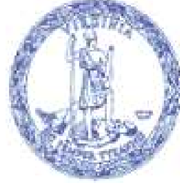

COMMONWEALTH of VIRGINIA

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ALISON G. LAND
COMMISSIONER

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DRAFT

July 1, 2021

TO: Forensic Review Panel
DBHDS Facility Directors
DBHDS Facility Medical Directors
DBHDS Facility Internal Forensic Privileging Committee Members (IFPCs)
DBHDS Facility Clinical Directors
CSB Executive Directors
CSB Mental Health Directors
CSB NGRI Coordinators
Other Interested Individuals

FROM: Alison G. Land, Commissioner

Subject: 2021 Edition of the NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity (NGRI)

A copy of the 2021 edition of the *NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity* has been enclosed for your use. A copy of the 2021 NGRI Manual is also available on-line at the website for the Department of Behavioral Health and Developmental Services (DBHDS) www.dbhds.virginia.gov.

It is my pleasure to inform you that this 2021 revision of the NGRI Manual replaces the 2003 version of this document. The 2021 revision of the NGRI Manual includes modifications to the procedures used by the DBHDS for the clinical and administrative management of individuals who have been committed by the courts of the Commonwealth to the custody of the DBHDS as a result of a judicial finding of Not Guilty Reason of Insanity (NGRI), pursuant to the provisions of *Chapter 11.1 of Title 19.2 of the Code of Virginia.*

The 2021 edition of the Manual includes all of the policy and procedural changes to the current NGRI treatment/management program. I have directed that these program and procedural changes be put into effect on July 1, 2021.

The current NGRI manual, as did its predecessors, outlines the basic procedures for the clinical and administrative management of this consumer group. The DBHDS program for NGRIs represents a comprehensive approach to providing intensive treatment, concomitant with ensuring the safety of the individual and the community.

The 2021 edition of the NGRI manual contains information of relevance to administrators, clinicians, case managers, DBHDS hospital treatment teams and Community Services Boards/Behavioral Health Authorities for providing evaluation, treatment and community placement services to individuals found Not Guilty by Reason of Insanity, in a manner that comports with both legal parameters and professional standards of ethical practice.

The Office of Forensic Services of the DBHDS Division of Forensic Services is available to provide information and consultation regarding all aspects of this program. The Office of Forensic Services can be contacted at (804) 786-9084.

DRAFT

Enclosure:
NGRI Manual

cc:
Allyson Tysinger, Senior Assistant Attorney General
Alicia Johnson, Assistant Attorney General
Angela Harvell, Deputy Commissioner Facilities, DBHDS
Walton Mitchell, Assistant Commissioner Facilities, DBHDS
Christine Schein, Deputy Director of Forensic Services, DBHDS

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

COMMONWEALTH OF VIRGINIA

Department of Behavioral Health & Developmental Services

OFFICE OF FORENSIC SERVICES
FACILITY SERVICES DIVISION

Revised July 2021

INTRODUCTION

Individuals who have been found Not Guilty by Reason of Insanity (herein referred to as insanity acquittees, acquittees, or NGRIs) by Virginia criminal courts 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/Behavioral Health Authorities 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 *Chapter 11.1 of Title 19.2 of the Code of Virginia*, specifically Sections 19.2-167 through 19.2-182 which describe proceedings on the question of insanity, Sections 19.2-182.2 through 19.2-182.16 which describe the legal process for Virginia's disposition of individuals acquitted 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 https://law.lis.virginia.gov/vacode.

This document revises and replaces previous versions of the *NGRI Manual: Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity*, which was originally disseminated in 1997 and updated in 2003. Any questions regarding these guidelines should be referred to the Office of Forensic Services at the Department of Behavioral Health & Developmental Services.

Christine Schein, LCSW
Deputy Director for Forensic Services
Virginia Department of Behavioral Health & Developmental Services

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CHAPTER 1

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 in order 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 their 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 a 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 a defendant's mental condition that warrants consideration 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: Between 2017 and 2021 there was an average of 80 NGRI acquittals per year

III. Tests for Insanity

A. Vary from state to state

1. Examples: M'Naghten, Irresistible Impulse Test, American Law Institute Test, and Federal 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, they

   a. did not understand the nature, character, and consequences of their act, or
   b. was unable to distinguish right from wrong, or
   c. was unable to resist the 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. Intellectual disabilities qualify
   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 the belief that the 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.

6. 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 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.

1. At least sixty days prior to trial, the defendant must give notice to the attorney for the Commonwealth of the intention to put sanity at issue and to present testimony of an expert (§ 19.2-168).

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

C. The defendant has the burden of proving insanity to the satisfaction of the judge or 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 general 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.

3. Misdemeanor cases may also be tried in the Juvenile & Domestic Relations court, as in the General District court.

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 in not available to juveniles in delinquency proceedings. (Commonwealth v Chatman, 260 Va. 562 (2000)). Juveniles whose cases are transferred to Circuit court to be prosecuted as adults may raise the insanity defense.

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 for hospitalization pursuant to special commitment laws that are different than those that regulate civil commitment.

1. Virginia civil commitment laws: Va. Code § 37.2-800 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.

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 Virginia’s law regarding the disposition of insanity acquittees. Further clarification regarding policy and practice in implementing the law is provided in the following chapters.

A. Initial period in the temporary custody of the Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) for the purpose of evaluation (§ 19.2-182.2)

1. Two evaluators (one clinical psychologist and one psychiatrist) are appointed by the Commissioner to conduct independent evaluations to determine whether the acquittee has a mental illness or intellectual disability, and to assess the need for hospitalization considering the factors in § 19.2-182.3.

2. Goal: Assist the court in determining disposition

3. Based on criteria outlined in the Virginia Code, the evaluators can 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 temporary custody period is extended for the preparation of a conditional release or discharge plan by the DBHDS and the appropriate CSB/BHA.

B. Post-evaluation hearing is 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 under the court's jurisdiction indeterminately, as long as they continue to meet the statutory commitment criteria.
   b. Only the court can determine when the acquittee is released with or without conditions (see later discussion).

3. This and all subsequent hearings are civil proceedings, as opposed to criminal proceedings (§19.2-182.3).

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 initial 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. Has a mental illness or intellectual disability and is in need of inpatient hospitalization based on consideration of the following factors

a. To what extent the acquittee has a mental illness or intellectual disability, as those terms are defined in § 37.2-100;
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 intellectual disability 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 § 37.2-100, in a state of remission when the illness may, with reasonable probability, become active.

D. The Commissioner is responsible for determining an acquittee's placement (including inter-facility transfers), and privileges (§ 19.2-182.4)

1. The Commissioner may make inter-facility transfers and treatment and management decisions without obtaining prior approval of the court.

2. The Commissioner delegates to the Forensic Review Panel (FRP) (§ 19.2-182.13) the authority to make decisions regarding an acquittee's privileges.

3. Commissioner may grant temporary visits from the hospital not to exceed 48 hours if the visit would be (i) therapeutic for the acquittee and (ii) not pose substantial danger to others. Court approval is not required.

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 the acquittee is confined (§ 19.2-182.4). The Commissioner must also give notice of the granting of an unescorted community visit to any victim of a felony offense against the person punishable by more than five years in prison that resulted in the charges on which the acquittee was acquitted, or the next-of-kin of the victim at the last known address, provided the person seeking notice submits a written

request for such notice to the Commissioner.

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

F. Court permission, after treatment team receives approval from FRP, is required for

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

2. Community visits longer than 48 hours; or

3. 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 and requests for release (§ 19.2-182.6 and §19.2-182.5(B))

a. An 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 evaluating the acquittee's need for inpatient hospitalization (§ 19.2-182.5(B)). If an acquittee petitions for release outside of the annual continuation of confinement hearing the court shall order two evaluations to report on the acquittee's need for inpatient hospitalization.
b. The Commissioner of the DBHDS may petition the committing court for conditional or unconditional release of the acquittee at any time he believes the acquittee no longer needs hospitalization.
c. Victim notification: For conditional release 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 has submitted 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 CSB/BHA 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 condition from deteriorating to a degree that he would need 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 specified; and
   d. Conditional release will not present an undue risk to public safety.

5. Implementation and Reporting: CSB/BHA 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 Forensic Services of the DBHDS. These reports are due for the first twelve months following conditional release.

