GUIDELINES FOR THE MANAGEMENT OF INDIVIDUALS FOUND NOT GUILTY BY REASON OF INSANITY

COMMONWEALTH OF VIRGINIA

Department of Mental Health, Mental Retardation and Substance Abuse Services

OFFICE OF FORENSIC SERVICES
DIVISION OF FACILITY MANAGEMENT

Revised May, 2003

INTRODUCTION

Individuals who have been found not guilty by reason of insanity (insanity acquittees, acquittees, NGRIs) by Virginia criminal courts pose a unique challenge to Virginia's mental health service system. These individuals require attention for clinical and legal needs as a result of their connection to both the mental health and criminal justice systems. This manual outlines the basic expectations regarding the management of individuals found not guilty by reason of insanity. This information should assist administrators, clinicians, court personnel, treatment team members in state operated mental health facilities, and staff of community services boards in evaluating, treating, and managing individuals found not guilty by reason of insanity in a manner that is consistent with legal mandates and professional standards.

This set of guidelines is based on Virginia Code Sections 19.2-167 through 19.2-182 which describe proceedings on the question of insanity, Virginia Code Sections 19.2-182.2 through 19.2-182.16 which describe the legal process for Virginia's disposition of individuals found not guilty by reason of insanity, and Virginia Code Section 19.2-174.1 which describes the information required prior to admission to a mental health facility. The *Code of Virginia* may be accessed at http://leg1.state.va.us.

This document revises and replaces the NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity, that was disseminated in February, 1997. This edition of the NGRI Manual is the third version of this set of guidelines to be published.

This current version of the NGRI Manual includes significant changes in the process of treating and managing those individuals who have been found not guilty by reason of insanity in the courts of Virginia, and who are ultimately committed to the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. Included among these changes are the revised procedures for the management of persons who have been found not guilty by reason of insanity of a misdemeanor offense. These changes are described in Chapter 7 of this volume.

The revised guidelines also include many of the procedural changes to the graduated release "privileging process" for insanity acquittees that were implemented by the DMHMRSAS in February, 2000. Those changes were developed to ensure that reviews of each insanity acquittee's treatment needs and progress occur on a frequent basis and in an in-depth manner. They have been incorporated into Chapters 3 and 4 of this document. The decentralization of aspects of the acquittee privileging process to the facility Internal Forensic Privileging Committees at the eight mental health facilities operated by the Department is also described in Chapter 4. The significant reworking and elaboration of the process for managing acquittees who

have been placed on Conditional Release by the courts is described in Chapters 5 and 6. Major changes to the process for assessing risk, and for the management of all clinical factors related to risk for violence and dyscontrol have been developed for this version of the manual (Appendix A). Finally, a full description of the procedures to be used for the integration of an acquittee's plan for risk management with his or her comprehensive hospital treatment plan has been outlined in Appendix F of these guidelines.

Any questions regarding these guidelines should be referred to the Forensic Coordinator in your facility (Appendix I) or the NGRI Coordinator at your community services board (Appendix J). If additional information is required, contact the Office of Forensic Services, Division of Facility Management, of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (804-225-2502). The Office of Forensic Services is available to provide any assistance needed to aid in the appropriate management of individuals who have been found not guilty by reason of insanity.

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Director, Office of Forensic Services

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CHAPTER 1

THE INSANITY DEFENSE IN VIRGINIA

The Insanity Defense in Virginia

I. The insanity defense is one of several legal questions that might be raised in a criminal case that requires psychological evidence to reach a resolution.

A. This defense focuses on the defendant's mental state at the time of the offense and asks whether the defendant is criminally responsible for his/her behavior as a result of that mental state. The insanity defense was designed to protect against the conviction and punishment of morally blameless persons.

B. Other legal questions requiring psychological evidence that might be raised in a criminal case include

1. Competency to Stand Trial

a. Focuses on defendant's current mental condition (rather than mental condition at the time of the offense)
b. Asks whether the defendant has an adequate understanding of the proceedings and an ability to assist in his/her defense
c. The goal is to assure a fair, accurate, and dignified trial
d. Most frequently asked referral question

2. Presentence referrals ask whether there is anything about defendant's mental condition that bears on relevant considerations at sentencing

3. Other, less frequent referral questions include "voluntariness" of confessions and competency to waive rights

II. Use of the Insanity Defense

A. Infrequently used and rarely successful

B. National use

1. Raised in approximately 1% of criminal cases

2. Successful only 25% of the time

3. Most states have an insanity defense.

C. Virginia use: There is an average of 35 NGRI acquittals per year

III. Tests for Insanity

A. Vary from state to state

1. Examples: M'Naghten, irresistible impulse, American Law Institute, and product test

2. Mental disorder alone is never sufficient

B. Virginia Test

1. Product of case law (DeJarnette v. Commonwealth, 75 Va. 867 (1881); Price v. Commonwealth, 228 Va. 452, 323 S.E.2d 106 (1984); Thompson v. Commonwealth, 193 Va. 704, 70 S.E.2d 284 (1952))

2. Defendant is insane if, at time of the offense, because of mental disease or defect, he/she

   a. Did not understand the nature, character, and consequences of his/her act, or
   b. Was unable to distinguish right from wrong, or
   c. Was driven by an irresistible impulse to commit the act

3. "Mental disease or defect" is defined as a disorder that "substantially impairs the defendant's capacity to understand or appreciate his conduct"

   a. Psychotic disorders qualify
   b. Mental retardation qualifies
   c. Voluntary intoxication does not qualify
      (1) "settled insanity" due to substance abuse may qualify. The criteria are organic impairment, with psychotic symptoms, resulting from long-term substance use
      (2) voluntary intoxication may negate "premeditation" to reduce homicide offense from first-degree or capital murder to second-degree murder
   d. Involuntary intoxication is an independent defense

4. "Nature, character, and consequences" are not defined. It is not clear whether the defendant must have believed that the act was legally justified or whether belief that act was morally justified suffices.

5. It is frequently unclear whether a defendant with a mental disorder was

legally insane at the time of the offense.

The degree of impairment in cognitive or volitional capacity necessary for a finding of insanity is a social value judgment for the judge or jury.

IV. Expert Evaluations for Indigent Defendants: Indigent defendants who show "probable cause" to believe that sanity will be a significant factor in their defense are entitled to a state-funded expert (psychiatrist or psychologist) to perform an evaluation and, "where appropriate, to assist in the development of an insanity defense" (Va. Code § 19.2-169.5; Ake v. Oklahoma, 470 U.S. 68 (1985)).

V. Presentation of Insanity Defense

A. Only the defendant may raise the defense of insanity at the time of the offense.

The defendant must give notice to the attorney for the Commonwealth of his intention to put his sanity in issue and to present testimony of an expert at least twenty-one days prior to trial (§ 19.2-168).

B. The Commonwealth's Attorney can then seek an evaluation of the defendant's sanity at the time of the offense, pursuant to § 19.2-168.1, after the defense attorney gives notice as described above.

C. The defendant has the burden of proving insanity to the satisfaction of the jury (Boswell v. Commonwealth, 61 Va. 860 [20 Gratt.] (1871)).

D. The judge or jury decides whether the defendant was insane at the time of the offense based on expert testimony and other evidence.

1. Misdemeanor cases are typically tried in district court where there are no jury trials.

2. Felony cases are tried in circuit court where the defendant may insist on a jury trial.

E. The majority of cases are the result of plea bargains in which the defense and the prosecution agree to the finding of insanity at the time of the offense. "Battles of experts" are rare.

VI. Use of the Insanity Defense in Juvenile Courts

The Supreme Court of Virginia has held that the insanity defense is not available to juveniles

in delinquency proceedings. (Commonwealth v Chatman, 260 Va. 562 (2000)).

VII. Disposition of Insanity Acquittees: What happens after an individual is found not guilty by reason of insanity?

A. Acquittees are not subject to penal sanctions (punishment) such as jail or prison sentences, probation, parole, and/or fines.

B. Acquittees may be committed pursuant to special commitment laws that are more restrictive than those that regulate civil commitment.

1. Virginia civil commitment laws (Va. Code § 37.1-67.01 et. Seq.)

2. Virginia insanity disposition and commitment laws (Va. Code §§ 19.2-182.2 through 19.2-182.16)

C. Court controls management of acquittee for an indeterminate period, as long as the acquittee continues to meet the criteria outlined in §§19.2-182.2 through 19.2-182.16.

D. Virginia Code §§ 19.2-182.2 through 19.2-182.16 address the post-adjudication stages, after a person has been found not guilty by reason of insanity.

1. In July 1992, § 19.2-181 was repealed and replaced by §§ 19.2-182.2 through 182.12.

2. In July 1993, these Code sections were further amended to comply with the U.S. Supreme Court decision in Foucha v. Louisiana, 504 U.S. 71 (1992). Sections 19.2-182.13 through 182.16 were also added at that time.

3. In July of 1999, § 19.2-182.7, which addresses the parameters for conditional release, was amended to allow the court to hold an acquittee in contempt of court for violation of the conditional release order.

4. In July of 2002, § 19.2-182.5 of the Virginia Code was amended to limit the period of hospital confinement of individuals found not guilty of a misdemeanor by reason of insanity to one year from the date of the acquittal.

VIII. Highlights of Virginia's Code-Mandated Disposition After a Finding of Not Guilty by Reason of Insanity

The following section provides a brief overview of the legal basis for disposition of

insanity acquittees. Further clarification regarding policy and practice in implementing the law is provided in the following chapters.

A. Initial 45 day temporary custody by the Commissioner of the DMHMRSAS for the purpose of evaluation (§ 19.2-182.2)

1. Two evaluators (one clinical psychologist and one psychiatrist) are appointed by the Commissioner to do independent evaluations.

2. Goal: Assist the court in determining disposition

3. Based on criteria outlined in the Virginia Code, the evaluators recommend

   a. Commitment for inpatient hospitalization;
   b. Conditional release; or
   c. Release without conditions.

4. If either evaluator recommends conditional release or release without conditions, the evaluation period is extended for the preparation of a conditional release or discharge plan by the hospital and the appropriate community services board.

B. Post-evaluation hearing held by the court in which acquittee was found not guilty by reason of insanity (§ 19.2-182.3)

1. Court's options:

   a. Commitment to the custody of the Commissioner for inpatient hospitalization;
   b. Conditional release; or
   c. Release without conditions.

2. Court maintains indeterminate jurisdiction over the acquittee.

   a. Unlike a jail, probation, or prison sentence in which the court sets a maximum length of time the defendant can be held, persons found not guilty by reason of insanity (NGRI) can be maintained indeterminately under the court's jurisdiction, as long as they continue to meet statutory criteria.
   b. Only the court can determine when the acquittee is released without conditions (see later discussion).

3. This and all subsequent proceedings are civil (as contrasted to criminal proceedings).

4. The court shall appoint counsel for the acquittee unless the acquittee waives his right to counsel (§§ 19.2-182.3 and 19.2-182.12).
   a. The acquittee is represented at the commitment hearing by the attorney who represented him/her at the criminal proceedings, unless otherwise ordered by the court (§ 19.2-182.3).
   b. For all subsequent hearings, the Court shall consider the appointment of the attorney who represented the acquittee at the last proceeding (§ 19.2-182.12).

C. Criteria for commitment to the custody of the Commissioner (§ 19.2-182.3)

1. Mentally ill or mentally retarded and in need of inpatient hospitalization based on consideration of the following factors

   a. To what extent the acquittee is mentally ill or mentally retarded, as those terms are defined in § 37.1-1;
   b. Likelihood acquittee will engage in conduct presenting substantial risk of bodily harm to other persons or to himself in the foreseeable future;
   c. Likelihood acquittee can be adequately controlled with supervision and treatment on an outpatient basis; and
   d. Such other factors as the court deems relevant.

2. There must be a finding of mental illness or mental retardation in order to commit an acquittee to inpatient hospitalization. For the purposes of disposition of insanity acquittees, mental illness includes any mental illness, as defined in § 37.1-1, in a state of remission when the illness may, with reasonable probability, become active.

D. Commissioner is responsible for determining acquittee's placement, confinement, and privileges while acquittee remains in Commissioner's custody (grounds privileges, community visits not to exceed 48 hours, civil transfers, etc.) (§ 19.2-182.4).

1. Does not require court permission

2. Commissioner delegates to the Forensic Review Panel (§ 19.2-182.13) the authority to render proper decisions regarding acquittee movement and privileges.

3. Commissioner may grant temporary visits from the hospital not to exceed 48 hours if the visit would be therapeutic for the acquittee and not pose substantial danger to others.

4. Written notification to the Commonwealth's Attorney for the committing

jurisdiction is required when acquittee is authorized to leave the grounds of the hospital in which he or she is confined (§ 19.2-182.4).

E. Any acquittee placed in the temporary custody of the Commissioner or committed to the custody of the Commissioner who escapes from the custody of the Commissioner may be charged with a Class 6 felony, pursuant to § 19.2-182.14.

F. Court permission, after treatment team receives approval from Forensic Review Panel, is required for

1. Conditional release (includes trial visits of over 48 hours as part of conditional release plan); or

2. Release without conditions.

G. Timing of judicial review hearings

1. Annual continuation of confinement hearings (§ 19.2-182.5) start twelve months after date of commitment

a. Yearly intervals for first five years, and
b. Biennial intervals thereafter.

2. Petitions for release (§ 19.2-182.6 and §19.2-182.5(B))

a. Acquittee may petition for release once in each year in which no annual judicial review is scheduled (§ 19.2-182.6(A). The acquittee may also request release at the annual continuation of confinement hearing. If the acquittee requests release at an annual continuation of confinement hearing, the court will order a second opinion evaluation of the acquittee's need for inpatient hospitalization (§ 19.2-182.5(B).
b. The Commissioner of the DMHMRSAS may petition the committing court for conditional or unconditional release of the acquittee at any time he or she believes the acquittee no longer needs hospitalization.
c. Victim notification required: For petitions filed under §19.2-182.6, the Commissioner must give notice of the hearing to any victim of the act resulting in the charges on which the acquittee was acquitted, or the next of kin of the victim, provided the person submits a written request for such notification to the Commissioner.

H. Conditional release

1. Jurisdiction: The Court maintains jurisdiction over an acquittee conditionally released into the community (§ 19.2-182.7).

2. Custody: Upon conditional release, the acquittee is discharged from the custody of the Commissioner.

3. Planning: The community services board must be actively involved with the acquittee and the facility treatment team in planning for the conditional release.

4. Criteria for conditional release

   a. Based on consideration of the factors that the court must consider in its commitment decision (see above), the acquittee does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his or her condition from deteriorating to a degree that would require inpatient hospitalization;
   b. Appropriate outpatient supervision and treatment are reasonably available;
   c. There is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions of release specified; and
   d. Conditional release will not present an undue risk to public safety.

5. Implementation and Reporting: Community services board implements the court's conditional release order and submits two types of reports

   a. Written reports to the court on the acquittee's progress and adjustment in the community no less frequently than every six months
   b. Monthly reports on the acquittee's progress and compliance with the conditional release plan to the Office of Forensic Services, of the Division of Facilities Management of the DMHMRSAS.

6. Revocation of conditional release: Return to the custody of the Commissioner for hospitalization (§§ 19.2-182.8 or 19.2-182.9)

   a. Two types of revocation
      (1) non-emergency process (§ 19.2-182.8), or
      (2) emergency process (§ 19.2-182.9)

   b. Criteria for revocation of conditional release
      (1) Acquittee has violated the conditions of his/her release, or is no longer a proper subject for conditional release based on the

criteria for conditional release, and

(2) Is mentally ill or mentally retarded and requires inpatient hospitalization.

c. Acquittee may be returned to conditional release if his condition improves to the degree that within 30 days after the Commissioner has resumed custody, the supervising community services board and facility agree (prior Forensic Review Panel approval is required) that he is an appropriate candidate for conditional release, and the court approves (§ 19.2-182.10).

d. Before recommending the return of the acquittee to conditional release, as part of a thorough risk assessment, the community services board, the facility, and the Forensic Review Panel should review all relevant documents, both current and historical, that pertain to the readiness of the acquittee to be returned to conditional release.

7. Emergency custody of an acquittee: If the acquittee is taken into emergency custody, detained or hospitalized while on conditional release, such action is considered to have been taken pursuant to the laws governing disposition of insanity acquittees (§ 19.2-182.9).

8. Escape of an acquittee placed on conditional release: Any acquittee who is on conditional release who leaves the Commonwealth without the permission of the court may be charged with a Class 6 felony (§ 19.2-182.15).

9. Modification or removal of conditions (§ 19.2-182.11)

a. The committing court may remove conditions placed on release, upon petition of :

(1) community services board,
(2) Commonwealth's Attorney,
(3) motion of the court, or
(4) the acquittee

b. Acquittee may only petition once a year starting six months after the beginning of conditional release.

I. Release without conditions: Discharge into the community and release of court's jurisdiction over acquittee

1. Criteria:

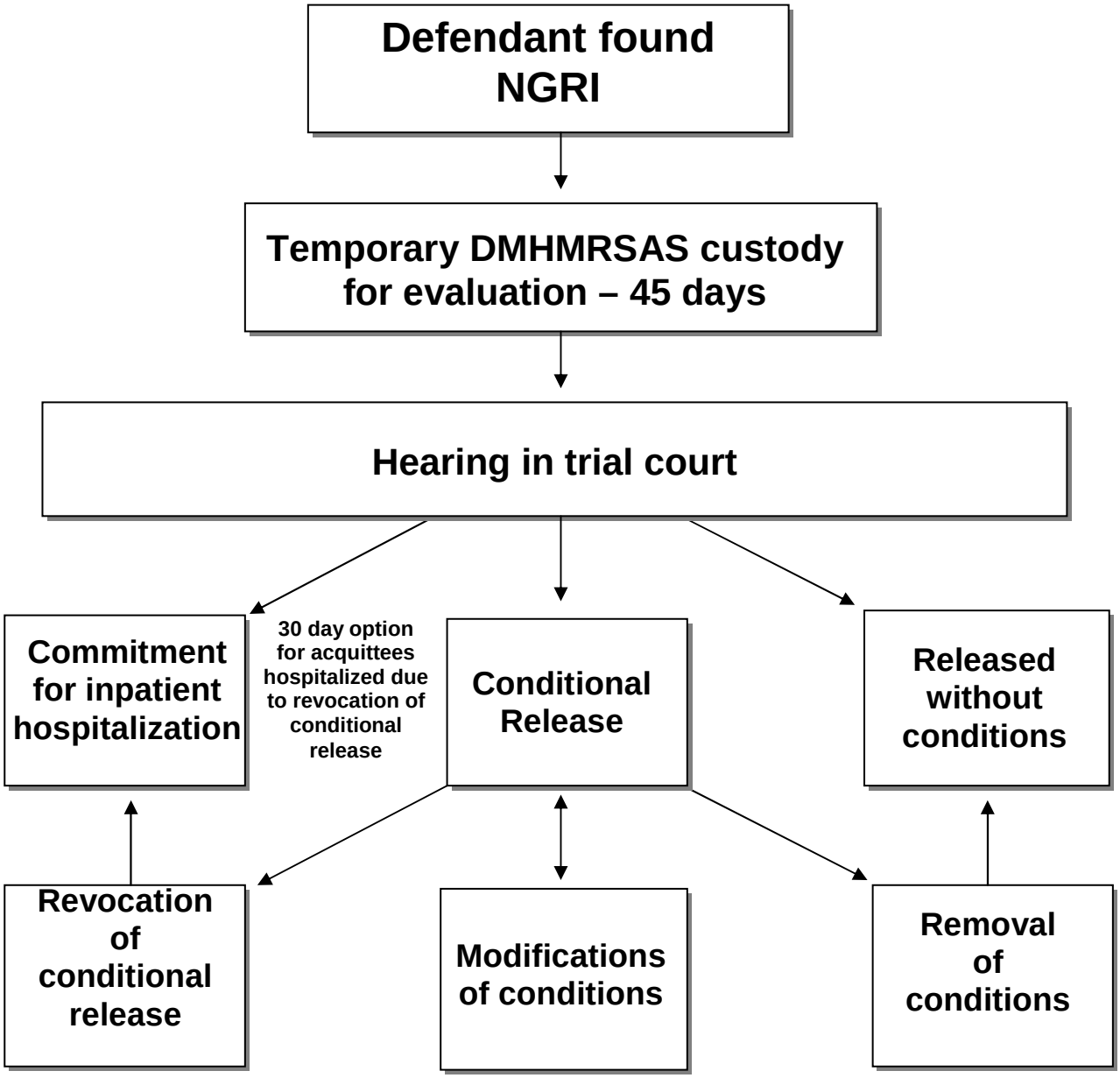
a. Does not need inpatient hospitalization, and
b. Does not meet criteria for conditional release.

2. The court is required to approve a discharge plan jointly prepared by the community services board and the facility (§ 19.2-182.3), when the acquittee is to be released without conditions from hospitalization.

IX. Multiple Courts of Jurisdiction

An acquittee can be found not guilty by reason of insanity by more than one court, for separate offenses. When a defendant has been adjudicated NGRI in multiple courts, each of those courts retains simultaneous jurisdiction over the acquittee. The procedures outlined in this manual relating to courts will apply to every court that has jurisdiction for the individual as an insanity acquittee.

DISPOSITION OF INSANITY ACQUITTEES UNDER VIRGINIA CODE Sections 19.2-182.2 through 19.2-182.16



Note: A new court order is required for each step in this process.

CHAPTER 2

TEMPORARY CUSTODY FOR EVALUATION

Temporary Custody For Evaluation (§ 19.2-182.2)

I. Placement

1. When a person is acquitted by reason of insanity, the court shall place the person so acquitted ("the acquittee") in the temporary custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services for evaluation as to whether the acquittee may be

    1. Released with conditions, or

    2. Released without conditions, or

    3. Committed.

2. Temporary custody placements shall be to the Forensic Unit of Central State Hospital, unless otherwise directed by the Office of Forensic Services. Acquittees who have been placed in the temporary custody of the Commissioner shall not be transferred to a civil unit or placed in a civil unit, unless approved in advance by the Temporary Custody triage team. (That team includes the Assistant Commissioner for Facility Management, Director of Forensic Services, Forensic Review Panel Chair or designee, and the forensic coordinators from the Forensic Unit and the designated civil facility.)

    1. Section 19.2-174.1 requires that certain information be provided to the Commissioner.

        a. Before the Commissioner assumes custody of the acquittee, the court shall provide the Commissioner of DMHMRSAS with the following information, if available:
            (1) The temporary custody order;
            (2) the names and addresses for the attorney for the Commonwealth, the attorney for the acquittee, and the judge having jurisdiction over the acquittee;
            (3) a copy of the warrant or the indictment; and
            (4) a copy of the criminal incident information as defined in § 2.2-3701, or a copy of the arrest report, or a summary of the facts relating to the crime.

b. If the information is not available prior to admission, it shall be provided by the party requesting admission, or the party with custody of the acquittee to the Commissioner of DMHMRSAS within ninety-six hours of admission.

2. Since temporary custody and evaluation is designed to assist the judge in making an appropriate disposition, facility staff shall immediately begin to gather the necessary information to complete the temporary custody evaluations.

a. Obtain the relevant Analysis of Aggressive Behavior (AAB) information and complete the Initial AAB within 30 days after admission (See Appendix A: Analysis of Aggressive Behavior for more information.).
b. Complete the initial Community Outpatient Treatment Readiness Scale (COTREI) within the first 30 days after admission (See Appendix B: Community Outpatient Treatment Readiness Scale).
c. Contact the appropriate community services board to gather relevant information and begin the collaborative planning required to manage the acquittee.
d. Obtain copies of the sanity evaluation(s) and competency evaluation(s), if available.

II. Assignment of Community Services Board Case Manager

A. The Procedures for Continuity of Care between Community Services Boards and State Psychiatric Facilities (Revised Client Service Management Guidelines, page 11) includes the following policy:

> "Community Services Boards shall ensure that each individual hospitalized in a state psychiatric facility who will require services and supports upon return to the community is assigned a CSB case manager who will be responsible for hospital liaison activity involving the individual's treatment and discharge planning".

B. As soon as an acquittee is placed in the temporary custody of the Commissioner, the responsible community services board shall assign a case manager to that acquittee.

C. Since the court may conditionally release an acquittee, or release an acquittee without conditions from temporary custody, it is essential that the CSB case manager be prepared to immediately (i) provide information to Forensic Unit staff and to the temporary custody evaluators, and (ii) engage in planning for conditional release or release without conditions.

D. All predischarge planning activities of the CSB case manager and the facility shall

be conducted in a manner that is consistent with the *Uniform Statewide DischargePlanning Protocols for Community Services Boards and State Mental Health and Mental Retardation Facilities* that have been issued by the Commissioner of the DMHMRSAS.

E. The CSB case manager who is assigned to each acquittee referred to the DMHMRSAS for inpatient care, shall provide predischarge planning for any acquittee who resided in the Board's service area prior to admission, or who chooses to reside there after discharge, in conformance with § 37.1-98 of the Code of Virginia, and in accord with the parameters outlined in the Performance Contract maintained by the DMHMRSAS with Community Services Boards.

III. Temporary Custody Evaluation

A. After an acquittee is placed in the temporary custody of the Commissioner, the Director of Forensic Services, acting for the Commissioner, shall appoint as soon as possible two evaluators to perform the evaluations. (See Table 2.1: Temporary Custody Evaluation.)

B. Qualifications of evaluators

1. One evaluator shall be a psychiatrist.

2. The other evaluator shall be a clinical psychologist.

3. Both evaluators shall be

   a. Skilled in diagnosis of mental illness and mental retardation, and
   b. Qualified by training and experience to perform such evaluations.

4. At least one temporary custody evaluator shall not be employed by the hospital in which the acquittee is primarily confined.

5. Neither evaluator shall have provided previous court evaluation or consultation regarding the acquittee's insanity or mental state at the time of offense.

C. The evaluation shall assess

1. Whether the acquittee is currently mentally ill or mentally retarded,

2. The acquittee's condition, and

3. The acquittee's need for hospitalization based upon factors set forth in § 19.2-182.3.

D. Parameters for the evaluations

1. The evaluators shall

a. Conduct their examinations separately,
b. Prepare separate reports, and
c. Report their findings to the court within 45 days of the Commissioner's assumption of temporary custody

2. The report to the court shall follow the outline provided in Appendix D of this manual.

3. Copies of the report shall be sent to the

a. Judge having jurisdiction
b. Acquittee's attorney
c. Attorney for the Commonwealth for the jurisdiction where the person was acquitted
d. NGRI Coordinator of the community services board serving the locality where the acquittee was acquitted,
e. Chair of the Forensic Review Panel,
f. Office of Forensic Services, Division of Facilities Management
g. Acquittee's facility Forensic Coordinator.

IV. Cases in Which One or Both Evaluators Recommend Conditional Release

A. When the facility is made aware of an evaluator's recommendation for conditional release, staff will begin developing an appropriate conditional release plan.

1. Facility staff shall immediately contact the appropriate community services board staff (CSB NGRI Coordinator) to make arrangements for prompt, joint development of the plan.

2. See also Chapter 5: Planning for Conditional Release.

B. Extension of Temporary Custody Evaluation Period

1. Upon receipt of an evaluation recommending conditional release, the Forensic Coordinator should write the court requesting a court order extending temporary custody if more time is needed to prepare the conditional release plan.

2. Virginia Code section 19.2-182.2 provides that the court shall extend the evaluation period to permit the facility and the appropriate community services board to jointly prepare a conditional release plan before the hearing.

C. The conditional release plan shall be submitted to the Forensic Review Panel for review before submission to the court.

D. If it is not possible to develop an appropriate conditional release plan, the treatment team shall make a referral to the Forensic Review Panel for consultation and guidance.

The referral shall contain:

1. A complete description of attempts made to develop an appropriate conditional release plan,
2. A discussion of why these attempts have not been successful, and
3. Alternative recommendation(s) for disposition of the acquittee.

V. Instances in Which One or Both Evaluators Recommend Release Without Conditions

A. The procedure described in Section IV above is used.

B. A discharge plan is developed instead of a conditional release plan.

VI. Hearing and Disposition

Upon receipt of the temporary custody evaluators' reports, and, when applicable, a conditional release or discharge plan, the court will schedule a hearing to determine whether or not the acquittee should be committed to the custody of the Commissioner, conditionally released, or released without conditions. (See Tables 2.2, 2.3, and 2.4 for the criteria for commitment to the Commissioner for inpatient hospitalization, conditional release, and release without conditions.)

Model Temporary Custody Order

VIRGINIA:
IN THE CIRCUIT COURT OF_____, or

IN THE GENERAL DISTRICT COURT OF _____

COMMONWEALTH OF VIRGINIA
VS.

NAME_____ DOCKET NO.-CR _____
FELONY _____
MISDEMEANOR _____

DATE OF BIRTH_____ OFFENSE DATE(S) _____

Finding of Not Guilty by Reason of Insanity
and
Temporary Custody Evaluations and Hearing Date

This date came the attorney for the Commonwealth, _____and the Defendant, _____, who was present in the court throughout the proceedings and was represented by counsel, _____. Based upon the written evaluation(s) submitted by _____, the oral testimony of_____, and the arguments of counsel, the Court finds the Defendant not guilty by reason of insanity to the charge(s) of _____.

It is hereby ADJUDGED, ORDERED AND DECREED that

1. The Acquittee, pursuant to Virginia Code Section 19.2-182.2, shall be placed in the temporary custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) for evaluation, in accordance with the provisions of that section, as to whether the Acquittee may be released with or without conditions or requires commitment.

2. The Clerk of the Court is directed to contact the Admissions Director for the Forensic Unit of Central State Hospital, or his designee, for an admission date and time. The Sheriff of _____ County, or his designee, shall transport the Acquittee to Central State Hospital -- Forensic Unit on the agreed date and time, together with (a) a copy of this order; (b) all supporting clinical documentation including evaluations of mental status at the time of the offense and evaluations of competency to stand trial, if available; and (c) legal documentation required by § 19.2-174.1. If the information is not available at the hearing, it shall be provided by the party requesting placement or the person having custody directly to the Commissioner within ninety-six hours of the person being placed into the Commissioner's custody.

Finding of Not Guilty by Reason of Insanity and Temporary Custody Evaluations and Hearing Date
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3. The evaluators' reports shall be sent to the court on or before forty-five days after the Commissioner's assumption of custody. Copies of the reports shall be sent to the Acquittee's attorney, the attorney for the Commonwealth of the jurisdiction where the Acquittee was acquitted, and the community services board serving the locality where the Acquittee was acquitted.

4. This cause is scheduled for a hearing at _____ o'clock on the _____ day of _____, 20____ to determine whether the Acquittee shall be released with or without conditions or requires commitment. The Acquittee shall have the right to be present at the hearing, the right to the assistance of counsel in preparation for and during the hearing, and the right to introduce evidence and cross-examine witnesses at the hearing.

5. Copies of this order shall be sent to the Acquittee, the counsel for the Acquittee, the attorney for the Commonwealth of the jurisdiction where the Acquittee was acquitted, the community services board serving the locality where the Acquittee was acquitted, and the Commissioner of DMHMRSAS.

6. In the event the Acquittee's presence is required at any hearing in this cause, the Court will issue an Order to Transport, directing the Sheriff of _____County, or his designees, to resume custody of and return the Acquittee to the jurisdiction of this Court.

7. This Court retains jurisdiction in this cause, and the Acquittee shall not be discharged or released from custody of the Commissioner without further Order of this Court.

ENTERED: _____
Date

_____
Signature

_____
Name of Judge

_____
_____
Defense Attorney
Name and Address

_____
_____
Commonwealth's Attorney
Name and Address

xc: Commonwealth's Attorney
Acquittee's Attorney
Community Services Board NGRI Coordinator
Commissioner of DMHMRSAS
Attn: Office of Forensic Services
P.O. Box 1797, Richmond, VA 23218-1797
Phone: 804-786-8044
FAX: 804-786-9621

TABLE 2.1
Temporary Custody Evaluation

LEGAL CITATION	**§ 19.2-182.2 The court shall place the person so acquitted in temporary custody of the Commissioner of DMHMRSAS for evaluation as to whether the acquittee may be released with or without conditions or requires commitment.**
EVALUATORS	**2 evaluators appointed by the Commissioner.** **One psychiatrist, and one clinical psychologist. Both shall be** **- skilled in the diagnosis of mental illness and mental retardation, and** **- qualified by training and experience to perform these evaluations.** **At least one evaluator shall not be employed by the hospital in which the acquittee is primarily confined.** **Examinations and reports shall be conducted separately.**
CONTENT	**The evaluators shall** **- determine whether the acquittee is currently mentally ill or mentally retarded, and** **- assess the acquittee and report on his condition and need for hospitalization with respect to the factors set forth in §19.2-182.3.**
TIME FRAME	**Report is due within 45 days of the Commissioner's assumption of custody.**

TABLE 2.2
Criteria For Commitment To Commissioner For Inpatient Hospitalization

LEGAL CITATION	**§ 19.2-182.3**
CRITERIA	**Is mentally ill or mentally retarded and in need of inpatient hospitalization, based on consideration of the following factors** **- To what extent the acquittee is mentally ill or mentally retarded, as those terms are defined in § 37.1-1;** **- The likelihood that the acquittee will engage in conduct presenting a substantial risk of bodily harm to other persons or to himself in the foreseeable future;** **- The likelihood that the acquittee can be adequately controlled with supervision and treatment on an outpatient basis; and** **- Such other factors as the court deems relevant**
SUPPORTING INFORMATION	**If the court determines that an acquittee does not need inpatient hospitalization solely because of treatment or habilitation he or she is currently receiving, but the court is not persuaded that the acquittee will continue to receive such treatment or habilitation, it may commit him for inpatient hospitalization.**

TABLE 2.3
Criteria For Conditional Release

LEGAL CITATION	**§ 19.2-182.7**
CRITERIA	**- Based on consideration of the factors which the court must consider in its commitment decision, the acquittee does not need inpatient hospitalization but does need outpatient treatment or monitoring to prevent his condition from deteriorating to a degree that he or she would need inpatient hospitalization;** **- Appropriate outpatient supervision and treatment are reasonably available;** **- There is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified; and** **- Conditional release will not present an undue risk to public safety.**
SUPPORTING INFORMATION	**- The court shall subject a conditionally released acquittee to such orders and conditions it deems will best meet the acquittee's need for treatment and supervision and best serve the interests of justice and society.** **- The acquittee must meet the criteria set forth above and the court must approve a conditional release plan prepared jointly by the hospital and the appropriate community services board.**

TABLE 2.4.
Criteria For Release Without Conditions

LEGAL CITATION	**§ 19.2-182.3**
CRITERIA	**- Does not need inpatient hospitalization, nor** **- Meet criteria for conditional release.**
SUPPORTING INFORMATION	**- The court must approve a discharge plan prepared jointly by the hospital staff and the appropriate community services board before the acquittee may be released without conditions.**

CHAPTER 3

COMMITMENT TO THE COMMISSIONER FOR INPATIENT HOSPITALIZATION

Commitment to Commissioner for Inpatient Hospitalization (§§ 19.2-182.3 through 19.2-182.6):

I. Placement following commitment to the custody of the Commissioner

A. If a court determines that the acquittee is mentally ill or mentally retarded and in need of inpatient hospitalization and commits the acquittee to the custody of the Commissioner, the Forensic Review Panel, as designated by the Commissioner, shall, in accord with § 19.2-182.4 of the Code: Determine the appropriate placement for each acquittee, based on clinical needs and safety and security requirements; and

B. Placement may be in any state-operated mental health, mental retardation or geriatric facility. Specific considerations include:

1. Potential for violence to self or others, and
2. Potential for escape.

C. The Office of Forensic Services of the Division of Facility Management is available to provide consultation and assistance in all matters regarding placement of acquittees.

II. Forensic Coordinator Responsibilities

A. Insanity acquittees shall be immediately brought to the attention of the Forensic Coordinator of the facility. The Forensic Coordinator monitors the progress, management, conditional release planning, and discharge planning for acquittees for the duration of their placement in the custody of the Commissioner.

B. The Forensic Coordinator serves as a consultant to the facility treatment teams with regard to the hospital's role with the courts in acquittee matters, and the acquittee privileging process.

C. The Forensic Coordinator ensures that the NGRI Coordinator of the appropriate community services board is notified of all court dates scheduled for acquittees in the custody of the Commissioner.

D. Each hospital shall develop its own internal procedures defining the role of the Forensic Coordinator in the processes described in this manual. The Forensic Coordinator Responsibilities, listed in Appendix I of this volume, should be a guide to this role definition. Specific tasks of forensic coordinators in the

acquittee management process are described further in the succeeding chapters of this document.

E. The Forensic Coordinator shall provide written notification to the DMHMRSAS Director of Forensic Services of any initial admission, escape, attempted escape, serious incident, death, transfer to another facility, conditional release or discharge of an insanity acquittee immediately, but not later than 1 working day subsequent to the event. (See **Appendix I** for additional forensic coordinator responsibilities.)

III. Transfer from a civil unit back to the Forensic Unit of Central State Hospital

A. In cases in which an acquittee requires a maximum-security environment, due to safety or security reasons, an immediate referral should be made to the Central State Hospital Forensic Unit administrator with notification to the Forensic Review Panel, and to the Director of Forensic Services. The Forensic Coordinator of the sending civil hospital should notify the Office of Forensic Services of DMHMRSAS within 24 hours of the transfer.

B. While at the Forensic Unit of Central State Hospital, the acquittee will be followed by a Forensic Unit treatment team with consultation from the referring civil unit treatment team regarding the goals of the Forensic Unit placement.

C. If the acquittee is returned to the civil unit within 90 days, the Panel and the Director of Forensic Services should be notified, but approval is not required.

D. If the stay on the Forensic Unit of Central State Hospital exceeds 90 days, the acquittee's eventual transfer to a civil unit will require the prior review and approval by the Panel. Review and approval by the Panel are also required before any other privileges can be restored to an acquittee, under these circumstances.

IV. Continuation of Confinement Hearings (§ 19.2-182.5) for those acquitted of felonies

A. The committing court shall hold hearings assessing need for continued inpatient hospitalization for individuals acquitted of a felony by reason of insanity.

1. Twelve months after date of commitment,

2. Yearly intervals for first five years after commitment, and

3. Biennial intervals, thereafter.

B. See Table 3.1: Required Court Hearings After Commitment to Commissioner for Inpatient Hospitalization.

C. The court shall schedule the matter for hearing as soon as possible after it becomes due, giving the matter priority over all pending matters before the court.

D. The treatment team shall provide to the court, thirty days prior to the continuation of confinement hearing, a report evaluating the acquittee's condition and recommending treatment, to be prepared by a psychiatrist or a psychologist.

1. See Table 3.2: Annual Continuation of Confinement Hearing Report/Evaluation

2. The facility Forensic Coordinator shall

   a. Review each final signed annual report to ensure that it addresses appropriate issues before it is provided to the court, and
   b. Attach a cover letter to the annual report, with a copy of model language to be considered by the court in drafting a new order to comply the Code of Virginia (see examples later in chapter), if the report recommends inpatient treatment.

3. Copies of the annual reports shall be sent to the

   a. Judge having jurisdiction,
   b. Acquittee's attorney,
   c. Commonwealth’s Attorney for the jurisdiction for which the acquittee was committed,
   d. NGRI Coordinator of the Community services board serving the locality to which the acquittee has been proposed for conditional release (and the original community services board if these are not the same),
   e. Administrative coordinator of the Forensic Review Panel, and
   f. Office of Forensic Services, Division of Facility Management.

4. Forensic Review Panel review and approval are required prior to submission of the annual report to the court in cases where the treatment team does not request continuation of hospitalization (e.g., in cases where the treatment team wishes to request conditional release, or release without conditions).

   a. If conditional release is requested by the treatment team, a complete conditional release plan shall also be submitted to the Forensic Review Panel and, subsequently, to the committing court, following approval.
   b. See Chapter 5: Planning For Conditional Release

5. Annual reports shall be provided to the courts each year whether or not the court is required to hold a hearing.

E. The treatment team or forensic coordinator shall notify the CSB as soon as possible of the date and time of the hearing. This is particularly important when the acquittee is returning to local jail to attend the hearing.

F. According to section 19.2-182.5(B), the acquittee may request release at each continuation of confinement hearing.

1. Upon such request, a second evaluation of the acquittee's condition shall be completed by an appropriately qualified clinical psychologist or psychiatrist.

2. A copy of that second evaluation shall be sent to the Commonwealth's Attorney for the jurisdiction from which the acquittee was committed.

3. The Commissioner shall appoint the second evaluator (§ 19.2-182.5(B)) to assess and report on the acquittee's need for inpatient hospitalization.

a. Appointment of evaluators:
   i. The Director of the Office of Forensic Services, acting for the Commissioner, shall make the appointments upon receipt of the court order.
   ii. This evaluation is an independent evaluation and the evaluator does not require the approval of the Forensic Review Panel when recommending conditional release or release without conditions.
   iii. Evaluations shall be completed and findings reported within 45 days of issuance of the court's order.
   iv. If the second evaluator recommends conditional release, the treatment team must develop a conditional release plan with the appropriate community services board, and submit the plan to the Forensic Review Panel. The Forensic Review Panel will, in turn, review and submit the conditional release plan to the court of jurisdiction, with their recommendation.

G. According to its determination following the hearing, and based upon the report and other evidence provided at the hearing, the court shall:

1. Order that the acquittee remain in the custody of the Commissioner if he or she is mentally ill or mentally retarded and continues to require inpatient hospitalization based on the factors set forth in § 19.2-182.3.
2. Place the acquittee on conditional release if
   a. He or she meets the criteria for conditional release, and
   b. The court has approved a conditional release plan prepared jointly

by the hospital staff and appropriate community services board(s); or

3. Release the acquittee from confinement if
   a. He or she does not need inpatient hospitalization,
   b. Does not meet the criteria for conditional release set forth in §19.2-182.7, and
   c. The court has approved a discharge plan prepared jointly by the hospital staff and appropriate community services board.

V. Acquittee Petitions for release, pursuant to § 19.2-182.6

A. Upon receipt of a petition for release, the court shall order the Commissioner to appoint two evaluators (§ 19.2-182.6(B)) to assess and report on the acquittee's need for inpatient hospitalization.

1. Appointment of evaluators

   a. The Director of the Office of Forensic Services, acting for the Commissioner, shall make the appointments upon receipt of the court order.
   b. This evaluations are independent evaluations and do not require the approval of the Forensic Review Panel when recommending conditional release or release without conditions.
   c. Evaluations shall be completed and findings reported within 45 days of issuance of the court's order.
   d. If either of the evaluators appointed pursuant to § 19.2-182.6(B) recommends conditional release, the treatment team must develop a conditional release plan with the appropriate community services board, and submit the plan to the Forensic Review Panel. The Forensic Review Panel will, in turn, review and submit the conditional release plan to the court of jurisdiction, with their recommendation.

B. According to its determination following the hearing, and based upon the reports and other evidence provided at the hearing, the court shall:

1. Order that the acquittee remain in the custody of the Commissioner if he or she is mentally ill and continues to require inpatient hospitalization based on consideration of the factors set forth in § 19.2-182.3.

2. Place the acquittee on conditional release if
   a. He or she meets the criteria for conditional release, and

b. The court has approved a conditional release plan prepared jointly by the hospital staff and appropriate community services board(s); or

3. Release the acquittee from confinement if
   a. He or she does not need inpatient hospitalization,
   b. Does not meet the criteria for conditional release set forth in §19.2-182.7, and
   c. The court has approved a discharge plan prepared jointly by the hospital staff and appropriate community services board.

VI. Escape from Custody of the Commissioner

A. Virginia Code § 19.2-182.14 provides that any person who is placed in the temporary custody of the Commissioner or committed to the custody of the Commissioner after an acquittal by reason of insanity, and escapes from that custody shall be guilty of a Class 6 felony.

B. Review by the Forensic Review Panel after acquittee returns to the Commissioner's custody from escape

1. Within three weeks of the acquittee's return to the Commissioner's custody, the treatment team shall submit the following packet of information to the Forensic Review Panel
   a. A review of the acquittee's escape, behavior during time on escape status, and a description of the circumstances of the return to hospitalization. This should include
      (1) the acquittee's perspective;
      (2) the treatment team's perspective;
      (3) other relevant parties' perspectives (including family, victim, and law enforcement, if available); and
      (4) other relevant information;
   b. An updated Risk Assessment including an Analysis of Aggressive Behavior (AAB);
   c. The results of a current mental status exam; and
   d. Recommendations for future treatment and management that include level of recommended privileges.
   e. All privilege levels are considered “revoked” until reviewed and approved by the Forensic Review Panel.

2. The Panel shall review the case and decide on appropriate placement and levels of privileges for the acquittee.

Notification to Commonwealth's Attorney

Date: _____

Commonwealth's Attorney
Address

Dear _____:

Under the provisions of Virginia Code § 19.2-182.4, this facility is required to notify you in writing when an individual who has been found Not Guilty by Reason of Insanity and placed in the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services has been authorized to leave the grounds of the hospital in which he or she is confined. The individual noted below has been so authorized:

Acquittee:
Case No.:
Court of Jurisdiction:
Register No.:
Date of Birth:
Date Of NGRI Finding:

This individual has been approved for community visits by the Forensic Review Panel. During community visits, the individual will:

_____ be accompanied by hospital staff.
_____ not be accompanied by hospital staff.

The length of the community visits will be:

_____ no longer than eight hours.
_____ no longer than 48 hours.
_____ as described in the court approved conditional release plan.

If you have any questions regarding the above, please contact me at _____.

