER

NAME OF CLIENT		DATE		_____, KENTUCKY LOCATION	
NAME OF EVALUATOR					
PSYCHO-SOCIAL EVALUATION					
IDENTIFYING DATA	AGE	SEX	MARITAL STATUS	EDUCATION	
			M S D W SEP.		
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.)

APPENDIX I (Continued)

Interpersonal Status (cont.)

Average Daily Routine (Including Eating/Sleeping patterns)

Employment and/or Educational History

Sexual Data (Education, Information, Traumatic experiences, Current functioning).

APPENDIX I (Continued)

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
HOMICIDE
OR
SUICIDE
RISK**

HOMICIDE or SUICIDE RISK (Describe thoughts, Recent attempts, Past attempts, Approximate dates)

Yes ___ No ___

APPENDIX I (Continued)

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 STATUS: Cognitive Functions (Describe 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.

**SUMMARY OF
PROBLEMATIC
LIFE AREAS**

CLINICAL IMPRESSION (May Include DSM II Diagnosis)

OTHER COMMENTS (Social Service Planning Activities Included Here)

Evaluator's Signature
Title

Supervisor(s) Signature
Title

COMPREHENSIVE CARE ^{APPENDIX J}CENTER

FILE NUMBER

REGION

LOCATION

KENTUCKY

LAST NAME

FIRST

MIDDLE

PSYCHOLOGICAL EVALUATION

BIRTHDATE

SEX

RACE

DATE OF EXAMINATION:

CONFIDENTIAL

FOR PROFESSIONAL USE ONLY

EXAMINER (S):

TESTS ADMINISTERED:

CODE

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

APPENDIX 1
SUGGESTED ORDER

STATE OF MISSOURI

-VS-

DEFENDANT

CASE NO. _____

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 M.
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 N

MENTAL STATUS EXAMINATION

(MISSOURI DEPARTMENT OF MENTAL HEALTH)

USE ADDRESSOGRAPH OR FILL IN:

REPORT DATE: MONTH DAY YEAR

PATIENT NAME: LAST NAME ONLY

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.

PATIENT NUMBER: HOSPITAL NUMBER CASE NUMBER C.D.

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 . . . 1 2 3
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 DEFENSIVE . . . 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 INCOHERENT . . . 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 DEPRESSIONED 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 PHOBIA . . . 1 2 3
247 OBSESSIONS . . . 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 PLANNES 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 CLUDDING 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

349-GLOBAL RATING - SEVERITY OF ILLNESS (CIRCLE ONE NUMBER): 1 2 3 4 5 6 7
NO MILD MODERATE SEVERE

DSM III DIAGNOSIS (TRANSFER CODES FROM REVERSE SIDE):

PRIMARY ☐ ☐ ☐ ☐ ☐ SECONDARY ☐ ☐ ☐ ☐ ☐

ADDITIONAL COMMENTS:

PHYSICIAN'S LAST NAME (PRINT)

SOCIAL SECURITY NUMBER

APPENDIX N (Continued)

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
- With each:
- ☐ 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

- ☐ 290.0. Senile dementia
- ☐ 290.1. Pre-senile dementia
- ☐ 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
- ☐ 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
- ☐ 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
- ☐ 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. Chikungunya
- ☐ 294.8. Other and unspecified physical condition

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

III PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY

- ☐ 295.0. Schizophrenia
- ☐ 295.1. Simple
- ☐ 295.2. Hebephrenic
- ☐ 295.3. 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*
- ☐ 296.0. Major affective disorders
- ☐ 296.1. Involutional melancholia
- ☐ 296.2. Manic-depressive illness, manic
- ☐ 296.3. Manic-depressive illness, depressed
- ☐ 296.33. Manic-depressive, circular, manic*
- ☐ 296.34. Manic-depressive, circular, depressed*
- ☐ 296.8. Other major affective disorder
- ☐ 297.0. Paranoid states
- ☐ 297.1. Paranoia
- ☐ 297.9. Involutional paranoid state
- ☐ 297.9. Other paranoid state
- ☐ 298.0. Other psychosis
- ☐ 298.0. Psychotic depressive reaction

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

- ☐ 301.0. Personality disorders
- ☐ 301.1. 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*
- ☐ 302.0. Sexual deviation
- ☐ 302.1. Homosexuality
- ☐ 302.2. Fetishism
- ☐ 302.3. Pedophilia
- ☐ 302.4. Transvestitism
- ☐ 302.4. Exhibitionism
- ☐ 302.5. Voyeurism*
- ☐ 302.6. Sadism*
- ☐ 302.7. Masochism*
- ☐ 302.8. Other sexual deviation
- ☐ 303.0. Alcoholism
- ☐ 303.1. Episodic excessive drinking
- ☐ 303.2. Habitual excessive drinking
- ☐ 303.2. Alcohol addiction
- ☐ 303.9. Other alcoholism

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. Alcoholism
- ☐ 303.1. Episodic excessive drinking
- ☐ 303.2. 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. Unsociated aggressive reaction*
- ☐ 308.5. Group delinquent reaction*
- ☐ 308.9. Other reaction

X CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON-SPECIFIC CONDITIONS

- ☐ 316.0. Social maladjustment without manifest psychiatric disorder
- ☐ 316.1. Marital maladjustment*
- ☐ 316.1. Social maladjustment*
- ☐ 316.2. Occupational maladjustment*
- ☐ 316.3. Dysocial behavior
- ☐ 316.9. Other social maladjustment*

Non-specific conditions

- ☐ 317. Non-specific conditions*
- ☐ 318. No mental disorders
- ☐ 318. No mental disorder*

XI NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE

- ☐ 319.0. Diagnosis deferred*

* Categories added to ICD-8 for use in the U.S. Only

DX Limited To Five Digits

FIFTH DIGIT QUALIFYING PHRASES			
SECTION II	SECTION III	SECTIONS IV THROUGH IX	ALL DISORDERS
1 Acute	5 Not psychotic	6 Mild	5 In remission
2 Chronic	now	7 Moderate	
		8 Se	

MALCOLM BLISS MENTAL HEALTH CENTER
NURSING ASSESSMENT

DATE: _____ INTERVIEWER: _____

INFORMANT (IF NOT PATIENT): _____

PREVIOUS HOSPITALIZATIONS: _____

I. SUPPORT SYSTEMS

A. FAMILY PROFILE: _____

Name and Relationship	Living	Deceased	Well	*Ill	*Other

Other _____

*Identify individual and explain: _____

What is your place in your family? _____

Whom are you closest to in your family? _____

B. EDUCATION/EMPLOYMENT: _____

(Possible Leading Questions)

Highest grade completed - year? _____

Describe school experience? _____

Grades/Interpersonal? _____

Where do you work? _____

What is your position there? _____

Do you like your job? _____

Do you have friends at work? _____

How do things go for you at work? _____

C. OTHER SUPPORTIVE UNITS:

Do you belong to any organizations, groups?
Do you have any hobbies? Pets?
How does religion fit in your life?
Do you belong to a church? Actively?
Do you have close friends? How can they help you?
What do you like in a friend?
Who cares about you the most?
Whom do you care about?
Whom do you confide in?
Whom should we notify in case of emergency?
Do you desire any restrictions of visitors?
If so, whom?

II. BIOPHYSICAL PATTERNS

A. PHYSICAL HEALTH

How is your physical health?
Do you have any physical limitations?
How is your vision? Glasses?
Is your hearing all right?
Are you an active person?
What type of exercise do you get?
Do you tire easily?
Do you worry about your health?

3. ALLERGIES

Do you have any allergies to:

Medication
Food
Other

C. MEDICATIONS

Are you currently on medication?
(List medications, dosages, and frequency)
Have you recently been on any other medica-
tion?

D. SLEEPING PATTERNS

Tell me about your sleeping habits?
How many hours of sleep at night?
What time do you go to bed?
Do you sleep well?
Do you need medication to sleep?
Do you awaken during the night?
Do you dream? What? Recurring?

What time do you usually awaken?

E. EATING HABITS

Are you on a special diet?
 Any specific food problems?
 What foods do you especially enjoy?
 Do you dislike any specific foods?
 How many times a day do you eat?
 Small meals? Main meal when?
 Do you enjoy eating?
 Do you gain weight easily?

F. PERSONAL HYGIENE

When do you prefer to bathe?
 Morning or Evening?
 Do you prefer shower or tub?
 How often do you brush your teeth?
 Specific skin care:

(Female) Menstrual Status:

Are you on contraceptives?

(Pill, IUD, Other)

G. ELIMINATION

What is your usual bowel pattern?
 Do you take laxatives? Type?
 Do you have any urinary problems:
 Frequency? Pain? Retention? Enuresis?
 Nocturia?

H. PERSONAL HABITS

Do you smoke? How much?
 When do you smoke most?
 How long have you smoked?
 Have you wanted to quit?
 Do you drink alcoholic beverages?
 What types? When?
 Do you feel drinking presents any problem
 for you?

III. RESPONSE TO STRESS

A. PRESENT PROBLEM AND HISTORY

What causes you to be here?
 Have you experienced this before?
 How long have you been feeling like this?
 (Long term) What keeps you here?

B. COPING /DEFENSE MECHANISMS

How do you tell you are upset?
What helps when you are upset?
What do you do when you are under stress?
At home? On the job?
Have you felt like hurting yourself?
Others?

IV. INTERPERSONAL RELATIONSHIP

A. SELF ESTEEM

How do you feel about yourself?
What do you like about yourself?
What do you dislike about yourself?

B. INTERPERSONAL SECURITY

How do others see you?
With whom do you feel closest:
What do you do together?
How do you feel at work?
In social situations?
How do you feel you get along with other
people?

V. MOTIVATION, LIFE STYLE, FUTURE PLANS

A. SELF ACTUALIZATION NEEDS OR CURRENT NEED LEVEL

(Possible Leading Questions)

What are your expectations of yourself?
How does your life fulfill your expectations?
Would you make any changes in your life
at home? at work? here?