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 processes for 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 release, or is no longer a proper subject for conditional release based on the criteria for conditional release, and
(2) acquittee has a mental illness or intellectual disability and requires inpatient hospitalization.

c. Acquittee may be returned to conditional release if his/her condition improves to the degree that within 60 days after the Commissioner has resumed custody, the supervising CSB/BHA and facility agree (prior FRP approval is required) that the acquittee 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 CSB/BHA, the facility, and the FRP 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 involuntarily hospitalized while on conditional release, such action is considered to have been taken pursuant to § 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 modify or remove conditions placed on release upon petition of:

(1) CSB/BHA;
(2) Commonwealth's Attorney; or
(3) the acquittee.

b. The committing court may also modify or remove conditions of release on its own motion.

c. Acquittee may only petition for change or modification of conditions 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:

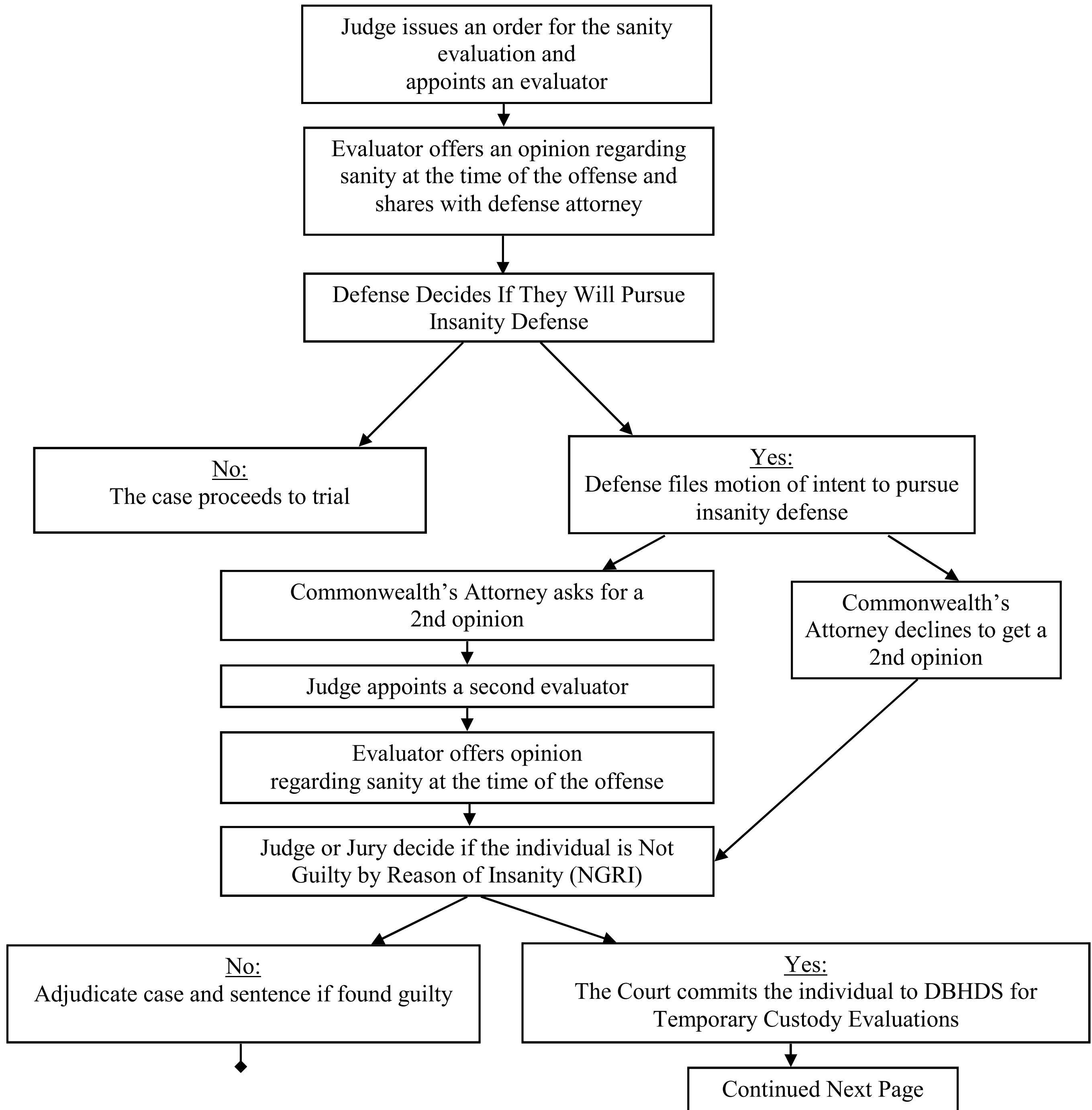
    a. Does not need inpatient hospitalization, and
    b. Does not meet criteria for conditional release.

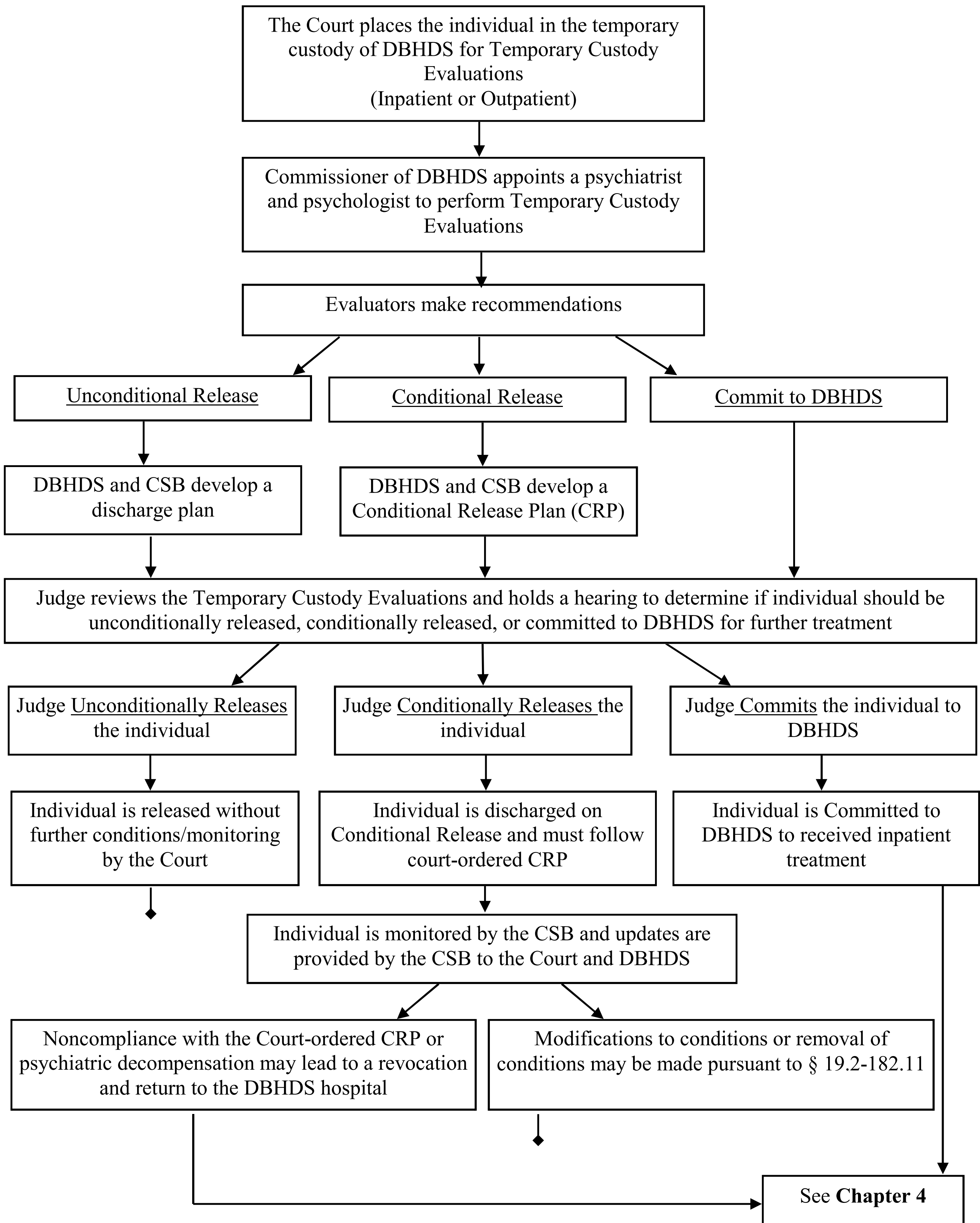
2. The court is required to approve a discharge plan jointly prepared by the CSB/BHA and the facility (§ 19.2-182.3, §19.2-182.6), when the acquittee is to be released without conditions.

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.