_____
Forensic Coordinator

xc: Office of Forensic Services, DMHMRSAS
Defense Attorney
Judge
Community Services Board NGRI Coordinator

TABLE 3.1

Required Court Hearings for Felony Acquittees After Commitment to Commissioner for Inpatient Hospitalization

TIME AFTER DATE OF COMMITMENT TO COMMISSIONER	REQUIRED CONTINUATION OF CONFINEMENT HEARING?	ACQUITTEE ALLOWED TO PETITION FOR RELEASE PURSUANT TO §19.2-182.6 (A)?*	ACQUITTEE ALLOWED TO REQUEST RELEASE IN CONJUNCTION WITH JUDICIAL REVIEW PURSUANT TO §19.2-182.5 (B)?**
12 months (1 yr.)	yes	no	yes
24 months (2 yrs.)	yes	no	yes
36 months (3 yrs.)	yes	no	yes
48 months (4 yrs.)	yes	no	yes
60 months (5 yrs.)	yes	no	yes
72 months (6 yrs.)	no	yes	no
84 months (7 yrs.)	yes	no	yes
96 months (8 yrs.)	no	yes	no
108 months (9 yrs.)	yes	no	yes
120 months (10 yrs.)	no	yes	no
132 months (11 yrs.)	yes	no	yes

NOTE: **The Commissioner may petition the committing court for conditional or unconditional release of the acquittee at any time he or she believes the acquittee no longer needs hospitalization (§ 19.2-182.6).**

***** **The acquittee may petition the committing court for release of felony acquittees only once in each year in which no annual judicial review is required (§ 19.2-182.6 (A)).**

****** **In years in which an annual judicial review is required pursuant to § 19.2-182.5 (B), at the time of the judicial review, the felony acquittee may request release.**

TABLE 3.2
Continuation of Confinement Hearing Report/Evaluation

LEGAL CITATION	**§ 19.2-182.5(A). The court shall conduct a hearing 12 months after date of commitment to assess each confined felony acquittee's need for inpatient hospitalization.**
EVALUATOR FOR ANNUAL REPORT	**One evaluator. (This would normally be a person on the acquittee's treatment team.)** **Psychiatrist or Clinical Psychologist** **Shall be** **- skilled in the diagnosis of mental illness and mental retardation,and** **- qualified by training and experience to perform forensic evaluations.**
EVALUATOR FOR SECOND EVALUATION	**If the court so orders, a second evaluator will be appointed by the Commissioner if the first examiner recommends release or the felony acquittee requests release.** **- Same credentials as above.** **- Not currently treating the acquittee.** **Examinations and reports shall be conducted separately.**
CONTENT	**A report** **- evaluating the felony acquittee's condition, and** **- recommending treatment.** **The annual report may not recommend conditional release or release without conditions unless approved by the Forensic Review Panel.**
TIME FRAME	**Report is due 30 days prior to the court's hearing. Continuation of confinement hearings are held annually, starting 12 months after the date of the commitment, for the first five years. Biennial intervals thereafter.**

Cover Letter for Annual Report to the Court

Date: _____

The Honorable _____
Address

Re:_____
Case No.:_____
Reg. No.:_____

Dear Judge _____:

Enclosed is a copy of the annual report to the court on the condition of _____, who was previously found Not Guilty of a Felony by Reason of Insanity. It is provided to you as required by Virginia Code Section 19.2-182.5. The report recommends that the acquittee meets criteria for continued hospitalization.

For your convenience, I am also enclosing a model order recommitting the acquittee to the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. This model order was developed in conjunction with the Virginia Supreme Court and the Office of the Attorney General. It complies with Virginia Code and a U.S. Supreme Court decision (Foucha v. Louisiana, 504 U.S. 71 (1992)); that decision requires a finding of mental illness in order to commit or recommit an insanity acquittee to hospitalization.

Please contact me at _____ if you have questions or if I may be of assistance to you.

Sincerely yours,

Forensic Coordinator

xc: Commonwealth's Attorney
Acquittee's Attorney
Community Services Board NGRI Coordinator
Office of Forensic Services, Virginia DMHMRSAS
Forensic Review Panel
Treatment Team

Model Order for Initial Commitment

VIRGINIA:
IN THE CIRCUIT COURT OF_____, or

IN THE GENERAL DISTRICT COURT OF _____

COMMONWEALTH OF VIRGINIA
VS.

NAME_____ DOCKET NO.-CR _____
DATE OF BIRTH_____ FELONY _____
MISDEMEANOR _____
OFFENSE DATE(S) _____

Not Guilty by Reason of Insanity
Hearing on Temporary Custody Evaluation Reports and Inpatient Hospitalization

The acquittee having been found not guilty by reason of insanity to the charge(s) of _____ on _____ and placed in temporary custody for evaluation. This date came the attorney for the Commonwealth, _____. The Acquittee, _____, was present in the court throughout the proceedings and was ably represented by the defense attorney, _____. Based upon the written evaluations submitted by _____, the oral testimony of _____, and the arguments of counsel, the Court finds that the acquittee is ___ mentally ill or ___ mentally retarded and in need of inpatient hospitalization based on the factors in Va. Code § 19.2-182.3. Therefore, the Court ORDERS that the acquittee be committed to the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

The Court further ORDERS that

1. On _____, a hearing shall be held to review the acquittee's need for inpatient hospitalization unless an earlier hearing is scheduled as provided by law.

2. Before the hearing, the Commissioner shall provide a report to the court evaluating the acquittee's condition and recommending treatment, as provided in Va. Code 19.2-182.5, together with a copy of this order.

3. Copies of the items described in (2) shall also be sent to the attorney for the Commonwealth for the jurisdiction from which the acquittee was committed, and the acquittee's defense attorney.

4. The clerk shall notify the judge of the receipt of the reports so that issues regarding acquittee's right to counsel may be timely addressed.

5. The acquittee remains under the jurisdiction of this court and shall not be released from custody and inpatient hospitalization without further Order of the Court.

6. [This order supersedes the prior orders of this Court in this case.]

ENTERED: _____
Date

_____
Signature

_____
Name of Judge

cc: Commonwealth's Attorney
Acquittee's Attorney
Community Services Board NGRI Coordinator
Commissioner of DMHMRSAS
Attn: Office of Forensic Services
P.O. Box 1797,
Richmond, VA 23218-1797

Model Order for Recommitment

VIRGINIA:
IN THE CIRCUIT COURT OF _____, or

IN THE GENERAL DISTRICT COURT OF _____

COMMONWEALTH OF VIRGINIA

VS.

NAME_____ DOCKET NO.-CR _____

FELONY _____
DATE OF BIRTH_____ MISDEMEANOR_____
OFFENSE DATE(S)_____

Not Guilty by Reason of Insanity
Hearing on Evaluation Reports and Inpatient Hospitalization

This day came the attorney for the Commonwealth, _____. The acquittee, _____, was present in the court throughout the proceedings and was represented by counsel, _____. Based upon the evaluation(s) submitted by _____, the testimony of _____, and the arguments of counsel, the Court finds that the acquittee is ___ mentally ill or ___ mentally retarded and in need of hospitalization based on the factors in Va. Code § 19.2-182.3. Therefore, the Court ORDERS that the acquittee be recommitted to the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

The Court further ORDERS that

1. On _____, a hearing shall be held to review the acquittee's need for inpatient hospitalization unless an earlier hearing is scheduled as provided by law.

2. Prior to the hearing, the Commissioner shall provide a report to the court evaluating the acquittee's condition and recommending treatment, as provided in Va. Code 19.2-182.5, together with a copy of this order.

3. Copies of the items described in (2) shall also be sent to the attorney for the Commonwealth for the jurisdiction from which the acquittee was committed and the acquittee's attorney.

4. The clerk shall notify the judge of the receipt of the reports so that issues regarding acquittee's right to counsel may be timely addressed.

5. The acquittee remains under the jurisdiction of this court and shall not be released from custody and inpatient hospitalization without further Order of the Court.

6. [This order supersedes the prior orders of this Court in this case.]

ENTERED: _____
Date

_____
Signature

_____
Printed Name of Judge

cc: Commonwealth's Attorney
Acquittee's Attorney
Community Services Board NGRI Coordinator
Commissioner of DMHMRSAS
Attn: Office of Forensic Services
P.O. Box 1797
Richmond, VA 23218-1797

CHAPTER 4

THE PRIVILEGING PROCESS FOR INSANITY ACQUITTEES

The Privileging Process for Insanity Acquittees

I. Graduated release:

The acquittee management program in the DMHMRSAS is based upon a graduated release approach. This approach is a "demonstration" model of clinical risk management, wherein each acquittee is afforded the opportunity to demonstrate his capability for functioning at increasing levels of community access. The following are guidelines for requesting (i) increases in levels of privileges and freedom, and (ii) transfers to less restrictive settings.

A. Privileges may be granted to insanity acquittees who have been committed to the custody of the Commissioner of the DMHMRSAS by the courts.

B. Requests for increased freedom and privileges for acquittees should be based upon the principle of graduated release; i.e., gradual increases in freedom based on successful completion of the previous, more restrictive level of privileges.

1. In all instances, the acquittee's current functional level is to be taken into account when evaluations state that there is a need for graduated release.

2. Graduated release prepares acquittees for conditional release by providing a careful, thoughtful progression in transitioning from the maximum security setting of the Forensic Unit to the freedom of community placement.

C. Goals of the graduated release process

1. Provide acquittees with privileges consistent with their level of functioning and need for security

2. Ensure adequate risk assessment is conducted before granting increased freedom

3. Provide opportunities for acquittees to manifest appropriate functioning at various levels of freedom

4. Provide treatment teams with information regarding acquittees' ability to handle additional freedom and to comply with risk management plans. This information is critical in considering the appropriateness of conditional release.

5. Minimize risk to public safety

D. Options in graduated release process

1. Transfer from maximum security Forensic Unit of Central State Hospital to civil unit of state-operated mental health facility

2. Escorted grounds privileges, accompanied by facility staff

3. Unescorted grounds privileges

4. Community visits, escorted by facility staff

5. Unescorted community visits, not overnight

6. Unescorted community visits, overnight, but less than 48 hours

* 7. Trial visits for greater than 48 hours.

* 8. Conditional release

* 9. Release without conditions

*** (Asterisks indicate levels of privilege that require prior approval by the court of jurisdiction.)**

II. Risk assessment factors considered by the Forensic Review Panel and the Internal Forensic Privileging Committees (IFPC): The Forensic Review Panel and the IFPCs base their evaluations of privilege and release requests explicitly on the following risk assessment criteria:

A. Has the treatment team identified and articulated the factors that increase and/or decrease the probability that the acquittee will engage in behaviors that present a risk to others?

B. Has the treatment team developed a risk management plan that adequately manages the assessed risk?

C. Is the increased freedom requested justified by the treatment team's assessment of risk and their plan for risk management?

III. Factors used to determine suitability for less restrictive settings and privileges include:

A. A recommendation from the treatment team that such a transfer or less restrictive privilege is appropriate

B. A review of the offense for which the individual was acquitted by reason of insanity, with particular attention to

1. The nature and seriousness of the offense;

2. Evidence of similar offenses or behavior in his or her past record; and

3. Reports of what the acquittee has said in regard to such behavior, particularly in regard to

a. Remorsefulness,
b. Acceptance of responsibility for the behavior, and
c. Insight into wrongful nature of the behavior.

C. Evidence from the medical records and other sources that

1. The acquittee has conducted him or herself in an appropriate manner and has not engaged in any activity which could be interpreted as being dangerous to self or others during his or her hospitalization, particularly during the past six months, and

2. If granted increased privileges or access to less restrictive settings, the acquittee will not present

a. A danger to the community or other clients,
b. Risk of escape, or
c. Danger to self.

D. Acquittee's current mental status, including

1. Current thoughts about prior delusions, current delusions, NGRI offense, and risk to the general community, identified individuals, family, and/or friends; and

2. Understanding of his or her mental illness and need for treatment.

E. Acquittee's involvement in treatment.

1. Assessment of how effectively and completely the acquittee has used the programs provided by the treating unit. For example, if the acquittee has not participated in the treatment and activities programs available, transfer or increased privileges for the purpose of making additional programs available would be seriously questioned.

2. Compliance with prescribed psychotropic medication treatment.

F. Rationale for request, including specific treatment goals to be achieved through increased freedom: It is expected that less restrictive privileges will be integrated with the acquittee's treatment plan, and used to facilitate a graduated transition to conditional release.

G. Risk management plan that addresses both general risk conditions and specific risk factors for the individual acquittee

1. Risk management plans must be individualized based on

a. Acquittee's unique risk factors;
b. Physical layout of the facility;
c. Management practices unique to the facility;
d. Specific names and phone numbers for persons to be contacted if problems arise; and
e. Relevant aspects of community resources and locale.

2. Phase-in periods are useful additions to risk management plans; they can introduce the acquittee to the new freedom in graduated steps.

3. The acquittee must sign risk management plans for all levels of privileges.

4. For community privileges wherein the acquittee will not be accompanied by facility staff, but will be accompanied by family or friends, that family member or friend should sign the risk management plan.

5. Risk management plans for escorted and unescorted community visits should be coordinated with, and signed by, the appropriate community services board(s).

H. In cases where the acquittee has been previously placed for treatment at a less secure hospital or received less restrictive privileges, attention is given to the acquittee's behavior and general adjustment to hospitalization, particularly

1. Previous aggressive behavior towards others;
2. Performance with prior privileges (including any prior restrictions on privileges);
3. Previous escape attempts; and
4. Risk of aggression the acquittee might present if an escape did occur.

I. In cases where the acquittee has had previous visits into the community, or has been conditionally released, attention is given to behavior during those times and compliance with established guidelines and conditions.

J. Input from appropriate community services board(s): The treatment team shall work closely with the appropriate community services board(s) as the acquittee progresses through the graduated release process.

1. The community services board(s) may provide input to the treatment team, to the IFPC, and to the Forensic Review Panel during the entire process of graduated release.

2. Collaboration with the community services board(s) is particularly important when planning and implementing civil transfer, visits to the community, and conditional release.

K. Documentation of personal psychosocial strengths, skills, potentially ameliorating "protective factors", and assets of the acquittee that may be relevant to consideration for increased privileges.

IV. Guidelines for specific steps in graduated release

A. Civil transfers from Maximum Security:

In cases where the acquittee is being transferred between state facilities, appropriate staff members in the receiving facility shall be involved in the decision-making process.

1. All instances of transfer from maximum security to civil placement require the approval of the Forensic Review Panel.

2. The Forensic Coordinator from the referring or "sending" facility shall send a referral packet to the Forensic Coordinator of the potential receiving facility 14 days in advance of the Forensic Review Panel meeting with a request for review and feedback from the potential receiving facility by the date of the Panel review.

3. The Administrative Coordinator for the Panel shall notify the designated receiving facility of the date of the scheduled review by the Panel.

4. The potential receiving facility shall review the referral packet, review other records as needed, interview the acquittee, as needed, and provide written recommendations to the Panel before the Panel review date.

5. If the designated receiving facility objects to the transfer of an acquittee to that facility, written notification of that objection should be forwarded by that facility to the Forensic Coordinator for the sending facility, to the Forensic Review Panel, and to the Director of the Office of Forensic

Services, prior to the Panel review date.

6. The FRP will review the referral packet and any objections from the receiving facility. The sending facility will be notified of the decision.

B. Grounds privileges

1. Requests for escorted grounds privileges may be reviewed and approved by the Forensic Review Panel, in conjunction with requests for transfer to a civil hospital unit. (The IFPC reviews all requests to the FRP prior to submission to the FRP.) All other requests for either escorted or unescorted grounds privileges must be reviewed by the Internal Forensic Privileging Committee, and approved by the Committee and the Facility Director.

2. A clear rationale for the request must be included in the referral packet: it is expected that grounds privileges will be an integral part of the treatment plan and used to facilitate the transition to an eventual conditional release.

C. Community visits

1. Requests for escorted visits to the community must be reviewed and approved by the Internal Forensic Privileging Committee.

2. Requests for unescorted community visits (not overnight) require review and approval by the IFPC and the Forensic Review Panel.

3. Following the granting of unescorted, non-overnight community privileges by the Forensic Review Panel, the Internal Forensic Privileging Committee must review and approve any subsequent request for unescorted community visits, up to 48 hours.

4. As with grounds privileges, community visits should be part of a thoughtful graduated release and an integral part of the treatment plan.

5. Emergency-visits (Visits that include staff escort into the community involving acquittees who have not yet been approved for such a privilege level by the Panel), such as to attend the funeral of an immediate family member, require the prior review and approval of the Forensic Review Panel.

a. Treatment teams should immediately contact the Chair of the Panel with their request and provide a written risk management plan that includes a current risk assessment, mental status interview, and any victim notification requirements.

b. Recommendation from the treatment team is required before the Panel will consider such requests.
c. The Panel may require appropriate security measures to include, but not be restricted to, the use of physical restraints, security personnel, etc.

6. Overnight visits (maximum of 48 hours) require the approval of the IFPC : Section 19.2-182.4 provides for temporary visits to the community of no more than 48 hours if

a. The visit is of therapeutic value for the acquittee; and
b. Such visit would pose no substantial danger to others.

7. Trial visits (visits to the community of more than 48 hours) shall be included only in an overall plan for conditional release and, therefore, must be approved by the court as part of conditional release, following review and approval by the IFPC and the FRP.

V. Notification to Commonwealth's Attorney (§ 19.2-182.4) regarding community visits

A. Section 19.2-182.4 requires that the attorney for the Commonwealth for the committing jurisdiction be notified in writing of changes in an acquittee's course of treatment that will involve authorization for the acquittee to leave the grounds of the hospital in which he or she is confined.

Specifically, this includes

1. Community visits (escorted by facility staff or unescorted), and
2. Trial visits (as part of a court approved overall conditional release plan).
3. Transfers from one DMHMRSAS facility to another, including transfer from the maximum-security forensic unit to a civil unit at Central State Hospital.

B. After approval from the Internal Forensic Privileging Committee, the Forensic Review Panel and the court, if necessary, and prior to implementation of the community visit or trial visit, the Forensic Coordinator shall provide written notification of this increase in liberty to the Commonwealth's Attorney for the acquittee's committing jurisdiction. The Forensic Coordinator should provide a copy of this notification to the Director of Forensic Services. See form for Notification of Commonwealth's Attorney later in chapter.

C. Implementation of grounds privileges only for an acquittee does not require notification to the Commonwealth's Attorney.

VI. Roles and responsibilities of the Internal Forensic Privileging Committee (IFPC) (See also Tables 4.2 & 4.3)

A. The role of the Internal Forensic Privileging Committee (IFPC, the "Committee") includes the following:

1. To review and recommend, with Facility Director approval, the following privileges:

   a. Escorted Grounds
   b. Unescorted Grounds
   c. Escorted Community
   d. Unescorted (up to 48 hour) Community, (subsequent to prior FRP approval of Unescorted (not overnight) Community)

2. To ensure the appropriateness of all requests for increases in privileges submitted to the Forensic Review Panel.

   a. Before any request is submitted to the FRP, the IFPC must ensure that the treatment team has successfully completed any modifications or additions to the submission that had been recommended by the IFPC.
   b. The support of both the IFPC and the treatment team is required before any request for an increase in level of privileges is forwarded to the Forensic Review Panel. The only exceptions to this requirement for support of the request by both the treatment team and the IFPC are:

      i. When the court has ordered the facility to prepare a conditional release plan or a plan for unconditional release, and the treatment team and/or the IFPC are not in agreement that the lessening of restrictions is clinically appropriate; or
      ii. When a Commissioner appointed evaluator (appointed pursuant to § 19.2-182.2, 19.2-182.5, or 19.2-182.6) has recommended that the acquittee is ready for conditional release or unconditional release and the treatment team and the IFPC do not believe that the lessening of restrictions is clinically appropriate.

B. Internal Forensic Privileging Committee Structure

1. Each Internal Forensic Privileging Committee, or IFPC is comprised of five (5) members, appointed by the facility director. The membership must include the following:

a. Facility director or designee administrator
b. Medical director or psychiatrist
c. Forensic coordinator
d. Licensed clinical psychologist (if forensic coordinator is not LCP)

2. The facility director will also appoint an additional member (or members) from the following group: Psychology Director; Nursing Director; Social Work Director; additional psychiatrist or clinical psychologist. Staff from other disciplines may be appointed, if approved in advance by the Office of Forensic Services.

3. The following qualifications are required of each IFPC member:

a. Completion of DMHMRSAS-mandated training in forensics
b. Appropriate clinical experience (clinical staff only)
c. Completion of prescribed privilege-granting training activities with the Forensic Review Panel, or other DMHMRSAS-approved entity.

4. The following additional parameters apply to each IFPC

a. The Chair of the IFPC must be a psychiatrist or clinical psychologist.
b. The Patient Advocate assigned to the facility attends scheduled meetings.
c. A voting quorum consists of at least three members. A psychiatrist and one licensed clinical psychologist must be present at an IFPC meeting, for a voting quorum to exist.
d. An IFPC meeting must be scheduled at least once per week.
e. A meeting of the IFPC must be held within 14 calendar days of receipt of a request for review of privileges from a treatment team or from an acquittee.
f. It is the IFPC's responsibility to review the privileges of every insanity acquittee every 90 days and to document its review findings in the acquittee's medical record. (The Office of Forensic Services is to be provided with a summary of each review, every 90 days.)
g. IFPC's will develop and maintain centralized files on acquittees. These files will include, at a minimum, the following:

i. Copies of all of the court, hospital and evaluative documents that were provided to the Forensic Review Panel at the initial request for privileges for an acquittee. This information should include the Temporary Custody evaluations, the Initial Analysis of Aggressive Behavior, and the initial FRP privilege request packet, if applicable.
ii. Privileging documents supporting all subsequent requests

to either the Forensic Review Panel or the IFPC, up to and including the current request.

5. A complete set of all privileging documents that are submitted directly to the IFPC for the granting of a privilege level for an acquittee will be provided to the Office of Forensic Services for review and quality assurance purposes, and for archiving for the Forensic Review Panel.

6. Scheduled meetings

   a. The Facility Director and the Chair of the IFPC shall establish times.
   b. The Committee Chair shall disseminate the dates and times of deadlines for submission of cases to be considered at the meetings.
   c. If the IFPC will not hold a regularly scheduled weekly meeting, the Facility Director and the Director of the Office of Forensic Services shall be notified in advance, by the Chair of the Committee. If the IFPC fails to convene a meeting, due to the inability to convene a quorum of its members, or due to a lack of packets to be reviewed, the Forensic Coordinator, on behalf of the Chair, will notify the Facility Director and the Director of Forensic Services. When Committee members are not able to attend a weekly Committee meeting, they will inform the IFPC Chair of their absence, as soon as possible, either by telephone, in person, via email, or in other written form. If a quorum is not met at any regularly scheduled weekly meeting, a meeting of the Committee will be convened on an alternate day of the same week.
   d. If the IFPC does not meet during a given week, an all day meeting or two partial-day meetings will be scheduled for the following week, in order to complete all reviews.
   e. The Forensic Coordinator is responsible for keeping a calendar record for the Chair of all meetings that are rescheduled.

VII. Roles and responsibilities of the Forensic Review Panel in the privileging process (See also Tables 4.2 & 4.3)

A. The Forensic Review Panel (FRP, the "Panel") is an administrative board established by the Commissioner pursuant to § 19.2-182.13 to ensure:

1. Release and privilege decisions for insanity acquittees appropriately reflect relevant clinical, safety, and security concerns

2. Standards for conditional release and release planning of insanity acquittees have been met; and

3. Expert consultation is provided to treatment teams working with insanity acquittees.

B. Authority

1. Section 19.2-182.13 provides the Commissioner of DMHMRSAS with the authority to delegate any of the duties or powers imposed on or granted to him or her to an administrative panel composed of persons with demonstrated expertise in such matters.
2. The Division of Facilities Management, Office of Forensic Services shall assist the Panel in its administrative and technical duties.
3. Members of the Panel shall exercise their powers and duties without compensation, and shall be immune from personal liability except for intentional misconduct.

C. Policy

1. Treatment team requests which fall within the categories outlined below shall be presented to, reviewed by, and approved by the Forensic Review Panel, as described herein, prior to implementation of status change.

2. The Panel shall consider the assessment of risk as a central issue in its decision-making.

   a. The Panel's function is to assess whether the treatment team has adequately considered the issue of risk.
   b. It is not the role of the Panel to provide an independent judgment on the issue of risk. Rather it is the role of the Panel to review risk assessments completed by treatment teams, and to recommend modifications to those risk assessments, if necessary.

3. The Panel shall review requests only regarding acquittees who are currently in the custody of the Commissioner.

4. It is the policy of the DMHMRSAS that acquittees with active court orders for conditional release who are awaiting placement shall remain under the aegis of the Panel, with regard to their privileging status. (Acquittees in this category will be accorded all community access necessary for implementation of the conditional release plan.)

5. Evaluations performed as a result of an appointment by the Commissioner ("Commissioner Appointed Evaluations") do not require review by the Forensic Review Panel.

D. Review by the Panel is required for all court-ordered Conditional Release Plans.

1. Whenever a committing court orders that the acquittee's facility and the relevant Community Services Board (CSB) develop a conditional release plan for the acquittee, that plan shall be developed by the acquittee's treatment team and submitted for review to the Forensic Review Panel.

2. The Forensic Review Panel shall make a recommendation, either approving or disapproving the conditional release plan. The plan shall be submitted to the court of jurisdiction, following review by the Panel, regardless of whether or not the Forensic Review Panel has approved it.

E. Review and approval by the Panel are required for:

1. All requests from treatment teams for court changes in acquittee's legal status. This includes changes from inpatient hospitalization and custody of the Commissioner to

   a. Conditional release status in the community, or
   b. Release into the community without conditions or further court jurisdiction.

2. Certain requests from treatment teams to increase acquittee's levels of liberty and access to the community while in the custody of the Commissioner

   a. Transfers to less restrictive units and/or hospitals
   b. Grounds privileges (escorted by facility staff), in conjunction with transfer from maximum-security hospital placement
   c. Unescorted community visits, not overnight

3. The Commissioner has delegated the granting of the following privileges to the Internal Forensic Privileging Committees at each DMHMRSAS hospital:

   a. Escorted Grounds Privileges (If not previously granted by the FRP)
   b. Unescorted Grounds Privileges
   c. Escorted Community Privileges
   d. Unescorted Community Privileges, up to 48 hours (following prior approval by the FRP of Unescorted Community Access, not overnight.)

4. Transfers between civil hospitals of acquittees (who have already been approved by the FRP for transfer from the maximum security forensic unit at Central State Hospital) for the purposes of proximity to family or access to appropriate treatment resources are not under the purview of the Panel, but are instead handled through the usual process for transfer between facilities, in consultation with the Office of Forensic Services. The Panel will be notified of such transfers, however.

F. Structural and Operational Parameters of the Panel

1. Composition of the Forensic Review Panel

a. The Structure of the Forensic Review Panel

i. The membership of the Forensic Review Panel shall include a minimum of at least seven (7) members.
ii. The membership of the Panel shall include at least two members from each of the following professional categories on the Panel:
iii. Psychiatrist
iv. Licensed Clinical Psychologist
v. Other licensed mental health practitioners, including CSB representatives, if available
vi. All Panel members will have requisite forensic experience and training, as prescribed by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.
vii. All individuals appointed to serve as members of the Panel who are not employees of DMHMRSAS are required to sign statements indicating their awareness of the need to maintain confidentiality of client records, and promising to maintain such confidentiality.
viii. Appointments shall be made and renewed at the discretion of the Commissioner. (Each term is for 3 years.)
ix. Panel members shall receive an orientation to the privileging process, upon appointment by the Commissioner. Panel members will also be provided with annual in-service training.

b. Functional Parameters of the Panel

i. A quorum of the FRP consists of one half of the total number of FRP members plus one. The quorum must include a psychiatrist and a clinical psychologist.
ii. All decisions of the Forensic Review Panel regarding privileges and/or Conditional Release require the agreement of a majority of the total Panel membership, including one psychiatrist and one clinical psychologist.
iii. The opinions and concerns of Panel members who dissent from a majority decision shall be documented and reviewed by the Office of Forensic Services, as requested.

2. Scheduled meetings

   a. The Chair of the FRP shall establish regular weekly meeting times.
   b. The Chair shall disseminate the dates and times of regular meetings, along with deadlines for submission of cases to be considered at the meetings.
   c. If the FRP will not hold a regularly scheduled weekly meeting, the Director of the Office of Forensic Services shall be notified in advance, by the Chair.
   d. When members are not able to attend a weekly FRP meeting, they will inform the administrative coordinator to the Chair of their absence, as soon as possible, either by telephone, in person, via email, or in other written form. If a quorum is not met at any regularly scheduled weekly meeting, a meeting of the Panel will be convened on an alternate day of the same week.
   e. If the Panel does not meet during a given week, an all day meeting or two partial-day meetings will be scheduled for the following week, in order to complete all reviews.
   f. The administrative coordinator is responsible for keeping a calendar record for the Chair of all meetings that are rescheduled.
   g. If the Panel fails to convene a meeting, due to the inability to convene a quorum of its members, the administrative coordinator, on behalf of the Chair, will notify the Director of Forensic Services. The Director of Forensic Services will notify his/her supervisor of the cancellation of the meeting.
   h. The Chair of the Panel will notify the Director of Forensic Services, or the administrative coordinator, of any cancellation of meetings as a result of a lack of packets for review. The Director of Forensic Services will notify his/her supervisor of the cancellation of the Panel meeting.

3. Chair of the Panel

   a. The Chair of the Forensic Review Panel is appointed by the Commissioner. Qualifications for appointment as Chair include: Licensed Clinical Psychologist (or equivalent) or Psychiatrist with forensic expertise, and qualifications and experience as an expert witness.

   b. The direct responsibilities of the Chair of the FRP include the following:

      i. Works with the Director and staff of the Office of Forensic Services in communicating with the courts, facilities and community services boards on acquittee matters.
      ii. Represents the FRP and Commissioner in response to witness subpoenas for the Panel from the courts.

4. A full-time administrative coordinator will be assigned to the Panel to provide support services, including:

   a. Setting and circulating agendas
   b. Distributing review packets
   c. Taking minutes of meetings (including attendance),
   d. Distributing minutes of meetings (including attendance) to all Panel members, and to the Director of Forensic Services, within 5 working days of the meeting
   e. Providing a copy of the Forensic Review Panel Decision Notification and the Forensic Review Panel Decision Signature Page to the Director of Forensic Services
   f. Polling the membership to ensure that a quorum will be present for each meeting
   g. Review of each referral packet, for completeness and readiness for review by the full Panel, in consultation with the Chair, prior to circulation to the Panel
   h. Notifying Panel members and the Director of Forensic Services of any canceled meetings, and
   i. Providing other necessary services in support of the Panel's functions

VIII. Facility Forensic Coordinator

A. Each DMHMRSAS Facility Director shall designate an appropriately trained and credentialed clinical psychologist or clinical social worker to serve as the Forensic Coordinator for that facility. The Forensic Coordinator serves as the primary point of communication between the facility and the FRP, as well as between facility treatment teams and the IFPC, regarding insanity acquittees (See also Appendix I: Facility Forensic Coordinators, for a full description of Forensic Coordinator Responsibilities.)

   1. The Forensic Coordinator must:

      a. Review all submissions from the treatment teams to the IFPC
      b. Review all submissions from the facility to the FRP for completeness and compliance with the format required for review of privilege request documents .
      c. Receive and deliver to the treatment team(s) all information received from the IFPC and/or the FRP

   2. The Forensic Coordinator must, in addition, provide appropriate information to the Office of Forensic Services, regarding IFPC privilege-granting and other acquittee privileging activities.

B. The Forensic Coordinator responsibilities are critical to the successful management of the NGRI privileging process. The Forensic Coordinator and the Facility Director are responsible for ensuring that the facility manages all insanity acquittees in an appropriate fashion according to the policies of the Department, orders of the court, laws of the Commonwealth and in coordination with the Department's Office of Forensic Services.

IX. The Facility Director

A. Each Facility Director is responsible for allocating the necessary resources to ensure that all responsibilities of the Forensic Coordinator and the IFPC are performed in an efficacious and expeditious manner. The accomplishment of these responsibilities is crucial to the successful management of forensic patients and is, therefore, a performance issue for the Facility Director, the IFPC, and the Forensic Coordinator, as well as for all personnel in the supervisory chain.

B. The Facility Director will assure that there are policies and procedures to provide that all staff members who are responsible for the safety and security of NGRI acquittees:

1. Are informed of, and have ready access to, information regarding the NGRI acquittee's current level of privileges, and
2. Continually monitor each NGRI acquittee's level of functioning and only permit the acquittee to exercise privileges consistent with the acquittee's level of functioning, in accord with current risk assessments and court orders.

C. The Facility Director also has final responsibility and signatory authority for approval of all privilege requests that are granted by the IFPC.

X. THE PROCESS FOR PRIVILEGES GRANTED BY THE INTERNAL FORENSIC PRIVILEGING COMMITTEE (IFPC)

(See Table 4.5 for a summary of the procedures required for the granting of privileges by the IFPC.)

A. Roles and responsibilities:

1. Insanity acquittee

The insanity acquittee may request an increase in privileges by completing the Acquittee Privilege Request Form. This is done with the assistance of the treatment team psychologist, or other designee responsible for NGRI

privileging at the treatment team level. This treatment team member will assist the acquittee in completing the request form, will obtain the acquittee's signature, and will sign and date the form. The form will then be presented at the next Treatment Team meeting within seven (7) calendar days. The Treatment Team must meet and review all requests for privileges at least once every seven (7) calendar days. The acquittee may only initiate a request for an increase in level of privileges once every 30 days.

2. The Treatment Team

Procedures to be used for privilege requests from the treatment team to the Internal Forensic Privileging Committee:

a. The treatment team shall submit the completed IFPC privilege request packet to the IFPC via the facility forensic coordinator. The Forensic Coordinator shall review the packet for the IFPC, and provide feedback regarding needed changes and clarifications, within seven (7) working days, prior to formal review of the packet by the IFPC. The treatment team shall submit the revised privilege request packet to the IFPC within 10 working days.
b. Within 1 working day of receipt of notification by the treatment team of a decision from the Internal Forensic Privileging Committee, regarding a request for an increase in level of privileges, the designated member of the treatment team shall meet with the insanity acquittee and provide to him or her a copy of the written decision of the IFPC, explain the decision, and discuss expectations of the acquittee. This meeting will be documented in the NGRI's medical record.

3. The Forensic Coordinator.

The general responsibilities of the Forensic Coordinator regarding privileges granted by the IFPC include:

a. Review all submissions from treatment teams to the IFPC, prior to their presentation to that group for formal review.
b. Receive and deliver to the treatment team(s) all information received from the IFPC.
c. Specific responsibilities of the Forensic Coordinator include the following:

i. Coordinate the submission of requests for increases in privilege levels to the IFPC. The Forensic Coordinator must sign item 27 of the IFPC submission summary sheet

signifying his or her:

(1) Verification that the packet of information is accurate and complete;
(2) Agreement that approval of the request is consistent with Departmental policy; and
(3) Verification that the treatment team has asserted that approval of the request will neither expose the NGRI acquittee, nor the community to undue risk.

ii. Establish the currency of the reports submitted to the IFPC by documenting on item 26 of the IFPC Submission Summary Sheet the date that he or she received the submission from the Treatment Team.

iii. Submit the privilege packet to the IFPC within 3 working days after he or she has received the revised and edited privilege request packet which had been previously reviewed by the coordinator and returned to the team, if the document had been returned for revision or editing.

d. Whenever the Forensic Coordinator receives notification from the IFPC that a decision has been deferred, pending the provision of additional information by the Treatment Team, the Forensic Coordinator shall obtain the requested data and provide it to the IFPC within twenty-one (21) calendar days. If the coordinator has not received the requested information from the treatment team within 21 calendar days of the original request for information, the coordinator shall notify the Facility Director that the requested information has not been received.

e. Upon receipt of a decision from the IFPC, the Forensic Coordinator will notify the Treatment Team of the decision within 1 working day. (The designated member of the Treatment Team will be instructed by the coordinator to inform the insanity acquittee of the Committees decision within 1 working day of receipt of such notification.)

B. Specific Operational Activities for Privileges Granted Directly by the IFPC

1. As noted at the beginning of this chapter, the Commissioner has delegated the granting of the following privileges to the IFPCs at each DMHMRSAS hospital:

a. Escorted Grounds Privileges (if not already approved by the FRP)

b. Unescorted Grounds Privileges

c. Escorted Community Privileges

d. Unescorted Community Access, up to 48 hours (following prior approval by the FRP of Unescorted Community Access, not overnight.)

2. The IFPC shall open a forensic file for each new acquittee upon admission for temporary custody, or upon transfer of an acquittee to placement in that facility. The facility Forensic Coordinator shall have responsibility for the establishment and maintenance of these files. (The Office of Forensic Services will provide copies of all relevant background case information.) These files shall include, at the minimum:

a. All relevant court orders

b. The Initial Analysis of Aggressive Behavior, and any previously completed Updates

c. All Competency and Sanity evaluations completed with the acquittee

d. Temporary Custody Evaluations and other Commissioner-Appointed Evaluations

e. Any Annual Continuation of Confinement Reports

f. Reports of criminal investigations and other background case material

g. Letters to judges and attorneys

h. Copies of Privilege Request Packets previously submitted to the FRP

i. All additional materials related to IFPC privileging activities at the facility. (The Forensic Coordinator will also provide these materials to the Office of Forensic Services, for inclusion in the acquittee's Central Office master file.)

j. Any previously completed consultative, specialized medical or psychological evaluations.

3. The Facility Director of each facility shall establish a process by which the Forensic Coordinator shall have the authority to coordinate the submission of requests from acquittees' Treatment Teams to the IFPC.

4. The following information (Review Packet) shall be submitted to the facility Forensic Coordinator for all requests for privilege levels granted by the IFPC:

   a. The facility forensic file of each acquittee to be reviewed at an IFPC meeting shall be available for review by the Committee, prior to and during its formal review of a privilege request.

   b. An updated, concise Analysis of Aggressive Behavior, completed within 30 days of receipt by the forensic coordinator for submission to the IFPC (See Appendix A).

      i. Include risk management plan.
      ii. An updated, analysis of aggressive behavior (AAB) addressing all risk factors identified in the initial and subsequent AAB updates, and including and addressing all risk factors identified during the course of evaluation and treatment.

   c. Mental Status Evaluation (MSE) completed within 30 days of receipt by the forensic coordinator for submission to the IFPC.

   d. Completed Internal Forensic Privileging Committee Submission Summary Sheet:

      i. All documentation required by the IFPC submission summary sheet must be included.
      ii. The members of the acquittee's treatment team must sign the submission summary sheet, indicating that they have reviewed all of the documents contained therein.
      iii. An assessment of the acquittee's current risk for escape.

5. Each item of documentation should be dated and signed.

6. Requests for escorted community privileges, and unescorted community visits (48 hours maximum) require a statement of agreement signed by the treatment team and the receiving community services board.

7. All requests for grounds or community privileges must include a risk management plan signed by the acquittee and, for cases involving community privileges, signed by the CSB representative. When

appropriate, relatives or other persons who have agreed to accept responsibility for the acquittee while he or she is in the community should also sign the risk management plan.

8. The facility Forensic Coordinator shall review each privilege request packet prior to circulation to the other IFPC members to ensure completeness. If the facility Forensic Coordinator determines that the packet is incomplete, the Coordinator will return the packet to the treatment team, with recommendations for modifications or additions.

9. The facility Forensic Coordinator shall forward copies of the final version of the privilege request packet to members of the IFPC one week prior to the regularly scheduled meeting.

10. Members of petitioning treatment teams may attend the IFPC's meeting regarding their cases, in order to receive consultation or to provide clarifying information. The Chair of the IFPC will document any information provided to the IFPC that assisted in the IFPC's decision making, but was not included in the original referral packet. This information will be documented in the written IFPC Decision Notification.

11. Acquittees and their designated family members or legal guardians, may attend IFPC meetings, upon request, for purposes of obtaining additional information regarding the Panel's process or decisions regarding that acquittee. (Participation of an acquittee's family shall require the written authorization of the acquittee as a prerequisite to the convening of any meeting of this type.) The IFPC shall provide sufficient time to discuss the relevant concerns of the acquittee at such meetings.

12. IFPC Decision-Making Process

    a. The IFPC, in accordance with the parameters of the FRP, bases its decision-making explicitly on the following risk assessment criteria:

        a. Has the treatment team identified and articulated the factors that increase and/or decrease the probability that the acquittee will engage in behavior that presents a risk to others?
        b. Has the treatment team developed a risk management plan that adequately manages the assessed risk?
        c. Is the increased freedom requested justified by the treatment team's assessment of risk and their plan for risk management?

b. Quorum

1. A quorum must be present before a final decision can be made.

2. A quorum consists of three IFPC members, with a minimum of one (1) psychiatrist and one clinical psychologist required for a quorum vote.

c. Majority Decision required for recommendations to the Facility Director regarding privilege requests

1. As noted above, all decisions of the IFPC regarding privileges require the agreement of at least 3 of the 5 IFPC members.

2. The opinions and concerns of IFPC members who dissent from a majority decision on a privilege shall be documented at each meeting, and reviewed by the Office of Forensic Services for quality assurance purposes, and as requested by IFPC members.

3. When a majority of the IFPC, as defined herein, has rendered a decision, the IFPC's decision is referred to the Facility Director, by the Committee Chair, within one (1) working day, for review and approval or disapproval.

d. Possible Decisions

i. Approve the team's privilege request, no revisions required.

ii. Approve with revisions (related to improving the risk assessment and management process) to be reviewed by the IFPC Chair and the Facility Director. The IFPC returns the case to the treatment team for revision with specific recommendations for additions or deletions. All revisions by the treatment team must be reviewed and approved by the Head of that treatment team, prior to resubmission.

iii. Defer approval, pending revisions and further review by the IFPC. The IFPC returns the case to the treatment team for more extensive revision, with the requirement that the case be again reviewed, after the changes have been made, by the IFPC and the Facility Director. All revisions by the

treatment team must be reviewed and approved by the Head of that treatment team prior to resubmission. The revisions to the request must be returned for review within two weeks of notification of the deferral.

iv. Disapprove the request and return the case to the treatment team with an explanation of the reasons for the disapproval, and a statement regarding the type and degree of improvement in the acquittee's functioning which would need to be manifested before the IFPC could grant approval of a privilege request for that acquittee.

e. Final Decision of IFPC

i. The IFPC Chair fills out the IFPC Decision Notification. That document includes:

(1) The request to the IFPC;
(2) The IFPC's assessment of the treatment team's assessment of risk, the risk management plan, and the justification of increased freedom;
(3) The decision of the IFPC, signed by the Facility Director; and
(4) The IFPC's comments to the treatment team, as appropriate.

ii. Notification of all IFPC decisions is provided to the Chair of the Forensic Review Panel within one (1) working day of the endorsement by the Facility Director of a privilege decision by the IFPC. The Facility Director, through the facility Forensic Coordinator, has direct responsibility for notification of the Chair of the Forensic Review Panel of all IFPC privilege decisions.

iii. The IFPC Decision Notification and Decision Signature Page are filed in the acquittee's IFPC record. Copies are sent to:

(1) The Chair of the FRP
(2) The Office of Forensic Services, for inclusion in the acquittee's FRP record
(3) The community services board's NGRI Coordinator
(4) The head of the acquittee's treatment team, for inclusion in the acquittee's medical record

iv. The IFPC, through the Forensic Coordinator, will notify the treatment team of its decision within two weeks of the IFPC's receipt of the complete request.

v. The treatment team informs the acquittee of the results of the IFPC review, within one working day of receipt of the Facility Director-endorsed decision by the treatment team. In the event that the IFPC has disapproved a request from the acquittee for an increase in privileges, the treatment team representative informs the acquittee of the reasons for the disapproval, and provides information regarding the decision review process, as appropriate.

f. Facility Director Endorsement of IFPC Decision Recommendations

All approvals of privileges granted directly by the IFPC require the written approval of the Facility Director, before they are official and valid.

i. Within one (1) working day of the rendering of a majority decision by the IFPC, regarding a privilege request, the Chair of the IFPC will forward all relevant documentation regarding the request and the IFPC's decision regarding that request to the Facility Director.
ii. The Facility Director will review and approve or disapprove the decision of the IFPC, within two (2) working days of receipt of the IFPC's decision materials.
iii. The Facility Director must give final approval of all IFPC decisions, in order for such decisions to be valid and final.

13. Review process for Privilege Requests Disapproved by the IFPC to the FRP.

In the event that the IFPC does not approve the referring treatment team's request additional privileges for an acquittee:

a. At the request of the acquittee, the treatment team shall document in the patient's record, the team's or the acquittee's request for review of an IFPC privilege request denial. The request shall be forwarded to the forensic coordinator (and copied to the IFPC) on behalf of the acquittee (or the team), within three (3) working days of the acquittee's initial request.

b. The forensic coordinator will work with the treatment team in

developing a formal review request of an IFPC decision. The coordinator will obtain written documentation from the acquittee's treatment team, addressing and requesting review and revision of the IFPC's decision, within ten (10) working days of receiving notification of the review request from the treatment team.

c. The FRP shall be provided with all additional documentation required for a thorough review, by the forensic coordinator. The provision of this documentation shall be coordinated with the administrative coordinator for the FRP.

d. The FRP will review and respond to the request within seven (7) working days from receipt of the review documentation. Following that review, the FRP will render one of the following decisions on the matter:

   i. A finding upholding the IFPC's original decision on the matter.

   ii. A directive to the IFPC, to reconsider the original privilege request of the acquittee.

   iii. A directive rescinding the original decision of the IFPC, and granting the privilege request of the acquittee.

e. The administrative coordinator will notify both the Chair of the IFPC and the Forensic Coordinator of the review decision within two (2) working days of receipt of the decision from the Chair of the FRP.

f. The forensic coordinator will notify the treatment team of the review decision within one (1) working day of receiving notification of that decision. The treatment team will notify the acquittee of the decision of the FRP within one (1) working day of notification of that decision, by the forensic coordinator.

g. If the IFPC is directed to reconsider the request by the FRP, the forensic coordinator will notify the acquittee's treatment team of that decision within two (2) working days. A treatment team member will inform the acquittee of the Committee's decision regarding a review, within one (1) working day of notification by the coordinator.

XI. THE PROCESS FOR PRIVILEGES GRANTED BY THE FORENSIC REVIEW PANEL

(See Table 4.6 for a summary of the procedures required for the granting of privileges by the FRP.)

A. The FRP must directly review all requests for the following privilege levels for all acquittees committed to the Custody of the Commissioner:

1. Transfer from Maximum Security to a Civil facility (with or without Escorted Grounds privileges)
2. Initial Unescorted Community Access (8 hour passes)
3. Conditional Release (all cases, including Temporary Custody)

B. The NGRI privileging process at the FRP level also involves the active participation of the acquittee, the Treatment Team, the IFPC, the Forensic Coordinator, the Facility Director, the Office of Forensic Services, and the Community Services Board. The roles and responsibilities of each of these entities remains as described in Section VII of this manual, in most respects, for FRP privileges. Additional or alternative actions required by each of the aforementioned entities, for the granting of privileges at the FRP level include the following:

C. The Treatment Team:

1. The treatment team prepares the privilege request packet for review by the FRP within 30 calendar days of the decision to request a privilege increase for an acquittee. The completed privilege packet must be reviewed and approved by the IFPC prior to submission to the FRP.