B. MOTIVATION/FUTURE PLANS

How would you like things to be different in
the future?
What can you do to accomplish this?
What do you think we can do to help you?
While here?
After discharge?

C. LIFE STYLE _____

What are your living arrangements? _____

How do you spend you time? (Typical day) _____

VI. THOUGHT PROCESSES: VERBAL & NONVERBAL BEHAVIOR:

A. REALISM OF THOUGHT _____

What do you think is happening to you now? _____

Do you have thoughts that disturb you? _____

Do you day dream? _____

Do you have difficulty concentrating? _____

B. NONVERBAL BEHAVIOR OBSERVATION (OBSERVATION ONLY) _____

Does patient appear reliable? _____

How does patient behave? _____

What is his affect? _____

Does he appear tense? Angry? _____

Passive? Preoccupied? _____

What is most noticeable or different? _____

VII. AWARENESS & HANDLING FEELINGS

A. AWARENESS & RECOGNITION OF FEELINGS _____

How are you feeling now? _____

What makes you angry? Sad? _____

How can you tell when you're angry? Sad? _____

B. HANDLING EMOTIONS _____

When you're angry, what do you do? _____

What helps most? _____

Do you get angry often? _____

Tell me about a very happy and a very sad
 time in your life. _____

VIII. TALENTS, STRENGTHS, AND ASSETS

A. SELF APPRECIATION _____

What do you like about yourself? _____

What do you feel you do well? _____

What are your strengths? _____

What do you consider your greatest asset? _____

IX. FAMILY/SIGNIFICANT OTHER INTERVIEW

AVAILABLE FOR INTERVIEW: YES ☐ NO ☐

PERSONAL: ☐

TELEPHONE:

A. RELIABILITY/AFFECT (OBSERVATION ONLY)

Does he/she appear reliable?

What is his/her affect?

How does he/she behave?

B. POSSIBLE LEADING QUESTIONS

What caused the client to be here?

Has anything like this happened before?

How do you feel about the client's illness?

How does this hospitalization affect your family life?

How do you think you can help the client?

How do you think we can help the client?

How can we help you/family?

How would you like things to be different at home?

How would you like things to be different in the future?

What are your specific plans for the client when discharged?

X. NURSING ASSESSMENT SUMMARY

INITIAL INTERVIEW:

DATE: _____ TIME: _____ R.N. SIGNATURE _____

COMPLETED INTERVIEW:

DATE: _____ TIME: _____ R.N. SIGNATURE _____

<h2 style="margin: 0;">SOCIAL SERVICE REPORT</h2> <p style="margin: 10px 0;">Forensic Social Service Data Base</p>	<p style="text-align: right; font-size: small; margin: 0;">NAME, HOSPITAL NUMBER, SEX</p> <p>Name _____</p> <p>MB#: _____</p> <p>Sex: _____</p> <p>D.O.B. _____</p> <p>SS#: _____</p> <p>Address _____</p>				
<p>Admitted: <u>date</u> _____</p> <p>Ward: <u>floor</u> _____</p> <p><u>PRESENT SITUATION:</u></p> <p>- Patient is a <u>age</u>, <u>marital status</u>, <u>race</u>, <u>employment status</u>, <u>sex</u>, ordered to Malcolm Bliss by <u>court</u>, by <u>judge</u>. Patient is charged with _____. Information for this report taken from _____.</p> <p><u>I. HOME:</u></p> <p>Where and when patient was born and raised. Who are parents. How many siblings, and what order. Siblings psychiatric history and present status.</p> <p>Patient's history for running away from home.</p> <p>Patient's history for emesis.</p> <p>Patient's childhood history for treatment of animals.</p> <p>Patient's history for lying.</p> <p>Patient's childhood history for stealing.</p> <p>Patient's childhood history for fighting and/or friendships.</p> <p>Patient's childhood history for firesetting.</p> <p><u>II. EDUCATIONAL HISTORY:</u></p> <p>Where did patient attend elementary and high school.</p> <p>What grades did the patient complete.</p> <p>How did patient perform in school.</p> <p>Was patient ever suspended, expelled or truant.</p> <p>How were patient's peer relationships in school.</p> <p>Did patient have any vocational or additional education.</p> <p><u>III. EMPLOYMENT HISTORY:</u></p> <p>- Include full time or part-time, longest job, present job, reason for termination, any history of poor peer relationships or poor relationships with supervisors.</p> <p><u>IV. SOURCE OF INCOME:</u></p> <p><u>V. MILITARY HISTORY:</u></p> <p>Dates of service, Branch, highest Rank, Discipline problems, type of discharge.</p> <p><u>VI. MARITAL HISTORY:</u></p> <p>Marriages, offspring, their ages and current status.</p> <p><u>VII. LEGAL HISTORY:</u> (chronological)</p> <p style="margin-left: 20px;">A. Juvenile:</p> <p style="margin-left: 20px;">B. Adult:</p> <p><u>VIII. PAST PROBLEMS:</u></p> <p>Miscellaneous, e.g. alcohol and drug abuse history; significant & relevant</p>					
<p style="font-size: small; margin: 0;">NAME OF PATIENT</p> <p style="margin: 5px 0;">Name _____</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; font-size: small;">HOSPITAL NO.</td> <td style="width: 50%; font-size: small;">LOCATION</td> </tr> <tr> <td style="margin: 5px 0;">MB#: _____</td> <td style="margin: 5px 0;">Floor _____</td> </tr> </table>	HOSPITAL NO.	LOCATION	MB#: _____	Floor _____
HOSPITAL NO.	LOCATION				
MB#: _____	Floor _____				

SOCIAL SERVICE REPORT (Continued)

medical problems, etc.