CHART 1.1




The Court places the individual in the temporary custody of DBHDS for Temporary Custody Evaluations
(Inpatient or Outpatient)
Commissioner of DBHDS appoints a psychiatrist and psychologist to perform Temporary Custody Evaluations
Evaluators make recommendations
Unconditional Release
Conditional Release
Commit to DBHDS
DBHDS and CSB develop a discharge plan
DBHDS and CSB develop a Conditional Release Plan (CRP)
Judge reviews the Temporary Custody Evaluations and holds a hearing to determine if individual should be unconditionally released, conditionally released, or committed to DBHDS for further treatment
Judge Unconditionally Releases the individual
Judge Conditionally Releases the individual
Judge Commits the individual to DBHDS
Individual is released without further conditions/monitoring by the Court
Individual is discharged on Conditional Release and must follow court-ordered CRP
Individual is Committed to DBHDS to received inpatient treatment
Individual is monitored by the CSB and updates are provided by the CSB to the Court and DBHDS
Noncompliance with the Court-ordered CRP or psychiatric decompensation may lead to a revocation and return to the DBHDS hospital
Modifications to conditions or removal of conditions may be made pursuant to § 19.2-182.11
See **Chapter 4**

CHAPTER 2

Temporary Custody For Evaluation
(§ 19.2-182.2)

I. Placement

A. 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 DBHDS for evaluation as to whether the acquittee may be

1. Released with conditions;

2. Released without conditions; or

3. Committed for further treatment.

B. Inpatient temporary custody placements shall be to the Forensic Unit of Central State Hospital, unless otherwise directed by the DBHDS 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 Deputy Director of Forensic Services, Forensic Services Operation Manager, and the Forensic Coordinators from the Central State Hospital Forensic Unit and the designated civil facility).

C. Under Virginia Code §19.2-182.2 the court may authorize the completion of Temporary Custody evaluations on either an inpatient or outpatient basis. If the court authorizes the evaluation be conducted on an outpatient basis, the Commissioner then determines whether the evaluations will be conducted on an inpatient or outpatient basis. If the Commissioner determines that inpatient evaluation is required in cases where the court has authorized outpatient evaluation, the court will be notified and any necessary modifications to the order will be requested within 10 business days of receiving the original order. Examples of possible reasons for outpatient evaluations include, but not limited to, when the acquittee is pregnant and will give birth during the period of temporary custody, when the individual is residing in a nursing home or other care environment which cannot be easily replicated in a DBHDS facility, when the individual is in VADOC custody and bringing them into DBHDS custody increases risk to public safety, or when the individual has been placed on bond, is following the conditions of bond and bringing them into an inpatient setting will

result in suspension/termination of benefits, loss of employment, and/or potential loss of support system.

D. Inpatient Temporary Custody Evaluations:

1. All court orders for NGRI inpatient temporary custody will be sent to Central State Hospital (CSH). CSH will gather all required documents (at minimum the court order and original sanity evaluation) and will proceed with admission to CSH Maximum Security.

2. If the recommendation is for the acquittee to be treated in a facility/unit other than CSH Maximum Security, then the Deputy Director of Forensic Services shall consult with the Temporary Custody triage team and will have three working days to respond, via email, with concerns/opinions/recommendations.

3. Upon final decision, the Deputy Director of Forensic Services shall notify the appropriate facility and Chief Forensic Coordinator at CSH.

4. Upon the Commissioner's assumption of custody, Central Office will assign evaluators to complete the Temporary Custody Evaluations and will send out required notifications.

5. CSH or designated hospital will be responsible for completing the Initial Analysis of Risk Report (IARR) and will send a copy to both evaluators.

6. The evaluators will coordinate with CSH, or the designated hospital where the acquittee is assigned, to make appointments to evaluate acquittee.

7. Each of the two evaluators will submit a completed evaluation to their facility's Forensic Coordinator, and the Forensic Coordinator or their designee will send the court a cover letter with the evaluation report attached. Once both evaluation reports have been sent, the facility where the acquittee is assigned will follow up with a summary letter with guidance on what happens next and a model order.

E. Outpatient Temporary Evaluations: All court orders for NGRI outpatient temporary custody will be sent to the facility nearest to the acquittee's physical location. The assigned facility will gather all required documents (at a minimum the court order, original sanity evaluation, competency evaluation if ordered, warrants, arrest reports, police reports, jail mental health records, and relevant DBHDS treatment records if available) and will send the temporary custody packet to DBHDS Central Office within 5 days of receipt of the order, in order for a decision to be made regarding appropriateness for outpatient evaluation.

1. Within two working days of receipt of the requisite materials, the Deputy Director of Forensic Services, or their designee, shall conduct a review of the case and make a recommendation for placement during Temporary Custody.

2. If the Deputy Director of Forensic Services, or their designee, determines that the evaluations will not be completed on an outpatient basis, the responsible facility will send a letter to the court requesting that the order be changed to inpatient evaluation and will follow up with the court until a response is received and/or a new order is issued.

3. If the decision is made that the evaluations will be conducted on an outpatient basis, the Deputy Director of Forensic Services shall notify the Forensic Coordinator at the assigned facility of their decision, and Central Office will assign evaluators to complete the Temporary Custody Evaluations and will send out required notifications.

4. All evaluations will be completed at the state hospital or CSB/BHA closest to where the acquittee is located if the acquittee is in the community. If the acquittee is in a nursing home or in the custody of the Department of Corrections then the evaluations will be completed at those locations.

5. The hospital closest to where the acquittee is located will be responsible for completing the Initial Analysis of Risk Report (ARR) and will send it to both evaluators within 30 days.

6. The evaluators will coordinate with the assigned hospital or the CSB/BHA to schedule appointments to meet with the acquittee.

7. Each of the two evaluators will submit their completed evaluation to the Forensic Coordinator at their hospital and the Forensic Coordinator, or their designee, will send the court a cover letter with the evaluation attached. Once both reports are sent, the designated facility will follow up with a summary letter with guidance on what happens next and a model order.

8. If the acquittee is non-compliant with the court order for evaluation, the designated facility will be responsible for notifying Central Office and will then submit a request in writing to the court, on behalf of the Commissioner, to order the individual be admitted to a hospital for

completion of the evaluations required pursuant to Virginia Code §19.2-182.2. Upon admission to a DBHDS facility under the new order, the evaluators shall conduct their examinations and report their findings within 45 days of the Commissioner's assumption of custody.

F. Virginia Code Section §19.2-174.1 requires that certain information be provided to the Commissioner.

1. Before the Commissioner assumes custody of the acquittee, the court shall provide the Commissioner of DBHDS with the following information, if available:

   a. The temporary custody order;
   b. The names and addresses for the attorney for the Commonwealth, the attorney for the acquittee, and the judge having jurisdiction over the acquittee;
   c. A copy of the warrant or the indictment; and
   d. A copy of the criminal incident information as defined in §2.2-3701 of the Virginia Code, or a copy of the arrest report, or a summary of the facts relating to the crime.
   e. 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 DBHDS within ninety-six hours of admission. If the 96-hour period expires on a Saturday, Sunday, or legal holiday, the 96 hours shall be extended to the next business day.

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 Risk (ARR) information and complete the Initial AAR within 30 days after admission (See Appendix A: Analysis of Risk for more information.).
   b. Contact the appropriate CSB/BHA to gather relevant information and begin the collaborative planning required to manage the acquittee.
   c. Obtain copies of the sanity evaluation(s) and competency evaluation(s), if available.

II. Assignment of Community Services Board/Behavioral Health Authority (CSB/BHA) Case Manager

A. As required by Virginia Code § 37.2-505 and detailed in the *Collaborative Discharge Protocols for Community Services Boards and State Hospitals: Adult & Geriatric* and the Community Services Performance Contract's *Community Services Board Administrative Requirements* (see *Continuity of Care Procedures*), it is the responsibility of CSBs/BHAs to assure that individuals receive discharge planning services, beginning at the time of admission to the state facility, that enable timely discharge from the state facility and appropriate post-discharge, community-based services.

B. All pre-discharge planning activities of the CSB/BHA case manager and the facility shall be conducted in a manner that is consistent with the *Collaborative Discharge Protocols for Community Services Boards and State Hospitals: Adult & Geriatric* that have been issued by the Commissioner of DBHDS.

C. As soon as an acquittee is placed in the temporary custody of the Commissioner, the responsible CSB shall assign a case manager to that acquittee.

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

E. The CSB/BHA case manager who is assigned to each acquittee referred to the DBHDS for inpatient care, shall provide pre-discharge 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 § 37.2- 505 of the Code of Virginia, and in accord with the parameters outlined in the Performance Contract maintained by the DBHDS with CSBs/BHAs.