2. At least once every 365 days, the Treatment Team shall submit to the IFPC for review and forwarding to the FRP, an annual report for each insanity acquittee who has been committed to the custody of the Commissioner. This report shall be submitted even if the treatment team is not requesting an increase in privilege level for the acquittee. The Annual Review Report shall be the same as the report submitted to the committing court, as described in Appendix E, and shall include all components contained therein, as well as a statement summarizing the reasons for the team's decision not to request an increase in privileges for the acquittee, if an increase has not been requested.

D. IFPC procedures for privilege requests from the treatment team to the FRP:

1. The IFPC shall review all requests for endorsement of privilege increase requests from treatment teams to the FRP within seven calendar days. The IFPC will make its final decision within that same seven calendar days, unless it must request additional information or clarification prior to making a final decision. The IFPC shall provide written feedback to the Treatment Team within 3 working days of its decision.
2. All approvals of requests from treatment teams for endorsement of requests for changes in privilege levels of the FRP require the approval of three-fifths of the IFPC membership, including one psychiatrist and one clinical psychologist. If there is not a three-fifths majority approval, the change will be considered disapproved.
3. The IFPC shall approve all modifications that the treatment team has made to the privilege request packet before submission to the FRP.
4. The Chair of the IFPC shall sign and date the FRP Submission Summary Sheet for each submission to the FRP.

E. The Forensic Coordinator, in addition to the responsibilities summarized above, has the following responsibilities with the FRP privileging process:

1. The Coordinator will submit the privilege packet to the FRP within 3 working days after he or she has received the completed privilege request packet that has been prepared by the Treatment Team, and approved by the IFPC.
2. The Coordinator ensures that the IFPC has approved all modifications made by the treatment team to the request, before verifying that the request is ready for submission to the FRP.
3. On or before January 10, April 10, July 10, and October 10 of each calendar year, the Forensic Coordinator will provide to the Facility Director, the Chair of the FRP, and the DMHMRSAS Director of Forensic Services a summary for the previous quarter. This summary shall include the decisions the IFPC has made during its quarterly reviews of the level of privileges of each insanity acquittee.
4. In those instances when the privilege request involves transfer of an NGRI acquittee to a less restrictive facility, the sending Forensic Coordinator shall send a referral packet that must be received by the Forensic Coordinator of the potential receiving facility 14 days in advance of the FRP's review of that request.

5. When there is a request to transfer an NGRI acquittee to a less restrictive treatment facility, the receiving Forensic Coordinator should have in place a process for:

    a. Documentation of the date he or she received a copy of the

submission packet to the FRP, and request for transfer and its completeness.

b. Reviewing the request for transfer,

c. Providing feedback to the Forensic Coordinator of the sending facility, and

d. Providing a written response to the FRP, prior to the date the FRP is scheduled to review the case.

6. In instances wherein the IFPC approves a request for Conditional Release, or should the court of jurisdiction pursuant to Section 19.2-182.6, order that a Conditional Release plan be prepared, a complete packet must be forwarded to the FRP by the Forensic Coordinator. In cases where the request is for conditional release:

a. As allowed by the court, an extension of up to thirty (30) days beyond the thirty-day period previously provided to prepare a packet may be granted to the Treatment Team by the IFPC in order to complete a viable conditional release plan in collaboration with the Community Services Board.

b. In cases where there is a court order requiring the submission to the court of a conditional release plan by a certain date, the facility may have less than 30 days to complete the entire process, including review by the FRP. The FRP must be notified by the Forensic Coordinator of the due date set by the court.

F. Specific Operational Activities for Privileges Granted Directly by the FRP

1. The FRP shall open a file for each new acquittee upon admission for temporary custody. All such files are kept in the DMHMRSAS Office of Forensic Services.

2. The following information (Review Packet) shall be submitted to the administrative coordinator of the FRP, for all privileging requests:

a. Recent Annual Report to the court (See Appendix E)

b. An Initial Analysis of Aggressive Behavior. (Required for all newly committed patients, and with court-ordered conditional release plans.) (See Appendix A).

c. Updated Analysis of Aggressive Behavior completed within 30 days of receipt by the forensic coordinator for submission to the FRP (See Appendix A).

i. Include current risk management plan.

ii. The updated analysis of aggressive behavior (AAB) will include and address all risk factors identified in the initial and subsequent AAB updates, and will include and address all risk factors identified during the course of evaluation and treatment. This update will include a narrative description of history, current status, and planned management strategy for each risk factor.

d. The initial and current updated Community Outpatient Treatment Readiness Scale (COTREI; See Appendix B) completed within 30 days of receipt by the forensic coordinator for submission to the FRP.

e. Mental Status Evaluation (MSE) completed within 30 days of receipt by the forensic coordinator for submission to the FRP.

f. Completed FRP Submission Summary Sheet

i. All documentation required by the submission summary sheet must be included.
ii. Item 13 on submission summary must be checked.
iii. The members of the acquittee's treatment team must sign the submission summary sheet, indicating their support for the submission, and that they have reviewed all of the documents contained therein.

g. An assessment of the acquittee’s current risk for escape.

h. Any other items specified in the Submission Summary Sheet.

3. Each item of documentation should be dated and signed.

4. Requests for Unescorted community visits (not overnight) require a statement of agreement signed by the treatment team and the receiving community services board.

5. All requests for grounds or community privileges must include a Risk Management Plan signed by the acquittee and, for cases involving community privileges, signed by the CSB representative. When appropriate, relatives or other persons who have agreed to accept responsibility for the acquittee while he or she is in the community should also sign the risk management plan.

6. Requests for conditional release shall include the following additional information (See Chapter 5 and Appendix G).

   a. Conditional release plan with components specified on the FRP Submission Summary sheet

   b. Completed Community Services Board (CSB) agreement and recommendations/comments regarding the proposed conditional release

   c. Completed acquittee review and agreement to terms of proposed conditional release

   d. Letters of support and consent from others involved in proposed conditional release plan. May include

      i. Family,
      ii. Providers other than CSB, and
      iii. Friends.

7. The Chair of the FRP, in conjunction with the Office of Forensic Services, shall review referral packets prior to circulation to the other FRP members to ensure completeness. If the Chair finds that the packet is not complete, the Chair, through the administrative coordinator, will return the packet to the facility Forensic Coordinator, with recommendations for modifications or additions.

8. The FRP's administrative coordinator shall forward copies of the entire referral packet to members of the FRP at least one week prior to the regularly scheduled meeting, during which the request will be considered.

9. The FRP may, at the discretion of the Chair,

   a. Invite or require attendance by the acquittee's Forensic Coordinator
   b. Require submission of medical and legal records for review.

10. Members of petitioning treatment teams may attend the FRP's meeting regarding their cases in order to receive consultation or to provide clarifying information. The Chair of the FRP will document any information provided to the FRP that assisted in the FRP's decision making, but was not included in the original referral packet. This information will be documented in the written Decision Notification.

11. Acquittees and their designated family members or legal guardians, may attend FRP meetings, upon request, for purposes of obtaining additional information regarding the FRP’s process or decisions regarding that

acquittee. (Participation of an acquittee's family shall require the written authorization of the acquittee as a prerequisite to the convening of any meeting of this type.) The FRP shall provide sufficient time to discuss the relevant concerns of the acquittee at such meetings.

12. FRP Decision-Making

a. The FRP bases its decision-making explicitly on the following risk assessment criteria:

i. Has the treatment team identified and articulated the factors that increase and/or decrease the probability that the acquittee will engage in behavior that presents a risk to others?
ii. Has the treatment team developed a risk management plan that adequately manages the assessed risk?
iii. Is the increased freedom requested justified by the treatment team's assessment of risk and their plan for risk management?

b. Quorum

i. A quorum of the FRP membership must be present before a final decision can be made.

ii. A quorum consists of one half of the total number of FRP members plus one. The quorum must include a psychiatrist and a clinical psychologist in order for the FRP to approve an increase in level of privileges.

c. Majority Decision

i. The Chair of the FRP shall take a vote for each decision and record the number and names of FRP members voting to approve or disapprove each privilege request in the minutes of the meeting. All decisions of the FRP regarding privileges and/or Conditional Release require the agreement of a majority of the total membership of the FRP, including at least one psychiatrist and one clinical psychologist voting with the majority in favor of a request. In the event that this majority of the FRP is unable, after thorough review, to reach a decision regarding approval or deferral of a request, the request will be considered disapproved. The members of the FRP will sign all FRP decisions, including those disapproved in this manner.

ii. The opinions and concerns of FRP members who dissent from a majority decision on a privilege shall be documented at each meeting, and routinely reviewed by the Office of Forensic Services for quality assurance purposes, and as requested by FRP members.

d. Possible Decisions

i. Approve the team's privilege request or Conditional Release Plan, no revisions required.

ii. Approve with revisions (related to improving the risk assessment and management process) to be reviewed by the Chair and/or FRP members. The FRP returns the case to the treatment team for revision with specific recommendations for additions or deletions. All revisions by the treatment team must be reviewed and approved by the Head of that treatment team, prior to submission to the FRP.

iii. Defer for revisions and further review required. The FRP returns the case to the treatment team for revision with specific recommendations for additions or deletions, or with the requirement that the case be again reviewed, after the changes have been made, by the full FRP. All revisions by the treatment team must be reviewed and approved by the Head of that treatment team, prior to submission to the FRP. Revised requests must be returned to the FRP within two weeks of notification of the deferral.

iv. Disapprove the request and return the case to the treatment team with an explanation of the reasons for the disapproval, and a statement regarding the type and degree of improvement in the acquittee's functioning which would need to be manifested before the FRP could grant approval of a privilege request for that acquittee.

v. Endorsement of the team's conclusions, or recommendations to the treatment team, when reviewing annual review packets.

e. Final Decision

i. FRP Chair fills out the FRP Decision Notification which includes:
   (1) The request to the FRP;
   (2) The FRP's assessment of the treatment team's assessment of risk, risk management plan, and justification of increased freedom;
   (3) The decision of the FRP; and
   (4) The FRP's comments to the treatment team, when appropriate.

ii. The FRP Decision Notification is filed in the acquittee's medical record and FRP file. Copies are sent to:

   (1) The acquittee's Forensic Coordinator,
   (2) The community services board's NGRI Coordinator, and
   (3) The Office of Forensic Services.

iii. The acquittee's Forensic Coordinator provides a copy of the FRP's Decision Notification to the treatment team.

iv. The treatment team informs the acquittee of the results of the FRP's review, within one working day.

v. In the case of Conditional Release submissions, the FRP provides a cover letter to the court recommending conditional release or release without conditions and includes a model order for the court's convenience. The packet includes the conditional release plan and supporting information deemed relevant by the FRP. If the FRP disapproves a conditional release plan that must be submitted to the court pursuant to the Code of Virginia, the FRP includes its reasons for disapproving the plan in the cover letter to the court, along with the Conditional Release Plan.

vi. The treatment team can expect a decision from the FRP within three weeks of the FRP's receipt of the request.

vii. FRP members are given a minimum of one week to review submissions before meeting as a group to reach a decision.

viii. When a request is for transfer to a less secure setting, the

hospital designated to receive the acquittee is permitted a maximum of ten days to review the submission and provide feedback, before the FRP's review of the request.

ix. The Chair, via the administrative coordinator, will ensure that FRP Decision Notifications are distributed to the requesting Forensic Coordinator within 48 hours of the decision.

x. The FRP Decision Signature Page is filed in the acquittee's medical record and in the FRP file.

13. Review process

In the event that the FRP does not approve the referring treatment team's request for transfer, increased privilege level, conditional release, or release without conditions for an acquittee, the following procedure applies:

a. At the request of the acquittee, the treatment team shall document in the patient's record, his or her request for review of a FRP privilege decision. The request shall be forwarded to the forensic coordinator (and copied to the IFPC) on behalf of the acquittee, within three (3) working days of the acquittee's initial request.

b. The Forensic Coordinator will work with the treatment team in developing a request for formal review of a FRP decision. The coordinator will forward the written request for review, within ten (10) working days of the treatment team's initiation of the review request.

c. The forensic coordinator will forward all documentation supporting the review request to the administrative coordinator for the FRP. Copies of all documents will be provided to both the Assistant Commissioner for Facility Management, and to the Chair of the FRP, within one (1) working day of their receipt from the facility.

d. The Assistant Commissioner for Facility Management shall be provided with all additional documentation required for a thorough review of the FRP's decision, by the administrative coordinator of the FRP.

e. The Assistant Commissioner for Facility Management will review and respond to the acquittee's review request within seven (7) working days from receipt of the review request documentation.

Following that review, the Assistant Commissioner for Facility Management will render one of the following decisions on the matter:

i. A finding that agrees with the original decision of the FRP on the matter.

ii. A directive to the FRP to reconsider the original privilege request of the acquittee.

iii. A directive rescinding the original decision of the FRP, and granting the privilege request of the acquittee.

f. The administrative coordinator will notify both the Chair of the FRP and the Forensic Coordinator of the review decision within two (2) working days of receipt of the decision from the Assistant Commissioner for Facility Management.

g. The Forensic Coordinator will notify the treatment team of the review decision within one (1) working day of receiving notification of that decision. The treatment team will notify the acquittee of the decision of the Assistant Commissioner for Facility Management within one (1) working day of notification of that decision by the forensic coordinator.

h. If the Assistant Commissioner for Facility Management directs the FRP to reconsider the request and the FRP changes its earlier decision to approval, the administrative coordinator for the FRP will notify the forensic coordinator of the revised decision within two (2) working days. The forensic coordinator shall inform the treatment team of all decisions of this type within one (1) working day. A treatment team member will inform the acquittee of the FRP's decision regarding an appeal, within one (1) working day of notification by the coordinator.

TABLE 4.1
Changes in Status:
Whose Permission Is Required Before Granting a Change in Status?

	IFPC	FORENSIC REVIEW PANEL	COMMITTING COURT	COMMONWEALTH'S ATTORNEY (NOTIFICATION ONLY)**
CIVIL TRANSFER	***Yes***	***Yes***	***No***	***No***
GROUND PRIVILEGES	***Yes***	***Yes*** ***(with transfer)***	***No***	***No***
COMMUNITY VISITS (ESCORTED BY FACILITY STAFF)	***Yes***	***No***	***No***	***Yes***
UNESCORTED COMMUNITY VISITS; NOT OVERNIGHT)	***Yes***	***Yes***	***No***	***Yes***
OVERNIGHT COMMUNITY VISITS (UP TO 48 HOURS)	***Yes***	***No***	***No***	***Yes***
CONDITIONAL RELEASE	***Yes***	***Yes****	***Yes***	***Yes***
RELEASE WITHOUT CONDITIONS	***Yes***	***Yes****	***Yes***	***Yes***
Civil Commitment (Misdemeanant NGRIs only)	***No***	***No***	***Yes***	***Yes******

* Review by and approval from the Forensic Review Panel is required before making a recommendation/request to the court for release from hospitalization, Conditional Release, or Release Without Conditions.

** Notification to the Commonwealth's Attorney is mandated by § 19.2-182.4

*** Notification to the Commonwealth's Attorney is mandated by § 19.2-182.5 (D)

Table 4.2
Forensic Review Panel and Internal Forensic Privileging Committee Responsibilities

Entity	Authority	Membership	Meetings	Decision Making
Forensic Review Panel (FRP)	Appointed By Commissioner, pursuant to § 19.2-182.13 of the Code	**At least 7 members,** including: 2 psychiatrists 2 clinical psychologists 1 member from CSB (if possible) Other MH professionals	**Weekly** **Quorum**: One more than one-half total full-time membership. One psychiatrist & one psychologist must be present at each meeting.	**Grants privileges at the following levels for all acquittees:** o Civil transfer from Maximum Security (with/without Escorted Grounds Privileges) o Unescorted (not overnight) Community (with/without 48 hour overnight Community) o Conditional Release Formal review of all Conditional Release Plans ordered by the courts. **Voting: Approval/Disapproval** Requires concurrence of majority of members
Internal Forensic Privileging Committee (IFPC)	Delegated to the facilities by the DMHMRSAS Commissioner, pursuant to § 19.2-182.13 of the Code	**A total of 5 members,** including: Facility Director or designee Medical Director or Psychiatrist; Forensic Coordinator; Clinical Psychologist; other Professionals	**Weekly** **Quorum:** Three members, with a minimum of one psychiatrist & one psychologist required for a quorum vote	**Grants privileges at the following levels:** o Escorted Grounds o Unescorted Grounds (with/without Escorted Community) o Escorted Community o 48 Hour Unescorted Community (after FRP approval of 8 hour unescorted Community) **Voting: Approval/Disapproval** Requires concurrence of 3/5 of the membership. Provides leadership/direction re: management of forensic patients at each facility. Review and quality control of all privilege requests from treatment teams to the FRP.

Table 4. 3
Roles of the IFPC and the FRP in the Acquittee Management Process

Entity	Temporary Custody	Initial Commitment	Privilege Levels	Conditional Release
Internal Forensic Privileging Committee	Reviews/Approves for submission to the Forensic Review Panel, court ordered Conditional Release Plans	CSH Maximum only: Reviews/Approves Treatment Team request for civil transfer All hospitals: Reviews/Approves Treatment Team requests for increased privilege levels from Forensic Review Panel	IFPC reviews request from Treatment Teams for approval of all privilege levels including: ▪ Escorted Grounds ▪ Unescorted Grounds ▪ Escorted Community ▪ 48 hours community (after FRP grants 8 hours) ▪	Review/ Approve all Conditional Release Plans developed by Treatment Team for submission to FRP.
Forensic Review Panel	Reviews all court ordered Conditional Release Plans Submits Conditional Release Plans to court with recommendations	Determines initial placement.	FRP Review required for all: ▪ Transfer from Maximum to Civil (with/without Escorted Grounds) ▪ Initial 8 hour Unescorted Community ▪ Conditional Release	Review for approval or disapproval of all Conditional Release Plans Sends CR plan to the court with recommendations.

Table 4.4
Documentation Required for Requesting Increases in Privileges

Internal Forensic Privileging Committee (IFPC)

-**Analysis of Aggressive Behavior updated** within 30 days of submission to Forensic Coordinator
-**Clinical Summary Report** which includes the following:
- -current diagnoses (DSM-IV Axis I – V)
- -mental status examination (completed within 30 days of submission, including current ideation related to the NGRI offense, suicidality, and aggression towards others)
- -brief contrast of current MSE to MSE of last FRP request
- -assessment of patient improvement and course of hospitalization
- -current list of treatment activities and medication orders
- -statement regarding level of medication compliance, if applicable
- -history of revocation of privileges, if applicable
- -history of substance abuse/dependence (list drugs)
- -risk assessment for escape (indicate high, medium, or low)
- -support for the request (description of how request fits into graduated release)

-**Risk Management Plan** signed by acquittee

Forensic Review Panel (FRP)

-Copies of **all Temporary Custody Evaluations** (if in Temporary Custody or prior to initial Annual Report)
-Copy of **most recent Annual Report to the Court**
-Results of **psychological assessments** (if available)
-**Insanity Evaluation** (if available)
-**Updated Community Outpatient Treatment Readiness Scale**
-**Description of past arrests**, if any; (to include description of NGRI offense; police/court reports, if available)
-**Initial Analysis of Aggressive Behavior**
-**Analysis of Aggressive Behavior updated** within 30 days of submission to Forensic Coordinator
-**Clinical Summary Report** which includes the following:
- -current diagnoses (DSM-IV Axis I – V)
- -mental status examination (completed within 30 days of submission, including current ideation related to the NGRI offense, suicidality, and aggression towards others.)
- -brief contrast of current MSE to MSE of last FRP request
- -assessment of patient improvement and course of hospitalization
- -current list of treatment activities and medication orders
- -statement regarding level of medication compliance, if applicable
- -history of revocation of privileges, if applicable
- -history of substance abuse/dependence (list drugs)
- -risk assessment for escape (indicate high, medium, or low)
- -support for the request (description of how request fits into graduated release)

-**Risk Management Plan** signed by acquittee

Table 4.5

Internal Forensic Privileging Committee Privileging Process: Summary of Roles and Procedures

Stage	Entity	Privilege Request Development	Timeline	Documentation Required
One	Acquittee	Submit formal request for increase in privilege to treatment team	Once per 30 calendar days	Privilege increase request form
Two	Treatment Team	Receives and reviews request for Increased privileges from acquittee.	Review within 7 calendar days of request	Documentation of team review in acquittee's medical record.
Three	Treatment Team	Development of Privilege Request Packet for IFPC; submission of packet to the IFPC for review	30 days to prepare for IFPC review	Complete IFPC Privilege Request Submission Packet
Four	IFPC	Reviews packet received from treatment team.	IFPC reviews within 7 working days of receipt of complete document.	IFPC, via forensic coordinator provides team with initial written feedback and requests for clarification.
Five	Treatment team	Reviews and edits privilege request packet, following receipt of reviews by IFPC.	Completes any requested changes or additions, within 10 working days, prior to scheduled IFPC review.	Submits revised packet.
Six	IFPC	Completes formal review of request for privileges, after receipt of completed packet with any requested edits or additions by the treatment team.	Facility Director notified of IFPC decision within 1 working days.	IFPC Decision Notification forwarded to Facility Director for formal approval.
Seven	Facility Director	Receives Decision Notification from the IFPC Chair for review, approval/disapproval, signature.	Reviews, approves or disapproves IFPC recommended decision within (2) working days. Submits documentation to Chair of Forensic Review Panel within (1) working day.	IFPC Decision Notification, including Facility Director's signed approval, sent to treatment team. Copy of the Decision Notification and complete privilege request document packet forwarded to the Chair of the Forensic Review Panel, for inclusion in FRP record.
Eight	Treatment team	Team informs acquittee of results of IFPC review. When privilege request has been disapproved, acquittee informed of appeal process	Acquittee informed within 1 working day	Acquittee provided with copy of IFPC Decision Notification. Copy placed in patient's medical record.
Nine	Acquittee	Acquittee exercises additional privileges, if granted by IFPC	Privilege implemented as determined by clinical status	Treatment team documents privilege implementation in acquittee's medical record

IFPC SUBMISSION SUMMARY SHEET
INTERNAL FORENSIC PRIVILEGING COMMITTEE

1. ACQUITTEE'S LAST NAME	2. FIRST NAME	3. MI	4. DATE

5. DOB	6. SS#	7. DATE OF ADMISSION/TRANSFER	8. DATE ADJUDICATED NGRI

9. CURRENT HOSPITAL	10. BLDG/WARD	11. HOSPITAL PATIENT #	12. NGRI OFFENSE(S):

13. IT IS THE OPINION OF THE TREATMENT TEAM THAT THE LESSENING OF RESTRICTIONS REQUESTED HERE ~ IS ~ IS NOT CLINICALLY APPROPRIATE, SUPPORTED BY THE INFORMATION PROVIDED.

14. CURRENT REQUEST *(PLEASE T)*

- ~ GROUND PRIVILEGES (ESCORTED)
- ~ GROUND PRIVILEGES (UNESCORTED)
- ~ COMMUNITY VISIT (ESCORTED)
- ~ COMMUNITY VISIT (UNESCORTED, UP TO 48 HOURS)

15. ALL REQUESTS MUST HAVE THE FOLLOWING ATTACHED. *(PLEASE T TO INDICATE INCLUSION OR MARK N/A IF NOT APPLICABLE.)*

- ~ REPORT WHICH INCLUDES THE FOLLOWING:
  - ~ ANALYSIS OF AGGRESSIVE BEHAVIOR UPDATED WITHIN 30 DAYS OF SUBMISSION TO FORENSIC COORDINATOR
  - ~ CURRENT DIAGNOSES (DSM IV AXIS I-V)
  - ~ MENTAL STATUS EXAMINATION (COMPLETED WITHIN 30 DAYS OF SUBMISSION, INCLUDING CURRENT IDEATION RELATED TO THE NGRI OFFENSE, SUICIDALITY & AGGRESSION TOWARDS OTHERS)
    - ~ BRIEF CONTRAST OF CURRENT MSE TO MSE OF LAST PRIVIILEGE REQUEST
    - ~ ASSESSMENT OF PATIENT IMPROVEMENT AND COURSE OF HOSPITALIZATION
    - ~ CURRENT LIST OF TREATMENT ACTIVITIES AND MEDICATION ORDERS
    - ~ STATEMENT REGARDING LEVEL OF MEDICATION COMPLIANCE, IF APPLICABLE
    - ~ HISTORY OF REVOCATION OF PRIVILEGES ~ N/A
    - ~ HISTORY OF SUBSTANCE ABUSE/DEPENDENCE (LIST DRUGS)
    - ~ RISK ASSESSMENT FOR ESCAPE (INDICATE HIGH, MEDIUM, OR LOW)
    - ~ SUPPORT FOR THE REQUEST (DESCRIPTION OF HOW REQUEST FITS INTO GRADUATED RELEASE)

16. ALL REQUESTS FOR GROUNDS/COMMUNITY PRIVILEGES INCLUDE: *(PLEASE T TO INDICATE INCLUSION OR MARK N/A IF NOT APPLICABLE.)*

- ~ RISK MANAGEMENT PLAN SIGNED BY ACQUITTEE

DATE RECEIVED PRIOR GROUNDS PRIVILEGES: ~ ESCORTED_____ ~ UNESCORTED _____ ~ NOT APPLICABLE

DATE RECEIVED PRIOR COMMUNITY PRIVILEGES: ~ ESCORTED_____ ~ UNESCORTED _____ ~ NOT APPLICABLE

HAVE PRIVILEGES EVER BEEN REVOKED? ~ YES ~ NO *(IF YES, ATTACH EXPLANATION.)*

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IFPC SUBMISSION SUMMARY SHEET: page 2

17. ALL REQUESTS FOR COMMUNITY VISITS MUST INCLUDE THE FOLLOWING INFORMATION:

- ~ PROPOSED PLAN FOR VISIT
  - ~ NAME, ADDRESS, AND PHONE # OF PERSON(s) VISITED; WHERE PATIENT WILL STAY
  - ~ RISK ASSESSMENT AND MANAGEMENT PLAN FOR POSSIBLE:
    (1) AGGRESSION, (2) SUBSTANCE ABUSE, (3) MEDICATION NON-COMPLIANCE, (4) ESCAPE (5) MODE OF COMMUNICATION
  - ~ PLAN FOR SERVICES DURING VISIT (SCHEDULED? PRN?) ~ NONE
- ~ DOCUMENTATION OF CSB AGREEMENT TO ESCORTED AND UNESCORTED COMMUNITY VISIT (INCLUDE FAMILY/PLACEMENT SITE AGREEMENT)

18. REQUEST DISCUSSED WITH PATIENT
~ YES ~ NO

19. WORKING PRIOR TO HOSPITALIZATION ~ YES ~ NO OCCUPATION:	20. EDUCATIONAL LEVEL	21. YEAR 1ST HOSP.	22. NO. OF PRIOR HOSPITALIZATIONS
23. SUBMITTED BY: HEAD OF TREATMENT TEAM (PRINT) _____SIGNATURE TREATMENT TEAM MEMBER (PRINT) SIGNATURE	TREATMENT TEAM MEMBER (PRINT) SIGNATURE_____ TREATMENT TEAM MEMBER (PRINT) SIGNATURE		TREATMENT TEAM MEMBER (PRINT) SIGNATURE_____ TREATMENT TEAM MEMBER (PRINT) SIGNATURE
24. CONTACT PERSON	25. PHONE NUMBER		26. DATE RECEIVED BY FORENSIC COORDINATOR:
27. APPROVED BY FACILITY FORENSIC COORDINATOR _____PRINT NAME SIGNATURE	PHONE DATE		

PLEASE SUBMIT THE ORIGINAL (NO FAX COPIES) (DMH 944E 1239 05/01/2003)

INTERNAL FORENSIC PRIVILEGING COMMITTEE (IFPC) DECISION NOTICE

PAGE 1

1. ACQUITEE'S LAST NAME	2. FIRST NAME, MIDDLE INITIAL	3. DATE REQUEST RECEIVED	4. DATE OF ACTION

5. REQUEST:

9 GROUND PRIVILEGES (ESCORTED)

9 GROUND PRIVILEGES (UNESCORTED)

9 COMMUNITY VISIT (ESCORTED)

9 COMMUNITY VISIT (UNESCORTED, UP TO 48 HOURS; FOLLOWING FRP APPROVAL OF UNESCORTED, NOT OVERNIGHT COMMUNITY)

9 CONSULTATION

6. BASED ON REVIEW OF THE MATERIALS SUBMITTED TO THE IFPC, COMMITTEE MEMBERS HAVE MADE THE FOLLOWING ASSESSMENT:

YES____	NO____	1.	HAS THE TREATMENT TEAM IDENTIFIED AND ARTICULATED THE FACTORS THAT INCREASE AND/OR DECREASE THE PROBABILITY THAT THE NGRI WILL ENGAGE IN BEHAVIORS THAT PRESENT A RISK TO OTHERS?
YES____	NO____	2.	HAS THE TREATMENT TEAM DEVELOP A RISK MANAGEMENT PLAN THAT ADEQUATELY MANAGES THE ASSESSED RISK?
YES____	NO____	3.	IS THE INCREASED FREEDOM REQUESTED JUSTIFIED BY THE TREATMENT TEAM□S ASSESSMENT OF RISK AND PLAN FOR RISK MANAGEMENT?

7. BASED UPON OUR REVIEW OF THE MATERIALS SUBMITTED TO THE COMMITTEE, AND USE OF THE RISK DECISION-MAKING CRITERIA, THE INTERNAL FORENSIC PRIVILEGING COMMITTEE HAS MADE THE FOLLOWING DECISION REGARDING THE REQUEST ON THE ABOVE REFERENCED NGRI:

9 APPROVED

9 APPROVED PENDING REVISION AS PER RECOMMENDATION, FURTHER REVIEW NECESSARY BY COMMITTEE

9 DEFERRED FOR REVISION OR MORE INFORMATION, ANOTHER REVIEW REQUIRED

9 DISAPPROVED

9 REFERRED TO OUTSIDE CONSULTANT

9 REMARKS

8. NOTE SPECIFIC AREAS CHECKED, IF ANY:

9 SUBMISSION INCOMPLETE - MISSING: . . .

9 THIS IS A ONE-TIME APPROVAL

9 ADDITIONAL COMMUNITY VISITS REQUIRE NEW SUBMISSIONS

9 PLEASE RESUBMIT WITHIN _____ WEEKS

9 NOTIFY COMMUNITY SERVICES BOARD OF COMMUNITY PRIVILEGES

9 NOTIFY COMMONWEALTH'S ATTORNEY'S OFFICE OF COMMUNITY PRIVILEGES

9 SEE ATTACHED COMMENTS

9. ANY PRIVILEGES GRANTED ARE TO BE VIEWED ONLY AS A CEILING LEVEL; THE TREATMENT TEAM HAS THE AUTHORITY AND RESPONSIBILITY FOR MONITORING THE NGRI□S CONDITION AND TO REDUCE THE LEVEL OF PRIVILEGES APPROPRIATE TO THE NGRI□S FUNCTIONING. SEE THE NGRI MANUAL FOR A DESCRIPTION OF THE APPEALS PROCESS IN CASES WHERE A REQUEST FOR A PRIVILEGE INCREASE HAS BEEN DENIED.

_____

CHAIR, INTERNAL FORENSIC PRIVILEGING COMMITTEE DATE HOSPITAL:

(DMH 944E 1241 05/01/2003)

INTERNAL FORENSIC PRIVILEGING COMMITTEE (IFPC) DECISION NOTICE

PAGE 2

1. ACQUITTEE'S LAST NAME	2. FIRST NAME, MIDDLE INITIAL	3. DATE REQUEST RECEIVED	4. DATE OF ACTION

5. COMMENTS:

COPIES:
CHAIR: FORENSIC REVIEW PANEL
CSB NGRI COORDINATOR
DIRECTOR OF FORENSIC SERVICES, CENTRAL OFFICE
FORENSIC COORDINATOR OF FACILITY
FORENSIC REVIEW PANEL FILE

(DMH 944E 1241 05/01/2003)

INTERNAL FORENSIC PRIVILEGING COMMITTEE (IFPC) DECISION NOTICE SIGNATURE PAGE

1. ACQUITTEE'S LAST NAME	2. FIRST NAME, MIDDLE INITIAL	3. DATE REQUEST RECEIVED	4. DATE OF ACTION

5. REQUEST

- 9 GROUND PRIVILEGES (ESCORTED)
- 9 GROUND PRIVILEGES (UNESCORTED)
- 9 COMMUNITY VISIT (ESCORTED)
- 9 COMMUNITY VISIT (UNESCORTED, UP TO 48 HOURS; FOLLOWING PRIOR APPROVAL OF UNESCORTED NOT OVERNIGHT BY FRP)
- 9 CONSULTATION

6. BASED UPON OUR REVIEW OF THE MATERIALS SUBMITTED TO THE PANEL, AND USE OF THE RISK DECISION-MAKING CRITERIA, THE INTERNAL FORENSIC PRIVILEGING COMMITTEE HAS MADE THE FOLLOWING DECISION REGARDING THE REQUEST ON THE ABOVE REFERENCED NGRI:

- 9 APPROVED
- 9 APPROVED PENDING REVISION AS PER RECOMMENDATION, FURTHER REVIEW NECESSARY BY: CHAIR / PANEL
- 9 DEFERRED FOR REVISION OR MORE INFORMATION, ANOTHER REVIEW REQUIRED
- 9 DISAPPROVED
- 9 REFERRED TO OUTSIDE CONSULTANT
- 9 REMARKS

7. COMMENTS:

SIGNATURE OF COMMITTEE MEMBERS:
8

_____

_____

_____

_____

9. ENDORSEMENT OF FACILITY DIRECTOR:

_____ _____

FACILITY DIRECTOR'S SIGNATURE DATE

COPIES: CHAIR: FORENSIC REVIEW PANEL
DIRECTOR OF FORENSIC SERVICES, CENTRAL OFFICE
FORENSIC REVIEW PANEL FILE
ACQUITTEE'S MEDICAL RECORD

(DMH 944E 1240 05/01/2003)

Table 4.6
Forensic Review Panel Privileging Process: Summary of Roles and Procedures

Stage	Entity	Privilege Request Development	Timeline	Documentation Required
One	Acquittee	Submit formal request for increase in privilege to treatment team	Once per 30 calendar days	Privilege increase request form
Two	Treatment Team	Receives and reviews request for Increased privileges from acquittee (Treatment team also submits Annual Review packet for each acquittee not eligible for privilege increase.)	Review within 7 calendar days of request	
Three	Treatment Team	Informs IFPC of decision to request privileges for acquittee	Reports results of review in 3 working days.	Written report of review to IFPC
Four	IFPC	Approves/Disapproves team request to develop privilege request to submit to Panel	Reviews initial request in 7 working days; Notifies team of decision in 3 working days	Written Approval or Disapproval of initial request to develop privilege packet.
Five	Treatment Team and IFPC	Notifies acquittee of IFPC approval/disapproval of acquittee's request Development of Privilege Request Packet for Forensic Review Panel; submit to Panel through the IFPC	Team member informs acquittee within 1 working day 30 days to prepare after IFPC approval	Complete FRP Privilege Request Submission Packet
Six	Forensic Review Panel (FRP)	Receives packet from IFPC; provides initial qualitative feedback to team	Panel reviews request within 3 weeks of receipt of complete document.	Panel staff provides team with initial written feedback and requests for clarification.

Table 4.6, continued: Forensic Review Panel Privileging Process				
Seven	Treatment team	Modifies privilege request packet, in response to FRP review, if necessary	Resubmits edited packet prior to scheduled FRP review.	Revisions, additions to privilege request packet provided to the FRP.
Eight	Forensic Review Panel	Formal review of request for privileges, after receipt of completed packet with any requested edits or additions.	Forensic Coordinator notified of FRP decision in 2 working days	Written FRP Decision Notification to Forensic Coordinator
Nine	Forensic Coordinator	Informs treatment team of FRP privilege decision	Team notified within 1 working day.	Provides copies of FRP Decision Notification to team.
Ten	Treatment Team	Notifies acquittee of FRP approval/disapproval of privilege request. If privilege request not approved, acquittee informed of review process. Include all FRP documents in acquittee's medical record	Team informs acquittee within 1 working day	Acquittee provided with copy of decision notification
Eleven	Acquittee	Acquittee exercises additional privileges, if granted by FRP	Privilege implemented as determined by overall clinical status	Treatment team documents privilege implementation in acquittee's medical record

DMHMRSAS FORENSIC REVIEW PANEL SUBMISSION SUMMARY SHEET

1. ACQUITTEE'S LAST NAME	2. FIRST NAME	3. MI	4. DATE

5. DOB	6. SS#	7. DATE OF ADMISSION/TRANSFER	8. DATE ADJUDICATED NGRI

9. CURRENT HOSPITAL	10. BLDG/WARD	11. HOSPITAL PATIENT #	12. NGRI OFFENSE(S):

13. IT IS THE OPINION OF THE TREATMENT TEAM THAT THE LESSENING OF RESTRICTIONS REQUESTED HERE ~ IS ~ IS NOT CLINICALLY APPROPRIATE, SUPPORTED BY THE INFORMATION PROVIDED.

14. CURRENT REQUEST *(PLEASE T)*

- ~ ANNUAL REVIEW (NO INCREASE IN PRIVILEGES)
- ~ TRANSFER TO CIVIL UNIT AT
- ~ GROUND PRIVILEGES (ESCORTED)
- ~ GROUND PRIVILEGES (UNESCORTED)
- ~ COMMUNITY VISIT (ESCORTED)
- ~ COMMUNITY VISIT (UNESCORTED, NOT OVERNIGHT)
- ~ COMMUNITY VISIT (UNESCORTED, UP TO 48 HOURS)
- ~ CONDITIONAL RELEASE
- ~ UNCONDITIONAL RELEASE
- ~ CONSULTATION

15. ALL REQUESTS MUST HAVE THE FOLLOWING ATTACHED. *(PLEASE T TO INDICATE INCLUSION OR MARK N/A IF NOT APPLICABLE.)*

- ~ COPIES OF ALL TEMPORARY CUSTODY EVALUATIONS (IF IN TEMPORARY CUSTODY OR PRIOR TO INITIAL ANNUAL REPORT), **OR**
- ~ COPY OF MOST RECENT ANNUAL REPORT TO THE COURT
- ~ RESULTS OF PSYCHOLOGICAL ASSESSMENTS (IF AVAILABLE)
- ~ INSANITY EVALUATION ~ DOES NOT EXIST
- ~ INITIAL & UPDATED COMMUNITY OUTPATIENT TREATMENT READINESS SCALES
- ~ DESCRIPTION OF PAST ARRESTS, IF ANY; (TO INCLUDE DESCRIPTION OF NGRI OFFENSE; POLICE/COURT REPORTS, IF AVAILABLE)
- ~ INITIAL ANALYSIS OF AGGRESSIVE BEHAVIOR
- ~ ANALYSIS OF AGGRESSIVE BEHAVIOR UPDATED WITHIN 30 DAYS OF SUBMISSION TO FORENSIC COORDINATOR
- ~ REPORT WHICH INCLUDES THE FOLLOWING:
  - ~ CURRENT DIAGNOSES (DSM IV AXIS I-V)
  - ~ MENTAL STATUS EXAMINATION (COMPLETED WITHIN 30 DAYS OF SUBMISSION, INCLUDING CURRENT IDEATION RELATED TO THE NGRI OFFENSE, SUICIDALITY & AGGRESSION TOWARDS OTHERS)
  - ~ BRIEF CONTRAST OF CURRENT MSE TO MSE OF LAST FRP REQUEST
  - ~ ASSESSMENT OF PATIENT IMPROVEMENT AND COURSE OF HOSPITALIZATION
  - ~ CURRENT LIST OF TREATMENT ACTIVITIES AND MEDICATION ORDERS
  - ~ STATEMENT REGARDING LEVEL OF MEDICATION COMPLIANCE, IF APPLICABLE
  - ~ HISTORY OF REVOCATION OF PRIVILEGES ~ N/A
  - ~ HISTORY OF SUBSTANCE ABUSE/DEPENDENCE (LIST DRUGS)
  - ~ RISK ASSESSMENT FOR ESCAPE (INDICATE HIGH, MEDIUM, OR LOW)
  - ~ SUPPORT FOR THE REQUEST (DESCRIPTION OF HOW REQUEST FITS INTO GRADUATED RELEASE)

16. ALL REQUESTS FOR GROUNDS/COMMUNITY PRIVILEGES INCLUDE: *(PLEASE T TO INDICATE INCLUSION OR MARK N/A IF NOT APPLICABLE.)*

- ~ RISK MANAGEMENT PLAN SIGNED BY ACQUITTEE

DATE RECEIVED PRIOR GROUNDS PRIVILEGES: ~ ESCORTED_____ ~ UNESCORTED _____ ~ NOT APPLICABLE

DATE RECEIVED PRIOR COMMUNITY PRIVILEGES: ~ ESCORTED_____ ~ UNESCORTED _____ ~ NOT APPLICABLE

HAVE PRIVILEGES EVER BEEN REVOKED? ~ YES ~ NO *(IF YES, ATTACH EXPLANATION.)*

(DMH 944E 1236 05/01/2003)

DMHMRSAS Submission Summary Sheet, Page 2

17. ALL REQUESTS FOR COMMUNITY VISITS MUST INCLUDE THE FOLLOWING INFORMATION:

- ~ PROPOSED PLAN FOR VISIT
- ~ NAME, ADDRESS, AND PHONE # OF PERSON(s) VISITED; WHERE PATIENT WILL STAY
- ~ RISK ASSESSMENT AND MANAGEMENT PLAN FOR POSSIBLE:
  (1) AGGRESSION, (2) SUBSTANCE ABUSE, (3) MEDICATION NON-COMPLIANCE, (4) ESCAPE (5) MODE OF COMMUNICATION
- ~ PLAN FOR SERVICES DURING VISIT (SCHEDULED? PRN?) ~ NONE
- ~ DOCUMENTATION OF CSB AGREEMENT TO ESCORTED AND UNESCORTED COMMUNITY VISIT (INCLUDE FAMILY/PLACEMENT SITE AGREEMENT)

18. ALL CONDITIONAL RELEASE REQUESTS MUST INCLUDE THE FOLLOWING INFORMATION:

- ~ COURT ORDER REQUESTING A CONDITIONAL RELEASE PLAN TO BE DEVELOPED (IF APPLICABLE)
- ~ A WRITTEN CONDITIONAL RELEASE PLAN WITH:
  - ~ STATEMENT AT TOP INDICATING FACILITY AND CSB STAFF COLLABORATED IN THE DEVELOPMENT OF THE PLAN
  - ~ PROPOSED TRIAL VISITS PRIOR TO FULL CONDITIONAL RELEASE, IF APPROPRIATE
  - ~ NAME, ADDRESS, & PHONE OF PROPOSED PLACEMENT, AND AGREEMENT TO PLACEMENT, IF APPROPRIATE
  - ~ STATEMENT OF PATIENT FINANCIAL RESOURCES
  - ~ SPECIFICATIONS OF COMMUNITY TREATMENT PROGRAM
  - ~ SPECIAL CONDITIONS: MANAGEMENT STRATEGIES FOR IDENTIFIED RISK FACTORS
    - ~ MEDICATION COMPLIANCE, IF APPLICABLE
    - ~ ALCOHOL OR DRUG USE
    - ~ FIREARMS OR WEAPONS
    - ~ OTHER RISK FACTORS IDENTIFIED IN AAB AND AAB UPDDATES
- ~ ALL NECESSARY SIGNATURES ON CONDITIONAL RELEASE PLAN
- ~ PLAN TO MONITOR COMPLIANCE WITH CONDITIONAL RELEASE
- ~ CSB AGREEMENT AND RECOMMENDATIONS/COMMENTS
- ~ STATEMENT REGARDING REPORTS TO THE COURT
- ~ ACQUITTEE'S REVIEW AND AGREEMENT TO PROPOSED PLAN

19. DATE REQUEST TO TRANSFER WAS SENT TO THE PROSPECTIVE RECEIVING FACILITY	20. REQUEST DISCUSSED WITH PATIENT ~ YES ~ NO

21. WORKING PRIOR TO HOSPITALIZATION ~ YES ~ NO OCCUPATION:	22. EDUCATIONAL LEVEL	23. YEAR 1ST HOSP.	24. NO. OF PRIOR HOSPITALIZATIONS

25. SUBMITTED BY: HEAD OF TREATMENT TEAM (PRINT) SIGNATURE TREATMENT TEAM MEMBER (PRINT) SIGNATURE	TREATMENT TEAM MEMBER (PRINT) SIGNATURE TREATMENT TEAM MEMBER (PRINT) SIGNATURE	TREATMENT TEAM MEMBER (PRINT) SIGNATURE TREATMENT TEAM MEMBER (PRINT) SIGNATURE

(DMH 944E 1236 05/01/2003)

DMHMRSAS Submission Summary Sheet, Page 3		
26. CONTACT PERSON	27. PHONE NUMBER	28. DATE RECEIVED BY FORENSIC COORDINATOR:
29. APPROVED BY IFPC CHAIR	30. PHONE NUMBER	31. DATE

31. APPROVED BY FACILITY FORENSIC COORDINATOR

PRINT NAME_____

SIGNATURE_____ DATE_____

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FORENSIC REVIEW PANEL DECISION NOTICE

PAGE 1

1. ACQUITTEE"S LAST NAME	2. FIRST NAME, MIDDLE INITIAL	3. DATE REQUEST RECEIVED	4. DATE OF ACTION

5. REQUEST

9 TRANSFER TO CIVIL UNIT AT
9 GROUND PRIVILEGES (ESCORTED)
9 GROUND PRIVILEGES (UNESCORTED)
9 COMMUNITY VISIT (ESCORTED)
9 CONSULTATION
9 COMMUNITY VISIT (UNESCORTED, NOT OVERNIGHT)
9 COMMUNITY VISIT (UNESCORTED, UP TO 48 HOURS)
9 CONDITIONAL RELEASE
9 UNCONDITIONAL RELEASE

6. BASED ON REVIEW OF THE MATERIALS SUBMITTED TO THE FORENSIC REVIEW PANEL, THE PANEL MEMBERS HAVE MADE THE FOLLOWING ASSESSMENT:

YES____ NO____ 1. HAS THE TREATMENT TEAM IDENTIFIED AND ARTICULATED THE FACTORS THAT INCREASE AND/OR DECREASE THE PROBABILITY THAT THE NGRI WILL ENGAGE IN BEHAVIORS THAT PRESENT A RISK TO OTHERS?