IX. SIGNIFICANT OTHERS INTERESTED IN PATIENT:

X. PLAN:

- 1) Patient is not to leave the ward unless ordered by Dr. 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

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) _____

I. HISTORIC INFORMATION

13. Grade Achieved _____

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

25. Hospitalization Pending Trial? _____ Yes
 _____ No
 _____ Not Answered
 _____ Not Asked
26. Mental Disease or Defect? _____ Yes
 _____ No
 _____ Deferred
 _____ Not Answered
 _____ Not Asked
27. Diagnoses _____ Primary
 DSM III _____ 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

DEK COUNTY
HALL OF JUSTICE ANNEX
205 N. LAUREL
PANTHER, FLORIDA 33830
PHONE 813 533-8171

MIDDLE COUNTY
MIDDLE COUNTY COURTHOUSE
WAUCHULA, FLORIDA 33873
PHONE 813 773-8738

HIGHLANDS COUNTY
HIGHLANDS COUNTY COURTHOUSE
SEDFORD, FLORIDA 33870
PHONE 813 383-2381



JACK O. JOHNSON
PUBLIC DEFENDER
TENTH JUDICIAL CIRCUIT

PLEASE REPLY

MEMORANDUM

TO: Dr. Burt Kaplan, Mental Health Center, Forensic Unit
RE: PRELIMINARY MENTAL SCREENING EXAMINATION

It is requested that a preliminary mental screening examination be conducted on the following defendant to determine if a full-scale examination is necessary.

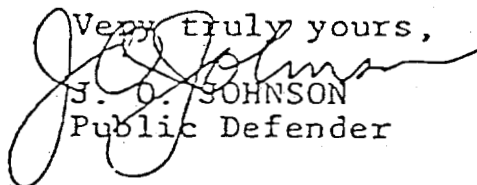
NAME: _____

D.O.B. 9-30-51

DATE OF REQUEST: May 13, 1980

UP-COMING COURT DATES: not yet filed on

COMMENTS: SPOKE TO TONI MALONEY BY PHONE: See enclosed paperwork
from our file

Very truly yours,

J. O. JOHNSON
Public Defender

FOR: CAROLE A. GRAYSON
Assistant Public Defender

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 defendant's 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

S

contendere,

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 T

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

11. BIRTHDATE

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

- ☐ Mental Health
☐ Alcohol Abuse
☐ Drug Abuse

38. TITLE XX ELIGIBLE

- ☐ 1. No
☐ 2. AFDC
☐ 3. SSI
☐ 4. Income Eligible
☐ 5. Grp. Eligibility
☐ 6. Medicare

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

APPENDIX T (Continued)

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

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: _____

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

APPENDIX U (Continued)

- 2 -

5. 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
--------------	--------------	------------	----------------

8. 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
--------------	--------------	------------	----------------

9. 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
--------------	--------------	------------	----------------

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

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

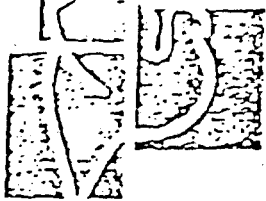
INTERVIEWEE

DATE _____

EXAMINER

TIME

- 188



peace river center for personal development, inc.

May 19, 1980

Mr. C. J. Benefield
Assistant Public Defender
495 N. Carpenter
Bartow, Florida 33830

RE:
DOB: 7/23/61

Dear Mr. Benefield:

██████████ D██████████ was seen on May 13, 1980 as per your request for a Preliminary Mental Screening. A Slosson Intelligence Test was administered as part of this evaluation. ██████████ D██████████ ██████████ D██████████ mother, was also interviewed to obtain further information about ██████████ D██████████ history.

██████████ D██████████ is a 19-year-old, white male, who was cooperative throughout the interview. His eye-contact was fair and his responses were spontaneous except when he was talking about his offense. He then became guarded and his eye-contact became poor.

██████████ D██████████'s mood was normal. His affect was somewhat elevated, probably because he was anxious during the interview. ██████████ D██████████ was oriented to person, place, time, and to his situation. His immediate recall was impaired by his anxiety but his remote and recent recall were adequate. His attention span and his ability to concentrate are somewhat impaired by his impulsivity.

██████████ D██████████'s low intellectual level has somewhat impaired his judgment and his ability to reason. The results of his Slosson indicate that he is functioning within the borderline range of Mental Retardation.