III. Temporary Custody Evaluation

A. After an acquittee is placed in the temporary custody of the Commissioner, the Deputy 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 psychiatrist and

2. One clinical psychologist.

3. The psychiatrist or clinical psychologist shall be skilled in the diagnosis of mental illness and intellectual disability and qualified by training and experience to perform such evaluations. The Commissioner shall appoint both evaluators, at least one of whom shall not be employed by the hospital in which the acquittee is primarily confined. If an evaluator is employed by the hospital in which the acquittee is confined then they shall not be currently providing treatment. The evaluators shall determine whether the acquittee currently has mental illness or intellectual disability and shall assess the acquittee and report on his condition and need for hospitalization with respect to the factors set forth in § 19.2-182.3.

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

D. The evaluation shall assess:

1. Whether the acquittee has a mental illness or intellectual disability,

2. The acquittee's condition, and

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

E. 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 reports to the court shall follow the outline provided in Appendix D of this manual.

3. Copies of the reports 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 CSB/BHA serving the locality or the case management CSB where the acquittee resides,
e. Chair of the FRP,

f. DBHDS Office of Forensic Services,
g. Forensic Coordinator of the hospital where the acquittee is assigned.

IV. Cases in Which One or Both Evaluators Recommend Conditional Release or Release without Conditions

A. When the facility is made aware of an evaluator's recommendation for conditional release or release without conditions, staff will begin developing an appropriate conditional release plan or discharge plan.

1. Facility staff shall immediately contact the appropriate CSB/BHA staff (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 or release without conditions, 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 or discharge plan. Typically an additional 45 day period is requested.

2. *Virginia Code* § 19.2-182.2 provides that the court shall extend the evaluation period to permit DBHDS and the appropriate CSB or BHA to jointly prepare a conditional release plan or discharge plan before the hearing.

C. The conditional release plan or discharge plan shall be submitted to the FRP for review before submission to the court.

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

The referral shall contain:

1. A complete description of attempts made to develop an appropriate conditional release plan or discharge plan,

2. A discussion of why these attempts have not been successful, and

3. Alternative recommendation(s) for disposition of the acquittee.

V. 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.)

TABLE 2.1
Evaluation during Temporary Custody

LEGAL CITATION	**§ 19.2-182.2 The court shall place the person so acquitted in temporary custody of the Commissioner of DBHDS for evaluation as to whether the acquittee may be released with or without conditions or requires commitment. The court may authorize the evaluation be conducted on an outpatient basis.**
EVALUATORS	**2 evaluators appointed by the Commissioner.** **One psychiatrist, and one clinical psychologist. Both shall be** **- skilled in the diagnosis of mental illness and intellectual disability, and** **- qualified by training and experience to perform these evaluations.** **If the acquittee is confined in a hospital, at least one evaluator shall not be employed by the hospital in which the acquittee is primarily confined.** **Evaluators shall conduct examinations and report findings separately.**
CONTENT	**The evaluators shall** **- determine whether the acquittee currently has a mental illness or intellectual disability, 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 for Inpatient Hospitalization

LEGAL CITATION	§ 19.2-182.3
CRITERIA	Has a mental illness or intellectual disability and is in need of inpatient hospitalization, based on consideration of the following factors - To what extent the acquittee has a mental illness or intellectual disability, as those terms are defined in § 37.2-100; - 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
ADDITIONAL 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 needs 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.
ADDITIONAL 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 CSB/BHA.

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.**
ADDITIONAL INFORMATION	**- The court must approve a discharge plan prepared jointly by the hospital staff and the appropriate CSB before the acquittee may be released without conditions.**

Model Temporary Custody Order

Virginia:
In the _______________________________court of
____

Commonwealth of Virginia
vs ____ Case No.: ________________________

NOT GUILTY BY REASON OF INSANITY· INITIAL FINDING AND ORDER FOR EVALUATION

The Defendant having been found not guilty by reason of insanity of the charge(s) of
____
__________________________________ it is hereby ORDERED AND ADJUDGED 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 Behavioral Health and Developmental Services (DBHDS) 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. The court hereby authorizes/ does not authorize **(circle one)** that such evaluations may be conducted on an outpatient basis. If the court has authorized outpatient evaluation but the Commissioner determines that inpatient evaluation is warranted, this order shall suffice to allow the Commissioner the authority to admit the individual for inpatient care.

2. The Clerk of the court is directed to contact the Chief Forensic Coordinator at Central State Hospital or his designee, for a designation of the appropriate facility, admission date and time. The Sheriff of __________________________County, or his designee, shall transport the Acquittee to the designated facility on the agreed date and time, together with a copy of this Order and any other supporting legal and clinical documentation.

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 DBHDS.

6. In the event the Acquittee's presence is required at any hearing in this cause, the court shall issue an Order to Transport, directing the Sheriff of ______________________________ County, or his designee, to resume custody of and transport the Acquittee back to the jurisdiction of this court.

7. This court retains jurisdiction in this cause, and in the case where the acquittee has been admitted to a DBHDS facility he shall not be discharged or released from custody of the Commissioner without further Order of this court.

ENTERED:

____

_____

____
SIGNATURE OF JUDGE

____
NAME OF JUDGE

cc: Commonealth's Attorney
Acquittee's Attorney
Community Services Board
Commissioner of DBHDS
Attn: Forensic Section
Division of Forensic Services
P.O. Box 1797 Richmond, VA 23218

Model Order for Extension of Temporary Custody

VIRGINIA:

IN THE_______________COURT OF_______________, COMMONWEALTH OF VIRGINIA

VS. NAME________________________ DOCKETT No.-CR_________________________

Not Guilty by Reason of Insanity
Extension of Temporary Custody Period for
Development of Conditional Release Plan or Discharge Plan and Hearing Date

The defendant previously having been found not guilty by reason of insanity and placed in the temporary custody of the Commissioner of the Department of Behavioral Health and Developmental Services for evaluation, and evaluations of the acquittee having been conducted resulting in a determination that the acquittee has a mental illness or intellectual disability and a recommendation by at least one evaluator that the acquittee be conditionally released or released without conditions;

Therefore, the court ORDERS that

1. Pursuant to Virginia Code § 19.2-182.2, the period of temporary custody for evaluation is extended.

2. The hospital to which the acquittee is assigned and the appropriate Community Services Board shall jointly prepare a conditional release plan or a discharge plan, as applicable. The conditional release plan or discharge plan shall be sent to the court on or before *_______________. Copies of the conditional release plan or discharge plan shall be sent to the acquittee's attorney and the attorney for the Commonwealth of the jurisdiction where the defendant was acquitted.

3. On *____________, a hearing will be held to determine whether the acquittee shall be released with or without conditions or requires commitment.

4. The acquittee shall not be discharged or released from custody without further order of this court.

Entered: ______________________________
Date

____
Signature

____
Name of Judge

cc: Commonwealth's Attorney
Acquittee's Attorney
Supervising Community Services Board
Chief Forensic Coordinator, Central State Hospital
Commissioner of DBHDS
Attention: Office of Forensic Services
P. O. Box 1797, Richmond, VA 23218

CHAPTER 3

Commitment to the 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 has a mental illness or intellectual disability and is in need of inpatient hospitalization and commits the acquittee to the custody of the Commissioner, the FRP, as designated by the Commissioner, shall determine the appropriate placement for the acquittee, based on the acquittee's clinical needs and security requirements.

B. Placement may be in any state-operated DBHDS facility. Specific considerations shall include:

1. Potential for violence to self or others, and

2. Potential for escape.

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

II. Forensic Coordinator Responsibilities

A. 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 their facility's 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 CSB or BHA 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 G** 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 DBHDS Office of Forensic Services of any initial admission, escape, attempted escape, serious incident, death, transfer to another facility, revocation admission, conditional release, or discharge of an insanity acquittee immediately, but not later than 1 working day subsequent to the event. (See **Appendix G** for additional Forensic Coordinator responsibilities.)

III. Transfer from a Civil unit back to the Maximum Security Unit of Central State Hospital

A. In cases in which an acquittee requires a maximum-security environment, due to safety or security reasons, the Forensic Coordinator of the referring facility will initiate an immediate referral to the Central State Hospital Forensic Coordinator(s) with notification to the FRP, and to the Director of Forensic Services. The Forensic Coordinator of the referring hospital should notify the Office of Forensic Services of DBHDS within 24 hours of the transfer.