YES____ NO____ 2.HAS THE TREATMENT TEAM DEVELOP A RISK MANAGEMENT PLAN THAT ADEQUATELY MANAGES THE ASSESSED RISK?

YES____ NO____ 3.IS THE INCREASED FREEDOM REQUESTED JUSTIFIED BY THE TREATMENT TEAM□S ASSESSMENT OF RISK AND PLAN FOR RISK MANAGEMENT?

7. BASED UPON OUR REVIEW OF THE MATERIALS SUBMITTED TO THE PANEL, AND USE OF THE RISK DECISION-MAKING CRITERIA, THE FORENSIC REVIEW PANEL HAS MADE THE FOLLOWING DECISION REGARDING THE REQUEST ON THE ABOVE REFERENCED NGRI:

9 APPROVED
9 APPROVED PENDING REVISION AS PER RECOMMENDATION, FURTHER REVIEW NECESSARY BY: CHAIR / PANEL
9 DEFERRED FOR REVISION OR MORE INFORMATION, ANOTHER REVIEW REQUIRED
9 DISAPPROVED
9 REFERRED TO OUTSIDE CONSULTANT
9 REMARKS

8. NOTE SPECIFIC AREAS CHECKED, IF ANY:

9 SUBMISSION INCOMPLETE - MISSING: . . .
9 THIS IS A ONE-TIME APPROVAL
9 ADDITIONAL COMMUNITY VISITS REQUIRE NEW SUBMISSIONS
9 PLEASE RESUBMIT WITHIN _____ WEEKS
9 NOTIFY COMMUNITY SERVICES BOARD OF COMMUNITY PRIVILEGES
9 NOTIFY COMMONWEALTH□S ATTORNEY□S OFFICE OF COMMUNITY PRIVILEGES
9 SEE ATTACHED COMMENTS

9.

_____

CHAIR, FORENSIC REVIEW PANEL DATE

10. ANY PRIVILEGES GRANTED ARE TO BE VIEWED ONLY AS A CEILING LEVEL; THE TREATMENT TEAM HAS THE AUTHORITY AND RESPONSIBILITY FOR MONITORING THE NGRI□S CONDITION AND TO REDUCE THE LEVEL OF PRIVILEGES APPROPRIATE TO THE NGRI□S FUNCTIONING. SEE THE NGRI MANUAL FOR A DESCRIPTION OF THE REVIEW PROCESS IN CASES WHERE THE PANEL HAS DENIED A REQUEST.

(DMH 944E 1237 05/01/2003)

FORENSIC REVIEW PANEL DECISION NOTICE

PAGE 2

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FORENSIC COORDINATOR OF FACILITY
NGRI COORDINATOR
FORENSIC REVIEW PANEL FILE

1. ACQUITTEE'S LAST NAME	2. FIRST NAME, MIDDLE INITIAL	3. DATE REQUEST RECEIVED	4. DATE OF ACTION

5. COMMENTS:

_____
CHAIR, FORENSIC REVIEW PANEL DATE

COPIES: DIRECTOR OF FORENSIC SERVICES, CENTRAL OFFICE
FORENSIC COORDINATOR OF FACILITY
NGRI COORDINATOR
FORENSIC REVIEW PANEL FILE

(DMH 944E 1237 05/01/2003)

FORENSIC REVIEW PANEL DECISION SIGNATURE PAGE

1. ACQUITTEE'S LAST NAME	2. FIRST NAME, MIDDLE INITIAL	3. DATE REQUEST RECEIVED	4. DATE OF ACTION

5. REQUEST

9 TRANSFER TO CIVIL UNIT AT _____
9 GROUND PRIVILEGES (ESCORTED)
9 GROUND PRIVILEGES (UNESCORTED)
9 COMMUNITY VISIT (ESCORTED)
9 COMMUNITY VISIT (UNESCORTED, NOT OVERNIGHT)
9 COMMUNITY VISIT (UNESCORTED, UP TO 48 HOURS)
9 CONDITIONAL RELEASE
9 UNCONDITIONAL RELEASE
9 CONSULTATION

6. BASED UPON OUR REVIEW OF THE MATERIALS SUBMITTED TO THE PANEL, AND USE OF THE RISK DECISION-MAKING CRITERIA, THE FORENSIC REVIEW PANEL HAS MADE THE FOLLOWING DECISION REGARDING THE REQUEST ON THE ABOVE REFERENCED NGRI:

9 APPROVED
9 APPROVED PENDING REVISION AS PER RECOMMENDATION, FURTHER REVIEW NECESSARY BY: CHAIR / PANEL
9 DEFERRED FOR REVISION OR MORE INFORMATION, ANOTHER REVIEW REQUIRED
9 DISAPPROVED
9 REFERRED TO OUTSIDE CONSULTANT
9 REMARKS

7. COMMENTS:

8. SIGNATURE OF PANEL MEMBERS:

_____
_____
_____
_____
_____
_____
_____

CHAIR, FORENSIC REVIEW PANEL DATE

COPIES: DIRECTOR OF FORENSIC SERVICES, CENTRAL OFFICE
FORENSIC REVIEW PANEL FILE

(DMH 944E 1238 05/01/2003)

Notification to Commonwealth's Attorney

Date: _____

Commonwealth's Attorney
Address

Dear _____:

Under the provisions of Virginia Code § 19.2-182.4, this facility is required to notify you in writing when an individual who has been found Not Guilty by Reason of Insanity and placed in the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services has been authorized to leave the grounds of the hospital in which he or she is confined. The individual noted below has been so authorized:

Acquittee:
Case No.:
Court of Jurisdiction:
Register No.:
Date of Birth:
Date Of NGRI Finding:

This individual has been approved for community visits by the Forensic Review Panel. During community visits, the individual will:

_____ be accompanied by hospital staff.
_____ not be accompanied by hospital staff.

The length of the community visits will be:

_____ no longer than eight hours.
_____ no longer than 48 hours.
_____ as described in the court approved conditional release plan.

If you have any questions regarding the above, please contact me at _____.

_____
Forensic Coordinator

xc: Office of Forensic Services, DMHMRSAS
Defense Attorney
Judge
Community Services Board NGRI Coordinator

(DMH 944E 1250 05/01/2003)

CHAPTER 5

PLANNING FOR RELEASE

Planning For Release
(§ 19.2-182.7)

I. Legal parameters of the Conditional Release planning process.

The Code of Virginia (§ 19.2-182.7) stipulates that at any time the court considers the acquittee's need for inpatient hospitalization, it shall place the acquittee on conditional release if it determines that:

A. Based on consideration of the factors which the court must consider in its commitment decision

1. The acquittee does not need inpatient hospitalization but needs outpatient treatment or monitoring to prevent his or her condition from deteriorating to a degree that he or she would need inpatient hospitalization;

2. Appropriate outpatient supervision and treatment are reasonably available;

3. There is significant reason to believe that the acquittee, if conditionally released, would comply with the conditions specified; and

4. Conditional release will not present an undue risk to public safety.

B. The court shall subject a conditionally released acquittee to such orders and conditions it deems will best meet the acquittee's need for treatment and supervision and best serve the interests of justice and society.

C. Only the court that originally found the acquittee not guilty by reason of insanity has the authority to conditionally release the acquittee.

D. An acquittee can be found not guilty by reason of insanity by more than one court, within the same time period. When this occurs, the procedures outlined here apply to all courts having jurisdiction over the acquittee.

II. At any time the hospital receives a recommendation for conditional release from the following sources, it must initiate the conditional release planning process:

A. An order for either conditional release or a conditional release plan, from the committing NGRI court.

B. A recommendation for conditional release as a result of an evaluation pursuant to § 19.2-182.2, § 19.2-182.5, or § 19.2-182.6.

C. A treatment team recommendation for conditional release approved by the IFPC.

Regardless of the reasons, the hospital must submit all requests for conditional release to the Forensic Review Panel for review and recommendations to the court.

III. Petitions for Release (§ 19.2-182.6)

A. By Commissioner, pursuant to § 19.2-182.6

1 On behalf of the Commissioner, the Forensic Review Panel may petition the committing court for an acquittee's conditional or unconditional release at any time it concludes hospitalization of the acquittee is no longer needed. See Table 3.3: Procedures for Petition For Release By the Commissioner.

2 After reviewing the submission packet from the treatment team requesting conditional release, if the Forensic Review Panel approves the submission, it will petition the court for the release of the acquittee. The petition shall be accompanied by

a. A report of clinical findings supporting the petition, and
b. A conditional release or discharge plan, as appropriate, prepared jointly by the hospital and the appropriate community services board(s).

3. A copy of the petition shall be sent to the

a. Judge having jurisdiction,
b. Acquittee's attorney
c. Attorney for the Commonwealth for the jurisdiction in which the acquittee was committed
d. NGRI Coordinator of the Community Services Board serving the locality to which the acquittee has been proposed for conditional release (and the original community services board if these are not the same).
e. Administrative Coordinator of the Forensic Review Panel, and the Office of Forensic Services.

4. Appointment of evaluators

   a. Upon receipt of a petition for release, the court shall order the Commissioner to appoint two persons to assess and report on the acquittee's need for inpatient hospitalization.
      (1) See Table 3.4: Petition For Release Hearing Evaluation
      (2) The Director of the Office of Forensic Services, acting for the Commissioner, shall make the appointments upon receipt of the court order.
      (3) As in other "Commissioner appointed" evaluations, these are independent evaluations and evaluators do not require the approval of the Forensic Review Panel when recommending conditional release or release without conditions.
   b. Evaluations shall be completed and findings reported within 45 days of issuance of the court's order.

B. By acquittee, pursuant to § 19.2-182.6

1. According to §19.2-182.6, the acquittee may petition the committing court for release only once in each year in which no annual judicial review is required.

2. According to § 19.2-182.6, a copy of the acquittee’s petition shall be sent to the attorney for the Commonwealth in the committing jurisdiction.

3. Appointment of evaluators

   a. Upon receipt of a petition for release, the court shall order the Commissioner to appoint two persons (§ 19.2-182.6(B)), to assess and report on the acquittee's need for inpatient hospitalization.
      i See Table 3.4: Petition For Release Hearing Evaluation
      ii The Director of the Office of Forensic Services, acting for the Commissioner, shall make the appointments upon receipt of the court order.
      iii As in other "Commissioner appointed" evaluations, these are independent evaluations and evaluators do not require the approval of the Forensic Review Panel when recommending conditional release or release without conditions.

   b. Evaluations shall be completed and findings reported within 45 days of issuance of the court's order.

4. Recommendation of Conditional Release by an evaluator

If either appointed evaluator recommends conditional release, the treatment team must develop a conditional release plan with the appropriate community services board, and submit the plan to the Forensic Review Panel. The Forensic Review Panel will, in turn, review and submit the conditional release plan to the court of jurisdiction, with their recommendation.

C. Court hearing

1. The court shall conduct a hearing on the petition for release upon receipt of the evaluation reports. As with all court hearings, the treatment team or forensic coordinator should notify the community services board of the scheduled date and time of the hearing as soon as it is made aware of an upcoming hearing.

2. Based upon the reports and other evidence provided at the hearing, the court shall

a. Order that the acquittee remain in the custody of the Commissioner if he or she is mentally ill and continues to require inpatient hospitalization based on consideration of the factors set forth in § 19.2-182.3, or

b. Place the acquittee on conditional release if
   (1) He or she meets the criteria for conditional release, and
   (2) The court has approved a conditional release plan prepared jointly by the hospital staff and appropriate community services board(s); or

c. Release the acquittee from confinement if
   (1) He or she does not need inpatient hospitalization,
   (2) Does not meet the criteria for conditional release set forth in §19.2-182.7, and
   (3) The court has approved a discharge plan prepared jointly by the hospital staff and appropriate community services board.

IV: Victim notification (§ 19.2-182.6(B))

A. Section 19.2-182.6(B) requires the Commissioner to give notice of the hearing on the petition for release to any victim of the act resulting in the charges on which the acquittee was acquitted or to the next of kin of the victim, provided the person submits a written request for such notification to the Commissioner.

B. Victims interested in receiving notification of these hearings should write the Commissioner expressing their interest and providing their names and addresses.

C. Upon receipt of a written request for victim notification, the Director of Forensic Services shall

1. Notify the acquittee's facility Forensic Coordinator of the request,

2. Write the committing court to request advance notification of any hearings regarding petitions for release,

3. Send a copy of the letter to the court to the person making the request for victim notification.

D. The Forensic Coordinator shall

1. Work closely with the treatment team and the court to monitor the acquittee's hearings pursuant to § 19.2-182.6(B),

2. Notify the person requesting victim notification in writing (and by phone if time before the hearing is limited) as soon as possible after becoming aware of the likelihood of a hearing pursuant to § 19.2-182.6(B), then

3. Make contact with the Commonwealth's Attorney or the clerk of the Court for the specific date and time of the hearing.

V. Guidelines for requesting conditional release

A. All requests for conditional release must be reviewed and approved by the Forensic Review Panel.

B. General guidelines used by the Forensic Review Panel to determine suitability for conditional release include:

1. Successful progression through the graduated release process. Most acquittees, with the exception of those the judge may conditionally release from temporary custody, will have progressed through graduated levels of treatment and freedom before becoming eligible for recommendation for conditional release. The ability to demonstrate safe behavior in an environment substantially similar to what is recommended for conditional release is important to the public and the courts and provides a stronger case for conditional release.

2. Acquittee compliance and collaborative involvement with the comprehensive treatment program that has been implemented at the facility. This compliance extends to adherence to regimens of prescribed medication. Evidence from hospital documentation that acquittee is actively participating in treatment, and is allowed and willing to take medication without coercion or even supervision is useful in preparing for conditional release.

3. Clinical stability of acquittee

4. Acquittee shows

    a. An understanding of his or her mental illness and how that mental illness was linked to the offense of which he or she was acquitted by reason of insanity,
    b. An ability to manage his or her mental illness in order to avoid future offenses, and
    c. An understanding of how he or she has changed since the time period of the NGRI offense.

VI. Development of the Conditional Release Plan

A. Joint Work with Community Services Boards (CSBs)

1. Virginia Code §§ 19.2-182.2, 19.2-182.5 (C), and 19.2-182.6(C) explicitly require CSBs to plan for conditional release in conjunction with hospital staff and to implement the conditional release plan approved by the court. The conditional release plan shall be prepared jointly by the hospital and the community services board where the acquittee shall reside upon conditional release.

2. Successful conditional release planning requires

    a. Close working relationships early in the process,
    b. Learning to trust each other's judgments and different perspectives,
    c. Fully considering community concerns, and
    d. Mutual work toward the goal of a timely, comprehensive, and safe conditional release outcome for the acquittee.

3. The CSB is a member of the treatment team for the acquittee. It is important for the CSB staff to meet with the acquittee as often as possible, and to routinely participate in the joint treatment team planning and conditional release planning process during the acquittee’s hospitalization.

B. Non-CSB Provider involvement in conditional release plans:

1. Other providers may contribute to the plan but the CSB must provide the oversight and is held responsible for the overall plan implementation.

2. Private and non-CSB staff providing components of the conditional release plan may be asked by the CSB to provide written confirmation of their willingness to provide specific components of the plan, regular progress updates to the supervising CSB, and shared information based upon mutually agreeable guidelines. Written confirmation might best be obtained prior to submission to the court of the proposed conditional release plan.

C. Cross-Jurisdictional Conditional Release Placements

1. In some cases, acquittees may be conditionally released to CSB catchment areas that are different from the jurisdictions of the committing courts. This may occur when

   a. The acquittee committed the NGRI offense away from his/her original CSB catchment area,
   b. The acquittee chooses to change residences,
   c. The family is willing to accept the placement of the acquittee after discharge; the family lives in a different county or city, etc.
   d. Change of residence comports with clinical and legal recommendations.

2. Individuals who have been found not guilty by reason of insanity may take up residence in any area of the state of their choosing. They are not required to return to the area from which they were originally acquitted by reason of insanity.

   a. The community services board in the area of the acquittee's conditional release residence is responsible for implementing the conditional release plan and providing appropriate services.
   b. The community services board from the original jurisdiction may provide consultation or collaboration, if appropriate.
   c. The community services board that implements the conditional release plan is responsible for the supervision and monitoring of the acquittee and for providing all of the required reports to the court and to the DMHMRSAS.

3. When the CSBs change, the original CSB should remain involved until the new CSB has accepted the transfer and the responsibilities for case management.

D. Community Resource Planning

It is important that the CSB meet with the acquittee as soon as possible upon hospitalization in order to begin the planning process for eventual community-based resources that will be needed by the acquittee when conditional release is ordered. Planning for appropriate community-based resources, especially residential, can take a significant amount of time and it is important to begin the planning as soon as possible.

VII. Components of Conditional Release Plan

A. Conditions of Release

1. See format for a conditional release plan, provided in **Appendix G**. (Diskettes are available from the Office of Forensic Services.)

2. Examples of general conditions
   a. Agreement to abide by all municipal, county, state and federal laws.
   b. Agreement not to leave the Commonwealth of Virginia without first obtaining the written permission of the judge maintaining jurisdiction over his or her case and the supervising community services board. The understanding that, pursuant to § 19.2-182.15, he or she may be charged with a class 6 felony if he or she leaves the Commonwealth of Virginia without court permission.
   c. Agreement not to use alcoholic beverages.
   d. Agreement not to use or possess any illegal drugs or other medication not prescribed for the acquittee.
   e. Agreement not to possess or use weapons.

3. Examples of special conditions of community care that are typically focused upon in treatment and service provision with acquittees:

   a. Substance abuse counseling and monitoring
   b. AA or Narcotics Anonymous groups
   c. Anger and aggression control groups
   d. Group psychotherapy
   e. Individual therapy
   f. Forensic support groups
   g. Vocational programming

4. Examples of other special conditions that might be added to the conditional release plan

   a. Limitations on visits to family members, particularly in cases of long-standing acquittee difficulties with family
   b. Limitations on unsupervised contact with children, particularly in cases where acquittee has a history of sex offenses against children
   c. Other criminal justice supervisory relationships such as a probation or parole officer supervising acquittee's probation or parole from other criminal convictions
      (1) in these cases, the probation/parole officer's name, address, and phone number should be spelled out and the working relationship between the community services board and the probation/parole officer should be clarified.
      (2) a copy of the probation/parole conditions should be reviewed to ensure that there are no conflicts with the conditional release plan.
      (3) a copy of the probation/parole conditions should be attached to the conditional release plan.

5. Community and trial visits

   a. Consistent with the underlying principles of graduated release, it is expected that acquittees will have an opportunity to make a careful transition to community placement by participating in a continuum of community visits (escorted by facility staff and unescorted) that include both day and overnight stays (maximum of 48 hours).
   b. If ordered by the court, visits for more than 48 hours (trial visits) can occur while the acquittee remains in the hospital. These trial visits allow an opportunity to test out the specifics of the conditional release plan prior to final discharge from the hospital. If appropriate for the acquittee, trial visits should be part of the conditional release plan submitted to the court.
   c. Trial visits also help the acquittee become adjusted to the significant change of release from the hospital and help avoid the more drastic step of revocation of conditional release.
   d. It is very important for the hospital staff to coordinate all community visits with the CSB staff. Although the IFPC or the FRP notifies the CSB of each increase in privilege level, it is critical that the hospital staff notify the CSB of each community visit once the acquittee has reached the privilege level of unescorted, not overnight. This notification will facilitate the coordination necessary for the conditional release planning process, and maximize integration with community resources.

B. Acquittee's agreement to the conditions of release

1. It is required that the acquittee review and agree to the proposed conditions of release.

2. The acquittee should be an active participant in the development of the conditional release plan.

a. The acquittee's interests and desires regarding conditional release should be taken into consideration in the development of the plan.
b. The acquittee should be familiar with the proposed conditional release plan and clearly indicate his/her willingness to comply with that plan.

C. Community Services Board (CSB) agreement to the conditions of release

1. The CSB staff who will supervise and implement the conditional release plan should collaborate in the development of the proposed conditional release plan, and they should sign the plan.

2. A separate form is provided to give the CSB staff an opportunity to make independent recommendations and/or comments to the Forensic Review Panel regarding the proposed conditional release plan. All documents submitted to the Forensic Review Panel should be signed and dated.

VIII. Release without conditions

A. The court shall release the acquittee from confinement if the acquittee does not need inpatient hospitalization and does not meet the criteria for conditional release set forth in § 19.2-182.7, provided the court has approved a discharge plan prepared jointly by the hospital staff and the appropriate community services board.

B. Only the court which found the acquittee not guilty by reason of insanity and placed the acquittee in the custody of the Commissioner has the jurisdiction to release the acquittee without conditions.

C. Treatment team requests or recommendations to the court for release without conditions shall occur only after the review and approval of the Forensic Review Panel.

D. A discharge plan prepared jointly by the hospital staff and appropriate community services board shall be submitted to the Forensic Review Panel with the request for release without conditions.

E. If the Forensic Review Panel provisionally approves the treatment team's request for unconditional release, the Panel shall follow the procedures set forth above regarding the Commissioner's petition for release of the acquittee.

IX. Discharge Procedures

A. Court orders

1. A signed court order for conditional release or release without conditions is required before the acquittee may be discharged from the facility.

2. The court order shall be reviewed by the Forensic Coordinator before discharge. Any ambiguities or questions about the court order should be handled immediately by the facility Forensic Coordinator working with the court before the discharge of the acquittee.

   a. The Office of Forensic Services is available to provide technical assistance.
   b. The facility Forensic Coordinator shall fax a notice of discharge and a copy of the court order to the Office of Forensic Services no later than one working day after discharge.

3. Formal notification to judge and others upon discharge

   a. As most acquittees are discharged from the hospital to conditional release or release without conditions after the court order is signed, the Forensic Coordinator shall send a formal letter to the judge and shall send copies to the attorneys, the community services board(s), and the Director of Forensic Services noting
      (1) The date of final discharge;
      (2) The name, address, and phone number of the community services board staff member supervising the conditional release;
      (3) Any other information that may be needed by the courts.
   b. A formal letter to the court clarifies the acquittee's change in status and ensures that the court and all interested parties are fully informed about this important transition to the community.

B. Unexpected Discharges

1. If an unexpected discharge occurs (e.g., when an acquittee is released directly from the courtroom by the judge), the forensic coordinator shall immediately notify the community services board where the acquittee was released. The released acquittee should be provided appropriate information and encouraged to make immediate contact with service

providers in the community in which he will reside.

X. Plan to monitor compliance with the conditions of release

A. A plan to monitor compliance, supporting the proposed conditions of release, shall also be part of the conditional release package. See format provided in Appendix G.

B. The purposes of the plan to monitor compliance are to

1. Clarify expectations regarding the conditions of release,

2. Set up standards for monitoring the conditional release,

3. Specify what noncompliance with the conditions would entail, and

4. Determine, in advance, appropriate responses to noncompliance with the conditions of release.

C. The goal is to discuss these issues in advance with the acquittee, the acquittee's family and support system, the facility treatment team, and the CSB staff responsible for supervising the acquittee.

D. The plan to monitor compliance is intended to "inoculate against setbacks" by helping the acquittee and supervising staff think through possible setbacks and develop a variety of solutions to barriers that might be encountered.

E. The plan to monitor compliance should be closely tied to the risk factors identified in the Analysis of Aggressive Behavior. Responses to noncompliance with the conditions of release should be developed keeping in mind the seriousness of individual risk factors. In order to promote continuity of care for acquittees on conditional release, hospital staff should provide copies of the Analysis of Aggressive Behavior, along with other risk assessment instruments and documents, to the NGRI Coordinator for the CSB. Every effort possible should be made by facility staff to promote CSB staff understanding of the importance of addressing acquittee risk factors in the clinical management of the acquittee's community adjustment.

CHAPTER 6

CONDITIONAL RELEASE
AND
RELEASE WITHOUT CONDITIONS

Conditional Release and Release Without Conditions

I. Community Services Board NGRI Coordinator

A. The Executive Director of each CSB shall designate a member of his/her staff to serve as the NGRI Coordinator. The CSB NGRI Coordinator will:

1. Oversee compliance of the CSB and the acquittee with court orders for conditional release,

2. Coordinate the provision of reports to the courts in a timely fashion, and

3. Maintain training and expertise needed for this role.

B. The CSB NGRI Coordinator is the single point to coordinate all NGRI cases.

1. Central point for accountability

2. Central point to facilitate communication with judges, attorneys, Forensic Coordinators and staff from the state mental health facilities, etc.

II. Implementing the conditional release plan

The conditional release plan is attached to or referenced in the conditional release order for the acquittee. The conditional release plan itself is, therefore, a court order in its entirety. Changing any of the general or special conditions in the conditional release plan must be pre-approved by the court of jurisdiction. Section 19.2-182.7 requires the CSB serving the locality in which the acquittee will reside upon release to

1. Implement the court's conditional release orders, and

2. Submit written reports to the court no less frequently than every six months on the acquittee's

a. Progress, and
b. Adjustment in the community.

III. Assistance from the DMHMRSAS Office of Forensic Services, Division of Facility Management

A. Technical assistance and consultation are available from the Office of Forensic Services, Division of Facility Management, regarding all acquittees placed on conditional release.

B. Copies of the following should be sent to Office of Forensic Servicesin a timely fashion.

1. Monthly reviews of conditional release (See format and instructions at end of this chapter)

2. Six month reports to the court (See format and instructions at end of this chapter)

3. Correspondence with the court, including

a. Petitions for modification or removal of conditions of release, and
b. Petitions for revocation of conditional release.

4. Court orders

5. Other pertinent information

IV. Reporting to the Courts – Six-month reports to the Court

A. Written reports shall be submitted to the court pursuant to §19.2-182.7 by the CSB no less frequently than once every six months, starting six months after the acquittee's discharge date on conditional release from the hospital.

1. Consult the conditional release order for more specific requirements regarding reporting that the court might impose.

2. The court has the option to request these reports more often.

B. Format for the six-month court reports

1. The CSB staff member who is responsible for supervising the implementation of the conditional release plan should complete these reports.

a. A formal forensic evaluation is not required.
b. See format and instructions at end of this chapter.

C. Before the due date of the six-month report, the CSB staff person supervising the acquittee's conditional release should collect information from all parties involved with the conditions of release.

1. Goal: Current, comprehensive assessment of the acquittee's progress and adjustment in the community.

2. People who should be contacted for their input
a. Providers of services
b. Family and/or friends of acquittee

c. Acquittee

D. The original of the six month court report should be submitted to the judge (or judges if multiple courts are holding jurisdiction) holding jurisdiction over the acquittee. Copies of the report should go to:

1. The attorney for the acquittee;

2. The attorney for the Commonwealth of the jurisdiction where the acquittee was found not guilty by reason of insanity, and

3. DMHMRSAS Office of Forensic Services, Division of Facilities Management.

V. Acquittee noncompliance with the conditional release plan

A. Deciding when to pursue revocation of conditional release, modification of the conditional release order, or other interventions with the acquittee can be difficult.

1. Many of the scenarios and consequences regarding compliance, or lack of compliance, should be anticipated and discussed with the acquittee, during conditional release planning. These outcomes and consequences should be described in the conditional release compliance-monitoring plan.

2. Responses to the acquittee's lack of compliance with the conditional release order should be closely tied to the seriousness of individual risk factors identified in the hospital-generated risk assessment, i.e., Analysis of Aggressive Behavior.

3. In each case, clinical judgment and consultation with supervisors and colleagues may be necessary to resolve problems with noncompliance.

a. It might also be useful to review the acquittee's progress or lack of progress with the facility treatment team which recommended and planned the conditional release.
b. Good practice suggests careful documentation of the rationale to revoke or not revoke the conditional release.

4. The DMHMRSAS Office of Forensic Services, Division of Facilities Management may also be of assistance.

5. Virginia Code Sections 19.2-182.7, 19.2-182.8, 19.2-182.9, and 19.2-182.11 outline several mechanisms to respond to serious instances of noncompliance with conditions of release, decompensation of the acquittee's mental condition, and other problems of conditional release. See discussion of each legal option later in chapter.

6. Writing to the court (with copies to acquittee and both attorneys) regarding

the acquittee's lack of compliance may be another useful tool. The letter

should include an offer to attend a court hearing reviewing the status of the acquittee's progress on conditional release if the court chooses to schedule such a hearing.

VI. Modifying Conditional Release Orders/Plans (§ 19.2-182.11)

A. Reasons for modification

The assigned CSB case manager must monitor the entire conditional release plan (all general and special conditions). When the CSB case manager determines that the conditional release plan needs to be modified, it is incumbent upon the CSB case manager to recommend that the court of jurisdiction modify the conditional release plan. Only the court of jurisdiction has the authority to actually modify the conditional release plan, and any of the general and special conditions. The reasons for modifying the conditional release plan may result from positive or negative compliance factors.

B. Examples of when the CSB case manager should recommend that the conditional release plan be modified include:

1. When the specific service needs identified in the plan change, i.e., the acquittee should now return to work full time and no longer needs to attend the psychosocial program on a full-time basis, or the acquittee only needs to attend the psychosocial program 3 days/week vs. 5 days/week.

2. The acquittee has improved and no longer requires services described in one of the conditions.

3. The acquittee’s compliance and the adjustment in the community is poor and additional conditions need to be added before recommending revocation.

C. Procedures for modification

1. The court of jurisdiction may modify conditions of release upon its own motion based upon reports of the supervising community services board, or upon petition of any of the following entities:

   a. Supervising community services board;

   b. Attorney for the Commonwealth; or

   c. The acquittee; who may petition only once annually commencing six months after the conditional release is ordered.

2. The court may issue a proposed order for modification of conditions as it deems appropriate, based on the community services board's report and any other evidence provided to it.

   a. In cases where the supervising CSB is requesting the modification, the petition should be accompanied by a report specifying the

request and providing clear rationale and support for the request.

b. Any other evidence supporting the request should also accompany the petition, such as letters from family members or other providers of conditional release services, etc.

c. Copies of this correspondence with the court should be sent to the DMHMRSAS Office of Forensic Services, Division of Facilities Management.

3. The court must provide notice of the order, and the right to object to it within ten days of its issuance, to the

a. Acquittee,
b. Supervising community services board,
c. Attorney for the Commonwealth for the committing jurisdiction, and
d. Attorney for the Commonwealth where the acquittee is residing on conditional release (if not the same as the committing jurisdiction).

4. The proposed order will become final if no objection is filed within ten days of its issuance.

5. If an objection is filed, the court shall:

a. Conduct a hearing at which the acquittee, the attorney for the Commonwealth, and the supervising community services board have an opportunity to present evidence regarding the proposed order, and
b. Issue an order, at the conclusion of the hearing, modifying conditions of release or removing existing conditions of release.

D. Court approval for out-of-state visits while on conditional release

Virginia Code § 19.2-182.15 makes it a class 6 felony for an acquittee who has been placed on conditional release, pursuant to § 19.2-182.7, to leave the Commonwealth without permission from the Court which conditionally released him.

1. In certain geographic regions and individual cases where an acquittee may need to work or attend medical appointments across state lines, consideration may be given to requesting that the court authorize such visits on a regular basis.

2. The following issues should be considered in any decision to request such a modification to the conditional release order:

a. Length of time acquittee has been on conditional release,
b. Degree of compliance with conditional release plan,
c. Degree of compliance with psychotropic medication,
d. Risk factors identified in the Analysis of Aggressive Behavior,

e. Acquittee's understanding of the criminal penalty for escape from conditional release (i.e., § 19.2-182.15),
f. The availability of support system, both personal and professional, should the acquittee begin to decompensate or have difficulties, and
g. The availability of a trusted person to accompany the acquittee.

3. The request for a modification to a conditional release order should specify dates and locations for the out-of-state visits and ask that the modified court order include those specifics.

VII. Revocation of Conditional Release

When revocation is being considered by the CSB, it is recommended that the NGRI Coordinator or the case manager discuss the acquittee's situation with the Forensic Coordinator of the last discharge hospital. This discussion would include the reasons for the revocation, risk factors and the appropriate DMHMRSAS hospital for revocation admission. Once the acquittee is revoked, the NGRI Coordinator of the CSB should ensure that the admitting hospital receives appropriate information about the reasons for revocation and that ongoing communication is established to discuss planning for the acquittee after the revocation admission.

Reasons for the acquittee's revocation of conditional release should include the need for psychiatric hospitalization. If the acquittee is in violation of his or her conditional release plan and does not need hospitalization, the CSB and the court have different options, such as modification of the conditional release plan, or citation of the acquittee for contempt of court.

A. Regular (Non-Emergency) Process (§ 19.2-182.8)

1. The court may order an evaluation of the acquittee if at any time the court that ordered conditional release finds reasonable ground to believe that the acquittee on conditional release has

   a. Violated the conditions of release, or is no longer a proper subject for conditional release based on application of the criteria for conditional release, and
   b. Requires inpatient hospitalization.

2. A format for a petition for revocation of conditional release is included later in this chapter to assist the supervising community services board in requesting a response from the court.

3. The evaluator may be a psychiatrist or a clinical psychologist who is qualified by training and experience to perform forensic evaluations.

4. The court may revoke the acquittee's conditional release and order him/her returned to the custody of the Commissioner if the court, based on the evaluation and after hearing evidence on the issue, finds by a preponderance of the evidence that an acquittee on conditional release has

   a. Violated the conditions of release, or
   b. Is no longer a proper subject for conditional release based on application of the criteria for conditional release, and is mentally ill or mentally retarded and requires inpatient hospitalization.

B. Emergency Process (§ 19.2-182.9)

1. When exigent circumstances do not permit compliance with revocation procedures set forth in § 19.2-182.8 (see above section)

   a. Any judge as defined in §37.1-1 or magistrate may issue an emergency custody order (ECO), upon the sworn petition of any responsible person or upon the court's own motion based upon probable cause to believe that an acquittee on conditional release
      (1) has violated the conditions of his or her release, or is no longer a proper subject for conditional release based on application of the criteria for conditional release, and
      (2) requires inpatient hospitalization.
   b. The Emergency Custody Order (ECO) shall
      (1) require the acquittee to be taken into custody, and
      (2) transported to a convenient location where a
      (3) person designated by the community services board who is skilled in the diagnosis and treatment of mental illness shall evaluate the acquittee and assess his or her need for hospitalization.

2. A law enforcement officer who, based on his or her observation or the reliable reports of others, has probable cause to believe that an acquittee on conditional release has violated the conditions of release and is no longer a proper subject for conditional release, and requires emergency evaluation to assess the need for inpatient hospitalization, may take the acquittee into custody and transport him or her to an appropriate location to assess the need for hospitalization without prior judicial authorization.

   a. The evaluation shall be conducted immediately.
   b. The acquittee shall remain in custody until a temporary detention order (TDO) is issued or until released, but in no event shall the period of custody exceed four hours.

3. A judge or magistrate, as defined above, may issue a Temporary Detention Order authorizing the executing officer to place the acquittee in an appropriate institution (this could be a community-based psychiatric hospital

or a state hospital) for a period not to exceed 48 hours prior to a hearing, if it appears from all evidence readily available that the acquittee

a. Has violated the conditions of release, or is no longer a proper subject for conditional release based on application of the criteria for conditional release, and
b. Requires inpatient hospitalization.

4. The committing court or any judge as defined in § 37.1-1 shall have jurisdiction to hear the matter.

a. Before the hearing, the acquittee shall be examined by a psychiatrist or a clinical psychologist who shall certify whether the person is in need of hospitalization.
b. Following the hearing, the court shall revoke the acquittee's conditional release and place him or her in the custody of the Commissioner if the court determines, based on a preponderance of the evidence presented at the hearing, that the acquittee
   (1) has violated the conditions of release, or is no longer a proper subject for conditional release based on application of the criteria for conditional release; and
   (2) is mentally ill or mentally retarded and in need of inpatient hospitalization

C. Placement back into the custody of the Commissioner after revocation from conditional release

Placement into custody of the Commissioner after revocation does not require hospitalization in the Forensic Unit of Central State Hospital, even if the acquittee was placed on conditional release directly from the Forensic Unit at Central State Hospital. The decision to place the acquittee in a particular hospital setting is made by the Office of Forensic Services, in consultation with the Forensic Coordinator at the hospital in which the acquittee was resident, immediately prior to conditional release.

1. First consideration should be given to returning the acquittee to the unit and treatment team that prepared the acquittee for conditional release, thus facilitating continuity of care.

2. The decision to place the revoked acquittee in a civil unit or in the Forensic Unit of Central State Hospital should be based upon an assessment of risk to include (i) danger to self or others, and (ii) risk of escape.

3. In those cases where a joint assessment of risk by the responsible CSB and the regional DMHMRSAS facility indicates that an acquittee requires a secure forensic treatment setting, due to safety or security reasons, an

immediate referral should be made to the Forensic Coordinator of the Forensic Unit at Central State Hospital.

4. If there is disagreement between the Forensic Coordinator of the regional DMHMRSAS facility and the Forensic Coordinator of the Secure Forensic Unit, the Director of Forensic Services will make the decision regarding placement.

VIII. Civil ECO, TDO, or Hospitalization of an insanity acquittee on conditional release

A. When an acquittee on conditional release is taken into emergency custody, detained, or hospitalized, such action shall be considered to have been taken pursuant to Virginia Code § 19.2-182.9, notwithstanding the fact that his or her status as an insanity acquittee was not known at the time of custody, detention, or hospitalization.

B. Detention or hospitalization of an acquittee pursuant to provisions of law other than those applicable to insanity acquittees under Chapter 11.1 of Title 19.2 of the Code of Virginia shall not render the detention or hospitalization invalid.

C. If a person's status as an insanity acquittee on conditional release is not recognized at the time of the civil emergency custody or detention, at the time his or her status as such is verified, the provisions applicable to such persons shall be applied and the court hearing the matter shall notify the committing court of the proceedings. The forensic coordinator shall also notify the committing court.

D. Based on a risk assessment conducted by the CSB, an acquittee can be admitted to a local psychiatric hospital on a temporary detention order or could remain on a voluntary admission. If the acquittee requires involuntary hospitalization and needs to be committed, however, the acquittee should be admitted to a state hospital and to the custody of the Commissioner.

IX. Contempt of Court (§ 19.2-182.7)

Section 19.2-182.7 of the Code of Virginia allows the court of jurisdiction to find an acquittee in contempt of court as a result of the acquittee's violation of his conditions of release, provided the acquittee does not need to be hospitalized.

X. Procedures following revocation of an acquittee from conditional release.

1. Required admitting court orders

    1. When an acquittee is admitted back into the state hospital following conditional release, the acquittee is considered revoked regardless of the Virginia Code Section upon which the admission was based. The acquittee can be placed back into the custody of the Commissioner

pursuant to Virginia Code Sections 19.2-182.8 (non-emergency revocation), 19.2-182.9 (emergency revocation), a civil TDO or a civil commitment order. If the acquittee is rehospitalized on the basis of a civil TDO or a civil commitment order because his status as an insanity acquittee on conditional release was not known at the time of the emergency custody or detention, the provisions for the revocation of acquittees apply once the acquittee's status has been verified. The court that acts on the request for emergency custody or detention notifies the committing court of the actions taken. The revocation process for the acquittee is begun upon admission in these instances.

2. When an acquittee is admitted to the hospital on a NGRI TDO or a civil TDO order, the acquittee must have a hearing within the prescribed times frames to determine if the acquittee meets the criteria for continued hospitalization and if the acquittee will remain hospitalized.

3. Whenever an acquittee is admitted to a state hospital following conditional release, the PRAIS legal status code is either a 74 or a 75 and will remain one of the revocation PRAIS codes for the duration of his NGRI status, regardless of the admitting court.

XI. Hospital readmission of the acquittee; return to the custody of the Commissioner.

As soon as possible after the revocation of the acquittee back into the custody of the Commissioner, the CSB staff and the treatment team will need to develop a recommendation regarding continued hospitalization or resuming conditional release. It is important for the CSB and treatment team staff to maintain close communication during this time in order to provide a joint recommendation based on information from the acquittee's previous experience on conditional release. The joint recommendation will be submitted to the FRP by the hospital staff within twenty-one (21) days of revocation.

If the recommendation to the FRP is conditional release, the previous conditional release plan will need to be updated and revised as appropriate. If the court approves conditional release, it will be necessary for a new court order for conditional release to be signed before the acquittee can be discharged back on conditional release.

If the recommendation is to continue hospitalization at this time, a proper court order may be necessary to continue hospitalization. The CSB staff will remain involved with the NGRI acquittee as a member of the treatment team.

XII. Review by the Forensic Review Panel after acquittee is returned from conditional release to the Commissioner's custody

A. Within twenty-one (21) days of the acquittee's return to the Commissioner's custody, the treatment team shall submit a packet of information to the FRP with recommendations for future treatment and management. The packet should clearly state whether the treatment team

1. Recommends continued hospitalization and the recommended privilege level if any, or

2. Recommends the return to conditional release within the first 30 days after resumption of Commissioner's custody

B. All packets should include the following:

1. A review of the acquittee's progress on conditional release and a description of the circumstances of the return to hospitalization. This should include:

   a. The acquittee's perspective;
   b. The supervising community services board's perspective;
   c. Other relevant parties' perspectives;
   d. The victim's perspective, if that information is available and relevant to the acquittee's course of conditional release and return to hospitalization; and
   e. Other relevant information.

2. An account of the NGRI offense

3. An updated Community Outpatient Treatment Readiness Scale (COTREI);

4. An updated Analysis of Aggressive Behavior (AAB);

5. The results of a current mental status exam;

6. Copy of sanity evaluation;

7. Appropriate risk management plan(s);

8. Current diagnosis;

9. Treatment team’s support for the request;

10. Current list of treatment activities and medication orders;

11. Revised conditional release plan if the recommendation is for resumption of conditional release.

C. FRP recommendations to the Court

The FRP will communicate its recommendation to the court within 30 days of the acquittee’s hospitalization.

1. If the FRP approves conditional release, the FRP shall make that recommendation to the court and submit the revised conditional release plan; or

2. If the FRP approves recommitment to the custody of the Commissioner, the FRP shall make that recommendation to the court with its reasons.

D. Forensic Coordinator responsibilities following FRP recommendations to the Court:

1. If the Court determines that the acquittee can be conditionally released following the recommendations of the FRP, the court must issue a new order for conditional release pursuant to § 19.2-182.7 before the acquittee can be discharged from the hospital on conditional release. The Forensic Coordinator is responsible for contacting the court to facilitate this process.

2. The Forensic Coordinator will:

a. Provide a written request to the court to arrange for a commitment hearing if the acquittee was revoked on a court order pursuant to §19.2-182.9 or a civil commitment order, if such a hearing is necessary to maintain the hospitalization of the acquittee.
b. A court order pursuant to §19.2-182.8 does not necessitate this request to the court following the continued hospitalization recommendation of the FRP.
c. In all revocation cases, the Forensic Coordinator will request that the annual commitment hearing process be implemented even if the acquittee had previously been in the custody of the Commissioner for more than 5 years prior to the conditional release from which he was revoked.

XIII. Release Without Conditions (§ 19.2-182. 11)

Acquittees are released without conditions by the court of jurisdiction from conditional release, or directly from the custody of the Commissioner. The individual is no longer under the jurisdiction of the court. The responsibility of the DMHMRSAS for monitoring the acquittee, and of the CSB for reporting to the DMHMRSAS regarding acquittee status, ceases with unconditional release. Since July, 1992, Virginia courts have released an average of eight acquittees from conditional release each year.

A. Release without conditions and the discontinuance of court jurisdiction occurs only at the committing court's discretion.

1. Criteria for release without conditions: acquittee does not need inpatient hospitalization and does not meet conditional release criteria in § 19.2-182.7.

2. The CSB may recommend removal of conditions to the court through the six-month court reporting process or through other formal communication with the court. Recommendation for removal of conditions should be accompanied with documented reasons for the recommendation.

3. As release without conditions is the final step in the graduated release of an insanity acquittee, careful consideration should be given to whether the acquittee is now ready and able to manage his/her mental illness and potential for violence without the court ordered monitoring of the community services board.

B. The court uses the same mechanism for removal of all conditions of release as it does for modification of conditional release.

1. See Section VI. Modifying Conditional Release Orders/Plans in this chapter.

2. At the end of this process, the court should issue an order removing conditions on the acquittee's conditional release and discontinuing the court's jurisdiction.

The following should receive copies of the order

a. Acquittee,
b. Supervising community services board,
c. Attorney for the Commonwealth for the committing jurisdiction,
d. Attorney for the Commonwealth where the acquittee was residing on conditional release (if that locality is not the same as the committing jurisdiction), and
e. DMHMRSAS Office of Forensic Services, Division of Facilities Management.