██████████ D██████████'s responses to questions were relevant and coherent. He denied having hallucinations or suicidal thoughts. He also denied being assaultive other than with his siblings. ██████████ D██████████ did admit being somewhat anxious during the interview, but this anxiety does not appear to be incapacitating.

██████████ D██████████ was interviewed to determine her perception of ██████████ D██████████'s disorder. ██████████ D██████████ stated that her son had always been in special education classes due to his impaired intellectual abilities. She stated that his friends, however, tend to be of average intellectual abilities. She also stated that her son has been taking Cylert, a medication prescribed by their physician to treat ██████████ D██████████'s hyperactivity. ██████████ D██████████ said that the doctor told her that ██████████ D██████████ would grow out of this hyperactivity, but she says that she has not

RE: ~~_____~~ ~~_____~~

noticed any significant change in his behavior. ~~_____~~ ~~_____~~ also indicated that she was interested in having ~~_____~~ ~~_____~~ obtain employment if possible. She said that he had gone to Vocational Rehabilitation in the past but he did not like it and he dropped out.

~~_____~~ ~~_____~~ admitted drinking heavily on weekends in an attempt to drink as much as his friends drank. He denied ever having been in any legal difficulties due to his drinking behaviors. He also denied any other drug ingestion.

~~_____~~ ~~_____~~'s account of his charges was somewhat contradictory, but this is felt to be an attempt to protect himself from the consequences of his behavior rather than from a mental disorder.

With respect to the above information the following conclusions and recommendations are offered:

1. As can be seen by ~~_____~~ ~~_____~~'s Competency Evaluation, he is competent to stand trial.
2. ~~_____~~ ~~_____~~ is functioning within the borderline range of mental retardation. His reasoning abilities are somewhat impaired by this low level of intellectual functioning.
3. ~~_____~~ ~~_____~~ has a strong desire to be a member of a group as evidenced by his drinking to keep up with his friends. Therefore, it is likely that ~~_____~~ ~~_____~~ would comply with requests made of him by other group members. Thus, even though he knows the difference between right and wrong, he is likely to be influenced by others.
4. ~~_____~~ ~~_____~~'s mother is concerned about his welfare and she stated that the rest of the family is also interested in him. Due to this supportive family network, it is felt that ~~_____~~ ~~_____~~ would be an appropriate candidate for probation. It is, however, unlikely that ~~_____~~ ~~_____~~ will understand the conditions of being placed on probation. Therefore, it is felt that his parents would need to be responsible for his activities if he is placed on probation.
5. It is recommended that ~~_____~~ ~~_____~~ be enrolled in a vocational training program. This would enable him to develop some employable skills and give him less free time in which to interact with his friends.

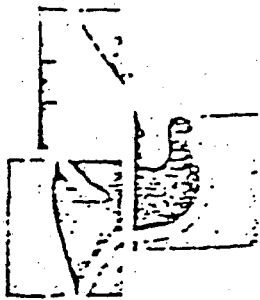
Respectfully submitted,

Debbie Nichols

Debbie Nichols, M.S.W.
Forensic Counselor

DN/fdl

cc: File

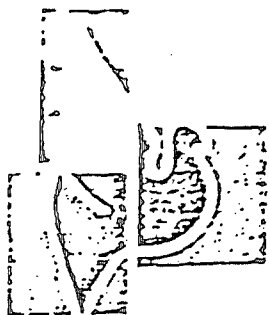


peace river center for personal development, inc.

COMPETENCY EVALUATION

Defendant: James D. [redacted] Date of Examination: May 13, 1980

	UNACCEPTABLE	QUESTIONABLE	ACCEPTABLE	NOT APPLICABLE
Appreciation of charges	X	X	(X)	X
Appreciation of range and nature of possible penalties.	X	X	(X)	X
Understanding of the adversary nature of the legal process.	(X)	X	X	X
Capacity to disclose to attorney pertinent facts surrounding the alleged offense.	X	X	(X)	X
Ability to relate to attorney.	X	X	(X)	X
Ability to assist attorney in planning defense.	X	(X)	X	X
Capacity to realistically challenge prosecution witnesses.	X	X	(X)	X
Ability to manifest appropriate courtroom behavior.	X	X	(X)	X
Capacity to testify relevantly.	X	X	(X)	X
Motivation to help self in legal process.	X	X	(X)	X
Capacity to cope with stress of incarceration prior to trial.	X	X	X	(X)



peace river center for personal development, inc.

WILLIAM G. KREMPER, Ph.D.
Executive Director

February 18, 1980

ROY GANTHER
Controller

HONORABLE WILLIAM K. LOVE
Circuit Judge
P. O. Box 51
Bartow, Florida 33830

RE: ~~_____~~ B ~~_____~~
CASE NOS: CF76-~~_____~~-1
CF76-~~_____~~-1
CF76-~~_____~~-1
CF77-~~_____~~-1
CF79-~~_____~~-1
CF79-~~_____~~-2
CF79-~~_____~~-2
CF79-~~_____~~-2
CF79-~~_____~~-2
CF79-~~_____~~-2

Dear Judge Love:

~~_____~~ B ~~_____~~ was seen on February 14, 1980 as per your request for a Mental Evaluation.