B. All privileges are suspended while the acquittee is placed in maximum security.

C. If the acquittee is returned to the referring facility or civil unit within 90 days, the FRP and the DBHDS Office of Forensic Services should be notified, but approval is not required. Privileges may be re-instated by the facility to which the acquittee is returned, following a review by the facility’s Internal Forensic Privileging Committee (IFPC).

D. If the stay on the Maximum Security 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 FRP. Review and approval by the Panel is required before any other privileges can be restored.

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

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

1. A continuation of confinement hearing shall be conducted twelve months after the date of commitment,

2. Continuation of confinement hearings shall be conducted at yearly intervals for first five years after commitment, and at 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. (See *Virginia Code* § 19.2-182.5)

D. Forty–five days prior to the annual continuation of confinement hearing the treatment team shall provide to the Office of Forensic Services a report evaluating the acquittee’s condition and recommending treatment, to be prepared by a psychiatrist or a clinical psychologist. The report shall be submitted to the court thirty days prior to the continuation of confinement hearing.

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 evaluates the acquittee’s condition and makes treatment recommendations 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 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 from which the acquittee was committed,
   d. NGRI Coordinator of the CSB or BHA serving the locality to which the acquittee has been proposed for conditional release (and the original CSB/BHA if these are not the same),
   e. Administrative coordinator of the FRP, and
   f. Office of Forensic Services.

4. FRP 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 or discharge plan shall be submitted to the FRP for review and approval, prior to submission to the court.
   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 shall notify the CSB/BHA 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 *Virginia Code* § 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 who is not treating the acquittee.

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 (§ 19.2-182.6(B)) to assess and report on the acquittee's need for inpatient hospitalization.

a. Appointment of evaluators:

(1) The DBHDS Office of Forensic Services, or designee, acting for the Commissioner, shall make the appointments upon receipt of the court order.
(2) This evaluation is an independent evaluation and does not require the approval of the FRP when recommending conditional release or release without conditions.
(3) Evaluations shall be completed and findings reported within 45 days of issuance of the court's order.
(4) Recommendation of Conditional Release by the second evaluator. If the second evaluator recommends conditional release or unconditional release, the treatment team must develop a conditional release or discharge plan with the appropriate CSB or BHA, and submit the plan to the FRP. The FRP will, in turn, review and submit the conditional release or discharge plan to the court of jurisdiction along with the Panel's 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 has a mental illness or intellectual disability and continues to require inpatient hospitalization based on the factors set forth in *Virginia Code* §

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 CSB/BHA; 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 CSB/BHA.

V. Acquittee Petition for release, pursuant to *Virginia Code* § 19.2-182.6

A. Upon receipt of an acquittee's 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 DBHDS Office of Forensic Services or designee, acting for the Commissioner, shall make the appointments upon receipt of the court order.
   b. These evaluations are independent evaluations and do not require the approval of the FRP 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. Recommendation of Conditional Release by either appointed evaluator. 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 CSB or BHA, and submit the plan to the FRP. The FRP will, in turn, review and submit the conditional release plan to the court of jurisdiction along with the Panel's recommendation.

B. At the conclusion of the hearing, 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 the acquittee 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. The acquittee meets the criteria for conditional release in § 19.2-182.7, and
   b. The court has approved a conditional release plan prepared jointly by the hospital staff and appropriate CSB or BHA; or

3. Release the acquittee from confinement if

   a. The acquittee 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 the hospital staff and appropriate CSB or BHA.

VI. Release without Conditions from the Custody of the Commissioner

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 that found the acquittee not guilty by reason of insanity and placed the acquittee in the custody of the Commissioner has the jurisdiction to discharge or 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 FRP.

D. A discharge plan prepared jointly by the hospital staff and appropriate CSB or BHA shall be submitted to the FRP with the request for release without conditions.

E. If the FRP provisionally approves the treatment team's request for unconditional release, the Panel shall follow the procedures set forth in Table 3.3 regarding the Commissioner's petition for release of the acquittee.

VII. Escape from Custody of the Commissioner

A. When an acquittee is unaccounted for the facility shall determine whether the acquittee has absconded from custody, including whether exigent circumstances have reasonably resulted in the acquittee's delayed return to the facility, or if the acquittee is out of compliance with the requirements of their risk management plan. The Forensic Coordinator, or designee, shall inform the Office of Forensic Services of the incident and the facility's determination within 1 working day of

the incident.

B. 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 escapes from that custody shall be guilty of a Class 6 felony.

C. If it is determined that an acquittee has absconded from custody, the facility shall

1. Notify appropriate law enforcement officials

2. Notify the court of jurisdiction, the Commonwealth Attorney, the acquittee's attorney and CSB/BHA.

3. Issue a warrant for the acquittee's return

4. Notify Central Office (Office of Forensic Services)

5. Revoke all privileges of the acquittee

6. If a request for victim notification has been received, notify victims or next-of kin of the victims.

7. Acquittees on escape status cannot be discharged from the hospital (including AVATAR) except by court order.

D. When it is determined that an acquittee's absence is due to exigent circumstances, or noncompliance with the risk management plan rather than escape, the treatment team shall suspend the acquittee's privileges pending a review by the acquittee's treatment team and the facility's IFPC.

The facility shall consider the acquittee's appropriateness for continued exercise of privileges, and develop a plan to mitigate the likelihood of the acquittee engaging in similar behavior. The results of the assessment and the facility's plan for mitigating the risk of escape shall be forwarded to the DBHDS Office of Forensic Services.

E. Review by the FRP is required after an 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 FRP

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 Risk (ARR);
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 FRP.

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

TABLE 3.1

Required Court Hearings for Felony Acquittees after Commitment to the 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
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, at the time of the judicial review, the felony acquittee may request release pursuant to § 19.2-182.5(B).**

TABLE 3.2

Procedures for Annual Continuation of Confinement Evaluations

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 intellectual disability, and** **- qualified by training and experience to perform forensic evaluations.**
EVALUATOR FOR SECOND EVALUATION	**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.** **Evaluators shall conduct examinations and report findings separately.**
CONTENT	**Each report must:** **- evaluate the felony acquittee's condition, and** **- recommend treatment.** **Annual reports recommending conditional release or release without conditions must be approved by the FRP prior to submission to the court.**
TIME FRAME	**The annual report must be submitted to the Office of Forensic Services 45 days prior to the hearing and is sent to the court 30 days prior to the 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.**

TABLE 3.3

Procedures for Commissioner Petitions for Conditional or Unconditional Release

LEGAL CITATION	**§ 19.2-182.6 A. 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.**
TREATMENT TEAM	**Requests consideration by the FRP of a request for release or conditional release**
FORENSIC REVIEW PANEL	**If the Panel approves the treatment team's request for conditional or unconditional release, then the Panel petitions the court on behalf of the Commissioner.**
THE PETITION	**The petition shall be signed by the Chair of the Panel, and shall be accompanied by** **- a report of clinical findings supporting the petition, and** **- a conditional release plan, or a discharge plan prepared jointly by the hospital and the appropriate CSB or BHA**
TIME FRAME	**Any time the FRP, as designated by the Commissioner, believes the acquittee no longer needs hospitalization.** **The Commissioner retains final decision-making authority regarding all placement decisions and recommendations to the court for the release of insanity acquittees.**

TABLE 3.4

Procedures for Acquittee Petition for Release Evaluations

EVALUATION	Acquittee Petition for Release Evaluation
LEGAL CITATION	§ 19.2-182.6.B.1. Upon receipt of a petition for release by the acquittee, unless otherwise required by the court.
EVALUATOR	2 evaluators appointed by the Commissioner. One psychiatrist, and one clinical psychologist Both shall be - Skilled in the diagnosis of mental illness and intellectual disability, 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. Evaluators shall conduct examinations and report findings separately.
CONTENT	The evaluators shall review the acquittee's condition with respect to the factors set forth in § 19.2-182.3.
TIME FRAME	Report is due within 45 days of issuance of the court's order for evaluation.

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 Behavioral Health and Developmental Services. This model order was developed in conjunction with the Office of the Attorney General.