Monthly Review of Conditional Release

NAME OF ACQUITTEE: _____DATE:_____

COURT HOLDING JURISDICTION: _____

TIME PERIOD COVERED IN REVIEW: _____

TO: Office of Forensic Services
DMHMRSAS
P.O. Box 1797 Phone: 804/786-8044
Richmond, VA 23218 Fax: 804/786-9621

If the acquittee has been **charged with any crime(s)*** during this period, please note offense & date:

_____

If the acquittee has been **convicted of any crime(s)*** during this time period, please note offense & date:

_____

***Includes traffic violations other than routine parking tickets**

GENERAL CONDITIONS OF RELEASE	ACQUITTEE'S COMPLIANCE			COMMENTS
	NEVER	SOMETIMES	ALWAYS	

Monthly Review of Conditional Release

SPECIAL CONDITIONS OF RELEASE	ACQUITTEE'S COMPLIANCE			COMMENTS
	NEVER	SOMETIMES	ALWAYS	

Date of last face-to-face contact with acquittee:_____

Dates and results of any substance abuse screening tests:

TYPE TEST	DATE(s) ADMINISTERED	RESULTS OF TESTS
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

(If more than 5 screenings administered, please continue listing on back of form)

Other comments on acquittee's progress and adjustment in the community:
_____

_____ / _____

Signature **Name (Print)**

_____

Title

_____

CSB

_____ _____

Phone **Fax**

THE MONTHLY REVIEW OF CONDITIONAL RELEASE REPORT INSTRUCTIONS FOR COMPLETING THE FORM:

GENERAL GUIDANCE**:**

- Read the currently approved conditional release plan carefully. Do not assume that any of the general or special conditions have been modified or deleted unless you have a court order or letter from the NGRI judge of jurisdiction confirming that status. If the court has deleted or modified a condition, label that status in the comment section. If the conditional release plan was written so that the CSB has the authority to discontinue a service, only then it is allowed to discontinue the condition(s) without the court's specific approval. Note these 2 distinctions appropriately in the comment section.
- Don't use local names of programs, i.e., Rainbow House or abbreviations, i.e., ACR. Describe the program type instead, i.e., club house, detox program, adult home, etc.
- The 6-month report to the court does NOT substitute for the monthly report.
- The reporting form is available on diskette for your convenience**.**

SPECIFIC INSTUCTIONS FOR THE FORM:

1. NAME OF ACQUITTEE – Complete the full name of the acquittee.

2. DATE – Complete the date that the report is written.

3. COURT HOLDING JURISDICTION – Complete the name of the court that holds jurisdiction for the acquittee. If there are 2 or more courts of jurisdiction, complete all that apply.

4. TIME PERIOD COVERED IN REVIEW – Complete the calendar month and year for which the report is written. This report should always be completed for a full calendar month, i.e., September 2000. Do not write reports for "split" months, i.e., November 14 – December 14, 2000.

5. CHARGED WITH ANY CRIMES – Complete any crimes for which the acquittee has been charged during the reporting month.

6. CONVICTED OF ANY CRIMES – Complete any crimes for which the acquittee has been convicted during the reporting month.

7. GENERAL CONDITIONS OF RELEASE – Read the currently approved conditional release plan and write/type all general conditions in detail and by their number on the left side column. If the general conditions are not written/typed in their entirety, write/type meaningful phrases for each general condition that represents the court's intent of the general conditions.

THE MONTHLY REVIEW OF CONDITIONAL RELEASE REPORT
INSTRUCTIONS FOR COMPLETING THE FORM CONTINUED
PAGE 2

Check off "never", "sometimes", or "always" to describe the acquittee's compliance with each general condition of their release.

Write/type in comments as needed to describe the acquittee's compliance with the general conditions of their release.

If you condense the wording of the general condition on the report, ensure that your version of the condition still represents the Court's intent and that it can be appropriately answered by the choices – "never", "sometimes" or "always". Do not just write/type in a number without a description of the general condition. Do not just write/type in that "all general conditions are fine".

8. SPECIAL CONDITIONS OF RELEASE – Read the currently approved conditional release plan and list all special conditions in detail and by their number on the left side column. If the special conditions are not written/typed in their entirety, write/type meaningful phrases for each special condition that represent the court's intent for each special condition.

   Check off "never", "sometimes", or "always" to describe the acquittee's compliance with each special condition of their release.

   Write/type in comments as needed to describe the acquittee's compliance with each special condition of their release.

   If you condense the wording of the special condition on the report, ensure that your version of the condition still represents the Court's intent and that it can be appropriately answered by the choices – "never", "sometimes" or "always". Do not just write/type in a number without a description of the special condition. Do not just write/type in that "all special conditions are fine".

9. DATE OF LAST FACE-TO-FACE WITH THE ACQUITTEE - Complete the date of the last face-to-face with the acquittee by the case manager.

10. DATES AND RESULTS OF ANY SUBSTANCE ABUSE SCREENING TESTS – Complete the type of each test, the date(s) administered and the results of each test. If drug of alcohol testing is not ordered by the court and is not being administered, write/type in "not applicable".

11. OTHER COMMENTS ON ACQUITTEE'S PROGRESS AND ADJUSTMENT IN THE COMMUNITY – This is the opportunity to provide information about the acquittee's progress, compliance, or maintenance with the conditional release plan. It also provides space to comment on factors that influence the acquittee's community adjustment.

THE MONTHLY REVIEW OF CONDITIONAL RELEASE REPORT
INSTRUCTIONS FOR COMPLETING THE FORM CONTINUED
PAGE 3

12. SIGNATURE AND PRINTED NAME – The case manager assigned should sign their name and then print/type their name. It is also recommended to add the credentials of case manager, i.e., LPC, MSW, BS, RN, etc.

13. TITLE – Print/type in the title of the CSB case manager.

14. CSB AND MAILING ADDRESS – Print/type the name of the CSB and the mailing address of the case manager.

15. PHONE AND FAX NUMBERS – Print/type the phone number and the fax where the case manager can be reached.

OTHER INFORMATION:

- The Monthly Review of Conditional Release form is due on the 10th of the month following the reporting month. An example is that the November 2000 report is due on December 10, 2000.

- Only fax or mail the Monthly Review of Conditional Release report. Do not send both faxed and mailed copies.

  Mailing address:
  Department of Mental Health, Mental Retardation and Substance Abuse
  Office of Forensic Services
  Forensic Mental Health Conditional Release Consultant
  P.O. Box 1797
  Richmond, Virginia 23218-1797
  Telephone number: 804-786-8044
  Fax number: 804-786-9621

Six Month Report To Court
Reviewing Conditional Release of Insanity Acquittee

Page 1

TO: The Honorable _____ DATE: _____

_____

_____

RE: Acquittee Name: _____

Court Case No.: _____

Date of Conditional Release Order: _____

GENERAL CONDITIONS OF RELEASE	ACQUITTEE'S COMPLIANCE			COMMENTS
	Never	Sometimes	Always	

(DMH 944E 1246 05/01/2003)

Six Month Report To Court
Reviewing Conditional Release of Insanity Acquittee

Page 2

SPECIAL CONDITIONS OF RELEASE	ACQUITTEE'S COMPLIANCE			COMMENTS
	Never	Sometimes	Always	

Other comments on acquittee's progress and adjustment in the community:

_____

_____

_____

_____

Six Month Report To Court
Reviewing Conditional Release of Insanity Acquittee
Page 3

Acquittee Name:_____ Date:_____

CSB Recommendation to the Court:

_____ Continue conditional release

_____ Modify current conditional release order

_____ Revoke conditional release

_____ Remove conditions of release

If making a request, provide specifics of request and rationale:

_____

_____

_____

_____

_____
Signature

_____
Name

_____
Address

_____

_____

_____
Phone

xc: Acquittee's Attorney
Attorney for Commonwealth
DMHMRSAS Office of Forensic Services

SIX-MONTH REPORT TO COURT
REVIEWING CONDITIONAL RELEASE OF INSANITY ACQUITTEES
INSTRUCTIONS FOR COMPLETING THE FORM:

GENERAL GUIDANCE:

- Report is submitted to the NGRI judge of jurisdiction. If there are two or more courts of jurisdiction, one report should be addressed to all judges or separate reports can be submitted to each NGRI judge of jurisdiction.
- The report should be completed and submitted every 6 months after the acquittee is placed on conditional release.
- Read the currently approved conditional release plan carefully. Do not assume that any of the general or special conditions have been modified or deleted unless you have a court order or letter from the NGRI judge of jurisdiction confirming that status. If the court has deleted or modified a condition, label that status in the comment section. If the conditional release plan was written so that the CSB has the authority to discontinue a service, only then it is allowed to discontinue the condition without the court's specific approval. Note the 2 distinctions appropriately in the comment section.
- Don't use local names of programs, i.e., Rainbow House or abbreviations, i.e., ACR. Describe the program type instead, i.e., club house, detox program, adult home, etc.
- The 6-month report to the court does NOT substitute for the monthly report.
- The reporting form is available on diskette for your convenience.

SPECIFIC INSTUCTIONS FOR THE FORM:

1. TO – Complete the name(s) of the NGRI judge(s) of jurisdiction and their address (es).

2. DATE – Complete the date that the report is written.

3. RE– Complete the full name of the acquittee, the court case number and the date of the conditional release order.

4. CONDITIONS OF RELEASE – Complete all the general and special conditions of release in this section.

   A.) GENERAL CONDITIONS OF RELEASE - Read the currently approved conditional release plan and write/type all general conditions in detail and by their number on the left side column. If the general conditions are not written/typed in their entirety, write/type meaningful phrases for each general condition that represents the court's intent of the general conditions.

   Check off "never", "sometimes", or "always" to describe the acquittee's compliance with each general condition of their release.

Write/type in comments as needed to describe the acquittee's compliance with each general condition of their release.

If you condense the wording of the general condition on the report, ensure that your version of the condition still represents the Court's intent and that it can be appropriately answered by the choices – "never", "sometimes" or "always". Do not just write/type in a number without a description of the general condition. Do not just write/type in that "all general conditions are fine".

B.) SPECIAL CONDITIONS OF RELEASE – Read the currently approved conditional release plan and list all special conditions in detail and by their number on the left side column. If the special conditions are not written/typed in their entirety, write/type meaningful phrases for each special condition that represent the court's intent for the special conditions.

Check off "never", "sometimes", or "always" to describe the acquittee's compliance with each special condition of their release.

Write/type in comments to describe variations in the acquittee's compliance with each special condition of their release.

If you condense the wording of the special condition on the report, ensure that your version of the condition still represents the Court's intent and that it can be appropriately answered by the choices – "never", "sometimes" or "always". Do not just write/type in a number without a description of the special condition. Do not just write/type in that "all special conditions are fine".

5. OTHER COMMENTS ON ACQUITTEE'S PROGRESS AND ADJUSTMENT IN THE COMMUNITY – This is the opportunity to complete more information about the acquittee's progress, lack of compliance, or maintenance of effort with the conditional release plan. It also provides space to remark on other factors that influence the acquittee's overall adjustment in the community.

6. CSB RECOMMENDATION TO THE COURT-This section is very important and delineates the four recommendations that can be made to the court. The case manager can make only one recommendation to the court. It may be helpful to discuss your report and recommendation with your supervisor and/or NGRI Coordinator before submitting to the court. In most cases, it is appropriate to inform the acquittee of the recommendation.

SIX-MONTH REPORT TO COURT
REVIEWING CONDITIONAL RELEASE OF INSANITY ACQUITTEES
INSTRUCTIONS FOR COMPLETING THE FORM
PAGE 3

7. IF MAKING A REQUEST, PROVIDE SPECIFICS OF REQUEST AND RATIONALE – Complete any details concerning a request of the court. A request would be required anytime you have made the recommendation of "modify the current conditional release order", "revoke conditional release", or "remove conditions of release".

8. SIGNATURE – The case manager should sign their name. It is also recommended to add the credentials of case manager, i.e., LPC, MSW, BS, RN, etc.

9. NAME – The case manager should print/type their name.

10. ADDRESS – Print/type the name of the CSB and the mailing address of the case manager.

11. PHONE AND FAX NUMBERS – Print/type the phone number and the fax where the case manager can be reached.

12. XC - The acquittee's attorney, the attorney for the commonwealth and the Forensic Office of DMHMRSAS should receive a copy of this report every 6 months. If there is more than one NGRI judge of jurisdiction, send to all defense and commonwealth attorneys involved.

OTHER INFORMATION:

- Only fax or mail the Six Month Report to Court Reviewing the Conditional Release of Insanity Acquittee. Do not send the report by both mail and fax.

  Mailing address:
  Department of Mental Health, Mental Retardation and Substance Abuse
  Office of Forensic Services
  Forensic Mental Health Conditional Release Consultant
  P.O. Box 1797
  Richmond, Virginia 23218-1797
  Telephone number: 804-786-8044
  Fax number: 804-786-9621

NOT GUILTY BY REASON OF INSANITY
PETITION FOR REVOCATION OF CONDITIONAL RELEASE,
PURSUANT TO § 19.2-182.8 OF THE CODE OF VIRGINIA

VIRGINIA:
IN THE CIRCUIT COURT OF _____, or

IN THE GENERAL DISTRICT COURT OF _____

COMMONWEALTH OF VIRGINIA

VS.

NAME_____ DOCKET NO.-CR _____

FELONY _____
DATE OF BIRTH_____ MISDEMEANOR_____
OFFENSE DATE(S)_____

The undersigned petitioner alleges that _____, an acquittee who was previously found not guilty by reason of insanity and later placed on conditional release, pursuant to Virginia Code § 19.2-182.7 (see attached court order), has:

_____ violated the conditions of his release, and/ or

_____ is no longer a proper subject for conditional release

and requires inpatient hospitalization. In support of the allegation, your petitioner submits the following facts:

_____

_____

_____

_____

Wherefore, your petitioner prays that the said acquittee be evaluated with respect to his suitability for conditional release and need for inpatient hospitalization.

Signed _____Date_____(DMH 944E 1247 05/01/2003)

The foregoing petitioner, being duly sworn, deposes and says that the statements set forth above are true and correct to the best of his knowledge and belief.
Subscribed and sworn to before me on this _____ day of _____.

_____
Judge, Special Justice, or Notary Public

xc: Acquittee's Attorney
Commonwealth's Attorney
DMHMRSAS Office of Forensic Services (DMH 944E 1246 05/01/2003)

CHAPTER 7

Procedures for the Management of Persons Found Not Guilty by Reason of Insanity of a Misdemeanor Offense

Procedures for the Management of Persons Found Not Guilty by Reason of Insanity of a Misdemeanor Offense, Pursuant to § 19.2-182.5(D)

I. The provisions of this chapter are restricted to individuals who have been acquitted only of a misdemeanor offense. Those individuals who have been acquitted by the courts as NGRI of both a felony and misdemeanor offense shall be subject to the provisions of this manual that apply to felony acquittees.

II. Section 19.2-182.5 (D) places statutory limitations upon the period of confinement in the custody of the Commissioner for individuals who have been found not guilty by reason of insanity of a misdemeanor offense.

1. Acquittees found not guilty of a misdemeanor by reason of insanity on or after July 1, 2002 shall remain in the custody of the Commissioner for a period not to exceed one year from the acquittal date.

2. If the Commissioner determines, prior to, or at the conclusion of one year, that the acquittee meets the criteria for: conditional release; release without conditions (unconditional release); temporary detention pursuant to §37.1-67.1; involuntary civil commitment pursuant to §37.1-67.3; emergency custody, pursuant to §37.1-67.01

    a. The Commissioner shall petition the committing court for such.
    b. The Commissioner's duty to file such a petition does not preclude the ability of any other person who meets the requirements defined in § 37.1-67.01 from doing so.

III. Misdemeanant NGRIs remain subject to the provisions of other sections of Chapter 11.1 of Title 19.2 of the Code.

A. The verdict of acquittal by reason of insanity of a misdemeanor offense, and the initial placement of the misdemeanant acquittee in the temporary custody of the Commissioner is based upon the criteria delineated in § 19.2-182.2 of the Code.

B. The revisions to § 19.2-182.5 did not change the statutory basis for the ("forensic") period of commitment to the custody of the Commissioner. That commitment period continues to be based upon the criteria set forth in § 19.2-182.3. That section of the Code provides for the commitment of the acquittee if he is mentally ill or mentally retarded and in need of inpatient hospitalization.

The court consider the following factors, in rendering its decision:

1. The extent to which the acquittee is mentally ill or mentally retarded;

2. The likelihood that the acquittee will engage in conduct presenting a substantial risk of bodily harm to other persons or to himself in the foreseeable future;

3. The likelihood that the acquittee can be adequately controlled with supervision and treatment on an outpatient basis; and

4. Such other factors as the court deems relevant.

C. The provisions of § 19.2-182.6, pertaining to Commissioner and acquittee petitions for release, and §19.2-182.7, pertaining to conditional release criteria and plans, are applicable to misdemeanant acquittees during the period of forensic commitment to the custody of the Commissioner.

D. For all misdemeanant acquittees who have been conditionally released from the custody of the Commissioner, those sections of the Code that address revocation from conditional release shall continue to apply.

IV. Specific operational procedures for the management of misdemeanant acquittees

A. Temporary Custody

1. Pursuant to § 19.2-182.2, misdemeanant acquittees are placed in the temporary custody of the Commissioner for the 45-day evaluation period, in the same manner as those acquitted of felony offenses. All departmental procedures for the evaluation and management of felony insanity acquittees, including initial placement in the maximum-security forensic unit at Central State Hospital, and the completion of the Analysis of Aggressive Behavior, are applicable to misdemeanant acquittees.

2. Verification that the offense for which the individual has been found not guilty by reason of insanity was a misdemeanor offense, and not a felony, and determination of the accurate date of acquittal of the misdemeanant offense by reason of insanity shall be completed as soon as possible following the placement of a misdemeanant acquittee in the temporary custody of the Commissioner.

a. The Office of Forensic Services will contact the committing NGRI

court to determine the classification (misdemeanor or felony) for all offenses for which the individual has been acquitted.

b. The Office of Forensic Services will seek proper verification of the actual date of acquittal (date of verdict) for all misdemeanant acquittees. (Court orders for temporary custody are typically signed at a later date than the actual date of the verdict.)

c. Each offense for which the acquittee has been found NGRI will be entered into the Forensic Information Management System (FIMS) along with the corresponding offense level (misdemeanor or felony) of each offense.

d. The verified acquittal hearing date shall be recorded in the Forensic Information Management System (FIMS).

e. The verified acquittal hearing date shall be used to set the termination date for the completion of the one-year commitment period.

B. The privileging process for misdemeanant acquittees

It is the policy of the DMHMRSAS that misdemeanant acquittees who have been committed to the custody of the Commissioner pursuant to § 19.2-182.3 shall remain under forensic status, and shall be subject to the acquittee privilege, risk management and treatment procedures of the DMHMRSAS throughout the portion of their period of forensic hospitalization, until they have been conditionally or unconditionally released from the custody of the Commissioner, or transferred to civil commitment status.

It shall also remain the goal of the DMHMRSAS that the principle of graduated release shall be adhered to with regard to the privileging process for misdemeanant acquittees who are in the custody of the Commissioner. The limited time parameters within which a misdemeanant may advance through the privileging process shall require that facility treatment teams maintain a proactive and expeditious approach with regard to identifying the readiness of misdemeanant NGRIs for increases in privileges, and with seeking appropriate privilege increases for eligible acquittees.

1. The Forensic Review Panel (FRP) and the Internal Forensic Privileging Committees (IFPC) shall continue, as designated and appropriate, to be charged with approval of all:

   a. Requests for increases in privileges, including transfer from the maximum security forensic unit to civil hospital placement;

   b. Requests for conditional release from acquittees and treatment teams

c. Requests for release without conditions
d. Requests for approval of court-ordered conditional release plans
e. Requests for approval of plans for return to conditional release for acquittees who have been revoked while under forensic commitment status from conditional release.

2. Special considerations for recommending conditional or unconditional release to the committing court

a. Whenever appropriate during a misdemeanant acquittees' period of hospitalization, the treatment team should seek IFPC and FRP approval of requests for conditional or unconditional release of the acquittee.
b. All entities involved in the development of requests for conditional or unconditional release of a misdemeanant acquittee by the committing court shall anticipate the time constraints that apply with misdemeanant acquittees.
c. There is no provision in § 19.2-182.5(D) for extension of the one-year commitment period for the completion of Commissioner-Appointed Evaluations, or for any other purpose.
d. In timing the development of requests for release, particular consideration should be given to the likelihood that petitions for release, pursuant to § 19.2-182.6, from the Commissioner to the committing court may require at least an additional 60 days for the completion of independent evaluations, pursuant to § 19.2-182.6(B), following the petition hearing.
e. The facility forensic coordinator shall have responsibility for informing the Commonwealth's Attorney for the jurisdiction of the committing court of the scheduled release of an acquittee not less than 30 days prior to the release date.

C. Placement on and duration of conditional release

1. A misdemeanant acquittee who has been placed on conditional release shall remain under that status for an indefinite time period, until and unless the committing court has unconditionally released him, revoked him from conditional release and recommitted him to the custody of the Commissioner, or civilly committed him as a result of a revocation process.

2. Revocation of Conditional Release

a. As noted above, the procedures defined in §§ 19.2-182.8, 19.2-

182.9, and 19.2-182.10, regarding revocation from conditional release are applicable to misdemeanant acquittees who have been placed on conditional release.

b. In the event a misdemeanant acquittee is in need of revocation, the CSB shall initiate the revocation process, in accord with the procedures outlined in § 19.2-182.8, or § 19.2-182.9.

c. Whenever a misdemeanant acquittee has been revoked to a DMHMRSAS hospital, all of the procedures outlined in Chapter 6 of these *Guidelines* shall be completed, with regard to the preparation of a packet for submission to the Forensic Review Panel within 21 days of the admission of the misdemeanant acquittee.

d. In the event that the treatment team requests that the acquittee be approved for return to conditional release, and the Forensic Review Panel approves that request, the Panel must notify the court within thirty (30) days of the acquittee's hospitalization of its recommendation.

e. If the court approves the conditional release of the acquittee at the scheduled hearing in the matter, and orders the acquittee's release, then the misdemeanant acquittee shall be returned to the community, following the approval of a proper conditional release plan by the court.

f. If it is the opinion of the treatment team that the misdemeanant acquittee is not ready for return to conditional release, and shall require continued hospitalization, the team should indicate that viewpoint in the privilege packet that is submitted to the Forensic Review Panel, following the revocation of the acquittee.

g. If the Forensic Review Panel disapproves a request from a treatment team for approval of conditional release of a revoked misdemeanant acquittee, or if the Panel concurs with the team's assessment that the misdemeanant acquittee is in need of continuing hospitalization, the Panel shall direct the facility treatment team to seek a civil commitment of the misdemeanant acquittee from the committing court, if the one year NGRI period has expired.

D. Procedures for misdemeanant acquittees recommended for civil commitment

The actions listed below are to be followed for all misdemeanant NGRIs who are considered ineligible for conditional or unconditional release, and who are candidates for civil commitment by the committing NGRI court:

1. Facilities should not submit privilege request packets to the FRP for civil

commitment of misdemeanant NGRIs, unless the acquittee is hospitalized as a result of a revocation from conditional release.

2. Following review of the individual's clinical and risk status, facility treatment teams shall notify the facility IFPC of any plans to seek civil commitment for a misdemeanant acquittee who will have been in the custody of the Commissioner for one year from the date of acquittal.

3. A designated member of the treatment team will notify the acquittee of the treatment team's intent to petition the court for civil commitment, prior to sending the petition to the court. Notification of the acquittee shall be documented in the acquittee's medical record.

4. The facility forensic coordinator shall serve as petitioner for the civil commitment of the misdemeanant acquittees at the facility. The coordinator shall complete all necessary arrangements for the prescreening and psychiatric evaluation of the acquittee, as well as scheduling of court hearings and other logistical matters in an expeditious and timely manner.

5. A qualified clinical psychologist or psychiatrist who is not currently treating the acquittee shall complete the physician's examination for the petition. That evaluator shall also attend the commitment hearing that the court schedules in the matter, in order to provide any requisite expert testimony.

6. The following documents should be sent to the committing NGRI court of jurisdiction for the misdemeanant acquittee as soon as the petition for civil commitment has been completed:

    a. The completed civil commitment petition;
    b. A cover letter notifying the court of the Virginia Code change, and indicating that it is the treatment team's recommendation that the misdemeanant acquittee be civilly committed due to his need for continued hospitalization.
    c. Copies of these documents shall be sent to the Commonwealth's Attorney in the case, the acquittee's defense attorney, the Chair of the FRP, the facility IFPC, and the Director of the Office of Forensic Services at the time that they are sent to the court.

7. Upon receipt of an order for the civil commitment of any misdemeanant acquittee by the committing court, a copy of that civil commitment order shall be forwarded to the head of the facility treatment team for inclusion in the patient's medical record. Copies of the commitment shall also be

forwarded to the Chair of the FRP, the Director of the Office of Forensic Services, and the facility IFPC. This procedure shall not obviate any other archiving of civil commitment documents that may occur at the facility.

8. The facility forensic coordinator shall also ensure that the patient's legal status in the PRAIS system is changed to a civil PRAIS code. Receipt of the civil commitment order by the facility will terminate the misdemeanant acquittee's status as an active forensic case, unless there is an additional forensic status in force with the acquittee.

9. The case records of misdemeanant NGRIs shall be closed in the Forensic Information Management System (FIMS), once a misdemeanant acquittee has been civilly committed.

10. All other factors notwithstanding, any misdemeanant acquittee who has been civilly committed shall be placed in a hospital treatment setting that is consistent with his status as a civilly committed patient, in accord with the level of privileges that he had attained prior to his civil commitment, and which addresses his current need for supervision or security.

E. Procedures for misdemeanor acquittees who have been found Not Guilty by Reason of Insanity in more than one court.

1. There are cases in which a misdemeanant acquittee has been acquitted in more than one court. In those instances in which the misdemeanant acquittee has also been acquitted of a felony in another court, it shall be necessary for the facility to coordinate all activities regarding the case with the court that will retain jurisdiction for the felony NGRI status of the acquittee.

2. In cases of this type, the facility forensic coordinator shall contact the Office of Forensic Services for consultation on the proper procedures to be followed.

APPENDIX A

ANALYSIS OF AGGRESSIVE BEHAVIOR

Analysis of Aggressive Behavior

I. The Analysis of Aggressive Behavior (AAB) is a systematic means to (1) assess the risk(s) of aggression for an individual acquittee and (2) develop means by which to address the risk(s).

A. The AAB is a psychological evaluation that includes data collected on the acquittee's past aggressive episodes, treatment and social history, and current functioning and is used as a basis for

1. Treatment interventions,

2. Decision-making regarding the management of privileges and placement for the acquittee,

3. Making recommendations to the court regarding conditional release and release without conditions,

4. Conditional release planning, and

5. Community aftercare.

B. The AAB is an anamnestic (Miller & Morris, 1988; Melton, Petrila, Poythress & Slobogin, 1997) approach to risk assessment and management that integrates known statistics on risk factors and base rates for aggressive behavior with clinical approaches that relate these statistics with the context of the individual case.

C. The focus of the AAB is identification of relevant risk factors for future aggression and for the planning of risk management strategies, rather than an attempt to predict aggression. Each risk factor should have a management strategy (some management strategies will apply to more than one risk factor, and some risk factors will require more than one management strategy).

The AAB focuses on containment of future aggression rather than strictly static predictions of dangerousness.

1. The AAB emphasizes a more dynamic understanding of the acquittee's history of aggressive behavior, the variables that influence that aggression, and suggestions for decreasing and preventing aggression in the future.

2. The assessment of risk factors is integrated into treatment planning and conditional release planning so that specific risk factors are identified and addressed directly to contain future risk.

II. A comprehensive review of aggressive and/or dangerous behaviors is conducted which is not limited to the NGRI offense.

A. A description of the NGRI offense, using collateral sources of information, the mental status at the time of the offense evaluation, police, reports, victim/witness statements and the acquittee's account (which may be presented in a combined form or separately to highlight differences).

B. All criminal charge(s) including those associated with a patient's acquittal by reason of insanity should be reviewed, noting the relative frequency, type and age of onset of aggression.

C. Records of previous hospitalizations should be reviewed for incidents of aggression in the community as well as in treatment settings.

D. Collateral sources of information, such as family members and community treatment providers should also be considered sources of information on past aggressive behaviors that have not resulted in arrest, criminal charges or hospitalization.

E. Past and current psychiatric, psychological and social history assessments as well as observations of hospital staff, as well as a mental status examination are also sources of information for patterns of aggressive behavior.

III. Once the data on past aggressive episodes are collected from multiple sources (both collateral sources and self-report from the acquittee), an analysis of the following is performed, and described in detail

A. The relationship, if any, of existing or pre-existing mental disorder(s) to past aggressive episodes, especially including:

1. The presence of Threat/Control Override symptoms (paranoid delusions of persecution or beliefs that one's thoughts or behavior are being controlled by an outside agency (Link & Stueve, 1994);

2. The presence of auditory command hallucinations related to the aggressive behavior;

3. Affective dyscontrol related to mood disorders;

4. Impairment in impulse control due to neurological or developmental disorder (e.g. seizure disorder, brain injury or disease, mental retardation).

B. Common characteristics or patterns across aggressive episodes should be identified, including (but not limited to)

1. Time (month, year, time of day)

2. Nature of aggressive act (description of act; include role of self-defense)

3. Legal outcome

4. Cognitive correlates (thoughts before, during, and after the incident; include threat/control override delusions, hallucinations, low IQ, and poor judgment, reasoning and/or verbal skills)

5. Affective correlates (emotions experienced before, during, and after the incident; include anger and impulsiveness, impaired frustration tolerance, interpersonal conflict vs. predatory acts planned with particular goal) aggression (many patterns are mixed: See Meloy, 1988)

6. Apparent motivation (e.g. related to mental illness, drug/alcohol use, criminal behavior, sex offenses)

7. Location

8. Weapon(s) (type of weapon, include how/why weapon was selected, any specialized training in the use of weapons)

9. Victim(s) (who; relationship to acquittee; how selected including age and gender; behavior of victim including provocation, exacerbation, and reduction of aggression)

10. Substance abuse (include types of substances used, frequency of use, age at which substance use commenced, prior failed treatment and any history of distribution of illegal substances)

11. Medication compliance

IV. Initial AAB completed during Temporary Custody

A. The Analysis of Aggressive Behavior begins at the time of admission to temporary custody placement.

Some acquittees, e.g., those who were adjudicated NGRI prior to the initiation of the requirement for completion of an AAB on each new acquittee, may not have an Initial AAB. If this is found to be the case, an Initial AAB should be completed as soon as possible for this individual.

B. The staff of the Forensic Unit of Central State Hospital (or other any other DMHMRSAS facility housing an acquittee in temporary custody) shall make efforts to obtain the relevant Analysis of Aggressive Behavior information and complete the Initial AAB within 30 days after admission. (In cases wherein Commissioner Appointed Evaluators have been assigned to complete the Initial AAB, the staff of the Forensic Unit or forensic staff at the hospital in which the acquittee is hospitalized shall be responsible for obtaining the relevant information for the completion of the Initial AAB.)

1. Attempts to obtain information should

    a. Begin immediately upon admission by faxing written requests for all information that was not available upon admission,
    b. Be systematically and promptly followed up if information is slow in arriving,
    c. Include the acquittee's self-report, and
    d. Include a significant emphasis on obtaining data from collateral sources, to include the Community Services Board and other treatment providers, family members, and significant others, and
    e. Be well documented.

2. Information gathering is an extremely important aspect of the AAB and the process of assessing risk.

3. A suggested format and hypothetical cases are included later in this chapter.

C. The AAB shall be provided as soon as possible to the two evaluators appointed by the Commissioner to perform the temporary custody placement evaluation. It is expected that this information will be integral in making assessments and recommendations to the court regarding disposition.

1. AAB information available during the first 30 days after admission and before completion of the temporary custody evaluations shall be immediately transmitted by fax to the appointed evaluators .
2. In cases where the AAB information is not complete at the end of 30 days, the staff of the Forensic Unit of Central State Hospital (or other designated treating facility) shall document

a. Contacts made,
b. Why information is not available, and
c. How the missing information may have an impact on the Analysis of Aggressive Behavior.
d. Attempts to obtain this information shall continue even after the Initial AAB is completed by the Temporary Custody evaluators.

V. Format for Initial Analysis of Aggressive Behavior

1. Identifying Information

2. Purpose of Evaluation

3. Statement of nonconfidentiality

4. Sources of Information

5. Relevant Background Information

6. NGRI Offense

    a. Acquittee's Account of the NGRI Offense
    b. Collateral Accounts of the NGRI Offense

7. Behavioral Observations and Mental Status Examination

8. Psychological Testing Results

9. Diagnostic Impression

10. Patient Strengths Which Mitigate the Probability of Future Aggressions

11. Analysis of Aggressive Behaviors

    a. Narrative description of current risk factors
        (1) Include past instances of occurrence of that factor
        (2) Frequency of occurrence
        (3) Intensity
        (4) Conditions under which factor is exhibited
        (5) Dates of occurrence(s) if available
        (6) Any other relevant information regarding why this factor represents a risk for this particular acquittee

b. Current status of risk factors
   (1) Indicate whether or not the acquittee has exhibited recent behavior relevant to the risk factor
   (2) Indicate whether the acquittee demonstrates insight into the factor or any gains or losses towards managing the risk factor

c. Means of addressing risk factors
   (1) Include a detailed description of interventions to be utilized in order to assure, to the extent possible, that the probability of the individual exhibiting this factor will be minimized.
   (2) Strategies for managing risk factors may be extensive and could involve medications, different forms of therapy, sanctions, etc.
   (3) Some management strategies will apply to more than one risk factor, and some risk factors will require more than one management strategy.

12. Factors which Mitigate the Probability of Future Aggression
Positive findings about the acquittee that could contribute to a decrease in the acquittee exhibiting inappropriate aggression are also important and can be integrated into risk management and treatment planning.

VI. Risk Factors to consider in Analyzing Aggressive Behavior

Any factor related to an increased risk of aggression towards self or others shall be identified as a risk factor (see Current Trends in Assessing Risk in this Appendix).

A. Risk factors may be conceptualized in terms of their demographic, historical, clinical and contextual aspects.

1. Demographic factors may include: age, gender, marital status and socioeconomic factors

2. Historical factors may include: criminal history, juvenile delinquency, age of onset of aggression, psychiatric history, employment history, prior supervision failure.

3. Clinical factors may include: substance abuse, psychopathy, brain injury or disease, active symptoms of mental illness such as paranoia or command hallucinations, impaired insight, medical issues such as hypothyroidism, diabetes, etc.

4. Contextual factors may include: use of weapons, victim characteristics, social or community support/lack thereof.

VII. Updates to the Initial AAB

A. The acquittee's treatment team shall update the AAB within 30 days prior to the submission of any requests to the Forensic Review Panel, or to the Internal Forensic Privileging Committee for increased freedom within the facility and/or access to the community. This includes requests for

1. Transfer from the forensic unit to civil units,

2. Grounds privileges (escorted by facility staff or unescorted),

3. Community visits (escorted by facility staff or unescorted),

4. Overnight therapeutic visits (48 hours maximum),

5. Conditional release,

6. Conditional release from temporary custody, and

7. Release without conditions.

B. The Initial AAB acts as a baseline for risk factors, establishing the current status of those risk factors at the point of temporary custody and the initial risk management plans. The AAB Updates demonstrate progress or lack thereof for each risk factor reported, providing a continuity of risk assessment.

1. Risk factors identified in the Initial AAB, or added thereafter shall not be deleted in subsequent updates, even if the risk is not considered current, or is thought to have been inappropriately applied.

2. The Risk Management Plan section for each risk factor, the acquittee's facility Comprehensive Treatment Plan, and any Conditional Release plans should show evidence of a thoughtful continuum of care, risk assessment, and risk management for the process of graduated release

C. The AAB updates shall include:

1. A narrative description of all previously and currently identified risk factors with an assessment of the current status and risk management plan for each risk factor

2. In order to further clarify the risk factor for the individual acquittee the description of the risk factor may be modified to include information from previous updates

3. The Current Status of the Risk Factor shall include any incidents related to that risk factor, since the last update, and any treatments or interventions attempted to manage this risk factor.

4. The Means of Addressing Risk Factors plan shall include recommendations for management of risk at the level of privilege which is being requested.

5. A listing of behaviors that have occurred since the last AAB in each of the following categories, including the date(s) of occurrence

    a. Physical assaults towards others,
    b. Suicidal attempts/gestures c. Destruction of property,
    c. Escape attempts/escapes, and
    d. Behaviors resulting in significant loss or reduction of privileges, including verbal threats of aggression.

6. Risk factors should be added in updates with the addition of new information, clarification of existing risk factors or new behavior patterns.

D. Each risk factor should be labeled and described specifically for the individual acquittee, but should also be categorized for entry into the Forensic Information Management System (FIMS) (see FIMS Categories for Risk Factors, below).

E. The AAB Update is generally part of another comprehensive report, e.g., FRP or IFPC Submission Report or Annual Continuation of Confinement Report. When the AAB-Update is part of another report it is not necessary to repeat items such as background information, mental status, description of NGRI offense, etc. that were included in the Initial AAB. If the AAB – Update is required to be a stand-alone report this additional information should be included.

VIII. General Risk Factors to be considered in Assessing Aggressive Behavior

A. HISTORY OF AGGRESSION IS THE STRONGEST SINGLE PREDICTOR OF FUTURE AGGRESSION.

1. Great care should be given to documenting a complete history of aggression. Clinicians should take into account the acquittee's history of violence in the following roles

    a. Observer
    b. Victim
    c. Perpetrator

2. Acquittee's aggressive behaviors should be considered to be the most important. Experience as an observer or victim of violence may be important but it should be related to the perpetration of aggressive behavior if it is relevant.

B. Clinicians should take into account risk factors of two kinds

1. Static risk factors cannot be changed through treatment or monitoring. Static risk factors include static characteristics (such as age, sex, intelligence, and aggression history).

2. Dynamic risk factors can be altered through treatment or monitoring. Dynamic risk factors include characteristics (such as status of mental illness, substance abuse, and access to weapons and access to previous victims or identified victims) that can be altered through treatment or monitoring).

   The focus on dynamic risk factors should be on how they have

   a. Increased,
   b. Been reduced, or
   c. Been managed through hospital intervention or community treatment/ monitoring.

C. General dynamic risk factors include, but are not limited to…

1. Marital status (single --> higher risk)

2. Substance abuse (present --> higher risk)

3. Access to weapons (easy --> higher risk)

4. Access to victims (easy --> higher risk)

5. Employment (unemployed -->higher risk)

D. General static risk factors (not specific to any particular population) for committing violent behavior toward others include, but are not limited to…

1. Age (younger --> higher risk)

2. Socioeconomic status (lower --> higher risk)

3. Intelligence (lower --> higher risk)

4. Previous violence (higher --> higher risk)

E. Mental illness

1. Diagnosis (Current APA Diagnostic and Statistical Manual; DSM)

   a. Serious mental illness, such as schizophrenia and affective disorder, functions as a weaker risk factor.
   b. Psychopathy (as measured by the Psychopathy Checklist-R Scale) is associated with higher risk.

2. Medication noncompliance strengthens mental illness as a risk factor.

F. **SUBSTANCE ABUSE: RISK IS HEIGHTENED CONSIDERABLY WHEN A DIAGNOSIS OF SERIOUS MENTAL ILLNESS IS COMBINED WITH A DIAGNOSIS OF SUBSTANCE ABUSE**.

G. Base rates for re-arrest for insanity acquittee population

1. Ideally, clinicians should compare the individual acquittee's risk factors with base rate information describing the national insanity acquittee population.

2. Following release from hospital to conditional release: there is a re-arrest rate of 5% to 22% when followed over a period of two to five years

   a. Generally, the closer the NGRI is monitored in the community, the lower the arrest rate, but the higher the re-hospitalization rate.
   b. Acquittees who did well on conditional release
      (1) were employed before the offense;
      (2) were married;
      (3) had committed a less severe offense;
      (4) adjusted well to hospitalization;
      (5) showed a general assessment score on the GAF of less than 50; and
      (6) showed fewer than 7 symptoms on the SADS-C.

3. The first nine months of conditional release were particularly high risk periods for revocation of conditional release.

4. Following release without conditions, there are significant increases in re-arrest rates (42 to 56%), as compared to re-arrest rates while on conditional release.

H. More information about risk factors and their impact on violent outcomes is available through the MacArthur Research Network's risk data on mental illness and violence. Updates on this major research initiative are provided regularly through the training and conferences offered by the Institute of Law, Psychiatry and Public Policy.

IX. Treatment teams, Forensic Coordinators, and staff completing the Analysis of Aggressive Behavior must remain current in the research and practice of assessing risk.

A. The Department of Mental Health, Mental Retardation & Substance Abuse Services contracts with the Institute of Law, Psychiatry and Public Policy to provide

1. A wide range of forensic training programs including: risk assessment;

2. Semi-annual Forensic Symposia that bring in nationally recognized experts on related risk assessment topics;

3. Annual Mental Health and the Law Symposium which also brings in national experts and covers a broader range of relevant topics; and

4. Consultation to facility and community services board staff.

B. Ongoing training and review of the developing risk assessment literature is essential.

Format for Initial AAB:

1. Identifying Information

2. Purpose of Evaluation

3. Statement of Nonconfidentiality

4. Sources of Information

5. Relevant Background Information

6. NGRI Offense

    a. Acquitee's Account of the NGRI Offense
    b. Collateral Accounts of the NGRI Offense

7. Behavioral Observations and Mental Status Examination

8. Psychological Testing Results

9. Diagnostic Impression

10. Patient Strengths Which Mitigate the Probability of Future Aggression

11. Analysis of Aggressive Behaviors

    a. Description
    b. Current Status of Risk Factors
    c. Means of Addressing Risk Factors

EXAMPLE
Initial Psychological Evaluation and
Analysis of Aggressive Behavior

Name: Mr. N. Sanity Acquittee
SS#: XXX-XX-XXXX
Date of Birth: 3/17/56
Age: 43
Sex: Male
Reg. #: XXXXXX.003
Marital Status: Divorced
Education: High School Grad
NGRI Offense: Murder
Case No. 99-XXX
Date of NGRI Adjudication: 11/12/1999
Date of Admission: 11/17/1999
Court: Circuit Court City of Smalltown
Judge: Honorable He B. DeJudge
Date of Report: 12/17/1999

Purpose of Evaluation:

Mr. Acquittee was adjudicated Not Guilty by Reason of Insanity (NGRI) pursuant to Virginia Code Section 19.2-182.2 on 11/12/99, having been charged with murder. This is the report of a routine assessment protocol for newly admitted patients who have been found NGRI. This report will focus on the patient's current psychological functioning, the risk of aggression, and recommendations for the management of risk.

Mr. Acquittee was informed concerning the purpose of this evaluation and the limits of confidentiality. He indicated that he understood these limits and agreed to proceed under these conditions.

Sources of Information:

1. Clinical interviews conducted in the Maximum Security Unit of CSH.
2. Review of the patient's current CSH medical and legal records.
3. Consultation with the patient's current CSH treatment team.
4. Review of Forensic Evaluation of Mr. Aquittee's Mental State at the Time of the Offense completed by Dr. Knowitall and dated 11/10/99.
5. Review of Evaluation of Legal Sanity conducted by Ms. Snickers, and Drs. Bruce Good and Gary Plenty, dated 10/20/99.
6. Review of records from the Marion Correctional Treatment Center.
7. Review of records from two admissions to the Smalltown Regional Medical Center (SRMC).
8. Results of psychological testing with the WAIS-III, MMPI-2, MCMI-III, the RRASOR, the PCL-R, and Thematic Apperception Test (TAT).

Statement of Non-confidentiality:

The purpose of the evaluation was explained to Mr. Aquittee. He was told that a report would be developed concerning his psychological functioning to include analysis for possible aggressive behavior, and that this report would be utilized in treatment planning, as well as by individuals reviewing his situation for increasing privileges. He was also told that this report

could be seen by court officials. Mr. Acquittee agreed to proceed with the evaluation.

Relevant Background:

Mr. Acquittee was born as the younger of two boys into a middle class family. He was born with jaundice and several allergies, and has been described by his mother as a "sickly baby." The family relocated several times in the Southeast United States during Mr. Acquittee's childhood due to his father's job. When he was five months old, Mr. Acquittee was left with his aunt when the family moved to Louisiana, reportedly due to his mother's concern about the child's ability to tolerate the climate. Mr. Acquittee was reunited with his family at some point, and they spent the greatest amount of time living in the Maryland area. Mr. Acquittee suffered an allergic reaction to penicillin at age ten, this reaction included significant edema, reportedly causing his entire body to swell; he also contracted typhoid fever at age 14, and mononucleosis at age 18.

Mr. Acquittee has reported that he made average to above-average grades and had little conflict with teachers or peers. Mr. Acquittee reported that he was suspended once in 8th or 9th grade for skipping school. He graduated in 1975 and enrolled in the University of Maryland Instead of attending college, he began working and subsequently got married. Mr. Acquittee has subsequently worked a number of different jobs, including construction work, stocking supplies, delivering office equipment, selling life insurance, carrying U.S. mail, doing factory work, and delivering pizzas. He has had frequent financial difficulties with credit problems which he attributed to "living beyond my means." Mr. Acquittee has abused alcohol and marijuana on occasion, but has not shown symptoms of dependence. His pattern of abuse has included occasional weekend binges during young adulthood, with declining substance abuse as he has grown older. He was reportedly drinking the night of the NGRI offense, but was not considered intoxicated by arresting officers.

The patient and his wife had significant marital problems, resulting in a legal separation in the summer of 1988 after approximately 13 years of marriage. Reports indicate that the defendant was using alcohol extensively and was physically abusive to his wife. The marital conflict culminated in an incident which Mr. Acquittee refers to as a "misguided attempt at reconciliation." Mr. Acquittee was convicted of rape and served four and a half years in the Virginia Department of Correction (DOC), primarily at the Bland Correctional Center.

Mr. Acquittee's adjustment to the DOC was poor. He was engaged in several fights, one involving a knife. He admitted to instigating some of these fights. He participated in a sex offender treatment program for a time until he was requested to sign a "contract" committing to the principles of the program. He became suspicious of the contract, refused to sign and was returned to general population.

At that time, Mr. Acquittee became increasingly paranoid and began to search his

environment for signs and signals of any impending danger. He also began to believe that God was sending him messages through the television and radio. Records of psychiatric treatment (during and after his incarceration) support the patient's claim that he did not hear voices. Mr. Acquittee has subsequently described obsessional and delusional thinking about the meaning of signals, scriptures from the Bible, and whether the food or water was being poisoned. Some delusions were of a sexual nature, like his belief that he saw a "naked woman" on television, and when he sent a signal to her, she somehow returned his signal.

His behavior became more bizarre and uncooperative with correctional officers, and on 10/27/94 he drank some cleanser and rubbed his face and eyes with the cleanser. Mr. Acquittee has reported that this was in response to obsessions and delusions about his sinfulness and need for "cleansing" rather than an attempt at self-harm. On 10/31/99 he attempted to grab a nurse's genital area.