As can be seen from the results of the Competency Evaluation, ~~_____~~ B ~~_____~~ is generally able to partake in legal proceedings.

Prior Mental Health Treatment

~~_____~~ B ~~_____~~ was an inpatient on the psychiatric wing of Polk General Hospital from September 25, 1976 to October 5, 1976. This admission was the result of a suicide attempt while he was incarcerated in the Polk County Jail. Following his discharge from the hospital he received treatment in the Jail from the Forensic Unit through December, 1976.

~~_____~~ B ~~_____~~ was again admitted to Polk General Hospital from May 20, 1977 through May 23, 1977 as a result of depression and family difficulties. He received several outpatient treatment sessions through our Mental Health Center in November, 1978.

~~_____~~ B ~~_____~~ was an inpatient in Polk General Hospital from January 12, 1980 through January 22, 1980 as a result of depression experienced while in the

RE: ~~██████████~~ B ~~██████████~~

Polk County Jail. Since his discharge from the hospital he has been receiving treatment from the Forensic Unit.

Interview with ~~██████████~~ B ~~██████████~~

During the interview ~~██████████~~ B ~~██████████~~ was in good contact with reality and he displayed appropriate affect. His mood and presentation were depressed. He appeared to be displaying some rigidity which may have been a result of the psychotropic medications he is taking. ~~██████████~~ B ~~██████████~~ was a verbally fluent and spontaneous individual who spoke in a low voice. He appeared to possess average to below average intellectual abilities. He displayed a lack of insight into his behaviors and poor social judgment.

~~██████████~~ B ~~██████████~~ admitted to feeling depressed; he feels others do not like him and that his life is not worthwhile. However, he did not have any definite suicidal plans although he has some suicidal thoughts. He desires some help for his depression and is awaiting the outcome of his legal difficulties. He admitted to several suicide attempts in the past characterized by overdoses of medications. He stated that he has generally dealt with his depressive feelings through abusing substances.

~~██████████~~ B ~~██████████~~ claimed to have hallucinations occasionally at night. These experiences are of people, on whom he has informed, threatening to kill him. These experiences did not appear to be significantly pathological and seemed to be based on some real fears of ~~██████████~~ B ~~██████████~~. He also claimed that he frequently hears a ringing in his ears.

~~██████████~~ B ~~██████████~~ did not display any signs of a thought disorder or delusional thinking. However, he is somewhat suspicious and distrustful of others.

~~██████████~~ B ~~██████████~~ said that he is generally nervous; he could not indicate the specific events which lead to these feelings. He is also generally restless with a high activity level.

~~██████████~~ B ~~██████████~~ was able to give a coherent account of his behaviors at the time of his offenses. Although he may have exercised poor social judgment and experienced some emotional difficulties during the course of his offenses, he was always in control of his actions, understood the nature and consequences of his behaviors, and was aware of the results of his interactions with law enforcement officials.

~~██████████~~ B ~~██████████~~ acknowledged the above-mentioned mental health treatment. In addition, he also received in 1978 some outpatient treatment from a psychiatrist in Lakeland. He has never been in the State Hospital nor received treatment in a residential program such as a halfway house. He felt that he was presently in need of long-term treatment in order to change his behaviors.

~~██████████~~ B ~~██████████~~ stated that he had a serious injury to his right hand in 1978 which resulted in nerve damage and a loss of some of the functions of that hand. In addition, he stated that he has a heart problem in which his heart will beat extremely rapidly at times when he becomes very tense and anxious. This disorder has resulted in his being taken to the hospital for treatment on three or four occasions.

RE: ~~██████████~~ ~~██████████~~

~~██████████~~ B~~██████████~~ admitted to a long history of substance abuse. During the past four years he was regularly using various drugs and consuming approximately a fifth of liquor every day.

~~██████████~~ B~~██████████~~ said that he has some close friends and that he likes to be around other people. However, he feels that many people do not like him and that they laugh at him because he is "strange". ~~██████████~~ B~~██████████~~ has difficulties in his relationships with women and has had two unsuccessful marriages.

~~██████████~~ B~~██████████~~ indicated that he is an impulsive individual who has a great deal of difficulty planning behaviors. He has a low frustration tolerance and a quick temper. He was involved in many aggressive encounters when younger and frequently will strike inanimate objects. His self-concept is low and his motivation and energy levels are insufficient. He described a pattern of hyperactivity as a child; he still has a high activity level.

~~██████████~~ B~~██████████~~ left school in the eleventh grade; he said that he had been in special education classes for slow learners during some of his school years. He had no plans for finishing his education.

~~██████████~~ B~~██████████~~ first marriage lasted five years. His second marriage was unsatisfactory and characterized by many difficulties and frequent separations. He blamed his marital problems and eventual divorce in 1978 for his poor adjustment during the past four years. He has an eight-year-old child from this second marriage; he has rarely seen this child since his divorce.

During the past four years ~~██████████~~ B~~██████████~~ has been unstable with regard to residence and employment. He presently feels that he cannot obtain work because of his injured hand.