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 DBHDS
Forensic Review Panel
Treatment Team

Model Order for Initial Commitment

VIRGINIA:

IN THE __________________ COURT OF _____________________

COMMONWEALTH OF VIRGINIA
v. _____________________________DOCKET No.:______________________
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 counsel, ___________. Based upon the written evaluations submitted by _____________, the oral testimony of ______________, and the arguments of counsel, the court finds that the acquittee has ___ mentally illness or ___ intellectual disability and is in need of hospitalization based on the factors in Virginia Code § 19.2-182.3. Therefore, the court orders that the acquittee be committed to the custody of the Commissioner of the Department of Behavioral Health and Developmental 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 Virginia 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 report so that issues regarding the 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
Supervising Community Services Board
Chief Forensic Coordinator, Central State Hospital
Commissioner of DBHDS
Attention: Director of Forensic Services
DBHDS Division of Forensic Services
P. O. Box 1797
Richmond, VA 23218

Model Order for Recommitment

Virginia:
In the ______________________ court of ___________________________________
Commonwealth of Virginia v. _________________________Case No:___________________

NOT GUILTY BY REASON OF INSANITY – RECOMMITMENT FOR 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 has a ___ mental illness or ___ intellectual disability, and is in need of hospitalization based on the factors in Virginia Code Section 19.2-182.3. Therefore, the court ORDERS that the Acquittee be recommitted to the custody of the Commissioner of the Department of Behavioral Health and Developmental 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 Virginia Code Section **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: _____________________

SIGNATURE OF JUDGE: _____________________
NAME OF JUDGE: ____________________

cc: Commonwealth's Attorney
Acquittee's Attorney
Community Services Board
Commissioner of DBHDS; Attn: Forensic Services,
P.O. Box 1797, Richmond, Va. 23218

CHAPTER 4

The Privileging Process for Insanity Acquittees

I. Graduated release:

The acquittee management program in the DBHDS 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 their capability for functioning at increasing levels of community access. The following are guidelines for requesting (i) transfers to less restrictive settings, (ii) increases in levels of privileges, and (iii) release from hospitalization.

A. Virginia Code § 19.2-182.4.A allows the Commissioner to: (a) make interfacility transfers and treatment and management decisions regarding acquittees in his custody without review by or approval of the court, (b) authorize a temporary pass from the hospital if the pass would be therapeutic for the acquittee, and would pose no substantial danger to others. Passes may not exceed 48 hours. Privileges may only be granted to insanity acquittees who have been committed to the custody of the Commissioner of the DBHDS.

B. Requests for increased privileges or release from hospitalization 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 less restrictive privileges are recommended.

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 demonstrate appropriate functioning at various levels of freedom

4. Provide treatment teams with information regarding an acquittees' ability to handle additional freedom and to comply with risk management plans. This information is critical in considering the appropriateness of conditional release, and whether an acquittee meets the statutory requirements for conditional release.

5. Minimize risk to public safety

D. Options in the graduated release process (see also Chart 4.1)

1. Transfer from Maximum Security Unit of Central State Hospital to a civil unit of a 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 approval by the court of jurisdiction.)**

II. Risk assessment factors considered by the Forensic Review Panel (FRP) and the Internal Forensic Privileging Committees (IFPC): The FRP 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 an undue risk to self or others?

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

C. Is the requested privilege supported 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 the acquittee's 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 and precipitants of the behavior.

C. Evidence from the medical records and other sources that the acquittee has sufficient clinical stability to exercise the privilege, and

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 hospitalization, particularly during the past 90 days, and

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

   a. A danger to the community or other clients,
   b. Risk of escape, or
   c. Danger to self.
   d. Acquittees adjudicated NGRI for a sex offense, that would have required registration if convicted, must register with the Virginia State Police sex offender registry (see Virginia Code § 9.1-901, -902). Failure/refusal to register may be cause to deny privileges.

D. Acquittee's current mental status, including

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

2. Understanding of their 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 recommended by the treating team. 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 privileges: It is expected that less restrictive privileges will be integrated into the acquittee's treatment plan, and used to facilitate a graduated transition toward conditional release. In certain instances multiple privileges can be part of a single request. Examples of combining privileges include combining escorted community privileges with escorted grounds privileges or unescorted grounds privileges. In certain instances privileges may be skipped, examples include individuals suffering from developmental issues, dementias or other neurocognitive issues that preclude their ability to exercise unescorted community privileges where allowing the acquittee to independently access the community would expose either the acquittee or the public to undue risk.

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; and
   d. Places to be avoided. Specific names and contact information for persons to be contacted if problems arise should be included.

2. Phase-in periods are useful additions to risk management plans; they can introduce the acquittee to the new privilege in graduated steps. Once a privilege level is approved by the IFPC/FRP, the treatment team has discretion to phase-in the privilege.

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 CSB or BHA.

H. In cases where the acquittee has been previously placed for treatment at a less restrictive unit or received less restrictive privileges, attention is given to the acquittee's behavior and general adjustment, 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 CSB/BHA: The treatment team shall work closely with the appropriate CSB or BHA as the acquittee progresses through the graduated release process.

1. The CSB/BHA(s) may provide input to the treatment team, to the IFPC, and to the FRP during the entire process of graduated release.

2. Collaboration with the CSB/BHA(s) is particularly important when planning and implementing transfer to a different facility, visits to the community, and conditional or unconditional 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. Transfers from Maximum Security:

In cases where the acquittee is being transferred from Maximum Security at Central State Hospital to another facility, appropriate staff members in the receiving facility shall be involved in the decision-making process.

1. All instances of transfer from Maximum Security require the approval of the FRP.

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 FRP 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, 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 FRP, and to the DBHDS 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, in conjunction with requests for civil transfer, revocation of conditional release, or following return from escape, must be reviewed and approved by the FRP. (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 IFPC 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 IFPC or the FRP.

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

3. Following the granting of unescorted, non-overnight community privileges by the FRP, the IFPC 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 FRP.

   a. Treatment teams should immediately contact their Forensic Coordinator, who will then contact the Chair of the FRP 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. 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 the Commonwealth's Attorney (§ 19.2-182.4.C) regarding community visits

A. Virginia Code Section 19.2-182.4.C 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 DBHDS facility to another, including transfer from the Maximum-Security unit to another unit at Central State Hospital.

B. After approval from the IFPC, the FRP and the court, if necessary, and prior to implementation of the community visit or trial visit, the Forensic Coordinator shall provide written notification of the approval for the acquittee to leave the grounds of the hospital to the Commonwealth's Attorney for the acquittee's committing jurisdiction. The Forensic Coordinator should provide a copy of this notification to the DBHDS Office of Forensic Services. See form for Notification

of Commonwealth's Attorney later in chapter.

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

VI. Roles and responsibilities of the Internal Forensic Privileging Committee (IFPC) (See also Tables 4.3 & 4.4)

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 (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 FRP. Before any request is submitted to the FRP, the IFPC must ensure that the treatment team has successfully completed any revisions to the submission that had been recommended by the IFPC. 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 FRP. The only exceptions to this requirement for support of the request by both the treatment team and the IFPC are:

   a. When the court has ordered the facility to prepare a conditional release plan or a discharge plan for unconditional release, and the treatment team and/or the IFPC do not believe that the lessening of restrictions is clinically appropriate; or
   b. 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/or the IFPC do not believe that the lessening of restrictions is clinically appropriate.

B. IFPC: Structure and Function

1. Each IFPC is composed of at least five (5) members, appointed by the facility director. The membership must include the following:

   a. Facility director or designee administrator

b. Medical director, psychiatrist, and Nurse Practitioner
c. Forensic coordinator
d. Licensed clinical psychologist (if Forensic Coordinator is not a clinical psychologist)

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 DBHDS-mandated training in forensics, including Basic Adult Forensic Evaluation, NGRI Management, and Violence Risk Assessment.
   b. Appropriate clinical experience (clinical staff only)
   c. Completion of prescribed privilege-granting training activities with the FRP, or other DBHDS-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 may attend scheduled meetings.
   c. A quorum of the IFPC is necessary to make a determination regarding any privilege request. A quorum consists of at least three members. A psychiatrist and one licensed clinical psychologist must be present at an IFPC meeting for a 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. The decision of the IFPC shall be provided to the Treatment Team within 2 working days following the IFPC's review of a privilege request.
   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. IFPCs will develop and maintain centralized files on acquittees. These files will include, at a minimum, the following:

      (1) Copies of all of the court, hospital and evaluative documents that were provided to the FRP at the initial

request for privileges for an acquittee. This information should include the Temporary Custody evaluations, the Initial Analysis of Risk Report, and the initial FRP privilege request packet, if applicable.

(2) Privileging documents supporting all subsequent requests to either the FRP 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 FRP.

6. Scheduled meetings

a. The Facility Director and the Chair of the IFPC shall establish times.

b. The IFPC Chair, or designee, shall disseminate the dates and times of deadlines for submission of requests to be considered at the meetings.

c. If the IFPC will not hold a regularly scheduled weekly meeting, the Facility Director and the DBHDS Office of Forensic Services (or designee) shall be notified in advance, by the Chair of the IFPC. 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 (or designee), on behalf of the Chair, will notify the Facility Director and the DBHDS Office of Forensic Services (or designee). When IFPC members are not able to attend a weekly IFPC 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 IFPC 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, as necessary to complete all reviews within the required time frames.