Mr. Acquittee was admitted to the Marion Correctional Treatment Center (MCTC), the psychiatric inpatient setting for DOC inmates on 11/8/94. He was described as extremely paranoid and was once considered "too regressed" to speak with his parents when they came from Florida for a visit. He was also described as masturbating compulsively and attempted, in separate incidents, to grab two more female nurses in the genital area and, on 11/15/94 he grabbed the genital area of a female officer. During his incarceration, he reported that he grabbed at female genital areas in order to allay rumors that he was homosexual. More recently, Mr. Acquittee has attributed these actions to psychotic experiences (e.g. believing he was receiving messages or signals from the females). Mr. Aquittee also engaged in an incident described as "inappropriate touching" of a female laboratory assistant's breast during an admission to the Riverside Liberty Forensic Unit.

Mr. Acquittee reported that he took medication offered to him at the MCTC, though records indicate that he may have been "cheeking" his medication some of the time. His mental status improved, but he remained in the MCTC until his mandatory parole date of 9/30/95 when he was released to the community. His diagnoses were Axis I : Dysthymia and Axis II: Borderline Personality Disorder.

Mr. Acquittee was next hospitalized at the Smalltown Regional Medical Center (SRMC) on 1/13/97 after he became agitated and was banging his head in his rented room. He'd been living in Smalltown VA and working at the Skinny River Mills factory since his release from prison. He has described being religiously obsessed and delusional concerning the identity of people around him and concerning persecution by the devil. Records indicate that he did not express delusions and he was discharged with a diagnosis of Depressive Disorder, not otherwise specified. Neurological studies (EEG) found no evidence of a seizure disorder.

In April of 1999, Mr. Acquittee experienced several days in which the radio and television appeared to be sending messages to him. He again became religiously obsessed and

"broke down" emotionally at work, crying and trembling and pleading for help. He was readmitted to SRMC on 4/19/99 where he was initially tremulous, mute and "catatonic." He was treated with Ativan and discharged on 4/22/99, the day of the NGRI offense. Mr. Acquittee apparently did not reveal any delusional or confused thinking prior to discharge, though his later accounts report that he was experiencing delusions concerning how his posture (e.g. not crossing his legs) affected his relationship to Christ and that he was listening to the radio for messages from Christ.

NGRI Offense:

Mr. Acquittee was charged with Murder for the stabbing death of his father. From the reports of the patient's mother and the arresting officer (as detailed in the Sanity at the Time of the Offense evaluation completed by staff of the Institute of Law, Psychiatry and Public Policy, dated 10/20/99), the patient was eating dinner with his mother and father when he began to look "like a caged animal" to his mother. He appeared menacing and held the steak knife he'd been eating with. After his father told him to put the knife down, Mr. Acquittee lunged at his father and began stabbing him in the genital area. Mrs. Acquittee called the police and the patient lay on the floor and began to cry. His father got on top of him and attempted to take the knife away from him, but the patient just slung his father off of him and continued to hold the knife.

At this point, Mrs. Acquittee went outside the apartment to get help and neighbors entered the scene to find Mr. Acquittee stabbing his father in the chest area several times and saying, "you better not do this again." As noted in the sanity evaluation, the patient "appeared unresponsive to calls for his attention and soon after the stabbing he was witnessed standing over his father shaking." The police soon arrived and reported hearing neighbors say "Hurry up, he's killing him," and then entered the apartment. The patient was noted to be standing over his father with a knife. The victim was bleeding from the groin area. The officer instructed Mr. Acquittee to drop the knife, and Mr. Acquittee began to walk toward him. He was again instructed to drop the knife, and this time he did drop the weapon and was placed under arrest. At the police station, the patient was observed rocking back and forth in a chair with his eyes closed, and he had urinated in his pants.

Mr. Acquittee has reported difficulty remembering exactly what happened to trigger his attack on his father. In a written account of his memory of the relevant events prepared at the suggestion of his attorney, Mr. Acquittee described believing that his father was the devil who'd taken on human form, and wondering if his "father" had always been the devil in disguise. He reported trying to remember how the devil had managed to appear in the Garden of Eden and how the devil had entered Judas Iscariot at the Last Supper. Then Mr. Acquittee described his father as standing "too close" and striking out at him with the knife. He recalled thinking, as he stabbed his father, that the devil had made himself vulnerable by taking on human form. Mr. **N.**

Acquittee indicated that he felt like Jesus being crucified when he was arrested. He recalled the story of Jesus being offered vinegar while on the cross and felt that he should experience a similar humiliation and urinated on himself. Mr. Aquittee reported that he had been drinking "heavily" that day.

Course of Hospitalization:

At Central State Hospital, Mr. Acquittee has been diagnosed as Psychotic Disorder, NOS, Rule Out Schizophrenia, Paranoid Type/Delusional Disorder. He has also had diagnoses in the past to include Dysthymia, Depressive Disorder, and Borderline Personality Disorder with paranoid and antisocial features. Mr. Acquittee has been generally calm and cooperative during this hospitalization. He has taken medication as prescribed, despite some doubts about how necessary this was or whether this was the correct medication or not. He has shown great concern that potential "errors" in his record be corrected; specifically he expressed concern that he would be inaccurately diagnosed as having a substance abuse disorder, and that "malingering" was mentioned in some of his initial evaluations, despite the ultimate finding that he was Not Guilty by Reason of Insanity. Although he has expressed remorse for "what happened," the patient has shown a great deal of concern about how he is perceived by others. Mr. Acquittee has attended all treatment groups which were recommended and has filled other time by playing cards and reading.

Current Mental Status:

Mr. Acquittee was generally well-groomed and healthy-looking Caucasian male with a moustache and "salt-and-pepper" graying dark hair. He was fully alert and oriented throughout the evaluation and showed no impairment in memory or concentration. His speech was coherent and goal-directed, though he had a distinctive "roundabout" way of speaking (his word) which seemed at times evasive but more often appeared circumstantial. He usually hesitated before responding to a question and did not offer a great deal of detail about the circumstances of any given event. He also appeared to have difficulty with briefly summarizing his memories of past events. On an occasion in which he did respond quickly and to the point, he then commented "I regret having answered so quickly," and proceeded to offer additional details which clouded the picture somewhat. It was frankly difficult to determine whether Mr. Acquittee was offering numerous details to minimize the seriousness of past events, to avoid responsibility, or because he was showing mild symptoms of a thought disorder marked by tangential and circumstantial speech. He did acknowledge that this has been his style for his entire adult life, and that his ex-wife used to complain about not being able to "nail him down" on anything.

Mr. Acquittee did not show any signs of delusional thinking, and was able to identify and describe past delusions. He denied that he was currently hearing voices or that he had ever heard

voices. He denied ever seeing things and did not appear to be actively hallucinating during the interview. His mood was calm and he showed a full range of affect during the interviews. Mr. Acquittee's affect was generally appropriate except that he seemed unusually confident and calm, given the circumstances. He denied and showed no evidence of suicidal thinking. Mr. Acquittee described having had bouts of depression throughout his life. Mr. Acquittee indicated he had experienced vague suicidal thoughts in the past, but had never developed a plan and never really considered actually completing the act. Mr. Acquittee indicated that his reason for drinking some cleanser and rubbing the cleanser in his eyes while incarcerated was his delusional belief that he could protect himself from the devil if he "washed his mouth out," rather than an attempt at self-harm. He denied having any homicidal thoughts at present.

The patient showed some insight into and understanding of his mental illness, though this would best be described as incomplete. When asked to describe the warning signs of a psychotic episode for him, Mr. Acquittee said "An insidiously increasing change in perception as to the relevance of things in the environment." This is a reasonable description of the gradual onset of paranoid and delusional thinking which Mr. Acquittee appears to have experienced on three separate occasions (10/94 while incarcerated, 1/98 and 4/99). He then went on to describe an example of, for instance, hearing staff jangle keys and not being able to tell whether a) it was just a coincidence that a number of people were doing it at once or b) it was an intentional experiment to see how he would react or c) he notices them more because he's looking for signals and special messages in his environment. He indicated that at present he was not experiencing the problem with alternative c), but he was unable to recognize the paranoid quality of alternative b). Mr. Acquittee also indicated that he was concerned that he could not know for certain that his symptoms were currently under control because he was not taking the right medicine for him, and he believed that he could help control his symptoms through the use of cognitive rational-emotive self-treatment. The patient indicated that he believes that he was receiving inspiration from God in committing the NGRI incident. He currently exhibits little insight. He believes the incident "should be considered a religious experience" and he then stated he intended to read the Bible this whole year so that he would know better the will of God. His memory appeared intact as indicated by his capacity to recall immediate, recent or remote events. There was no indication of cognitive impairments.

Results of Psychological Testing:

The defendant completed the WAIS-III, an individually administered test of intelligence. On this instrument, he scored a verbal IQ of 117, a performance IQ of 106, and a full-scale IQ of 111. This places him in the High-Average Range of intelligence. On the reading component of a screening test of academic achievement, he scored on a high school level.

Results of previous testing conducted at the MCTC during his incarceration, and later at

the Riverside Liberty Forensic Unit, during his pre-trial evaluation period have shown a consistent pattern of attempting to present himself in the best light while minimizing any problems or shortcomings he might have. He completed the MMPI-2 at the MCTC. The results of that test revealed, in addition to the minimizing of his problems, a pattern consistent with individuals who are rebellious toward authority, and who often have stormy or conflictual relationships with family and friends. Individuals with similar scores are often impulsive and act without adequate planning or consideration of the consequences of their actions.

The patient completed the MMPI-2 and the MCMI-III for his 10/20/99 evaluation at the Riverside Unit, .The results of those measures showed a guarded response pattern, and an unwillingness to admit common shortcomings. The MMPI-2 showed some tendency toward tightly controlling and inhibiting socially unacceptable responses, especially hostility and aggression, in direct contrast to his recent behavior. The acquittee, also on the MMPI, scored in a manner similar to those individuals who are experiencing paranoid symptoms, and who have a need to blame others for their problems, often denying and minimizing their own roles in their difficulties. Such individuals have also been shown to exhibit loss of reality contact and psychotic processes. On the Thematic Apperception test, the acquittee exhibited signs of underlying depression and feelings of inadequacy and hostility.

Mr. Acquittee again completed the MCMI-III for the current evaluation. The results indicated a distinct tendency toward avoiding self-disclosure which could be a characterological evasiveness, or a general unwillingness to avoid disclosure of a personal nature. It is noted that the patient has been described as vague and evasive throughout his adult life.

The Psychopathy Checklist-Revised (PCL-R) was completed using a combination of clinical interview and collateral information. This test reflects the relative degree of psychopathy or antisocial tendencies reflected in an individual’s behavior and history. Mr. Acquittee's overall score of 12 is greater than 16% of adult male forensic patients, and is in the low range. His score on Factor 1 of the PCL-R, which reflects a selfish, callous and remorseless use of others, is greater than 55% of male forensic patients, which is in the moderate range and suggests that this pattern of interpersonal relationships may be clinically significant. The patient’s Factor 2 score, which reflects a chronically unstable and antisocial lifestyle was in the 9% range, which is a low score. This pattern of scores does not reflect the presence of significant psychopathy but may be associated with individuals who show features of other personality disorders such as Narcissistic or Borderline personality traits.

The Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR) was completed, That measure is a screening instrument used as an actuarial method for assessing future risk for sexual re-offending. Mr. Acquittee's score is associated with a 4.4% rate of recidivism in a five-year period, which is considered a low score.

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Diagnostic Impressions:

The evaluation indicates that Mr.Acquittee has experienced a Psychotic Disorder, NOS, with paranoid features, e.g. delusions. He also has signs of Depression and exhibits features of Narcissistic, Paranoid, Antisocial and Borderline Personality Disorders. The aquittee has also had significant problems with alcohol.

Features (Strengths) which Mitigate the Probability of Future Aggression:

Mr. Acquittee has several characteristics which could contribute to a decrease in the probability of future aggression. He is a high school graduate with some college, and on a test of intelligence he scored within the High-Average Range. When stable, he exhibits no indications of neurological/cognitive impairment. In addition, Mr. Acquittee has the capacity to exhibit good social skills. He is articulate and can express himself well when stable. These positive factors could be integrated into treatment and in the development of vocational/training for Mr. Acquittee.

Analysis of Aggressive Behavior/Risk Factors:

1. <u>Mental Illness</u> (FIMS - Major Mental Illness)

A. Description of Risk Factor and Current Status: Mr. Acquittee shows a highly atypical pattern of symptoms of mental illness. This pattern includes paranoid and delusional thinking, sometimes associated with bizarre and ritualistic behavior. He first experienced these symptoms when incarcerated at the age of 39. He denies ever having experienced auditory hallucinations, but reports experiencing delusions that he was receiving messages from the television and radio and beliefs that he could protect himself from persecution by the devil through certain ritualistic behaviors. These symptoms include Threat/Control Override symptoms, in which Mr. Acquittee believes he is threatened by the devil, delusions which were related directly to the NGRI offense.

Mr. Aquittee has also exhibited symptoms of a Psychotic Disorder, NOS with paranoid features. Mr. Acquittee additionally shows features of Narcissistic, Borderline, Paranoid and Antisocial Personality disorders, including consistent irresponsibility, impaired empathy for others, careless disregard for the safety of others, impulsivity, an exaggerated concern for how he is perceived by others, and the perception of threat or attack in benign remarks or events.

B. Means of Addressing Risk Factor: Mr. Aquittee should continue to receive anti-psychotic medication and participate in group therapies designed to help him identify and understand the symptoms of his mental illness. Individual psychotherapy in the context of external limits on behavior is considered the treatment of choice for long-standing personality disorders.

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Differential diagnosis will be important to determine whether or not the defendant has an actual schizophrenic process or if his behavior is more a function of severe personality dysfunction with possible psychotic features. At this time, it appears the defendant is in need of inpatient hospitalization, given that he still continues to exhibit signs of psychosis.

2. <u>History of Physically Aggressive Behavior</u>: (FIMS - Aggression/Dangerousness to Others)

A. Description of Risk Factor and Current Status: Mr. Acquittee has exhibited significant acts of aggression in the past. He reportedly was physically abusive to his wife and had gotten in fights in prison. In addition, his inappropriate sexual behavior appears to have an aggressive component to it. The NGRI act itself involved the stabbing of his father repeated times in the genital area and chest. Psychological assessment indicates that he experiences significant hostility. His paranoia and emotional instability contribute to an increased probability of aggression. This history of aggression and psychological functioning places Mr. Aquittee at risk for future aggression.

B. Means of Addressing Risk Factors: Mr. Acquittee's aggression appears to be, at least partially, related to significant personality disturbance and can be exacerbated by periods of psychosis. It is imperative that Mr. Aquittee remain on his medication to control for emotional instability and distorted thinking. Mr. Acquittee should participate in Anger Management group in which he would identify the triggers to aggression and alternative behaviors. Assumption of responsibility for acts of aggression and for preventing future acts of aggression should be addressed directly with Mr. Acquittee. Individual therapy could assist in helping Mr. Acquittee explore the source(s) of his anger and vent his hostilities in a controlled environment. It should be made clear to Mr. Acquittee that inappropriate aggressive behavior can result in negative outcome for him to include possible legal ramifications. Issues related to sexual aggression are discussed below.

3. <u>History of Sexually Aggressive Behavior</u>: (FIMS - Sexual Assault)

A. Description of Risk Factor and Current Status: The acquittee has a history of inappropriate and aggressive sexual behavior towards females. He reportedly raped his wife and has on four different occasions attempted to grab female staff in the genital area. He has also been described as having approached females aggressively as possible compensation for issues of sexual identity. Past reports indicates that he has exhibited excessive masturbation. This pattern suggests a tendency towards sexually preoccupied aggression that sometimes occurs in conjunction with psychosis.

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B. Means of Addressing Risk Factor: Mr. Acquittee should participate in a complete Sexual Offender Evaluation despite his low score on the RRASOR. Given his past history of aggressive sexual behavior, intervention directed towards assisting the acquittee in more effectively dealing with hostile feelings and aggression, as indicated above may also prove beneficial relevant to his sexual activity. Adherence to his medication regimen is also important. Group work directed towards appropriate sexual conduct in relating to the opposite sex is also recommended, as well as individual psychotherapy to assess, and if appropriate, to intervene relevant to sexual concerns, and identity issues.

4. <u>Denial of Mental Illness</u>: (FIMS - Denial/Lack of Insight)

A. Description of Risk Factor and Current Status: - Mr. Acquittee reportedly tends to minimize and deny his role in his difficulties. Psychological testing indicates he tends to project blame onto others, not accepting responsibility for his actions. He evades questions through becoming circumstantial. He also doubts the necessity of his medication and believes that his behavior during the NGRI incident was justified, e.g., he was acting for God. Therefore the defendant at this time seems to have little insight into his illness. This represents a risk factor in that he may, under similar circumstances to those surrounding the NGRI incident, react in the same manner as he did during the NGRI offense, exhibiting inappropriate aggressive behavior.

B. Means of Addressing Risk Factor: It is recommended that the defendant be maintained on his medication and participate in individual and group therapy to address his denial and minimization of his symptoms. It is important that he develop some insight into the fact that his symptoms can be destructive and are a component of his mental illness.

5. <u>Non-Compliance with Treatment</u>: (FIMS - Noncompliance with Treatment and/or Medication)

A. Description of Risk Factor and Current Status - Mr. Acquittee did not participate in follow-up treatment for mental illness following his discharge from either the MCTC while incarcerated, or from the SRMC. When asked about his legal history during his last admission at the SRMC, he refused to discuss his incarceration, and did not reveal that he was treated for psychosis, or that he was experiencing psychotic symptoms. During the present evaluation, Mr. Acquittee questioned how, in fact, he could be sure that he needed medication, or if he was on the right medication. He has been suspected of "cheeking" his medication in the past. Given this,

it is likely, particularly under stress, that Mr. Acquittee would be at risk for not taking his medication.

B. Means of Addressing Risk Factor: Mr. Acquittee should participate in Symptom Management and Understanding Mental Illness groups in which the importance of accepting the need for psychiatric treatment is addressed. Mr. Acquittee would also learn to identify his symptoms, warning signs of relapse and appropriate interventions for relapse prevention. It is also important that he maintain his medication compliance. Medication compliance should be monitored.

6. <u>Substance Abuse</u>: (FIMS - Substance Abuse)

A. Description of Risk Factor and Current Status: Mr. Acquittee has used alcohol in the past and has been aggressive under the influence of alcohol. He has also reportedly used marijuana in the past. He was drinking alcohol at the time of the NGRI offense. Although he currently does not appear to be experiencing alcohol or substance dependence, any substance use, however, increases the risk of future aggression. Alcohol can disinhibit emotional control and may place one in contact with other individuals who are likely involved with alcohol or drugs and illicit drugs and illegal activity. Also, substance use can impede psychological growth and can cause neurological damage. Given the defendant's history of substance involvement, especially alcohol, and the fact that he was using at the time of the NGRI incident, alcohol use represents a particular risk factor for Mr. Acquittee.

B. Means of Addressing Risk Factor: It is recommended that Mr. Acquittee participate in a Substance Abuse Education and Relapse Prevention group to gain information about the importance of remaining drug and alcohol free, despite the likelihood that he does not suffer from a dependence on alcohol or drugs, at this time. However when the defendant is no longer in a controlled environment, it is particularly imperative that he is not involved with alcohol/substance abuse. At that time, random drug screens may be necessary as well as continued intensive programming for substance abuse depending upon clinical need.

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JF/GW/sdl
February 28, 2001

UPDATED AAB FORMAT

It is generally not necessary for an Updated AAB to have all the components of the Initial AAB due to the fact that it is usually part of a more comprehensive report (e.g., submission to the Forensic Review Panel, Annual Confinement of Hearing Report, etc.) which already contains relevant background information, mental status, and other information that would complete the report as "stand alone." The Updated AAB, when part of another submission/report, should minimally include the following:

1. **Identifying Information**

2. **Risk Factor Updates**

    a. **Description of Risk Factor**
    b. **Update and Current Status of Risk Factor**
    c. **Means of Addressing Risk Factors**

Example AAB Update
Analysis of Aggressive Behavior
Risk Factor Update

Name: Mr. N. Sanity Acquittee
SS#: XXX-XX-XXXX
Date of Birth: 3/17/56
Age: 44
Sex: Male
Reg. #: XXXXXX.003
Marital Status: Divorced
Education: High School
NGRI Offense: Murder
Case No. 99-XXX
Date of NGRI Adjudication: 11/12/1999
Date of Admission: 11/17/1999
Court: Circuit Court City of Smalltown
Judge: Honorable He B. DeJudge
Date of Report: 1/12/2001

Analysis of Aggressive Behavior/Risk Factors:

1. <u>Mental Illness</u>: (FIMS - Major Mental Illness)

A. Description of Risk Factor: Mr. Acquittee has shown a highly atypical pattern of symptoms including paranoid and delusional thinking, sometimes associated with bizarre and ritualistic behavior. He first experienced these symptoms when incarcerated at the age of 39. He denies ever having experienced auditory hallucinations, but reports experiencing delusions that he was receiving messages from the television and radio and beliefs that he could protect himself from persecution by the devil through certain ritualistic behaviors. These symptoms include Threat/Control Override symptoms, in which Mr. Acquittee believes he is threatened by the devil, as well as delusions that were related directly to the NGRI offense.

Mr. Acquittee also shows features of Narcissistic, Borderline, Paranoid and Antisocial Personality disorders, including consistent irresponsibility, impaired empathy for others, careless disregard for the safety of others, impulsivity, an exaggerated concern for how he is perceived by others, and the perception of threat or attack in benign remarks or events. The features of Narcissistic Personality disorder appear most prominent, though he does not meet full diagnostic criteria.

B. Update and Current Status of Risk Factor: Mr. Acquittee currently has been given the diagnosis of Schizophrenia, Paranoid Type. This was determined after further psychological testing, observation and evaluation. His medication has been adjusted accordingly. In January and February of 2000 he showed some difficulty sleeping and expressed paranoid ideas that another patient might be somehow getting urine and feces into his tube of toothpaste. He responded to an adjustment in medication and has not shown psychotic symptoms since February 2000. However, he continues to exhibit some suspiciousness about the motives of others. He has participated in Group Psychotherapy and had individual psychotherapy from January 2000 through June 2000.

C. Means of Addressing Risk Factor: Mr. Acquittee should continue to receive anti-psychotic medication and participate in group therapies designed to help him identify and understand the symptoms of his mental illness. Given Mr. Acquittee's personality features, individual and milieu therapy in the context of external limits on behavior are also recommended Referral for more long-term individual therapy may be considered upon his transfer to the civil facility (XSH). Mr. Acquittee appears to be in need of further hospitalization given that he continues to exhibit some signs of his mental illness, although he has improved.

2. <u>History of Physically Aggressive Behavior</u>: (FIMS- Aggression -Dangerousness to Others)

A. Description of Risk Factor : Mr. Acquittee has exhibited a history of past physical aggression. He reportedly was physically abusive to his wife and participated in many physical altercations while in prison. In addition, he has exhibited inappropriate sexual behavior which seems to have an aggressive component. The NGRI act itself involved the stabbing of his father in the genital area and chest repeatedly. At the time of the Initial AAB, psychological evaluation indicated that Mr. Acquittee has harbored considerable hostility. His paranoia and emotional instability contribute to an increased probability of aggression. This history of aggression and psychological functioning places Mr. Acquittee at risk for future aggression.

B. Update and Current Status of Risk Factor: Mr. Acquittee has not engaged in threatening or physically aggressive behavior at any time during this hospitalization. He has participated in Anger Management and Handling Hassles groups to identify alternative means of dealing with frustration and anger. It appears Mr. Acquittee's risk for aggression increases when he is psychotic with associated delusions and impaired judgment. He may also have some risk for aggression in the context of intimate interpersonal conflict, as in the rape of his estranged wife. He has been compliant with his medication and is beginning to examine the efficacy of medication compliance. He is also involved in individual psychotherapy that focuses on anger management and exploring the sources of his hostilities. Mr. Acquittee continues to exhibit some anger in interpersonal relationships; this could contribute to a risk of future aggression.

C. Means of Addressing Risk Factor: Mr. Acquittee should remain compliant with medication and treatment. Assumption of responsibility for acts of aggression and for preventing future acts of aggression should be addressed directly with Mr. Acquittee in the context of ongoing psychotherapy. He will continue in Anger Management Training both on a group and individual basis. He is also to begin to examine, in individual and group therapy, his interpersonal relationships and his tendency to blame others for his difficulties. Cognitive Behavioral Intervention on an individual and milieu basis has also been initiated as a component of this behavior.

3. <u>Sexually Aggressive Behavior</u>: (FIMS - Sexual Assault)

A. Description of Risk Factor: Mr. Acquittee appears to have a history of sexually aggressive behavior towards females. He has reportedly raped his wife and on four different occasions

attempted to grab female staff in the genital area. He has also been described as approaching females aggressively as possible compensation related to issues of sexual identity. Past reports have indicated that he has exhibited excessive masturbation. This pattern suggests a tendency toward sexually preoccupied aggression, typically in the presence of active psychosis.

B. Update and Current Status of Risk Factor: Mr. Acquittee has not engaged in sexually aggressive behavior since being admitted to the hospital. Mr. Acquittee has also been compliant with medication. Mr. Acquittee has participated in group therapies and individual therapies with emphasis on appropriate interpersonal relating to include interaction with the opposite sex. Mr. Acquittee appears to be gaining some understanding of the impact of his behavior on others and seems to recognize that change in this area would be beneficial. He also participated in a sex offender evaluation, which indicated that he did not suffer from a paraphilia and showed no evidence of experiencing fantasies of sexual aggression. It appears Mr. Acquittee's risk for sexual aggression increases when he is psychotic with associated delusions and impaired judgment. Although he has made gains relevant to this risk factor, he continues to be at risk for inappropriate aggressive sexual behavior, especially should he experience a relapse of psychosis.

C. Means of Addressing Risk Factor: Mr. Acquittee should remain compliant with his medication. He should also continue in individual and group therapies focusing on appropriate sexual behavior and his own sexual issues. Assumption of responsibility for acts of sexual aggression and for preventing future acts of sexual aggression should be addressed directly with Mr. Aquittee in the context of ongoing psychotherapy. It appears that Mr. Acquittee's sexual difficulties may be, in part, a function of compensation for possible sexual identity concerns/inadequacy in the context of psychotic delusions and impaired judgment. He has begun to participate in individual and group therapy directed towards appropriate interpersonal interactions with emphasis on relating to the opposite sex. In individual therapy, he should begin to examine his own sexual issues, to the extent appropriate, given his clinical condition.

4. <u>Lack of Insight/Denial of Mental Illness</u>: (FIMS - Denial/Lack of Insight)

A. Description of Risk Factor: Mr. Acquittee denied and minimized his mental illness, increasing the risk for future relapse. When asked about his legal history during his last admission at the SRMC, he refused to discuss his incarceration and did not reveal that he was treated for psychosis or that he was experiencing psychotic symptoms. During his initial AAB, Mr. Wilson wondered whether he needed medication or if he was on the right medication. Mr. Acquittee did not complete follow-up treatment for mental illness following his discharge from either the MCTC while incarcerated or from the SRMC.

B. Update and Current Status of Risk Factor: Mr. Acquittee has participated in Symptom Management and Understanding Mental Illness groups in which he has acknowledged having a mental illness and has identified warning signs of relapse. He has been compliant with medication and treatment throughout his admission to the Forensic Unit. He appears to be gaining some insight into his mental illness and need for treatment.

C. Means of Addressing Risk Factor: Mr. Acquittee should participate in group therapies in which the importance of accepting the need for psychiatric treatment is addressed. He should be the subject of regular monitoring through blood tests for medication compliance. The acquittee is continue in Symptom Management Group as well as individual therapy to address his tendency to deny and minimize his problems, although he has shown some progress in this area.

5. <u>Treatment Non-Compliance</u>: (FIMS - Non-compliance with Treatment and/or Medication)

A. Description of Risk Factor: Mr. Acquittee did not participate in follow-up treatment with the community mental health center in the past. When asked about his psychiatric history, he did not reveal that he had been treated for psychosis in the past. He also periodically believes that he does not need his medication or that he is not on the right kind of medication. Given this, Mr. Acquittee is at risk for non-compliance (to include medication) with treatment in the future.

B. Update and Current Status of Risk Factor: Mr. Acquittee has participated in Symptom Management and Understanding Mental Illness groups and appears to be gaining some understanding of the need for him to maintain an accurate medication regimen and to participate in therapy. He continues, at times, to question whether or not he has been prescribed the correct medication. Given this, he continues to remain at some risk for non-compliance.

C. Means of Addressing Risk Factor: Mr. Acquittee should continue to participate in individual and group therapy which would focus on the importance of accepting the need for psychiatric treatment. Medication monitoring is also recommended. Mr. Acquittee needs to learn to identify warning signs of relapse and appropriate interventions for relapse prevention.

6. <u>Substance Abuse</u>: (FIMS - Substance Abuse)

A. Description of Risk Factor - Although, Mr. Acquittee does not appear to meet criteria for alcohol or substance dependence, any substance use, however, increases the risk for future aggression. Mr. Acquittee was drinking at the time of the NGRI offense. He has used alcohol prior to this, and has been aggressive while under the influence of alcohol. He has also reportedly used marijuana. Alcohol can disinhibit emotional controls, may contribute to exacerbation of mental illness. Given Mr. Acquittee's history of aggression and alcohol use, this represents a particular risk for him.

B. Update and Current Status of Risk Factor: Mr. Acquittee has participated in the Substance Abuse Relapse Prevention group and in Symptom Management group in which the importance of abstinence for maintaining a stable mental status was emphasized. Involvement with AA has been initiated. He appears to have gained some understanding of the relationship between the use of alcohol and his behavior, i.e., aggression. However, he continues to minimize his involvement with alcohol. This places Mr. Acquittee at continued risk for inappropriate substance involvement.

C. Means of Addressing Risk Factor: Mr. Acquittee should continue to participate in groups which support abstinence and is starting to make connection with the AA community. Once he earns independent privileges, Mr. Acquittee should be subject to random occasional blood or urine screens for drugs and alcohol. Also, when and if Mr. Acquittee returns to the community random drug screens may be necessary as well as continued programming for substance abuse, depending on clinical need at that time.

7. Use of a Weapon: (FIMS - Weapons)

A. Description of Risk Factor: Use of a weapon has been added as a risk factor given that the acquittee used a knife in committing the past NGRI offense. Mr. Acquittee used a steak knife to kill his father. He does not have a history of possessing or using weapons, but individuals who use a weapon in the commission of a crime are at risk for an increasing level of aggression in future crimes.

B. Update and Current Status of Risk Factor: Mr. Acquittee has not attempted to possess or fashion weapons during this admission. He has acknowledged that he will be prohibited from owning or possessing weapons in the future.

C. Means of Addressing Risk Factor: Mr. Acquittee will be reminded that he is not to have weapons in his possession as a component of his NGRI status and doing so could have negative outcomes to include legal consequences. Mr. Acquittee should be the subject of occasional searches of his person and property to insure that he is not in possession of weapons.

8. Community Supports: (FIMS - Family/Psychosocial Issues)

A. Description of Risk Factor: This risk factor was added after additional evaluation of Mr. Acquittee's familial dynamics and social supports. Although Mr. Acquittee was in frequent contact with his parents prior to the NGRI offense, he did not use this support to his advantage. He did not comply with the recommendations for outpatient treatment, and had no support system of mental health services.

B. Update and Current Status of Risk Factor: Mr. Acquittee has been able to reconcile with his mother in the wake of the murder of his father (the NGRI offense) with therapeutic visits to the Forensic Unit. The patient has acknowledged his understanding of the importance of establishing and maintaining a support network through the local Community Services Board in Smalltown.

C. Means of Addressing Risk Factor: Mr. Acquittee would benefit, in the future, from being transferred to XSH where he could begin to establish ties with the local Community Services Board during the graduated release process. His relationship with his mother will be explored and reinforced with therapeutic visits. In the meantime, individual and group therapy will focus on appropriate interpersonal behavior, which should increase his opportunities for forming positive social supports both within and outside the hospital.

9. <u>Hypothyroidism</u>: (FIMS - Medical Issues)

A. Description of Risk Factor : This risk factor was added after medical evaluation which indicated Hypothyroidism. Mr. Acquittee, when questioned about these findings, stated that he has a history of hypothyroidism first diagnosed in the mid-1980s (but not identified when first admitted to the Forensic Unit). While not directly related to an increased risk of aggression, hypothyroidism can include such psychiatric symptoms as depression, poor appetite, slowed speech, apathy, impaired memory, and, in rare cases, delusions and hallucinations.

B. Update and Current Status of Risk Factor: Mr. Acquittee's hypothyroidism has been treated with 0.15 mg of Levothyroxin daily, and has been stable. He has been compliant with medication and shown no symptoms during this admission.

C. Means of Addressing Risk Factor: Mr. Acquittee should remain compliant with his treatment for hypothyroidism and have regular physical checkups.

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References

Appelbaum, P. S., Robbins, P. C., Monahan, J. (2000) Violence and delusions: Data from the MacArthur Violence Risk Assessment Study. *American Journal of Psychiatry*, 157, 566-572.

Bell, C. C. (Ed.) (2000) *Psychiatric Aspects of Violence: Issues in Prevention and Treatment* Vossey-Bass, Inc., San Francisco, CA.

Binder, Renee L. (1999) Are the mentally ill dangerous? *Journal of the American Academy of Psychiatry and Law*, 27, 189-201.

Boer, D. P., Wilson, R. J., Gauthier, C. M. & Hart, S. D. (1997) Assessing risk of sexual violence: Guidelines for clinical practice. In Webster, C. D. & Jackson, M. A. (Eds.) *Impulsivity: Theory, Assessment and Treatment* (pp. 326-342), the Guilford Press, New York, NY.

Borum, R., Fein, R., Vossekuil, B. & Berglund, J. (1999) Threat assessment: Defining an approach for evaluating risk of targeted violence. *Behavioral Sciences and the Law*, 17, 323-337.

Dolan, M. & Doyle, M. (2000) Violence risk prediction: Clinical and actuarial measures and the role of the Psychopathy Checklist. *British Journal of Psychiatry*, 177, 303-311.

Grisso, T., Davis, J., Vesselinov, R., Appelbaum, P. S. & Monahan, J. (2000) Violent thoughts and violent behavior following hospitalization for mental disorder. *Journal of Consulting and Clinical Psychology* 68, 388-398.

Hanson, C. K. & Thorton, D. (2000) Improving risk assessment for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior*, 24, 119-136.

Hare, R. D. (1999) Psychopathy as a risk factor for violence. *Psychiatric Quarterly*, 70, 181-197.

Hare, R. D. (1998) The Hare PCL-R: Some issues concerning use and misuse. *Legal and Criminal Psychology*, 3, 99-119.

Hare, R. D., Cooke, D. J., & Hart, S. D. (1999) Psychopathy and sadistic personality disorder. In Millon, T. & Blaney, P. H. (Eds.) *Oxford Textbook of Psychopathology* (pp. 555-584), Oxford University Press, New York, NY.

Hare, R. D., Forth, A. E. & Strachan, K. E. (1992) Psychopathy and crime across the lifespan. In Peters, R. D., McMahon, et at (Eds.) *Aggression and Violence Throughout the Lifespan* (pp. 285-300) Sage Publications, Inc., Thousand Oaks, CA.

Hare, R. D. & Hart, S. D. (1993) Psychopathy, mental disorder and crime. In Hodgins, S. (Ed.) *Mental Disorder and Crime* (pp. 104-115), Sage Publications, Inc., Thousand Oaks, CA.

Harris, G. T., Rice, M. E., & Quinsey, V. L. (1993) Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior,* 20, 315-335.

Hart, S. D., Forth, A. E. & Hare, R. D. (1990) Performance of criminal psychopaths on selected neurological tests. *Journal of Abnormal Psychology,* 99, 374-379.

Heilbrun, K., Hart, S. D., Hare, R. D., Gustafson, D., Nunez, C. & White, A. J. (1998) Inpatient and post discharge aggression in mentally disordered offenders: The role of psychopathy. *Journal of Interpersonal Violence,* 13, 514-527.

Heilburn, K. (1997) Prediction versus management models relevant to risk assessment: The importance of legal decision-making context. *Law and Human Behavior*, 21, 347 – 359.

Hemphill, J. P., Hare, R. D. & Wong, S. (1998) Psychopathy and recidivism: A review. *Legal and Criminal Psychology,* 3 , 139-170.

Kernberg, O. F. (1992) *Aggression in Personality Disorders and Perversions.* Yale University Press, New Haven, CT.

Kropp, P. R. & Hart, S. D. (1997) Assessing risk of violence in wife assaulters: The Spousal Assault Risk Assessment Guide. In Webster, C. D. & Jackson, M. A. (Eds.) *Impulsivity: Theory, Assessment and Treatment* Guilford Press, New York, NY.

McNeil, D. E. & Binder, R. L. (1994) Relationship between acute psychiatric symptoms, diagnosis, and short-term risk of violence. *Hospital Community and Psychiatry,* 45, 133-137.

Michaud, S. G. & Hazelwood, R. (1998) *The Evil that Men Do*. St. Martin's Press, New York, NY.

Meissner, W. W. (1988) *Treatment of Patients in the Borderline Spectrum.* Jason Aronson, Inc. Northvale, N. J.

Meissner, W. W. (1986) *Psychotherapy and the Paranoid Process*. Jason Aronson, Inc. Northvale, N. J.

Meloy, J. R. (1988) *The Psychopathic Mind*. Jason Aronson, Inc. Northvale, N.J.

Monahan, J., Steadman, H. J., Appelbaum, P. S., Robbins, P. C., Mulvey, E. P., Silver, E., Roth, L. H. & Grisso, T. (2000) Developing a clinically useful actuarial tool for assessing violence risk. *British Journal of Psychiatry,* 176, 312-319.

Monahan, J. & Steadman, H. J. (1994) *Violence and Mental Disorder: Developments in Risk Assessment.* University of Chicago Press; Chicago, IL

Quinsey, V. L., Harris, G. T., Rice, M. E. & Cormier, C. A. (1998) Violent Offenders: *Appraising and Managing Risk.* American Psychological Association; Washington, D.C.

Roesch, R. & Hart, S. D. (1999) *Psychology and the Law: The State of the Discipline.* Kluner Academic/Plenum Publishers; New York, NY.

Screenivosan, S., Kirkish, P., Shoptaw, S., Welsh, R. K. & Ling, W. (2000) Neuropsychological and diagnostic differences between recidivistically violent not criminally responsible and mentally ill prisoners. *International Journal of Law and Psychiatry,* 23, 161-172.

Silver, E., Mulvey, E. P. & Monahan, J. (1999) Assessing violence risk among discharged psychiatric patients: Toward an ecological approach. *Law and Human Behavior,* 23, 237-255.

Skeem, J. L., Mulvey, E. P., & Lidz, C. W. (2000) Building mental health professionals' decisional models into tests of predictive validity: The accuracy of contextualized predictions of violence. *Law and Human Behavior,* 24, 607-628.

Soyka, M. (2000) Substance misuse, psychiatric disorder and violent and disturbing behaviour. *British Journal of Psychiatry,* 176, 345-350.

Soyka, M. (1999) Substance abuse as a risk factor for violence in major mental disorders. *Archives of General Psychiatry,* 56, 582.

Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H., & Silver, E. (1998) Violence by people discharged from acute psychiatric inpatient facilities and others in the same neighborhoods. *Archives of General Psychiatry,* 55, 393-401.

Steadman, H. J. Silver, E., Monahan, J., Appelbaum, P. S., Clark-Robbins, P., Mulvey, E. P., Grisso, T., Roth, L. H. & Banks, S. (2000) A classification tree approach to the development of actuarial violence and risk assessment tools. *Law and Human Behavior,* 24, 83-100.

Taylor, P. J., Garety, P., Buchanan, A., Reed, A., Wessely, S., Ray, K., Dunn, G. & Grubin, D. (1994) Delusions and violence. In Monahan, J. & Steadman, H. J. (Eds.), *Violence and Mental Disorder: Developments in Risk Assessment*. (pp. 161-182). University of Chicago Press; Chicago, IL.

Tengstroem, A., Grann, M., Langstroem, N. & Kullgren, G. (2000) Psychopathy (PCL-R) as predictor of violent recidivism among criminal offenders with schizophrenia. *Law and Human Behavior*, 24, 45-58.

Webster, C. D., Douglas, K. S., Eaves, D. & Hart, S. D. (1997) HCR-20: *Assessing Risk for Violence.* Mental Health, Law and Policy Institute, Simon Fraser University. Burnaby, B.C., Canada.

RISK FACTOR CATEGORIES FOR FIMS

1 DEMOGRAPHIC/STATIC FACTORS

2 PSYCHOPATHY

3 MAJOR MENTAL ILLNESS

4 DEMENTIA/OTHER NEUROLOGICAL DISEASES

5 PERSONALITY DISORDER/TRAITS

6 TRAUMATIC HEAD INJURY

7 COGNITIVE IMPAIRMENT/MENTAL RETARDATION

8 THREAT CONTROL OVERRIDE SYMPTOMS

9 DENIAL/LACK OF INSIGHT

10 SUBSTANCE ABUSE

11 SUICIDE/SELF INJURY

12 ESCAPE

13 WEAPONS

14 AGGRESSION/DANGEROUSNESS TO OTHERS

15 SEXUAL ASSAULT

16 ARSON

17 FAMILY/PSYCHOSOCIAL ISSUES

18. EMPLOYMENT/DAY TIME ACTIVITY ISSUES UPON CONDITIONAL RELEASE

19. FAILURE ON PREVIOUS COMMUNITY RELEASE

20. NONCOMPLIANCE WITH TX. AND/OR MEDICATION

21. MEDICAL ISSUES

22. NON-VIOLENT CRIMINAL BEHAVIOR

23. VICTIMS

Further reading

Gardner, W., Lidz, C.W., Mulvey, E.P., & Shaw, E. C. A comparison of actuarial methods for identifying repetitively violent patients with mental illness. *Law and Human Behavior*, 20, 35-48.

Grisso, T. & Appelbaum, P. (1992). Is it unethical to offer predictions of future violence? *Law and Human Behavior,* 136, 216-221.

Halleck, N.H. & Petrila, J. (1988). Risk management in forensic services. International *Journal of Law and Psychiatry*, 11, 347-358.

Harris, G.T., Rice, M.E., & Cormier, C.A. (1991). Psychopathy and violent recidivism. *Law and Human Behavior,* 15, 625-637.

Harris, G. T., Rice, M.E., & Quinsey, V. L. (1993). Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior*, 20, 315-335.

Klassen, D. & O'Connor, W.A. (1988a). Predicting violence in schizophrenic and non-schizophrenic patients: A prospective study. *Journal of Community Psychology*, 16, 217-227.

Klassen, D. & O'Connor, W.A. (1988b). A prospective study of predictors of violence in adult male mental health admissions. *Law and Human Behavior,* 12, 143-158.

Klassen, D. & O'Connor, W.A. (1988c). Crime, inpatient admissions, and violence among male mental patients. *International Journal of Law and Psychiatry*, 11, 305-312.

Klassen, D. & O'Connor, W.A. (1990). Assessing the risk of violence in released mental patients: A cross-validation study. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 1, 75-81.

Lidz, C.W., Mulvey, E.P., & Gardner, W. (1993). The accuracy of predictions of violence to others. *Journal of the American Medical Association*, 269, 1007-1011.

Link, B.G. & Stueve, C.A. (1994). Psychotic symptoms and the violent/illegal behavior of mental patients compared to community controls. In J. Monahan & H. Steadman (Eds.). *Violence and mental disorder: Developments in risk assessment*. Chicago: University of Chicago Press.

Link, B.G., Andrews, H., & Cullen, F.T. (1992). The violent and illegal behavior of mental patients reconsidered. *American Sociological Review*, 57, 275-292.

Lowenstein, M., Binder, R.L., & McNiel, D.E. (1990). The relationship between admission symptoms and hospital assaults. *Hospital and Community Psychiatry*, 41, 311-313.

McNiel, D.E., Binder, R.L., & Greenfield, T.K. (1988). Predictors of violence in civilly committed acute psychiatric patients. *American Journal of Psychiatry*, 145, 965-970.

Monahan, J. (1981). *Predicting violent behavior: An assessment of clinical techniques*. Beverly Hills, CA: Sage Publications.

Monahan, J. (1993). Limiting therapist exposure to Tarasoff liability: Guidelines for risk containment. *American Psychologist*, 48, 242-250.

Monahan, J. & Steadman, H.J. (Eds.) (1994). *Violence and mental disorder: Developments in risk assessment*. Chicago: University of Chicago Press.

Monahan, J. & Steadman, H.J. (1994). Toward a rejuvenation of risk assessment research. In J. Monahan & H. Steadman (Eds.). *Violence and mental disorder: Developments in risk assessment*. Chicago: University of Chicago Press.

Otto, R. (1992). The prediction of dangerous behavior: A review and analysis of "second generation" research. *Forensic Reports*, 5, 103-134.

Poythress, N.G. (1990). Avoiding negligent release: Contemporary clinical and risk management strategies. *American Journal of Psychiatry*, 147, 994-997.l

Poythress, N.G. (1992). Expert testimony on violence and dangerousness: Roles for mental health professionals. *Forensic Reports*, 5, 135-150.

Steadman, H.J. (1982). A situational approach to violence. *International Journal of Law and Psychiatry*, 5, 171-186.

Swanson, J., Holzer, C., Ganju, V., & Jono, R. (1990). Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area Surveys. *Hospital and Community Psychiatry*, 41, 761-770.

APPENDIX B

COMMUNITY OUTPATIENT TREATMENT

READINESS SCALE

Community Outpatient Treatment Readiness Scale

I. The Community Outpatient Treatment Readiness Scale (COTREI) is a revision of a scale originally developed by Harry R. Eisner, Ph.D. ("Returning the Not Guilty by Reason of Insanity to the Community: A New Scale to Determine Readiness", Bulletin of the American Academy of Psychiatry and the Law, Vol. 17, No.4, 1989, pages 401-413.) Staff at the North Florida Evaluation and Treatment Center in Gainesville, Florida revised the scale to assist them in treatment planning and release decisions for insanity acquittees.

II. Procedures

A. The treatment team staff who work with insanity acquittees shall become familiar with the scale, its values, and its use in the treatment planning and conditional release process. (The article cited above provides background for the scale and its use.)

B. During the first 30 days of the 45 day temporary custody placement, treatment team members shall complete an initial COTREI and discuss the COTREI items during meetings, over the phone, and/or informally.