~~██████████~~ B~~██████████~~ stated that he was placed on probation in 1976. He claimed that he had no further difficulties with the law until his present charges. He denied any legal difficulties before 1976 as an adult or a juvenile.

Conclusions and Recommendations

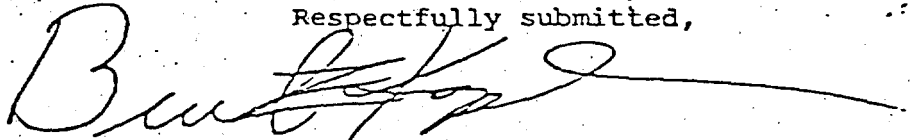
With respect to the above information we offer the following conclusions and recommendations:

1. ~~██████████~~ B~~██████████~~ is competent to appear before the Court.
2. ~~██████████~~ B~~██████████~~ was competent at the time of his offenses and his interactions with the police. Although he may have exercised poor social judgment and may have been experiencing some psychological difficulties, ~~██████████~~ B~~██████████~~ was aware of the nature and consequences of his actions and able to control his behaviors.
3. ~~██████████~~ B~~██████████~~ suffers from a personality disorder characterized by depression; substance abuse; poor interpersonal relationships; antisocial behaviors; impulsivity; low frustration tolerance; aggression; low motivation; and suspiciousness.

RE: HOYT BRYANT, JR.

4. ~~REDACTED~~ B ~~REDACTED~~ could benefit from placement in a long-term structured treatment facility such as a drug rehabilitation program. His prognosis for significant behavioral change is fair. He could also possibly benefit from services from Vocational Rehabilitation in order to assist him in dealing with the problems with his hand.
5. If ~~REDACTED~~ B ~~REDACTED~~ is sentenced for a substantial period of incarceration, he should be carefully watched by the confinement officers as there is a good possibility he might attempt suicide.
6. ~~REDACTED~~ B ~~REDACTED~~ will continue to receive treatment from the Forensic Unit while he remains incarcerated in the Polk County Jail.

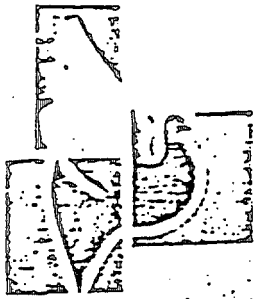
Respectfully submitted,



Burt E. Kaplan, Ph.D.
Clinical Psychologist
Director of Forensic Services

BEK/fdl

cc: C. Daniel Akes, Esquire
Robert Nettleton, Esquire
Don Wilcox, Esquire
File



peace river center for personal development, inc.

COMPETENCY EVALUATION

 Defendant: James B. [redacted] Date of Examination: February 14, 1980

	<u>UNACCEPTABLE</u>	<u>QUESTIONABLE</u>	<u>ACCEPTABLE</u>	<u>NOT APPLICABLE</u>
. Appreciation of charges	X	X	(X)	X
. Appreciation of range and nature of possible penalties.	X	X	(X)	X
. Understanding of the adversary nature of the legal process.	X	X	(X)	X
. Capacity to disclose to attorney pertinent facts surrounding the alleged offense.	X	X	(X)	X
. Ability to relate to attorney.	X	X	(X)	X
. Ability to assist attorney in planning defense.	X	X	(X)	X
. Capacity to realistically challenge prosecution witnesses.	X	X	(X)	X
. Ability to manifest appropriate courtroom behavior.	X	X	(X)	X
. Capacity to testify relevantly.	X	X	(X)	X
. Motivation to help self in legal process.	X	X	(X)	X
. Capacity to cope with stress of incarceration prior to trial.	X	(X)	X	X

Forensic Services
160 E. Church Street
Bartow, FL 33830
(813) 533-9068



peace river center
for personal development, inc.

May 30, 1980

HONORABLE _____
Circuit Judge
P. O. Box _____
Bartow, Florida 33830

RE: MR. X
CASE NO: _____

Dear Judge _____:

Pursuant to the Court's order of Date of Court order the above-named defendant was examined on Date of exam resulting in the following conclusions:

1. (a) The defendant is competent to stand trial.
(b) The defendant is not competent to stand trial.
2. (a) The defendant was insane at the time of the alleged offense (s).
(b) The defendant was not insane at the time of the alleged offense (s).

Sincerely,

Burt E. Kaplan, Ph.D.
Clinical Psychologist
Director of Forensic Services

BEK/fdl

cc: State Attorney
Public Defender or Defense Attorney
File

GENERAL MENTAL HEALTH
SERVICE TICKET

(Please print service ticket)

Program _____

Facility _____

CLIENT NAME _____ ID No. _____

DATE OF SERVICE _____ SERVICE CODE _____

UNITS OF SERVICE _____ HOURS OF SERVICE _____ (to the nearest quarter hour)

Co-therapist, if any _____

COMMENTS: _____

STAFF MEMBER: _____ NO. _____

NEXT APPOINTMENT: _____

PROGRESS NOTES

DISCHARGE SUMMARY

Discharge Diagnosis

Secondary	
3	

10. REFERRED to

13 ☐

☐ 01-Clergy

☐ 02-Priv. Pract. MH Prof.