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

A. The Forensic Review Panel (FRP, the "Panel") is an administrative board established by the Commissioner pursuant to *Virginia Code* § 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. Virginia Code §19.2-182.13 provides the Commissioner of DBHDS with the authority to delegate any of the duties or powers imposed on or granted to him or her, by this chapter, to an administrative panel composed of persons with demonstrated expertise in such matters.

2. The Division of Forensic Services, 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 while acting within the scope of their duties except for intentional misconduct.

C. Policy

1. Treatment team requests which fall within the categories outlined below in D and E shall be presented to, reviewed by, and approved by the FRP, 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 (including outpatient temporary custody).

4. It is the policy of the DBHDS that acquittees with active court orders for conditional release who are awaiting placement shall remain under the

supervision 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 FRP prior to submission to the court.

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 CSB or BHA develop a conditional release plan for the acquittee, that plan shall be jointly developed by the acquittee's treatment team and CSB or BHA and submitted for review to the FRP.

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

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

1. All requests from treatment teams for:

   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 an acquittee's level of privilege and access to the community while in the custody of the Commissioner:

   a. Transfers to less restrictive units and/or hospitals.
   b. Additional privileges, in conjunction with transfer from maximum-security hospital placement. Acquittees whose temporary custody occurs at a civil facility must have a packet submitted to the FRP, upon their commitment to the custody of the Commissioner. The packet shall indicate whether or not the acquittee remains appropriate for continued placement in a civil facility and request an appropriate level of additional privilege(s)
   c. Unescorted community visits, not overnight

3. The Commissioner has delegated the granting of the following privileges to the IFPCs at each DBHDS hospital:

   a. Escorted Grounds Privileges
   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 visits, 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.

5. At any time an acquittee's level of privilege needs to be adjusted, treatment teams may either suspend a privilege, or may request either the IFPC or FRP, as appropriate, revoke a level of privilege. Privilege levels exclusively approved by the FRP require FRP review and approval in order to revoke the privilege.

F. Structural and Operational Parameters of the Panel (See also Tables 4.3 & 4.4)

1. Composition of the FRP

a. The Structure of the FRP

(1) The membership of the FRP shall include a minimum of at least seven (7) members.
(2) The membership of the Panel shall include at least two members from each of the following professional categories:

i. Psychiatrist
ii. Licensed Clinical Psychologist
iii. Other licensed mental health practitioners, including CSB representatives, if available

(3) All Panel members will have requisite forensic experience and training, as prescribed by the Commissioner of the DBHDS.
(4) All individuals appointed to serve as members of the Panel who are not employees of DBHDS are required to sign statements indicating their awareness of the need to maintain confidentiality of client records, and promising to maintain such confidentiality.
(5) Appointments shall be made and renewed at the discretion of the Commissioner. Each term is for three (3) years.
(6) Upon appointment by the Commissioner, Panel members shall receive an orientation to the privileging process. Panel members will also be provided with annual in-service

training.

b. Functional Parameters of the Panel

(1) 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. A quorum must exist for the FRP to take action on a request.
(2) All decisions of the FRP regarding privileges, Conditional Release, or Unconditional Release require the agreement of a majority of the members at the meeting present and voting,
(3) 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 Operations Manager of the Office of Forensic Services shall be notified in advance by the Chair.
d. When Panel 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, or via email. 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 if necessary.
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 Operations Manager for the Office of Forensic Services. The Operations Manager for the Office of Forensic Services will notify their supervisor of the cancellation of the meeting.
h. The Chair of the Panel will notify the Operations Manager for the Office of Forensic Services, or the administrative coordinator, of any cancellation of meetings as a result of a lack of packets for review. The Program Manager for the Office of Forensic Services

will notify their supervisor of the cancellation of the Panel meeting.

3. Chair of the Panel

   a. The Chair of the FRP 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:

      (1) Works with the Director and staff of the Office of Forensic Services in communicating with the courts, facilities and CSBs on NGRI acquittee matters.
      (2) Represents the FRP and Commissioner in response to witness subpoenas for the Panel.

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. Polling the membership to ensure that a quorum will be present for each meeting
   e. 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
   f. Notifying Panel members and the Program Manager for the Office of Forensic Services of any canceled meetings, and
   g. Providing other necessary services in support of the Panel's functions

VIII. Facility Forensic Coordinator

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

   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. 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 if the acquittee requests assistance. 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. 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 IFPC:

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 via the Forensic Coordinator within 10 working days.
b. Within one (1) working day of receipt of notification by the treatment team of a decision from the IFPC 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 acquittee'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 the IFPC's formal review.
b. Receive and deliver to the treatment team(s) all information received from the IFPC.

Specific responsibilities of the Forensic Coordinator include the following:

a. Coordinate the submission of requests for increases in privilege levels to the IFPC.

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

b. Submit the privilege packet to the IFPC within three (3) working days after receipt of 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.
c. 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.
d. Upon receipt of a decision from the IFPC, the Forensic Coordinator will notify the Treatment Team of the decision within one (1) working day. The designated member of the Treatment Team will be instructed by the coordinator to inform the insanity acquittee of the Committee's decision within one (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 DBHDS 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 Risk Report, 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 Risk Report completed by the treatment team within the 30 days immediately prior to the

submission of the review packet (See Appendix A).

(1) Include risk management plan.
(2) An updated, Analysis of Risk Report (ARR) addressing all risk factors identified in the initial and subsequent ARR updates, and including and addressing all risk factors identified during the course of evaluation and treatment.

c. Mental Status Evaluation (MSE) completed by the treatment team within the 30 days immediately prior to the submission of the review packet to the IFPC.
d. Completed IFPC Submission Summary Sheet:

(1) All documentation required by the IFPC submission summary sheet must be included.

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

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

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 or BHA 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:

        (1) 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?
        (2) Has the treatment team developed a risk management plan that adequately manages the assessed risk?
        (3) 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 a majority of the quorum.
        (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

(1) Approve the team's privilege request, no revisions required.
(2) 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.
(3) Defer approval, pending revisions and further review by the IFPC. The IFPC returns the case to the treatment team for revision, with the requirement that the case be again reviewed, by the IFPC and the Facility Director, after the changes have been made. All revisions by the treatment team must be reviewed and approved by the head of that treatment team prior to resubmission.
(4) 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 that would need to be manifested before the IFPC could grant approval of a privilege request for that acquittee.

e. Final Decision of IFPC

(1) The IFPC Chair, or designee, fills out the IFPC Decision Notification. That document includes:

i. The request to the IFPC;
ii. The IFPC's assessment of the treatment team's assessment of risk, the risk management plan, and the justification for increased freedom;
iii. The decision of the IFPC, signed by the Facility Director; and
iv. The IFPC's comments to the treatment team, as appropriate.

(2) Notification of all IFPC decisions is provided to the Chair of the FRP 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 FRP of all IFPC privilege decisions.

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

i. The Chair of the FRP
ii. The Office of Forensic Services, for inclusion in the acquittee's FRP record
iii. The CSB's NGRI Coordinator
iv. The head of the acquittee's treatment team, for inclusion in the acquittee's medical record

(4) 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.

(5) 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.

(1) 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.

(2) 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.

(3) 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 the documentation. Following that review, the FRP will render one of the following decisions on the matter:

   (1) A finding upholding the IFPC's original decision on the matter.
   (2) A directive to the IFPC, to reconsider the original privilege request of the acquittee.
   (3) 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 Forensic Coordinator.

XI. The Process for Privileges Granted by the Forensic Review Panel (FRP)

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

A. The FRP must 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 additional privileges)

2. Initial Unescorted Community Access (8 hour passes)

3. Conditional Release (all cases, including Temporary Custody)

4. Unconditional 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 CSB. 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 who has not had a privilege increase during the preceding 365 days. 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 D, and shall include all components contained therein, as well as a separate 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 72 hours 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 a majority of the quorum of the IFPC membership, including one psychiatrist and one clinical psychologist. If there is not a 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 DBHDS Office 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 or Unconditional Release, or should the court of jurisdiction pursuant to Virginia Code Section 19.2-182.5, order that a Conditional Release or discharge plan be prepared, a complete packet must be forwarded to the FRP by the Forensic Coordinator. In cases where the request is for conditional or unconditional 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 or discharge plan in collaboration with the CSB.
b. In cases where there is a court order requiring the submission to the court of a conditional release or discharge 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 DBHDS 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. FRP report (template, use narrative report for requesting release)
b. Recent Annual Report to the court (See Appendix D)
c. An Initial Analysis of Risk Report. (Required for all newly committed patients, and with court-ordered conditional release plans.) (See Appendix A).
d. Updated Analysis of Risk Report completed within 30 days of receipt by the Forensic Coordinator for submission to the FRP (See Appendix A). The updated Analysis of Risk Report (ARR) will include and address all risk factors identified in the initial and

subsequent ARR updates, and will include and address all risk factors identified during the course of evaluation and treatment.

e. Include current risk management plan.

f. 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

(1) All documentation required by the submission summary sheet must be included.