1. Goals of this discussion

   a. Identify barriers to conditional release,
   b. Resolve differences of opinion, and
   c. Achieve consensus.

2. A preliminary rating for the COTREI may be distributed for each member to review.

3. The appropriate community services board should be included in the development of the initial COTREI.

C. Treatment Planning Meeting: During the initial treatment planning meetings, the treatment team shall work to achieve consensus on

1. What is an acceptable score for each of the 15 items for the individual acquittee?

This process will engage the team in determining how high a standard to hold the acquittee to prior to making recommendations for increased privileges conditional release.

2. What is the acquittee's current score on each of the 15 items?

   The discrepancy between the acceptable score and the current score should guide the team in identifying those items that are barriers to conditional release.

3. Prioritize barriers for treatment and conditional release.

4. Determine what treatment, activities, and other services to provide.

D. The Forensic Coordinator of Central State Hospital shall provide the completed initial COTREI to the two evaluators appointed by the Commissioner to perform the temporary custody evaluations as soon as they have been completed. This information will be helpful to the temporary custody evaluators in making assessments and recommendations to the court regarding disposition.

III. Updates to the Initial COTREI

A. The acquittee's treatment team shall update the COTREI within 30 days prior to the submission of any requests to the Forensic Review Panel for increased freedom within the facility and/or access to the community. This includes requests for

1. Transfer from the forensic unit to civil units,

2. Ground privileges (escorted by facility staff or unescorted),

3. Community visits,

4. Conditional release,

5. Conditional release from temporary custody, and

6. Release without conditions.

B. The initial COTREI, and subsequent COTREI updates shall be included in each submission to the Forensic Review Panel.

IV. All previous and updated COTREI scores shall be provided to the Forensic Review Panel each time a request is made for greater freedom and access to the community.

A. The initial COTREI, each update of the COTREI scores, and any comments must be signed and dated.

B. The summary included in the referral package to the Forensic Review Panel should note any significant changes to the COTREI and any discrepancies in COTREI comments as compared to the rest of the referral package.

Appendix B.5

Community Outpatient Treatment Readiness Evaluation Instrument

Scale Values

August 30, 1995

Table of Contents

Reference:

Adapted from "Returning the Not Guilty by Reason of Insanity to the Community: A New Scale to Determine Readiness" by Harry Eisner, Ph.D., in the Bulletin of the American Academy of Psychiatry and the Law, Vol. 17, No.4, 1989.

Item 1: Illness

It is best for acquittees to show a longstanding remission of symptoms that does not break down under stress. Many acquittees, for example those with chronic illness and long term drug abusers, will not show a full remission of symptoms. If the continued illness will not be problematic in the proposed setting, then these individuals can be viewed as strong candidates for outpatient treatment.

1. No signs of illness for at least six months. Remission appears durable.
2. No signs of illness for at least three months, or continued minimal predisposing factors (occasional depression, significant family conflicts when patient not planning to return to parents).
3. Continued residual signs of illness that will not interfere in proposed life style (occasional, benign hallucinations, moderate social isolation or signs of poor judgment, moderate authority conflicts). Also individuals with predictable, readily recognizable, slowly developing repeated decompensations.
4. Episode of active illness brought under control within last three months. More pronounced residual signs (more open suspiciousness, frequent authority conflicts, nonorganic problems with concentration). Also individuals who may remain stable for at least six months, but have sudden unpredictable onset of illness. Fragile remissions.
5. Actively ill or unpredictable, readily developing recurrent episodes of illness.

Item 2: Behavior

In order to be successful in community placement, an acquittee must be able to get along with others and accept structure imposed by program personnel. Behavior problems can also act as a signal of continued illness. This item screens for individuals with substantial problems in this area without heavily penalizing those with less serious but persistent problems in adapting to the hospital environment.

1. Follows unit routine without problem. Contributes actively and energetically to maintenance of unit. Strives to participate in ward government and community meetings. No rule-breaking on grounds. (This category applies to actively involved residents, not those who avoid problems because of passivity.) Conflicts with staff and peers handled constructively.
2. Follows rules on and off unit. Does assigned tasks and follows directions without undue complaint. Conflicts with staff and peers are minimal and generally avoided by using good judgment and forbearance.
3. Minor conflicts occur on a regular basis, acquittee accepts partial responsibility. Minor rule-breaking and testing the limits with appropriate response to structuring and discipline.
4. Minor conflicts occur regularly and acquittee will not accept responsibility or resists structuring and discipline. Single major episode of acting out within last six months. Strong resistance to unit routine or rules without major acting out.
5. Repeated major incidents of rule-breaking or acting out. Behavior suggests general unwillingness or inability to conform.

Item 3: Substance Abuse

This is a crucial item for many acquittees and may receive emphasis by reviewers. It is difficult to know if any real change of patterns of abuse have occurred while an individual is hospitalized. This item suggests a number of clues that may be helpful in determining if change has occurred. Score 1 if substance abuse has not been identified as a problem.

1. Convincing awareness of how drug use is or can be connected to mental illness. Active, motivated participation in AA and/or NA. Negative monthly drug screens for six months. Avoids drug users, sellers.
2. Knows relationship between drug use and mental illness. Good attendance in AA and NA, adequate participation. Negative monthly drug screens for at least six months. Avoids drug users and sellers.
3. Aware of danger potential of drugs but minimizes importance of use of marijuana and/or alcohol. Limited participation in AA and/or NA, although attendance is adequate. May have friends who use or sell drugs.
4. Considers above areas with help. Has difficulty seeing importance of general self-exploration. Has considered significant areas related to crime but behavioral change is minimal or fragile.
5. Resists self-exploration. Very threatened by suggestion of need to change. Talks about crime but little change in thinking or behavior, or only superficial change.

Item 4: Treatment Attendance

This item emphasizes attempts to use treatment productively, not progress. Treatment participation provides a degree of external control, while motivation for treatment offers evidence of an individual's commitment to change.

1. Rarely, if ever, misses treatment activities. Actively participates and to best of ability tries to understand self and illness. Knows and understands problem list and makes efforts to relate issues to life and address them in treatment. May pursue reading and family therapy on own.
2. Attends therapy regularly. Talks about self and crime and is willing to consider therapist's perspective on illness. Does recommended exercises.
3. Misses occasionally but cooperates when present. May have difficulty speaking seriously about self, and may become bored when others are speaking. Invested in appearing "well" and resists looking at self from new perspective.
4. Misses group regularly or frequently leaves early. Strongly invested in appearing "well" and contributions center only on how well resident is doing. May argue with therapist or try to focus on irrelevant issues, such as injustices perpetrated by staff. Resists treatment planning process.
5. Refuses group, or attends very sporadically or only for short time. Hostile to treatment planning process. If attends group, uses as an opportunity to lecture, showing no interest in self-exploration.

Item 5: Medication

When medication is necessary, active involvement with it through consultation with the physician, awareness of side effects, and knowledge of function of medications, implies better compliance and more successful outcome. Score 1 if no medication is prescribed.

1. Takes medication willingly. Knows type, dosage, and function. Consults productively and actively with physician regarding medication. Accepts side effects, including restructuring of

activities. (Also score 1 if no medication for last six months.)

2. Takes medication regularly. Knows type, dosage, and function. Cooperates in medication review. Accepts side effects.
3. Takes medication regularly. Knows medication name and function. Does not express resentment, although not adjusted to side effects.
4. Takes medication but regularly needs reminder. Knows only general function of medication. Resents side effects. Talks about being medication-free after leaving hospital.
5. Needs frequent reminder and "mouth check" to be sure medications are taken. Does not know medication name, dosage, or function. Very uncomfortable with side effects or need to take medications.

Item 6: Self-Awareness

This item addresses what is often referred to as "insight". The item attempts to make the term more concrete, while keeping the focus on crime and illness. Behavior is also emphasized.

1. Through hospital experiences, has developed a deep awareness of needs, motivation, emotional and behavioral responses, interpersonal style, interests, family conflicts, coping style, strengths, limitations. Has carefully considered areas of significant conflict and demonstrated change which has led to substantially more effective observable or easily elicited behavior.
2. Has explored above areas and recognizes the importance of continued self-exploration, although may still lack substantial self-awareness. Has, however, thoroughly explored areas directly related to crime and illness and demonstrates change leading to change in observable behavior.
3. Willing to consider self, as above, but requires much work to do so. With help explores significant areas related to crime and illness, with some behavioral change.
4. Considers above areas with help. Has difficulty seeing importance of general self-exploration. Has considered significant areas related to crime but behavioral change is minimal or fragile.
5. Resists self-exploration. Very threatened by suggestion of need to change. Talks above crime but little change in thinking or behavior, or only superficial change.

Item 7: Understands Signs of Illness

Because , for these acquittees, illness was a primary cause of dangerous behavior, recognizing and responding appropriately to illness is extremely important. This item asks the acquittee to play a major role in the detection of illness.

1. Can describe own active illness in full detail. Can describe at least six significant early and middle signs of illness. Recognizes their presence in own original and later occurring illness.
2. Knows prominent features of own illness. Can give good description of several important early and middle warning signs and can give examples from illnesses.
3. Can identify one or two prominent features of own illness. Speaks generally about warning signs but can=t identify in own illness.
4. Knows general prominent features and warning signals of illness but much difficulty relating to own illness.
5. Vague notions of mental illness. Little awareness of own illness. Rote repetition of general signs and warning signals.

Item 8: Life Style Adjustment

Environmental stress plays an extremely important role in the recurrence of illness. This item addresses the acquittee's ability to recognize stress and its causes, and make changes that will keep stressors under control.

1. Can specify environmental stressors that contributed to illness. Can specify dysfunctional patterns of thinking, feeling, and responding that magnified environmental stressors. Demonstrates change in dysfunctional patterns of thinking, feeling, responding. Future plans realistically address relevant stressors originating in family, work, etc.
2. Identifies and has worked to change at least one prominent environmental factor. One clear change in at least one dysfunctional pattern relevant to illness. Demonstrated competence in handling probable stressors. Future plans may be vague but generally acknowledge potential environmental and internal stressors.
3. Identifies significant environmental stressors but needs help with restructuring, although responds favorably to guidance. Showing change in dysfunctional patterns of thinking, feeling, acting, although additional strengthening needed. Working to devise constructive future plans.
4. General awareness of relationship of environmental factors and stress but difficulty specifying for self. Able to recognize dysfunctional patterns but control and change is tenuous. (Example: Regular angry outbursts or depressive episodes.) Future plans vague.
5. Very limited or only rote awareness of relationship of environment to stress. (The "not me" type.) Still focuses on others= need to change ("I wouldn't have to behave this way, if they....").

Item 9: Concern About Becoming Ill

Since, for these acquittees, illness was a primary cause of dangerous behavior, recognizing and responding appropriately to illness is extremely important. This item asks that the resident know the potential danger of becoming ill.

1. Shows appropriate concern about becoming ill. Appropriate affective response to effects on life, dangerousness, and self-image.
2. Appropriate concern about illness, but may be more emotionally detached. Fewer specific concerns about effects on life, but clearly motivated to avoid dangerousness.
3. Concerned about future illness but difficulty accepting the possibility of recurrence. Same for dangerousness. Motivation to avoid illness is good, although may not specify reason.
4. Minimizes possibility of recurrence of illness. Minimizes possibility of future dangerousness.
5. Believes recurrence of illness is impossible or extremely unlikely.

Item 10: Plans for Reemergence of Illness

Since, for these acquittees, illness was a primary cause of dangerous behavior, recognizing and responding appropriately to illness is extremely important. This item requires adequate plans for coping with illness if it recurs.

1. Family and friends are aware of symptoms and prepared to alert mental health personnel if necessary. Acquittee can be expected to establish good contact with Community Service Board (CSB) personnel. Acquittee, family, and friends aware of emergency services. Resident trusts mental health personnel and knows importance of early intervention.
2. Limited independent support system (i.e., family and friends) but can be expected to make good

contact with CSB personnel. Aware of emergency services. Knows importance of early intervention. Shows good trust of mental health personnel.

3. Can be expected to rely on at least one responsible friend or family member, and make good contact with at least one member of the CSB community. Knows importance of early intervention.
4. May have adequate support, as in 3., but prefers to make early attempts to control illness on own. Has good potential support system, but difficulty with trust prevents effective use of support system.
5. Limited support and poor contact with mental health professionals. Adequate support but very mistrustful. Strong belief that mental illness can be self-controlled ("Now I'll know that the voices aren't real").

Item 11: Relationship of Illness to Crime

This item is an important adjunct to the items on recognizing illness. The various motivations to avoid illness that are suggested in this item are indicators of internal control.

1. Can identify personal dynamics that predispose to illness and commission of crime.
2. Difficulty identifying predisposing dynamics, although open to work in this area. Can describe affective states or distortions of reality produced by illness and understands how these distortions or states are linked to crime.
3. Can describe affective states or distortions of reality produced by illness and understands how these distortions or states are linked to crime. Resists idea of predisposing factors.
4. Knows that illness leads to loss of control but has difficulty identifying specific distortions or affective states.
5. Believes crime is independent of illness, although may acknowledge being ill at time of crime.

Item 12: Acceptance of Responsibility for Crime

Accepting responsibility can act as a cornerstone for change, a sign that change has occurred, or a motivating factor in the avoidance of future problems. As a measure of acceptance of responsibility, this item asks that the acquittee be willing to talk about the crime in detail. Affective response to the material is expected, but the nature and timing of that response can be quite varied.

1. Able to provide clear description of crime with roles of relevant factors such as drugs, aspects of illness, etc. Documentation that resident has displayed appropriate emotional response to the material.
2. May not remember all details of crime but accepts responsibility. Able to relate relevant factors as above. Appropriate emotional response as above.
3. Reluctant to describe crime and other efforts to distance. When questioned will provide detail. Embarrassment and other attempts at emotional distancing.
4. Focuses on lack of importance of talking about crime ("I've told the story so many times"). Needs to share blame with family, environment, drug use. Minimizes impact of crime ("I'd feel sorry, but...).
5. Will not talk about crime or does so glibly without assigning importance. Blames others or environment and may show anger attached to blaming.

Item 13: Need to Continue Treatment

In recognition of the often cyclic nature of mental illness, it is important for acquittees to continue contact with a mental health support system for an extended period. Continued treatment is also necessary because many issues of daily living can not be addressed in the relative isolation of the hospital setting.

1. Shows consistent interest and progress in therapy and is motivated to pursue treatment following release.
2. Attempts to use therapy may meet with only moderate success, but good cooperation and strong recognition of continued need of preventive supervision.
3. Prefers to view self as not needing support services, but when approached properly maintains investment in treatment. Has a good history of in-hospital treatment participation.
4. Believes that illness is well-controlled and may only be willing to participate in medication review. Although may attend therapy, consistently resistant to therapeutic intervention, either passively or actively. If there is any meaningful participation, it only occurs with a specific therapist.
5. Looks on hospital experience as punishment and looking forward to "topping out." Willing to accept community treatment only as a rapid means of exiting from the hospital.

Item 14: Future Plans

Working toward personally satisfying, achievable goals can have a positive influence on post-hospital adjustment.

1. Has constructive and achievable goals for living, work, school, family. Has made initial steps in hospital toward achieving goals.
2. At least one clearly defined, well-conceived goal that will help organize acquittee's life. Steps toward goal started.
3. Goals sound realistic but steps toward goal vague or initiated only with difficulty.
4. Goals are vague or deferred, even though acquittee shows motivation to avoid past errors.
5. Impractical, unachievable, fantasy-based plans or goals that fail to acknowledge need to avoid past difficulties (e.g., "I think I can handle my mother now" even though no significant contact has occurred).

Item 15: Accepts Community Outpatient Treatment Restrictions

Most revocations of community treatment status are due to breaking program rules. The ability to understand and adjust creatively to the rules is an important determinant of success in community treatment.

1. Understands rules and shows ability to creatively adjust life-style to rules.
2. May question rules and experience as limiting but willing to follow rules because will lead to achievement of long-term goals.
3. Finds rules to be limiting and shows occasional opposition. Generally willing to follow rules and responds well to guidance.
4. Although no outright rule breaking, persistent challenging of authority and stretching of limits.
5. Can not understand rules. Strong oppositional tendencies.

Appendix B.12

COMMUNITY OUTPATIENT TREATMENT READINESS EVALUATION INSTRUMENT

Item		**Rating**
1	Illness	1 2 3 4 5
2	Behavior	1 2 3 4 5
3	Substance Abuse	1 2 3 4 5
4	Treatment Attendance	1 2 3 4 5
5	Medication	1 2 3 4 5
6	Self-Awareness	1 2 3 4 5
7	Understands Signs of Illness	1 2 3 4 5
8	Lifestyle Adjustment	1 2 3 4 5
9	Concern about Becoming Ill	1 2 3 4 5
10	Plans for Reemergence of Illness	1 2 3 4 5
11	Relationship of Illness to Crime	1 2 3 4 5
12	Acceptance of Responsibility for Crime	1 2 3 4 5
13	Need to Continue Treatment	1 2 3 4 5
14	Future Plans	1 2 3 4 5
15	Accepts Community Outpatient Treatment Restrictions	1 2 3 4 5

COMMENTS (Please list relevant item number next to each comment):

_____

_____

_____

_____

_____

_____
SIGNATURE

_____ _____
TITLE **DATE COMPLETED**

APPENDIX C

WORKING WITH THE VIRGINIA COURTS

Working With The Virginia Courts

I. Understanding the Law

A. Constitutional law: Virginia and United States Constitutions establish principles of law

B. Statutory law: legislatures (Virginia General Assembly and the U.S. Congress) enact statutes which are collected in codes (Virginia Code and U.S. Code, respectively)

C. Administrative law: government agencies promulgate regulations on authority delegated by legislatures (e.g., Human Rights Regulations)

D. Case law: appellate courts resolve questions in the law not made clear elsewhere; appellate decisions establish precedent that trial courts within the same jurisdiction must follow

E. Federal law may supersede any state law in conflict if it is specifically designed to preempt state law.

II. The Court Systems

A. Organization of Virginia Courts (see flow chart in this chapter)

1. District Courts

a. General District Courts
   (1) civil trials involving relatively small claims
   (2) misdemeanor trials (less serious criminal offenses)
   (3) felony preliminary hearings (more serious criminal offenses)
   (4) civil commitment and emergency revocation of NGRI conditional release (district court judges or "special justices")

b. Juvenile and Domestic Relations District Courts
   (1) delinquency and status offenses
   (2) custody, support of children
   (3) crimes against children or within families (preliminary hearings in felony cases, trials in misdemeanor cases)
   (4) concurrent jurisdiction for commitment of adults with general district court (' 16.1-241 B.)

2. Circuit Courts

    a. Civil cases involving relatively large claims
    b. Felony trials
    c. Misdemeanor "appeals" (new trial)

3. Court of Appeals

    a. No trials
    b. Hears appeals on the record from circuit court decisions

4. Supreme Court

    a. No trials
    b. Hears appeals on the record from trial court decisions and decisions of the Court of Appeals, in some cases

B. Federal courts hear federal cases.

1. Trials in cases arising under federal law (e.g., defendants charged with federal crimes or diversity of citizenship cases involving citizens from different states)

2. Appeals involving federal claims (e.g., violation of constitutional rights)

3. Federal insanity acquittees committed to federal facilities under federal law

C. Most crimes are prosecuted in state courts.

III. Working Effectively with the Courts

A. Knowing the players

1. Commonwealth's attorney: prosecutor

2. Defense attorney may be

    a. The public defender in some Virginia county/city jurisdictions,
    b. A court-appointed attorney, or
    c. Employed by defendant

3. Magistrate: judicial officer who issues warrants, sets bail, and issues temporary detention orders

4. Special Justice: attorney appointed to serve as civil commitment judge

5. Clerk: controls docket, maintains records

B. Communicating with the courts: general rules

1. Stay relevant

2. Do not give opinions you cannot support with data

3. Do not give opinions outside your area of expertise

4. Be concise

5. Watch for jargon: define, explain, or avoid

   a. Diagnostic labels (e.g., schizophrenia)
   b. Mental status terminology (e.g., affect)
   c. Medication names (e.g., Mellaril)

6. Stay calm and try not to be intimidated by the adversarial nature of the courts

C. Communicating with the courts: in writing

1. Address correspondence to the judge to "The Honorable (name of judge)"

2. Organize reports carefully

3. Keep facts separate from opinions and recommendations

4. Provide the source for facts (e.g., "The acquittee's brother reported that.....")

5. Support opinions and recommendations with clear rationale

D. Communicating with the courts: orally

1. As a "fact witness"

   a. Present just the facts
   b. Do not present inferences or opinions

2. As an "expert witness"

   a. May present inferences and opinions if based on "specialized" clinical knowledge or skills that will add to what the court would

be able to discern for itself

b. Requires qualification as an expert
   (1) educational requirements vary according to issues asked to address
   (2) specialized training and experience (such as evaluating/treating defendants, offenders, NGRI acquittees)
   (3) appropriate evaluation procedure
c. Speak only in response to questions; do not volunteer information
d. Say what you know and acknowledge what you do not know

APPENDIX D

COMMISSIONER APPOINTED EVALUATIONS

FOR THE COURT

Commissioner Appointed Evaluations For The Court

The attached NGRI evaluation emphasizes a broadly based assessment approach. Depending on individual considerations, various sections in the outline may be covered in more or less detail. For example, evaluations during temporary custody regarding newly admitted acquittees may emphasize background data in order to inform the court as fully as possible. For longer term patients and evaluations after petitions for release, the court may be well aware of much background material, and recent adjustment information would be an area of inquiry having greater importance for dispositional considerations. Psychometric information, as determined by individual cases, may be useful to obtain and include (e.g., MMPI, WAIS, Brief Psychiatric Rating Scale, Psychopathy Checklist, etc.)

A specific section should be devoted to an assessment of risk of future aggression. The outline suggests several factors which should be considered in such an assessment, including identification of risk factors based on the NGRI offense and other aggressive incidents in the acquittee's history. See Initial Analysis of Aggressive Behavior and AAB Updates (see **Appendix A**). Consideration of the offense for which the NGRI individual was acquitted is important because judicial decisions in Virginia have explicitly upheld different commitment standards for insanity acquittees, in part because they have already been shown beyond a reasonable doubt to have committed at least one dangerous act (i.e., the criminal offense for which they were acquitted). It is also appropriate to discuss the limitations and imprecision of assessing risk of future aggression, such as the difficulty of generalizing from one environment (e.g., the hospital) to another environment (e.g., the community).

The community services board and other community treatment providers who treated the acquittee in the past should be contacted for information about the acquittee's course of treatment with them, adherence to community treatment, and the community services board's resources for future conditional release. This is particularly necessary for temporary custody evaluations, and whenever a recommendation for conditional release or release without conditions is being considered.

Based upon background information, clinical data, and risk of future aggression assessments and taking into consideration the factors outlined in ' 19.2-182.3, the evaluation should include summary opinions regarding the acquittee's need for inpatient hospitalization. Provide clear rationales linking background information, assessment, and the ' 19.2-182.3 factors considered to your summary opinion. Tables 2.2, 2.3, and 2.4 clearly outline the criteria and supporting information needed in order to provide opinions regarding an acquittee's need for inpatient hospitalization, eligibility for conditional release, or eligibility for release without conditions. Consult those tables carefully.

Opinions regarding mental retardation should be based upon current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. These criteria require deficits in both level of intellectual functioning and adaptive capacity. See also the definition of mental retardation specified in Virginia Code section 37.1-1, and the criteria established by the AAMR.

Note that the phrase "maximum benefit of hospitalization" is not included in Virginia's criteria for commitment, conditional release, or release without conditions. Opinions regarding disposition of acquittees should be based directly upon the criteria outlined in Virginia Code. Therefore, recommendations based on an acquittee reaching "maximum benefit of hospitalization" should be avoided.

The evaluator shall summarize his or her final recommendation regarding court disposition within the criteria set forth in Virginia Code. The evaluator shall use the language in one of the following three paragraphs to conclude each Commissioner-appointed evaluation:

CONCLUSION A
ACQUITTEE MENTALLY ILL OR MENTALLY RETARDED
AND IN NEED OF INPATIENT HOSPITALIZATION

Based on my evaluation of Mr./Ms. _____ as discussed in this report, it is my opinion that Mr./Ms. _____ is mentally ill/mentally retarded and requires inpatient hospitalization at the present time. Taking into account Mr./Ms. _____'s current mental condition, psychiatric history, risk of aggressive behavior, amenability to outpatient supervision and treatment, and other relevant information, I believe that if Mr./Ms. _____ is not hospitalized, there would be a significant risk of bodily harm to other persons/himself/herself in the foreseeable future. I do not believe that Mr./Ms. _____ can be adequately controlled with supervision and treatment on an outpatient basis at this time. (Although the symptoms of Mr./Ms. _____'s mental illness are in/partially in remission, I do not believe outpatient treatment or monitoring would prevent his/her condition from deteriorating to a degree that he/she would need inpatient hospitalization.)

CONCLUSION B
ACQUITTEE NOT IN NEED OF INPATIENT HOSPITALIZATION
BUT A SUITABLE CANDIDATE FOR CONDITIONAL RELEASE

Based on my evaluation of Mr./Ms. _____ as discussed in this report, it is my opinion that Mr./Ms. _____ is not in need of inpatient hospitalization at the present time but needs outpatient treatment and monitoring to prevent his/her condition from deteriorating to a degree that he or she would need inpatient hospitalization. Appropriate outpatient supervision and treatment are reasonably available, as discussed in this report. There is significant reason to believe that Mr./Ms. _____, if conditionally released, would comply with a reasonable set of conditions. Based on my assessment of Mr./Ms. _____'s risk of future aggressive behavior, I do not believe conditional release would present an undue risk to public safety.

CONCLUSION C
ACQUITTEE NOT IN NEED OF INPATIENT HOSPITALIZATION NOR IN NEED OF CONDITIONAL RELEASE

Based on my evaluation of Mr./Ms. _____ as discussed in this report, it is my opinion that Mr./Ms. _____ is not in need of inpatient hospitalization at the present time nor does he or she need outpatient treatment and monitoring to prevent his/her condition from deteriorating to a degree that he or she would need inpatient hospitalization.

Commissioner appointed evaluations are independent evaluations provided to the courts. As such, they do not require approval from the Forensic Review Panel when recommending conditional release or release without conditions.

Should inpatient hospitalization be recommended, an assessment of the appropriate level of security required during that hospitalization should be made.

Should conditional release be recommended, suggestions regarding appropriate conditions of release are useful for both the court and the staff developing appropriate conditional release plans.

This outline is offered as a guide and includes those issues that clinicians should consider or discuss in order to meaningfully inform the court regarding commitment, conditional release, or release without conditions decisions. As noted above, clinicians will choose to emphasize different elements of this outline depending upon the case at hand. As in any forensic report, it is important to use language that is comprehensible to the lay reader and to avoid excessive psychological jargon. Although it is reasonable to assume that the court may require testimony in order to clarify important issues or points, this does not justify the preparation of reports that are cursory or conclusory in nature. It is wise to prepare such a report assuming that you may be asked to re-examine an acquittee for the same issues one year hence. In such a case, a prudent clinician should develop the best data base possible in order to do a good job the next time around.

Appendix D.5

See the relevant tables included within the Guidelines for the following evaluations and dispositions

Evaluations Appointed By The Commissioner

Table 2.1	Temporary Custody Evaluation
Table 3.2	Evaluation after Commissioner's Request for Conditional Release in an Annual Continuation of Confinement Report
Table 3.4	Petition for Release Evaluation

Criteria for Dispositions

Table 2.2	Commitment to Commissioner for Inpatient Hospitalization
Table 2.3	Conditional Release
Table 2.4	Release Without Conditions

Appendix D.6

NGRI Commissioner Appointed Evaluation Outline

I. Identifying Information

A. Name

B. Sex

C. Age

D. Date of birth

E. Level of education completed

F. Judge

G. Court of jurisdiction

H. NGRI court case number

I. NGRI offense(s)

J. Date of NGRI adjudication

K. Date of admission

L. Type of evaluation

1. Temporary custody evaluation, pursuant to ' 19.2-182.2,

2. Evaluation after Commissioner's request for conditional release in an annual continuation of confinement report, pursuant to ' 19.2-182.5 (A), or

3. Petition for release evaluation, pursuant to ' 19.2-182.6 (A).

M. Date appointed by Commissioner to do evaluation.

II. Background Data

A. Pre-offense history (education, employment, marital/family status, living situation)

B. Mental illness and treatment history

1. Psychiatric (dates, medication, treatment, response)

a. Hospitalizations

b. Community treatment (include any involvement by community services board)

2. Medical (disorders, treatment)

3. Substance abuse (types, frequency, duration, periods of abstinence)

C. Criminal history (juvenile history, arrests, sentences, probation, parole, etc.)

D. Date and description of NGRI offense

1. From criminal records

2. From pre-trial evaluations of criminal responsibility

3. From acquittee's self-report

4. From any other collaborating sources

E. Information used in preparing evaluation

F. Information sought but not obtained (note specific attempts with dates)

G. Other (COTREI, psychometric testing, etc.)

III. Recent Adjustment

A. Participation in treatment

Include acquittee's perception of mental condition, need for treatment, nature of treatment, and value of treatment

B. Medication regimen

1. Response

2. Compliance

C. Behavioral strengths

D. Behavioral problems/deficits

E. Seclusions/special precautions

F. Escapes/escape attempts

IV. Mental Status Examination

A. Description of present symptomatology

B. Note level of patient cooperativeness, defensiveness, and insight into condition

C. Diagnostic Impression

1. Summary of past diagnoses and current diagnoses

2. Describe conditions and comment on discrepancies

D. Clearly and specifically describe acquittee=s current thoughts about any prior delusions, as well as content of any current delusions.

V. Risk of Future Aggression Assessment

A. Summary of aggressive episodes and brief description of each, including recent hospital aggression

B. Identification and exploration of any relevant risk factors

C. Description of associated treatment and management for each risk factor

D. Identification and exploration of supports and strengths related to future adjustment

E. Conclusion regarding current risk of future aggression

VI. Summary Opinions/Recommendations

A. Assess mental illness and mental retardation and need for inpatient hospitalization, based on factors described in ' 19.2-182.3. (NOTE: A 1992 U.S. Supreme Court decision, Foucha v. Louisiana, 504, U.S. 71 (1992), ruled that there must be a legal finding of mental illness or mental retardation in order to commit an acquittee to inpatient hospitalization.)

If recommending conditional release or release without conditions, specifically address the Virginia Code criteria for that disposition.

1. If inpatient hospitalization is needed, suggest level of security required.

2. If inpatient hospitalization is not needed and acquittee meets criteria for conditional release, suggest conditions needed for an appropriate conditional release plan.

3. If inpatient hospitalization is not needed and acquittee does not meet criteria for conditional release, suggest components needed for an appropriate

discharge plan.

B. The evaluator shall summarize his or her final recommendation regarding court disposition within the criteria set forth in Virginia Code. The evaluator shall use the language in one of the following three paragraphs to conclude each Commissioner-appointed evaluation:

CONCLUSION A
ACQUITTEE MENTALLY ILL OR MENTALLY RETARDED
AND IN NEED OF INPATIENT HOSPITALIZATION

Based on my evaluation of Mr./Ms. _____ as discussed in this report, it is my opinion that Mr./Ms. _____ is mentally ill/mentally retarded and requires inpatient hospitalization at the present time. Taking into account Mr./Ms. _____'s current mental condition, psychiatric history, risk of aggressive behavior, amenability to outpatient supervision and treatment, and other relevant information, I believe that if Mr./Ms. _____ is not hospitalized, there would be a significant risk of bodily harm to other persons/himself/herself in the foreseeable future. I do not believe that Mr./Ms. _____ can be adequately controlled with supervision and treatment on an outpatient basis at this time. (Although the symptoms of Mr./Ms. _____'s mental illness are in/partially in remission, I do not believe outpatient treatment or monitoring would prevent his/her condition from deteriorating to a degree that he/she would need inpatient hospitalization.)

CONCLUSION B
ACQUITTEE NOT IN NEED OF INPATIENT HOSPITALIZATION
BUT A SUITABLE CANDIDATE FOR CONDITIONAL RELEASE

Based on my evaluation of Mr./Ms. _____ as discussed in this report, it is my opinion that Mr./Ms. _____ is not in need of inpatient hospitalization at the present time but needs outpatient treatment and monitoring to prevent his/her condition from deteriorating to a degree that he or she would need inpatient hospitalization. Appropriate outpatient supervision and treatment are reasonably available, as discussed in this report. There is significant reason to believe that Mr./Ms. _____, if conditionally released, would comply with a reasonable set of conditions. Based on my assessment of Mr./Ms. _____'s risk of future aggressive behavior, I do not believe conditional release would present an undue risk to public safety.

CONCLUSION C
ACQUITTEE NOT IN NEED OF INPATIENT HOSPITALIZATION
NOR IN NEED OF CONDITIONAL RELEASE

Based on my evaluation of Mr./Ms. _____ as discussed in this report, it is my opinion that Mr./Ms. _____ is not in need of inpatient hospitalization at the present time nor does he or she need outpatient treatment and monitoring to prevent his/her condition from deteriorating to a degree that he or she would need inpatient hospitalization.

APPENDIX E

REPORTS TO THE COURT

Reports To The Court

This chapter covers treatment team submissions of annual reports to the court and requests for conditional release or unconditional release. These are not independent evaluations as are the Commissioner-appointed evaluations outlined in Appendix D. No report to the court shall include a recommendation for conditional release, release without conditions, or an opinion that the acquittee no longer needs hospitalization without prior review and approval from the Forensic Review Panel.

The attached outline includes a broad range of background and behavioral data covering treatment and adjustment issues that may be of interest to the court. The sections regarding identifying information and background data serve to review pertinent historical and background information, and should succinctly convey those circumstances that led to the NGRI adjudication. This section will necessarily be longer and more detailed for recent insanity acquittees, but can probably be abbreviated considerably for longer term patients with whom the court may be well acquainted. Do not assume, however, that the court is familiar with a particular individual's background and be sure to review that information of which the court should clearly be aware, such as a notably serious offense or extensive treatment history.

The recent adjustment section should specifically focus on the patient's progress and behavior since the last report to the court. Note strengths as well as problems, treatment compliance, and medication response.

A specific section should be devoted to an assessment of risk of future aggression and should be based on the Analysis of Aggressive Behavior (see **Appendix A**). The outline suggests several factors which should be described in the report, including identification of risk factors based on the NGRI offense and other aggressive incidents in the acquittee's history. Consideration of the offense for which the NGRI individual was acquitted is important because it has already been shown beyond a reasonable doubt that the individual committed at least one dangerous act (i.e., the criminal offense for which he or she was acquitted). It is also appropriate to discuss the limitations and imprecision of assessing risk of future aggression, such as the difficulty of generalizing from one environment (e.g., the hospital) to another environment (e.g., the community).

The mental status and diagnostic impression sections, along with the risk of future aggression section, should serve to describe the acquittee's present condition and prognosis.

Based upon background information, clinical, and risk of future aggression assessments and taking into consideration the factors outlined in Virginia Code ' 19.2-182.3, the report should include summary opinions regarding the NGRI individual's need for inpatient hospitalization. Provide clear rationales linking background information, assessment, and the ' 19.2-182.3 factors considered to your summary opinion. Tables 2.2, 2.3, and 2.4 clearly outline the criteria and supporting information needed in order to provide opinions regarding an acquittee's need for inpatient hospitalization, eligibility for conditional release, or eligibility for

release without conditions. Consult those tables carefully. Make specific references to the criteria outlined in the law for the disposition you are recommending.

Opinions regarding mental retardation should be based upon DSM criteria which require deficits in both level of intellectual functioning and adaptive capacity. See also the definition of mental retardation specified in Virginia Code ' 37.1-1, as well as AAMR criteria.

Avoid using "maximum benefit of hospitalization" as a criterion for release from hospitalization. This factor is not included in the criteria for commitment or release outlined in Virginia Code '' 19.2-182.2 through 19.2-182.16.

Should inpatient hospitalization be recommended, an assessment of the appropriate level of security (maximum security of Central State Hospital---Forensic Unit vs. civil hospital placement) required during that hospitalization is useful.

Should conditional release be recommended, a complete conditional release plan (see **Chapter 5---Planning For Conditional Release**) should be attached with a description of the community services board's involvement in the development of the plan. Recommendations for either conditional release or release without conditions require prior review and approval by the Forensic Review Panel before submission to the committing court.

This outline is offered as a guide and includes those issues that clinicians should consider or discuss in order to meaningfully inform the court regarding commitment, conditional release, or release without conditions decisions. As noted above, clinicians will choose to emphasize different elements of this outline depending upon the case at hand. As in any forensic report, it is important to use language that is comprehensible to the lay reader and avoids excessive jargon.

See the required language for concluding paragraphs that summarize the recommendations for court disposition within the criteria set forth in Virginia Code.

See the relevant table within the Guidelines for the following reports and dispositions

Reports To The Court

Table 4.2	Annual Continuation of Confinement Report
Table 4.3	Petition for Release by Commissioner

Criteria for Dispositions

Table 2.2	Commitment to Commissioner for Inpatient Hospitalization
Table 2.3	Conditional Release
Table 2.4	Release Without Conditions

Appendix E.5

NGRI Report Outline

I. Identifying Information

- A. Name
- B. Sex
- C. Age
- D. Date of birth
- E. Level of education completed
- F. Judge
- G. Court of jurisdiction
- H. NGRI court case number
- I. NGRI offense(s)
- J. Date of NGRI adjudication
- K. Date of admission
- L. Date of commitment to DMHMRSAS
- M. Date of last annual report to the court
- N. Time frame covered by this annual report
- O. Type of evaluation
    1. Annual continuation of confinement hearing report, pursuant to ' 19.2-182.5 (A), or
    2. Petition for release by the Commissioner report, pursuant to ' 19.2-182.6 (A)

II. Background Data

- A. Pre-offense history (education, employment, marital/family status, living situation)
- B. Mental illness and treatment history
    1. Psychiatric (dates, medication, treatment, response)

a. Hospitalizations
b. Community treatment

2. Medical (disorders, treatment)

3. Substance abuse (types, frequency, duration, periods of abstinence)

C. Criminal history (juvenile history, arrests, sentences, probation, parole, etc.)

D. Date and description of NGRI offense

1. From criminal records

2. From pre-trial evaluations of criminal responsibility

3. From acquittee's self-report

4. From any other collaborating sources

E. Information used in preparing evaluation

F. Information sought, but not obtained (note specific attempts with dates)

G. Other (COTREI, psychometric testing, etc.)

III. Recent Adjustment

A. Participation in treatment: Include acquittee's perception of mental condition, need for treatment, nature of treatment, and value of treatment

B. Medication regimen

1. Response

2. Compliance

C. Behavioral strengths

D. Behavioral problems/deficits

E. Seclusions/special precautions

F. Escapes/escape attempts

IV. Mental Status Examination

A. Description of present symptomatology

B. Note level of patient cooperativeness, defensiveness, and insight into condition

C. Diagnostic Impression

1. Summary of past diagnoses and current diagnoses

2. Describe conditions and comment on discrepancies

D. Clearly and specifically describe acquittee=s current thoughts about any prior delusions, as well as content of any current delusions.

V. Risk of Future Aggression Assessment

A. Summary of aggressive episodes and brief description of each, including recent hospital aggression

B. Identification and exploration of any relevant risk factors

C. Description of associated treatment and management for each risk factor

D. Identification and exploration of supports and strengths related to future adjustment

E. Conclusion regarding current risk of future aggression

VI. Summary Opinions/Recommendations

A. Assess mental illness and mental retardation and need for inpatient hospitalization, based on factors described in ' 19.2-182.3. NOTE: A 1992 U.S. Supreme court decision, Foucha v. Louisiana 504, U.S. 71 (1992), ruled that there must be a legal finding of mental illness or mental retardation in order to commit an acquittee to inpatient hospitalization.

1. If inpatient hospitalization is needed, suggest level of security required.

2. If inpatient hospitalization is not needed and acquittee meets criteria for conditional release, suggest conditions needed for an appropriate conditional release plan.

3. If inpatient hospitalization is not needed and acquittee does not meet criteria for conditional release, suggest components needed for an appropriate discharge plan.

B. Recommendation to court for disposition

1. Commitment (recommitment) to inpatient hospitalization,

2. Conditional release, or

3. Release without conditions.

One of the following three summary conclusions shall be used for developing the concluding paragraphs summarizing your final recommendations about court disposition

CONCLUSION A
ACQUITTEE MENTALLY ILL OR MENTALLY RETARDED
AND IN NEED OF INPATIENT HOSPITALIZATION

Based on my evaluation of Mr./Ms. _____, as discussed in this report, it is my opinion that Mr./Ms. _____ is mentally ill/mentally retarded and requires inpatient hospitalization at the present time. Taking into account Mr./Ms. _____'s current mental condition, psychiatric history, risk of aggressive behavior, amenability to outpatient supervision and treatment, and other relevant information, I believe that if Mr./Mrs. _____ is not hospitalized, there would be a significant risk of bodily harm to other persons/himself/herself in the foreseeable future. I do not believe that Mr./Ms. _____ can be adequately controlled with supervision and treatment on an outpatient basis at this time. (Although the symptoms of Mr./Ms. _____'s mental illness are in/partially in remission, I do not believe outpatient treatment or monitoring would prevent his/her condition from deteriorating to a degree that he/she would need inpatient hospitalization.)

CONCLUSION B
ACQUITTEE NOT IN NEED OF INPATIENT HOSPITALIZATION
BUT A SUITABLE CANDIDATE FOR CONDITIONAL RELEASE

Based on my evaluation of Mr./Ms. _____, as discussed in this report, it is my opinion that Mr./Ms. _____ is not in need of inpatient hospitalization at the present time but needs outpatient treatment and monitoring to prevent his/her condition from deteriorating to a degree that he or she would need inpatient hospitalization. Appropriate outpatient supervision and treatment are reasonably available, as discussed in this report. There is significant reason to believe that Mr./Ms. _____, if conditionally released, would comply with a reasonable set of conditions. Based on my assessment of Mr./Ms. _____'s risk of future aggressive behavior, I do not believe conditional release would present an undue risk to public safety.

CONCLUSION C
ACQUITTEE NOT IN NEED OF INPATIENT HOSPITALIZATION
NOR IN NEED OF CONDITIONAL RELEASE

Based on my evaluation of Mr./Ms. _____, as discussed in this report, it is my opinion that Mr./Ms. _____ is not in need of inpatient hospitalization at the present time nor does he or she need outpatient treatment and monitoring to prevent his/her condition from deteriorating to a degree that he/she would need inpatient hospitalization.

APPENDIX F

TREATMENT APPROACHES FOR

INSANITY ACQUITTEES

Active Treatment Approaches for Insanity Acquittees

I. Treatment of Insanity Acquittees in DMHMRSAS Facilities addresses both symptom reduction and reduction of risk to community safety.

Insanity acquittees committed to the custody of the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRAS) are in the unique position of requiring care in the context of their dual status as persons confined as a result of involvement with the criminal courts, and as psychiatric inpatients subject to the treatment parameters that govern nationally accredited psychiatric facilities. Addressing the treatment and management needs of individuals having such dual status presents a unique set of challenges to the professionals assigned to provide treatment to insanity acquittees.

During the past decade, there has been a general increase in efforts on the part of mental health experts, in accord with the tenets of Section 504 of both the Vocational Rehabilitation Act and the Americans with Disabilities Act (ADA), to provide care and treatment for the disabled that is both appropriate for the needs of the individual, and that is delivered within the least restrictive setting necessary for the care and safety of the individual and the community. Recently, at least one landmark U.S. Supreme Court decision (Olmstead v. L.C., 119 S. Ct. 2176, 2188; [1999]) has specifically applied the ADA standards to the individuals that are civilly confined in publicly operated state facilities. In the Olmstead ruling, the Court verified that there is a need for the implementation of comprehensive and efficacious treatment plans, geared toward providing care in appropriate and least restrictive settings, for individuals who are housed in long-term care facilities.

The confluence of forces that includes human rights mandates that both prescribe the need for active, least restrictive treatment, and proscribe the inappropriate confinement of those with psychiatric disabilities, on the one hand, and the legal mandate that proper caution be taken with the process of gradual release of insanity acquittees, on the other, has engendered the need for a highly active and responsive approach to providing mental health care to insanity acquittees. In practical terms, responding to the aforementioned mandates requires that psychiatric care and rehabilitation of insanity acquittees occur within an enriched treatment context that promotes symptom reduction and decreased risk to public safety, in as expeditious a manner as is appropriate.

The developing application of clinical risk assessment principles to the clinical decision making process with high risk patients, including insanity acquittees, has generated risk management approaches to treatment of such populations, as well. Heilbrun (1997), for example, asserted that the process for guiding the psychiatric care and treatment of high

risk forensic patients should combine active, ongoing risk assessment with treatment planning and service delivery. Such a program of care has been in place for some time in the DMHMRSAS facilities that provide treatment for insanity acquittees. Those individuals who are currently committed to the custody of the Commissioner of the DMHMRSAS as insanity acquittees are involved, from the point of first admission to the hospital for Temporary Custody, in the process of active, restorative and rehabilitative care that is provided to all patients hospitalized in DMHMRSAS psychiatric facilities. To ensure that the treatment provided conforms to current standards, the Office of Health and Quality Care, in conjunction with the Office of Forensic Services of the Division of Facility Management maintains a comprehensive program of staff training in the treatment of individuals having forensic legal status. In addition, it is the mission of each of the aforementioned Divisions to also ensure that all DMHMRSAS facilities provide care that is comprehensive and appropriate, and occurs within the least restrictive setting available.

II. General guidelines for provision of active treatment for insanity acquittees in DMHMRSAS facilities.

A. In accordance with departmental policy (DMHMRSAS departmental instruction 111(TX)01 *Requirements for Treatment and Habilitation Planning)*, each insanity acquittee will, to the extent feasible, actively participate in all aspects of the treatment planning process, on an ongoing basis, and in a manner that is reflected in the Comprehensive Treatment Plan.

B. For all insanity acquittees, conditional release from hospitalization shall be a primary goal of treatment.

C. Predischarge planning for acquittees shall be ongoing, as mandated by DMHMRSAS policy, and shall involve the active participation of the representative to the acquittee's treatment team from the community services board (CSB) that serves the jurisdiction to which he or she is likely to be discharged.