☐ 03-Non-Psychiatric Physician

☐ 04-Public Psychiatric Facility

☐ 05-Private Psychiatric Facility

☐ 06-MR Hosp./Program

☐ 07-Public/Private Social/Comm. Agency

☐ 08-Public Physical Health

☐ 09-Vocational Rehab.

☐ 10-Adult Protect. Service

☐ 11-Children & Youth Services

☐ 12-School System

☐ 13-Civil Court

☐ 14-Criminal Justice System

☐ 15-Nursing Home

☐ 16-Other Medical Facility

☐ 17-Public/Private Alcohol Program

☐ 18-Public/Private Drug Program

☐ 19-Other

11. TREATMENT OUTCOME

☐ 1-Complete Improvement

☐ 2-Much Improvement

☐ 3-Some Improvement

☐ 4-Unchanged or Undetermined

☐ 5-Worse

Employee Signature: _____

Title: _____

NARRATIVE

199

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

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 precipitating 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_____

Relationship to Applicant_____

I hereby authorize_____ to submit pre-screening admissions
(Name of CHIC)

data to _____ Hospital.

Date_____

Signature of Applicant or Petitioner

Date_____

Signature of Screener

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:

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: _____

NAME OF PATIENT:

[illegible]

STAFFING NOTE

NAME: _____

DIAGNOSIS:

DISPOSITION:

TREATMENT GOALS:

COMMENTS:

signature

APPENDIX GG

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 HH
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 Psychological 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-0578

The Occasional Papers Series

PERSPECTIVES ON MENTAL HEALTH AND THE LAW

Forensic Mental Health Screening and Evaluation of Client-Offenders: an Overview. By Ingo Keilitz, W. Lawrence Fitch, and Thomas B. Marvell. An overview of the practice of forensic mental health screening and evaluation, including an operational definition and a survey of purposes, points of application, and resource allocation for forensic mental health evaluation in the criminal justice system. 111 pages, including two appendixes: an annotated bibliography and a state-by-state directory of forensic mental health programs in courts, jails, detention centers, state hospitals and correctional facilities, and community facilities. Order No. OPS 1 \$5.00.

Forensic Mental Health Screening and Evaluation in Court Clinics. By Ingo Keilitz and W. Lawrence Fitch. Five clinics attached to courts for forensic mental health screening and evaluation are described in detail using a uniform format. The clinics are in Baltimore, New York City, Hartford (Connecticut), Cambridge (Massachusetts), and Tucson (Arizona). 151 pages, including 35 pages of sample forms used in referrals, evaluations, and reports. Order No. OPS 2. \$6.50.

Forensic Mental Health Screening and Evaluation in Jails. By Joel Zimmerman, Ingo Keilitz, W. Lawrence Fitch, Thomas B. Marvell, and Mary Elizabeth Holmstrup. General types of arrangements between jail and mental health systems are described, and four local programs are described in detail: Cook County (Chicago) Correctional Complex, Diagnostic Services of the Nashville (Tennessee) Sheriff's Office, Pierce County (Washington) Jail Social Services and Central Intake Unit, and the Wyandotte County (Kansas) Pretrial Services Project. 83 pages, including 19 pages of sample forms. Order No. OPS 3. \$5.00.

Forensic Mental Health Screening and Evaluation in Community and Regional Forensic Mental Health Centers. By Ingo Keilitz, W. Lawrence Fitch, Thomas B. Marvell, and Mary Elizabeth Holmstrup. Forensic mental health examinations performed in community-based mental health centers are explored in six such centers: Dayton, Ohio; San Mateo County, California; Bowling Green, Kentucky; St. Louis, Missouri; Bartow, Florida; and Newport News, Virginia. 206 pages, including 70 pages of sample forms. Order No. OPS 4. \$7.00.

Screening and Evaluation in Centralized Forensic Mental Health Facilities. By Mary Elizabeth Holmstrup, W. Lawrence Fitch, and Ingo Keilitz. A federal institution and two state institutions performing forensic psychiatric services are detailed including profiles of the Biggs Unit of the Fulton State Hospital (Missouri); the Pretrial Branch, Division of Forensic Program, St. Elizabeths Hospital (Washington, D.C.); and the Center for Forensic Psychiatry (Ann Arbor, Michigan). 96 pages, including 29 pages of sample forms. Order No. OPS 5. \$5.00.

Forensic Mental Health Screening and Evaluation in Community Corrections. By Thomas B. Marvell, W. Lawrence Fitch, and Ingo Keilitz. Efforts to divert offenders from prison or jail sentences or to facilitate their successful reintegration in the community are reflected in local programs of probation, halfway houses, counseling, restitution, and the like. Two such programs--the Larimer County (Colorado) Community Corrections and the Island County (Washington) District Court Probation Department--are described. 52 pages, including 14 pages of sample forms. Order No. OPS 6. \$4.00.

National Center for State Courts
Publications Department
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