D. As soon as possible after the admission of an NGRI acquittee to a DMHMRSAS facility, the Comprehensive Treatment Plan for that acquittee, prepared in accordance with departmental policy and in a manner that is consistent with accreditation standards, shall be composed or revised to include all identified Risk Factors that are subject to treatment or preventive management, as delineated in Appendix A of this document, as clinical problems in need of active treatment.

E. The Comprehensive Treatment Plan shall also include all relevant treatment goals, objectives, interventions and treatment strategies aimed at ameliorating the symptoms and risk factors that promote the continued hospitalization of the acquittee. All revisions of the Comprehensive Treatment Plan for an acquittee shall, in conformance with facility standards, reflect any changes in the clinical status and treatment needs of the acquittee, with particular regard to all identified risk factors.

F. All relevant "protective factors" or patient strengths shall be cited and included in the treatment planning and implementation process.

G. All increases in privileges that are granted to the acquittee by the Forensic Review Panel or the Internal Forensic Privileging Committee shall be addressed in the acquittee's Comprehensive Treatment Plan, with regard to any corresponding need or eligibility of the acquittee for a change in treatment activities, and with regard to the manner in which the granted privileges shall be best implemented. Risk Management Plans developed to address changes in risk that are presented by increased levels of privilege, shall also be incorporated into the acquittee's Comprehensive Treatment Plan.

H. Treatment of each acquittee shall be consistent with the biopsychosocial model of psychiatric care, and shall include the multimodal application of medical, psychosocial, psychoeducational and psychotherapeutic interventions, in addressing the acquittee's treatment (and placement) needs. To the extent possible, treatment efforts shall be especially focused upon interventions that promote the development of improved acquittee strategies for self-management, self-control, and facilitation of an enhanced internal locus of emotional and behavioral control.

I. Any need of any acquittee for accommodative supports and interventions necessary to enable his or her full participation in the treatment program shall be addressed in the treatment planning process.

III. Insanity acquittees have special needs for treatment as a result of their legal status, history of criminal behavior, and mental illness linked with criminal behavior.

The development of effective psychotherapeutic and psychosocial treatments that reduce an individual's risk for violent and/or significant disruptive behavior has been the focus of much clinical research, for more than a decade. Treatment programs that focus upon Anger Management, in particular, have been widely applied in correctional and forensic mental health settings. The results of several major studies of the effects of anger management training upon individuals at high risk for violent behavior have yielded positive outcomes, particularly when used in conjunction with cognitive psychotherapy methods. A recent study of high-risk, violent offenders, for instance (Serin & Brown, 1997) found that completion of a comprehensive program of anger management therapy, prior to release from incarceration, was associated with a significant reduction in the rate of recidivism in the group that had received such treatment, when compared with controls.

Currently, each of the DMHMRSAS facilities that treat insanity acquittees has a highly structured and active program of individual and psychosocial treatments that is directed at addressing the range of risk factors and treatment needs presented by the insanity acquittees who have been placed in that facility. Mental health professionals who have

extensive training and expertise in forensic psychiatric treatment are responsible for conducting these programs. The treatment programs described below serve as examples of the range of psychosocial interventions that is currently available at each DMHMRSAS facility. These approaches to treatment for insanity acquittees may be useful in providing treatment/interventions in both the mental health facilities and community settings.

A. Aggression and Anger Control Therapy

1. This is treatment focusing specifically on the patterns of thinking, feeling, and behavior associated with an acquittee's aggression.

    a. Goal: decrease the risk of future aggression.

    b. In contrast to "management of aggression," a facility's method for controlling the immediate impact of an aggressive response and preventing further harm to others or the aggressive individual.

2. Three broad stages of aggression control therapy

    a. Stage 1---Mutual Discovery

        i. Acquittee gives a comprehensive history of aggression and the situations in which it is expressed, and learns to identify the triggers, fantasies, and feelings associated with it.
        ii. Behavioral repertoire of acquittee is identified and then divided into aggressive and non-aggressive behaviors.

    b. Stage 2---Building Alternative Responses to Aggression

        i. Focus here is on increasing the number of available options for handling potentially aggression-inducing situations in a nonviolent way.
        ii. Possible alternatives
            (1) avoidance
            (2) assertiveness
            (3) early warning and recognition
            (4) compliance and cooperation with "helping professionals"
            (5) effective management of symptoms

    c. Stage 3---Development of Plans

        i. Develop plan for handling important risk factors for aggression in a nonaggressive way, based on knowledge gained in first two

stages
ii. Develop written plan
iii. Acquittee practices plan and discusses it sufficiently often enough that he or she has a good working understanding of it

d. Stage 4---Relapse Prevention

i. Unstructured group focused on
ii. work with relapse prevention plan developed in Stage 3
iii. implementing that plan on a daily basis
iv. preparing and fine-tuning plan for use during conditional release.
v. This group could also include acquittees who have been revoked from their conditional release because of threat of aggression, incident in the community, etc.

B. Orientation for Acquittees

1. Group meetings to provide information and answer questions regarding status as an acquittee.

2. Possible topics.

a. Rights
b. Legal process
c. Understanding legal status
d. Use whenever moving to new legal status

i. Temporary custody
ii. Commitment to Commissioner
iii. Civil transfer
iv. Conditional release.
e. Petitions for release

3. The Human Rights Advocates should be encouraged to contribute to this group.

C. Forensic Peer Support Group

1. Ongoing, unstructured group meetings to provide support and opportunity for discussion of specific forensic concerns

2. Address special concerns of this group, such as

3. Anxiety of moving through criminal justice system

4. Publicity from past criminal offense(s)

5. Fear of moving into the community after long hospitalization

6. Dealing with less structure in the community

7. Difficulty making transitions

8. Stress of "doing time" (clinically, but not legally, ready for release)

9. Stigma of acquittee status

IV. Helpful references

Bloom, Joseph D. (1993). *Management and Treatment of Insanity Acquittees: A Model for the 1990s*. Washington, D.C.: American Psychiatric Press.

Bloom, J.D., Williams, M., Rogers, J., & Barbur, P. (1986). Evaluation and treatment of insanity acquittees in the community. *Bulletin of the American Academy of Psychiatry & the Law*, 14, 231-244.

Carter, D., & Prentky, R. (1993). Massachusetts Treatment Center. *International Journal of Law and Psychiatry*, 16, 71-81.

Clark, C., Holden, C., Thompson, J., Watson, P., & Wightman, L. (1993). Treatment at Michigan's Forensic Center. *International Journal of Law and Psychiatry*, 16, 71-81.

Derks, F., Blankstein, J., & Hendricks, J. (1993). Treatment and security: The dual nature of forensic psychiatry. *International Journal of Law and Psychiatry*, 16, 1/2, 217-240.

Dixon, J., & Rivenbark, W. (1993). Treatment at Alabama's Taylor Hardin Secure Medical Facility. *International Journal of Law and Psychiatry*, 16, 1/2, 105-116.

Golding, S.L., Eaves, D., & Kowaz, A.M. (1989). The assessment, treatment and community outcome of insanity acquittees: Forensic history and response to treatment. *International Journal of Law and Psychiatry*, 12, 149-179.

Harris, G., & Rice, M. (1994). The violent patient. In M. Hersen & R.T. Ammerman (Eds.), *Handbook of prescriptive treatments for adults* (pps. 463-486). New York: Plenum Press.

Heilbrun, K. (1997) Prediction versus management models relevant to risk assessment: The importance of legal decision-making context. *Law and Human Behavior*, 21, 347 – 359.

Heilbrun, K., & Griffin, P. (1993). Community-based forensic treatment of insanity acquittees. *International Journal of Law and Psychiatry*, 16, 1/2, 133-150.

Marques, J., Haynes, R., & Nelson, C. (1993). Forensic treatment at Attascadero State Hospital. *International Journal of Law and Psychiatry*, 16, 57-70.

Novaco, R. W., Ramm, M., & Black, L. (2000). Anger treatment with offenders. In C. Hollin (Ed.), *Handbook of offender assessment and treatment (pp 281-296).* London: John Wiley and Sons.

Poythress, N. (1993). Forensic treatment in the United States: A survey of selected forensic hospitals: Introduction. *International Journal of Law and Psychiatry*, 16, 53-55.

Psychiatric Security Review Board, State of Oregon (1994). A Model for the Management and Treatment of Insanity Acquittees. *Hospital and Community Psychiatry*, 45, 1127-1131.

Rice, M.E., & Harris, G.T. (1988). An empirical approach to the classification and treatment of maximum security psychiatric patients. *Behavioral Sciences & the Law*, 6, 497-514.

Rice, M., & Harris, G. (1993). Ontario's Maximum Security Hospital at Penetanguishene: Past, present, and future. *International Journal of Law and Psychiatry*, 16, 1/2, 195-215.

Roth, L. (Ed.) (1987). *Clinical treatment of the violent person*. New York: Guilford.

Serin, R.C. & Brown, S.L. (1997). Treatment programs for offenders with violent histories: A national survey. *Forum on Corrections Research, 9, 35-38.*

Wack, R. (1993). Treatment services at Kirby Forensic Psychiatric Center. *International Journal of Law and Psychiatry*, 16, 83-104.

Webster, C.D., Hucker, S.J., & Grossman, M.G. (1993). Clinical programmes for mentally ill offenders. In K. Howells & C.R. Hollin (Eds.), *Clinical approaches to the mentally disordered offender* (pp. 87-109), New York: John Wiley & Sons, Ltd.

Wexler, D.B. (1991). Health care compliance principles and the insanity acquittee conditional release process. *Criminal Law Bulletin*, 27, 18-41.

APPENDIX G

CONDITIONAL RELEASE PLAN

MODEL

CONDITIONAL RELEASE PLAN

FOR _____

The signatures at the end of this conditional release plan indicate that _____ understands that he or she has been found not guilty by reason of insanity of_____, pursuant to Virginia Code Section 19.2-182.2, and is under the continuing jurisdiction of the _____ court as a result of that finding. The acquittee, _____, and all undersigned parties have reviewed this conditional release plan and agree to follow the terms and conditions.

A. GENERAL CONDITIONS

1) The acquittee agrees to abide by all municipal, county, state, and federal laws.

2) The acquittee agrees not to leave the Commonwealth of Virginia without first obtaining the written permission of the judge maintaining jurisdiction over his or her case and the supervising Community Services Board. The acquittee further understands that, pursuant to ' 19.2-182.15, he or she may be charged with a class 6 felony if he or she leaves the Commonwealth of Virginia without court permission.

3) The acquittee agrees not to use alcoholic beverages. (If the acquittee has been granted any special permission to use alcohol, such permission should be specified below, in the Special Conditions section of this plan.)

4) The acquittee agrees not to use or possess any illegal drugs or prescribed medications unless prescribed by a licensed physician for him or her.

5) The acquittee understands that he or she is under the legal control of the judge maintaining jurisdiction over him or and the supervision of the _____ Community Services Board (and/or CSB designee) implementing his or her conditional release plan. The acquittee agrees to follow their directives and treatment plans and to make him or herself available for supervision at all reasonable times.

6) The acquittee agrees to follow the conditions of his or her release and conduct him or herself in a manner that will maintain his or her mental health.

7) The acquittee understands that, even if it is not his or her fault or the result of any specific violation of conditions, he or she may be returned to a state hospital if his or her mental health deteriorates. The acquittee further understands that, when an acquittee on conditional release is hospitalized in the custody of the Commissioner, his or her conditional release is considered to have been revoked.

8) The acquittee agrees to pay for mental health and substance abuse services, when appropriate, on a sliding fee schedule set by the provider. The acquittee will receive approximately $_____ per month in _____ funds or benefits, or salary upon discharge from the hospital.

9) The acquittee agrees that he or she will not own, possess, or have access to firearms and/or other illegal weapons of any kind. The acquittee further agrees not to associate with those persons or places which do.

10) The acquittee agrees to the release of all information and records concerning his or her mental health and compliance with the conditions of release to the community services board, CSB designated treatment and service providers, and DMHMRSAS, Forensic Services Section. The acquittee further agrees to provide any release or other permission to release information requested by his or her treating physician, psychotherapist, community services board supervisor, or other staff providing services to the acquittee as a part of conditional release.

B. SPECIAL CONDITIONS

1) The acquittee agrees to reside where authorized by the supervising community services board. Initially, the acquittee agrees to reside with:

(Name)_____

(Relationship)_____

residing at:

Address_____

Phone_____

If, at any point during the conditional release, the acquittee chooses not to live at the above location or is asked to move out, then the supervising community services board will evaluate the situation and consider alternative living placements. The acquittee agrees to be financially responsible for the cost of residing at the alternative placement.

If the acquittee chooses not to reside at the alternative placement, he or she shall be considered to be in noncompliance with the conditions of release. Any changes in residence will be coordinated by the supervising community services board, with notification to the court.

2) Case management for the acquittee while on conditional release in the community will be provided by staff at the supervising community services board. The name of the acquittee=s case manager at the time of conditional release is: _____. The case manager=s phone number is: _____. The acquittee agrees to meet with his or her case manager for the purpose of monitoring compliance with the conditions of release. This meeting may take the form of a home visit.
Frequency of case management contacts:
_____

_____

Frequency of home visit case management contacts:
_____

_____

3) The acquittee agrees to be assessed by a vocational rehabilitation counselor and to follow the recommendations made from this assessment. These services will be provided by treatment staff of the supervising community services board (or CSB designee).

4) The acquittee agrees to participate in individual therapy with treatment staff of the supervising community services board (or CSB designee) as described below unless otherwise specified by the therapist.

Duration of Therapy:_____

Frequency of Individual Sessions:_____

Location of Therapy Sessions:_____

5) The acquittee agrees to participate in the following special focus groups for the duration of conditional release unless otherwise specified by his or her case manager or other staff of the supervising community services board.

Name of Group #1: _____

Location of Meetings: _____

Days and Times of Meetings: _____

Appendix G.5

(DMH 944E 1242 05/01/2003)

Name of Group #2: _____

Location of Meetings: _____

Days and Times of Meetings: _____

6) The acquittee agrees to take psychotropic medication as recommended by his or her treating psychiatrist. The acquittee agrees to meet with the treating psychiatrist (or psychiatrist's designee) at the supervising community services board (or CSB designee) for the purposes of monitoring the acquittee's psychotropic medications and to have prescriptions renewed and refilled. The acquittee will participate in psychiatric treatment for the duration of conditional release unless otherwise specified by the treating psychiatrist.

Psychotropic medications:_____

_____

Location of meetings with psychiatrist: _____

_____

Frequency of meetings with psychiatrist: _____

_____

7) The acquittee agrees to be assessed by a substance abuse counselor at the supervising community services board (or CSB designee) and to follow the treatment recommendations made as a result of this assessment.

Location of Substance Abuse Assessment: _____

Date and Time of Assessment:_____

8) The acquittee agrees to submit to random and/or periodic breathalizer, blood or urine analysis as directed by treatment staff of the supervising community services board for purposes of monitoring alcohol consumption and illicit drug screening. When indicated, the acquittee agrees to a full drug panel screening. The acquittee further agrees to pay any lab fees associated with this screening. Detection of any illegal substances in any of the lab results or detection of alcohol use or refusal to participate in these screenings shall constitute noncompliance with the conditional release plan.

9) The acquittee agrees to submit to periodic breathalizer, blood or urine analysis as directed by treatment staff of the supervising community services board for the purposes of monitoring medication compliance and tolerance.

10) The acquittee agrees that, if he or she can not attend a meeting or session as required by this conditional release plan, the acquittee will provide advance notice by calling the person with whom he or she is scheduled to meet. If the acquittee is unable to contact that person, he or she must contact one of the following individuals:

Alternative contact #1:_____

Phone #:_____

Alternative contact #2:_____

Phone #:_____

11) The acquittee is responsible for arranging transportation between home and activities required under this conditional release plan. The acquittee may arrange for rides through family or friends. Lack of transportation may not be accepted as an excuse for missing activities specified by this conditional release plan.

12) Please itemize and detail any other special conditions deemed necessary by discharging facility staff and supervising community services board, or allowed or ordered by the court:

i. _____

_____

ii. _____

_____

iii. _____

_____

C. ACQUITTEE AGREEMENT TO CONDITIONAL RELEASE PLAN

** I HAVE READ OR HAD READ TO ME AND UNDERSTAND AND ACCEPT THE CONDITIONS UNDER WHICH I WILL BE RELEASED BY THE COURT. I AGREE TO ABIDE BY AND CONFORM TO THEM AND FULLY UNDERSTAND MY FAILURE TO DO SO MAY RESULT IN REVOCATION OF MY CONDITIONAL RELEASE.

** I UNDERSTAND THAT NONCOMPLIANCE WITH ANY OF THE CONDITIONS OF MY RELEASE MAY RESULT IN ANY OR ALL OF THE FOLLOWING:

1. Notification to the proper legal authorities;
2. Arrest and prosecution;
3. Notification to the court which conditionally released the acquittee;
4. Emergency custody and hospitalization pursuant to ' 19.2-182.9;
5. Notification to the Department of Mental Health, Mental Retardation and Substance Abuse Services, Forensic Services Section;
6. Revocation of conditional release and hospitalization pursuant to ' 19.2-182.8; or
7. Modification conditional release pursuant to ' 19.2-182.11

** I UNDERSTAND THAT IF I AM RETURNED TO THE CUSTODY OF THE COMMISSIONER FOR INPATIENT TREATMENT PURSUANT TO REVOCATION PROCEEDINGS AND MY CONDITION IMPROVES TO THE DEGREE THAT, WITHIN 30 DAYS OF MY RESUMPTION OF CUSTODY FOLLOWING THE HEARING, AND, IN THE OPINION OF THE SUPERVISING COMMUNITY SERVICES BOARD AND THE HOSPITAL STAFF TREATING ME, I AM AN APPROPRIATE CANDIDATE FOR CONDITIONAL RELEASE, I MAY BE, WITH THE APPROVAL OF THE FORENSIC REVIEW PANEL AND COURT, CONDITIONALLY RELEASED AS IF REVOCATION HAD NOT TAKEN PLACE.

I FURTHER UNDERSTAND THAT IF TREATMENT IS REQUIRED FOR LONGER THAN 30 DAYS, I SHALL BE RETURNED TO THE CUSTODY OF THE COMMISSIONER FOR A PERIOD OF HOSPITALIZATION AND TREATMENT APPLICABLE TO COMMITTED ACQUITTEES.

_____ _____

Signature of Acquittee Date

_____ _____

Signature of Witness Date

D. COMMUNITY SERVICES BOARD

1. This conditional release plan will be coordinated by _____ Community Services Board and their designees. As of the beginning of the conditional release plan, the designated coordinator is

   Name_____
   Title_____
   Community Services Board_____
   City, State, Zip_____
   Phone_____ FAX_____

2. The community services board shall provide the court written reports no less frequently than once every six months, to begin six months from the date of the conditional release, in accordance with ' 19.2-182.7. These reports shall address the acquittee's progress, compliance with conditions of release, and adjustment in the community. Additionally, a copy of all 6 month reports shall be sent to

   Office of Forensic Services
   DMHMRSAS
   P.O. Box 1797
   Richmond, VA 23218

   PHONE: (804) 786-8044
   FAX: (804) 786-9621

3. The community services board shall provide DMHMRSAS, Office of Forensic Services, with monthly written reports of progress for the acquittee addressing his or her progress, compliance with conditions of release, and adjustment in the community. These reports are due to the Office of Forensic Services at the above address no later than the 10th day of the month following the month to be reported.

4. The community services board understands that, pursuant to ' 19.2-182.11, any proposed changes or deviations from this plan must be approved by the court maintaining jurisdiction over this case.

5. The community services board understands that, pursuant to ' 19.2-182.16, copies of all court orders and notices related to the disposition of the acquittee while on conditional release shall be forwarded to DMHMRSAS, Office of Forensic Services, at the above address immediately upon receipt.

E. SIGNATURES

THIS CONDITIONAL RELEASE PLAN HAS BEEN DEVELOPED JOINTLY AND APPROVED BY THE FOLLOWING COMMUNITY SERVICES BOARD AND HOSPITAL STAFF:

_____ _____
Signature Date

Name
Title
Community Services Board

_____ _____
Signature Date

Name
Title
Community Services Board

_____ _____
Signature Date

Name
Title
Facility

_____ _____
Signature Date

Name
Title
Facility

_____ _____
Signature Date

Name
Title
Facility

MODEL PLAN FOR MONITORING COMPLIANCE: GENERAL CONDITIONS OF RELEASE

GENERAL CONDITIONS	PROVIDER/ MONITOR	NONCOMPLIANCE EQUALS	PROVIDER/MONITOR RESPONSE
G1: Acquittee will follow all laws.	Supervising CSB Staff Name	Any violation of the law.	Notify proper legal authorities. Notify court which conditionally released acquittee. Pursue emergency custody and/or revocation of release.
G2: Acquittee will leave Virginia only with permission of CSB and Judge.	Supervising CSB Staff Name	Leaving Virginia without CSB and court permission. Pursuant to Virginia Code Section 19.2-182.15, acquittee shall be guilty of a Class 6 Felony for leaving Virginia without court permission.	Notify proper legal authorities. Notify court which conditionally released acquittee. Pursue emergency custody and/or revocation of release.
G3: Acquittee will not use alcohol. (Use of alcoholic beverages by the acquittee may only be permitted with the prior written approval of the CSB and the court.)	Supervising CSB Staff Name	Use of alcohol.	Notify court that conditionally released acquittee. Pursue emergency custody and/or revocation of conditional release.
G4: Acquittee will not use or possess illegal drugs or prescription medications unless such medications have been prescribed by his or her current treating licensed physician.	Supervising CSB Staff Name	Possession or use of any illegal or non-prescribed drug.	Notify proper legal authorities. Notify court which conditionally released acquittee. Pursue emergency custody and/or revocation of conditional release.

G5: Acquittee will follow directives of the supervising CSB and make himself or herself available to supervision at all times.	Supervising CSB Staff Name	Missed appt's w/CSB, physician, or other providers as directed by CSB, repeated failure to follow orders or treatment plans, or failure to make himself or herself available for supervision.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
G6: Acquittee will follow mental health regimen.	Supervising CSB Staff Name	Persistent behavior that threatens success of plan and/or causes deterioration of mental health.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
G7: Acquittee will be returned to hospital if mental condition deteriorates.	Supervising CSB Staff Name	Symptoms become too severe to manage in community.	Notify court that conditionally released acquittee. Pursue emergency custody and/or revocation of conditional release.
G8: Acquittee will pay for services as appropriate.	Supervising CSB Staff Name	A pattern of failure to pay for services based on ability to pay.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
G9: Acquittee will not possess, have access to, or associate with persons who possess weapons.	Supervising CSB Staff Name	One incident of possession of any type of weapon or association with person or places who do.	Notify court that conditionally released acquittee. Pursue emergency custody and/or revocation of conditional release.
G10: Acquittee will release information to CSB and all involved parties.	Supervising CSB Staff Name	Persistent failure to consent to release of information to involved parties.	Notify court that conditionally released acquittee. Consider revocation of conditional release.

Appendix G.13

MODEL PLAN FOR MONITORING COMPLIANCE: SPECIAL CONDITIONS OF RELEASE

SPECIAL CONDITIONS	PROVIDER/ MONITOR	NONCOMPLIANCE EQUALS	PROVIDER/MONITOR RESPONSE
S1: Acquittee will reside where authorized by the supervising community services board.	Supervising CSB Staff Name	1) Refusal to dwell in CSB authorized living situation and/or, 2) Moving to unauthorized living situation without CSB approval.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
S2: Acquittee will attend all case management appointments and be present for all home visits.	Supervising CSB Staff Name	Any unexcused absence from case management appointments or missed home visit.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
S3: Acquittee will participate in specified vocational rehabilitation programs.	Supervising CSB Staff Name	Any unexcused absence from prescribed vocational rehabilitation program.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
S4: Acquittee will participate in specified individual therapy plan.	Supervising CSB Staff Name	Any unexcused absence from therapy appointments.	Notify court that conditionally released acquittee of any incident of noncompliance. Pursue emergency custody and/or revocation of conditional release.
S5: Acquittee agrees to participate in prescribed special focus groups.	Supervising CSB Staff Name	Any unexcused absence from any of the prescribed special focus groups.	Notify court that conditionally released acquittee. Consider revocation of conditional release. (DMH 944E 1242 05/01/2003)

S6: Acquittee agrees to take psychotropic medication as recommended by treating psychiatrist and attend psychiatric consults as required.	Supervising CSB Staff Name	1) Refusal to take prescribed medications and/or, 2) Missed appt's w/physician, or other such providers as directed by CSB.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
S7: Acquittee agrees to substance abuse assessment and agrees to follow treatment recommendations made as a result of this assessment.	Supervising CSB Staff Name	1) Refusal to participate in assessment and/or, 2) Unexcused absence from substance abuse treatment program.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
S8: Acquittee will submit to periodic breathalizer, blood or urine analysis as directed by CSB for the purposes of screening for controlled substances and/or alcohol use.	Supervising CSB Staff Name	1) Refusal to submit to urine and/or blood analysis, and/or 2) Urine or blood screens positive for controlled substances and/or, 3) Urine or blood screens positive for alcohol use.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
S9: Acquittee will submit to periodic breathalyzer, blood or urine analysis as directed by CSB for purposes of monitoring medication compliance and tolerance.	Supervising CSB Staff Name	1) Refusal to submit to urine and/or blood analysis, and/or 2) Urine or blood screens indicating client is not taking prescribed medications.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
S10: Acquittee will provide advance notice if unable to attend scheduled appointment/ activity or will contact designated alternate contact.	Supervising CSB Staff Name	1) Failure to provide advanced notice of inability to attend appointment or meeting and/or, 2) Failure to contact alternate contact person.	Notify court that conditionally released acquittee. Consider revocation of conditional release.
S12: Any other special conditions deemed necessary by CSB.	Supervising CSB Staff Name		(DMH 944E 1242 05/01/2003)

F. Community Services Board Recommendations and Comments

This is an opportunity for the supervising Community Services Board staff to provide recommendations and comments to the Forensic Review Panel. It is not required if the CSB staff has signed the proposed conditional release agreement and has no recommendations or comments.

Recommendations:

Comments:

Signature/Print Name	Title/CSB	Date
_____	_____	
_____	_____	
_____	_____	

APPENDIX H

STATE BOARD POLICY:

PROVISION OF FORENSIC SERVICES

POLICY MANUAL

State Mental Health, Mental Retardation and Substance Abuse Services Board
Department of Mental Health, Mental Retardation and Substance Abuse Services

POLICY 1014(SYS)86-20 Provision of Forensic Services

Authority Board Minutes Dated October 22, 1986 Effective Date November 19, 1986
Approved by Board Chairman s/James C. Windsor

References §§19.1-168.1, 19.2-169.1, 19.2-169.2, 19.2-169.5, 19.2-169.6, 19.2-175, 19.2-176, 19.2-177.1, 19.2-178, 19.2-182.2 through 19.2-182.16, 19.2-264.3:1,19.2-301 and, 37.1-197(12), *Code of Virginia* (1950) as amended.
NGRI Manual: Guidelines For The Management of Individuals Found Not Guilty By Reason of Insanity.
State Board Policy 1031(SYS)90-4 Emergency Services

Purpose To establish the State Board's position in regard to the provision of forensic services.

Definition of Forensic Services In the broadest sense, forensic services are evaluation or treatment services for individuals who are involved in both the mental health and criminal justice systems. Services can be provided in a variety of settings, including general inpatient psychiatric units, civil hospitals, maximum security hospitals, jails, and the community. Forensic clients are distinguished by their current level of involvement in the criminal justice system. That is, clients may be defendants (pretrial), jail inmates (post conviction), acquittees found not guilty by reason of insanity (NGRI), or at other points in the criminal justice system. Forensic services are unique in that evaluation or treatment services typically have some impact upon the client's legal situation.

Evaluation activities may include, but are not limited to, pretrial assessment to determine: (1) competency to stand trial; (2) criminal responsibility; or (3) waivers of juvenile court jurisdiction. Post-trial evaluation issues may include: (1) amenability to treatment; (2) need for hospitalization; (3) risk assessment and the need for treatment in a secure setting or the community; (4) NGRI conditional release to the community; or (5) capital sentencing.

Continued on next page

Definition of Forensic Services
(*continued)*

Treatment interventions may take place at any point during an individual's involvement in the criminal justice process. Treatment services that successfully ameliorate the manifestations of mental illness may enable an individual to attain competency and, thus, be able to participate in legal proceedings or to be safely returned to the community. Some services, such as emergency treatment prior to trial or treatment delivered to inmates in jail are considered forensic services, although they may not be tied to an identified legal outcome.

The provision of forensic services requires a full recognition of the goals and standards of both the mental health and criminal justice systems, including the interface between these two complex systems. Service providers must receive specialized training regarding complex legal issues, evaluations, courtroom testimony, court report writing protocols, and the ethical issues specific to this area of practice. In all forensic treatment activities, a constant balance must occur between providing high quality evaluation and treatment services to individuals while maintaining both legal standards and public safety.

At the present time, all treatment services for Virginia prison inmates are provided by the Department of Corrections (DOC) with the sole exception of involuntary hospitalization for female prison inmates. This is currently provided at Central State Hospital-Forensic Unit while DOC works to add this service to its comprehensive continuum of care.

General Policy

It is the policy of the State Mental Health, Mental Retardation and Substance Abuse Services Board to provide quality services to citizens involved in the criminal justice system as set forth in the *Code of Virginia*. Forensic services shall be provided in the community whenever possible. The Board recognizes the uniqueness of forensic services issues and the special needs of individuals at the interface of the mental health and criminal justice systems.

Policy for the Department

It is the policy of the State Mental Health, Mental Retardation and Substance Abuse Services Board that:

The Department of Mental Health, Mental Retardation and Substance Abuse Services shall provide or arrange provisions for forensic services consisting of specialized evaluations and treatment consistent with the *Code of Virginia.*

The Department shall develop and maintain appropriate forensic services within its facilities and provide leadership in the further development of forensic services with the community services boards.

The Department shall provide ongoing appropriate training, education, and research activities regarding the provision, evaluation, and development of forensic evaluation and treatment services.

Continued on next page

Policy for the Department *(continued)*

The Commissioner shall designate hospitals as appropriate for treatment and evaluation of persons under criminal charge, as required in §§19.2-169.1 (B), 19.2-169.5 (B), and §19.2-169.6 (B).

The Department shall maintain a Memorandum of Agreement with the Department of Corrections clarifying the responsibility of each agency in providing mental health services to prison inmates. The Department of Corrections currently agrees to assume full responsibility and authority for the mental health treatment of inmates convicted and sentenced to Department of Corrections facilities. It also agrees to operate a psychiatric facility licensed by DMHMRSAS to provide mental health services.

Policy for Community Services Boards

It is the policy of the State Mental Health, Mental Retardation and Substance Abuse Services Board that:

Community services boards shall develop and maintain joint annual written agreements with local courts and sheriffs, in compliance with §37.1-197 (12).

Community services boards shall provide emergency services to local jails, in compliance with State Board Policy 1031(SYS)90-4 Emergency Services.

Community services boards shall consult with local courts in placement decisions for hospitalization of forensic clients based upon the individual's clinical conditions, need for a secure environment, and other relevant factors.

Community services boards shall consider seeking Commissioner designation of local hospitals for the treatment and evaluation of persons under criminal charges, in accordance with §§19.2-169 (B), 19.2-169.5 (B), and 19.2-169.6 (B).

Community services boards shall provide or arrange for the provision of forensic evaluations required by local courts, in accordance with the Board's commitment to a high quality community-based forensic evaluation system.

Community services boards shall work jointly with DMHMRSAS staff in evaluating, treatment planning, planning for conditional release/discharge, and in implementing conditional release of insanity acquittees in the community, in compliance with §§ 19.2-182.2 through 19.2-182.16.

Access to Services

Access to forensic services will not be inhibited by the needs of individuals with physical, sensory, cognitive, and cultural differences.

Monitoring of this policy

The Director of Forensic Services will develop a plan for implementation, monitoring, and evaluation of this policy.

APPENDIX I

FACILITY FORENSIC COORDINATORS

DMHMRSAS OFFICE OF FORENSIC SERVICES STAFF

FACILITY	FORENSIC COORDINATOR	PHONE/FAX/E-MAIL
CATAWBA HOSPITAL	Walton Mitchell, II, M.S.W. Admissions Program Director Forensic Coordinator	P.O. Box 200 Catawba, VA 24070 PHONE: 540/375-4387 FAX: 540/375-4394 BEEPER: 540/224-0115 E-MAIL: wmitchell@catawba.state.va.us
	Teresa Douglas, Administrative Assistant (FIMS User)	PHONE: 540/375-4208 E-MAIL: tdouglas@catawba.state.va.us
CENTRAL STATE HOSPITAL	Jeff Feix, Ph.D. Chief Forensic Coordinator, Secure Forensic Units	P.O. Box 4030 Petersburg, VA 23803 PHONE: 804/524-7054 FAX: 804/524-7069 BEEPER: 804/861-7214 E-MAIL: jfeix@CSH.state.va.us
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FORENSIC COORDINATOR RESPONSIBILITIES

Since 1987, the Commissioner has requested that all DMHMRSAS operated mental health facilities designate a Forensic Coordinator. The primary focus of the Forensic Coordinator is to improve the management of forensic patients in our facilities. Due to the unique involvement of forensic patients in both the mental health and criminal justice systems, they require special focus to ensure that they are being managed in a most appropriate fashion.

Our system is responsible for providing treatment and evaluation services to forensic patients while remaining sensitive to the needs of the courts as well as the security and safety concerns of the patient, staff and the general public. Forensic patients frequently have unique reporting requirements to the courts or restrictions which need to be addressed. The Forensic Coordinator for each facility is responsible for ensuring that the facility manages all forensic patients in an appropriate fashion according to the policies of the Department, orders of the court, and laws of the Commonwealth and in coordination with the Office of Mental Health and Substance Abuse Services, Forensic Section.

Please reference Interim Departmental Instruction 127: Implementing Privileges for Forensic Patients (5/19/94). Each facility should establish internal procedures to ensure that the Forensic Coordinator is immediately notified of all forensic patients admitted to the facility.

The responsibilities of each Forensic Coordinator include, but are not limited to, the following. The Forensic Coordinator shall

I. Ensure that all forensic admissions, transfers and discharges, are made in accordance with appropriate policies, court orders, and legal standards.

II. Review each court order for the hospitalization, evaluation, temporary custody, commitment, treatment, or discharge of forensic patients for legal sufficiency. Whenever a court order does not comport with the Code of Virginia or other legal standards, the Forensic Coordinator will work with the courts and the attorneys to obtain a revised court order which meets legal standards. If, after making documented attempts to obtain an appropriate court order, the Forensic Coordinator requires assistance, he or she shall contact the Director of Forensic Services in a timely manner to request technical assistance and support.

III. Monitor the management, progress, conditional release planning, and discharge planning for all forensic patients.

A. Notify the Director of Forensic Services of all admissions, transfers, and discharges of insanity acquittees (NGRIs) within one working day of the event.

B. Notify the Director of Forensic Services of any escape, attempted escape, serious incident, or death of any forensic patient within one working day of the event.

C. Consult with the treatment team(s) and other appropriate staff regarding management decisions for forensic patients. Ensure that a mechanism is in place to identify forensic patients upon their

admission and provide notification of that forensic status to appropriate personnel which include, but are not limited to, treatment team members, direct care staff, and safety and security staff. Develop and monitor appropriate means of managing the security of acquittees during off-site special hospitalization episodes, or when acquittees must be transported to medical appointments away from the facility.

D. Work closely with the treatment team(s) and the court(s) to monitor the schedules of due dates of reports and dates of hearings for forensic patients.

1. Maintain current listings of all scheduled court hearings, and due dates for reports to the courts for forensic patients.

2. Ensure that appropriate persons and entities are notified of hearing dates.

3. Ensure that reports are submitted to the court(s) on time.

4. Ensure that the NGRI Coordinator of the appropriate community services board is notified of all court dates scheduled for insanity acquittees in the custody of the Commissioner.

5. Notify any person(s) who have requested victim notification in writing (and by phone if time before the hearing is limited) as soon as possible after becoming aware of the likelihood of a court hearing for an insanity acquittee. Verify the specific date and time of the hearing by contacting the Commonwealth's Attorney or the Clerk of the Court. If scheduling changes occur, notify any person(s) who have requested victim notification of the accurate time and date of the hearing, as soon as possible.

6. Review and approve, personally, each final signed NGRI annual report before it is provided to the court in order to ensure that policies and procedures are followed.

7. Submit copies of all subpoenas for any staff member to provide court testimony regarding an insanity acquittee to the Office of Forensic Services, along with a statement from the subpoena recipient, regarding whether or not he or she plans to testify in favor of release or continued commitment of the acquittee, when questioned on the matter, by the court.

E. Serve as the primary point of communication with the Forensic Review Panel regarding insanity acquittees to insure that requests for privileges are congruent with patients' clinical needs and the legal parameters determined by the patients' forensic status.

1. Review and approve all submissions from the facility to the Panel.
2. Receive and deliver to the treatment team(s) all information received from the Panel.

IV. Oversee the process for the implementation and monitoring of privileges for all forensic patients, with a process of appropriate documentation.

A. Develop and maintain a database summarizing the current forensic status and approved privileges for each forensic patient within the facility.
B. Oversee a means to audit that privileges are being appropriately implemented.
C. Ensure that forensic patients are served in the most appropriate level of security.
D. Make certain that all the clinical teams responsible for the evaluation and treatment of forensic patients are aware of any case management restrictions.
E. Participate in the Forensic Review Committee internal to each facility which reviews levels of privileges for forensic patients.

V. Advise the facility Director of all forensic training needed by facility staff

A. Maintain a listing of all facility staff who are qualified, by education and training, to perform Commissioner-Appointed Evaluations of insanity acquittees
B. Develop an annual schedule for all qualified staff, who lack the requisite training, to attend appropriate training provided by the Institute of Law, Psychiatry and Public Policy.
C. Provide to the facility Director, on an annual basis, a listing of all psychologists and psychiatrists responsible for the evaluation and treatment of forensic patients.

1. Note the names of those individuals who have not completed the requisite training provided by the Institute of Law, Psychiatry and Public Policy, and

2. Provide a plan for scheduling their attendance at appropriate training.

VI. Maintain communication with the Office of Forensic Services to provide information and to seek consultation regarding forensic cases.

VII. Remain abreast of changes in forensic issues, policies and practices and communicate this information to appropriate staff. Attend training events and annual symposia presented by the Institute of Law, Psychiatry and Public Policy.

VIII. Attend all meetings of the facility Forensic Coordinators. Subsequently, distribute pertinent information to facility staff. Convene meetings of facility staff, when appropriate.

IX. Maintain and supervise the currency of all patient data for patients admitted to the facility, in the Forensic Information Management System (FIMS) database. Provide monthly statistical reports of forensic services at the facility; participate in other data collection activities for the Office of Forensic Services.

X. Review the forensic policies and procedures of the facility on an annual basis.

XIV. Develop and maintain currency of facility NGRI legal and privileging files for each acquittee.

XV. Provide comprehensive oversight of document production, transmission and receipt among facility

treatment teams, the IFPC, the Forensic Review Panel, and the Office of Forensic Services, regarding the process of privileges granted by the facility IFPC.

APPENDIX J

COMMUNITY SERVICES BOARD DETERMINATION

AND

DMHMRSAS FACILITIES

DETERMINING APPROPRIATE COMMUNITY SERVICES BOARD:
City/County of Jurisdiction By Court Circuit/District
and Community Services Board

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
Accomack County	2	Eastern Shore CSB
Albemarle County	16	Region Ten CSB
Alexandria City	18	Alexandria CSB
Alleghany County	25	Alleghany Highlands CSB
Amelia County	11	Crossroads CSB
Amherst County	24	Central Virginia CSB
Appomattox County	10	Central Virginia CSB
Arlington County	17	Arlington CSB
Augusta County	25	Valley CSB
Bath County	25	Rockbridge Area CSB
Bedford County	25	Central Virginia CSB
Bedford City	24	Central Virginia CSB
Bland County	27	Mount Rogers MH&MR Services
Botetourt County	25	Blue Ridge Behavioral Healthcare
Bristol City	28	Highlands CSB

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
Brunswick County	6	Southside CSB
Buchanan County	29	Cumberland Mountain CSB
Buckingham County	10	Crossroads CSB
Buena Vista City	25	Rockbridge Area CSB
Campbell County	24	Central Virginia CSB
Caroline County	15	Rappahannock Area CSB
Carroll County	27	Mount Rogers MH&MR Services
Charles City County	9	Henrico Area MH&R Services
Charlotte County	10	Crossroads CSB
Charlottesville City	16	Region Ten CSB
Chesapeake City	1	Chesapeake CSB
Chesterfield County	12	Chesterfield CSB
Clarke County	26	Northwestern CSB
Clifton Forge City	25	Alleghany Highlands CSB
Colonial Heights City	12	District 19 CSB
Covington City	25	Alleghany Highlands CSB
Craig County	25	Blue Ridge Behavioral Healthcare

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
Culpeper County	16	Rappahannock-Rapidan CSB
Cumberland County	10	Crossroads CSB
Danville City	22	Danville-Pittsylvania CSB
Dickenson County	29	Dickenson County CSB
Dinwiddie County	11	District 19 CSB
Emporia City	6	District 19 CSB
Essex County	15	Middle Peninsula-Northern Neck CSB
Fairfax County	19	Fairfax-Falls Church CSB
Fairfax City	19	Fairfax-Falls Church CSB
Falls Church City	17	Fairfax-Falls Church CSB
Fauquier County	20	Rappahannock-Rapidan CSB
Floyd County	27	New River Valley CSB
Fluvanna County	16	Region Ten CSB
Franklin County	22	Piedmont Regional CSB
Franklin City	5	Western Tidewater CSB
Frederick County	26	Northwestern CSB
Fredericksburg City	15	Rappahannock Area CSB

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
Galax City	27	Mount Rogers MH&MR Services
Giles County	27	New River Valley CSB
Gloucester County	9	Middle Peninsula-Northern Neck CSB
Goochland County	16	Goochland-Powhatan CSB
Grayson County	27	Mount Rogers MH&MR Services
Greene County	16	Region Ten CSB
Greensville County	6	District 19 CSB
Halifax County	10	Southside CSB
Hampton City	8	Hampton-Newport News CSB
Hanover County	15	Hanover County CSB
Harrisonburg City	26	Harrisonburg-Rockingham CSB
Henrico County	14	Henrico Area MH&R Services
Henry County	21	Piedmont Regional CSB
Highland County	25	Valley CSB
Hopewell City	6	Planning District 19
Isle of Wight County	5	Western Tidewater CSB
James City	9	Colonial MH&MR Services Board

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
King and Queen County	9	Middle Peninsula-Northern Neck CSB
King George	15	Rappahannock Area CSB
King William County	9	Middle Peninsula-Norther Neck CSB
Lancaster County	15	Middle Peninsula-Northern Neck CSB
Lee County	30	Planning District I CSB
Lexington City	25	Rockbridge Area CSB
Loudoun County	20	Loudoun County CSB
Louisa County	16	Region Ten CSB
Lunenberg County	10	Crossroads CSB
Lynchburg City	24	Central Virginia CSB
Madison County	16	Rappahannock-Rapidan CSB
Manassas City	31	Prince William County CSB
Manassas Park City	31	Prince William County CSB
Martinsville City	21	Piedmont Regional CSB
Mathews County	9	Middle Peninsula-Northern Neck CSB
Mecklenberg County	10	Southside CSB
Middlesex County	9	Middle Peninsula-Northern Neck CSB

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
Montgomery County	27	New River Valley CSB
Nelson County	24	Region Ten CSB
New Kent County	9	Henrico Area MH&R Services
Newport News City	7	Hampton-Newport News CSB
Norfolk City	4	Norfolk CSB
Northampton County	2	Eastern Shore CSB
Northumberland County	15	Middle Peninsula-Northern Neck CSB
Norton City	30	Planning District I CSB
Nottoway County	11	Crossroads CSB
Orange County	16	Rappahannock-Rapidan CSB
Page County	26	Northwestern CSB
Patrick County	21	Piedmont Regional CSB
Petersburg City	11	District 19 CSB
Pittsylvania County	22	Danville-Pittsylvania MHS Board
Poquoson City	9	Colonial MH&MR Services Board
Portsmouth City	3	Portsmouth Dept. of Behavioral Healthcare
Powhatan County	11	Goochland-Powhatan CSB

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
Prince Edward County	10	Crossroads CSB
Prince George County	6	District 19 CSB
Prince William County	31	Prince William County CSB
Pulaski County	27	New River Valley CSB
Radford City	27	New River Valley CSB
Rappahannock County	20	Rappahannock-Rapidan CSB
Richmond County	15	Middle Peninsula-Northern Neck CSB
Richmond City	13	Richmond Behavioral Health Authority
Roanoke County	23	Blue Ridge Behavioral Healthcare
Roanoke City	23	Blue Ridge Behavioral Healthcare
Rockbridge County	25	Rockbridge Area CSB
Rockingham County	26	Harrisonburg-Rockingham CSB
Russell County	29	Cumberland Mountain CSB
Salem City	23	Blue Ridge Behavioral Healthcare
Scott County	30	Planning District I CSB
Shenandoah County	26	Northwestern CSB
Smyth County	28	Mount Rogers CSB

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
South Boston City	10	Southside CSB
Southampton County	5	Western Tidewater CSB
Spotsylvania County	15	Rappahannock Area CSB
Stafford County	15	Rappahannock Area CSB
Staunton County	25	Valley CSB
Suffolk City	5	Western Tidewater CSB
Surry County	6	District 19 CSB
Sussex County	6	District 19 CSB
Tazewell County	29	Cumberland Mountain CSB
Virginia Beach City	2	Virginia Beach CSB
Warren County	26	Northwestern CSB
Washington County	28	Highlands CSB
Waynesboro City	25	Valley CSB
Westmoreland County	15	Middle Peninsula-Northern Neck CSB
Williamsburg City	9	Colonial MH&MR Services Board
Winchester City	26	Northwestern CSB
Wise County	30	Planning District I CSB

CITY/COUNTY of JURISDICTION	CIRCUIT/ DISTRICT	COMMUNITY SERVICES BOARD
Wythe County	27	Mount Rogers MH&MR Services
York County	9	Colonial MH&MR Services Board

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