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

h. Any other items specified in the Submission Summary Sheet

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

j. Requests for Unescorted community visits (not overnight) require a statement of agreement signed by the acquittee, the treatment team and the receiving CSB.

k. 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.

l. Requests for conditional or unconditional release shall include the following additional information (See Chapter 5 and Appendix F).

(1) Conditional release or discharge plan with components specified on the template

(2) Completed CSB agreement and recommendations/comments regarding the proposed conditional or unconditional release

(3) Completed acquittee review and agreement to terms of proposed conditional release or unconditional release

(4) 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.

3. The Chair of the FRP, or designee, 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, may return the packet to the facility Forensic Coordinator, with

recommendations for modifications or additions.

4. 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.

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

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

6. 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.

7. 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.

8. FRP Decision-Making

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

      (1) 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?
      (2) Has the treatment team developed a risk management plan that adequately manages the assessed risk?
      (3) 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 of the FRP membership must be present before a final decision can be made.
      (2) 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

(1) 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 quorum. The members of the FRP will sign all FRP decisions, indicating their participation in the decision making process).

(2) 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

(1) Approve the team's privilege or release request, no revisions required.

(2) 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.

(3) 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.

(4) 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 that would need to be manifested before the FRP could grant approval of a privilege request for that acquittee.

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

e. Final Decision

(1) FRP Chair fills out the FRP Decision Notification which includes:

i. The request to the FRP;
ii. The FRP's assessment of the treatment team's assessment of risk, risk management plan, and justification of increased freedom;
iii. The decision of the FRP; and
iv. The FRP's comments to the treatment team, when appropriate.

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

i. The acquittee's Forensic Coordinator,
ii. The CSB's NGRI Coordinator, and
iii. The Office of Forensic Services.

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

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

(5) In the case of Conditional or Unconditional Release submissions, the FRP provides a cover letter to the court petitioning conditional release or release without conditions and includes a model order for the court's convenience. Release requests initiated by the treatment team shall include the conditional release or discharge plan, report of clinical findings (see Virginia Code §19.2-182.6) and other supporting information deemed relevant by the FRP. If the FRP disapproves a court ordered conditional release or discharge 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 or Discharge Plan.

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

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

(8) 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.

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

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

f. 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:

(1) 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.

(2) 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.

(3) 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 Deputy Director of Forensic Services, and to the Chair of the FRP, within one (1) working day of their receipt from the facility.

(4) The Deputy Director of Forensic Services shall be provided with all additional documentation required for a thorough review of the FRP's decision, by the administrative coordinator of the FRP.

(5) The Deputy Director of Forensic Services 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 Deputy Director of Forensic Services 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. In its reconsideration the FRP may request that the treatment team provide additional information for the FRP's consideration.
iii. A directive rescinding the original decision of the FRP, and granting the privilege request of the acquittee.

(6) 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 Deputy Director of Forensic Services.
(7) 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 Deputy Director of Forensic Services within one (1) working day of notification of that decision by the Forensic Coordinator.
(8) If the Deputy Director of Forensic Services directs the FRP to reconsider the request and 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.

Chart 4.1
Graduated Release Flow Chart

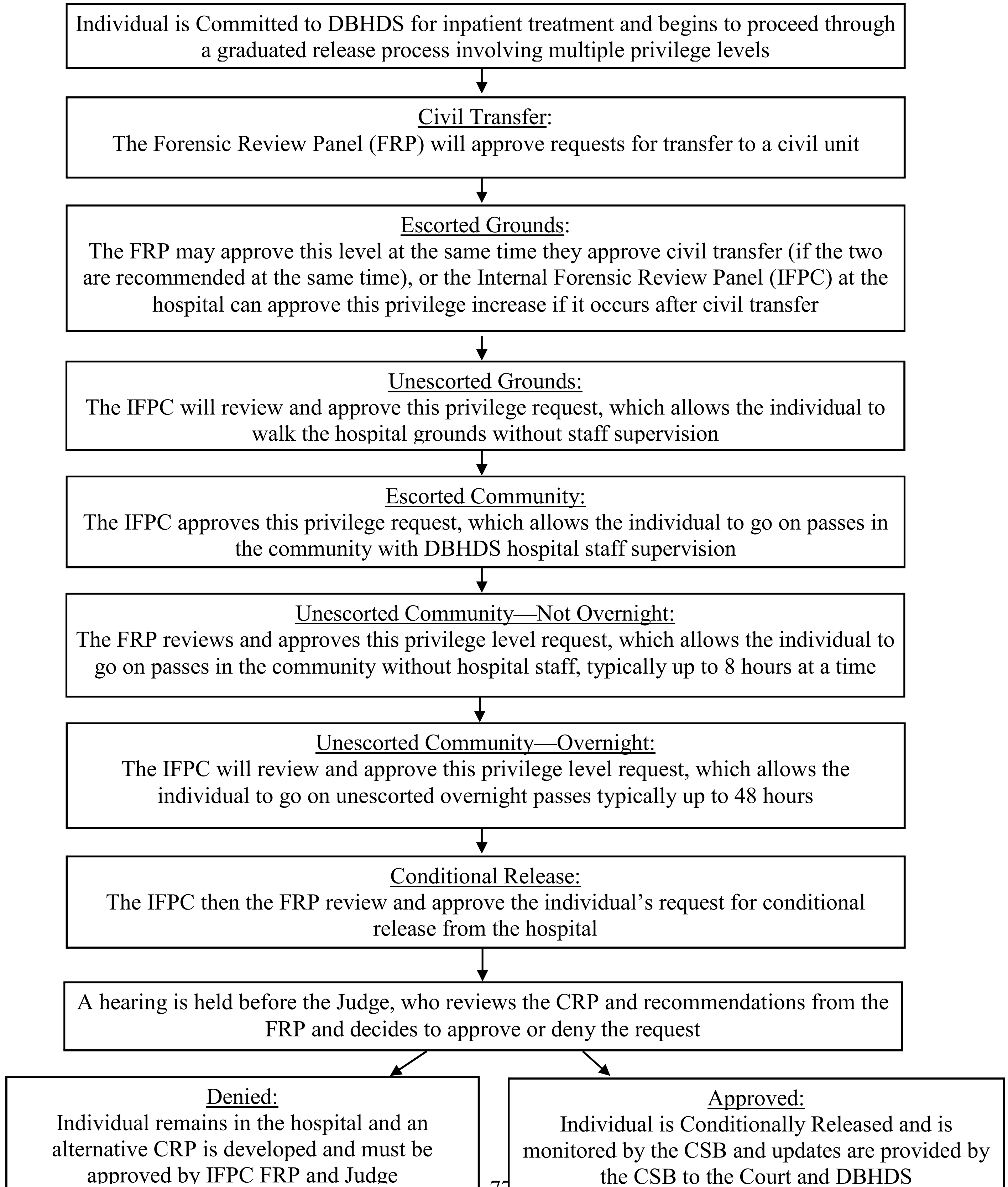


TABLE 4.2
Changes in Status:
Whose Permission Is Required Before Granting a Change in Status?

	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 4.3
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 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 DBHDS Commissioner, pursuant to § 19.2-182.13 of the Code	**A total of 5 members, including:** Facility Director or designee Medical Director or designee 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 4.4
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 FRP, 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 FRP	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 4.5
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, and signature.	Reviews, approves or disapproves IFPC recommended decision within (2) working days. Submits documentation to Chair of FRP 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 FRP, 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

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 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.

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	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.	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

FORENSIC REVIEW PANEL PRIVILEGE REQUEST AND DECISION NOTICE

FACILITY: ______________________________

Last Name: ____________________ **First Name:** ____________________ **Reg. No:** ______________

Date Request Received: ____________________ **Date Reviewed:** ______________________________

PRIVILEGE REQUESTED: *(check all that apply)*

☐ Transfer to Civil __________ Facility: __________

☐ Escorted Grounds ______________________________

☐ Unescorted Grounds ______________________________

☐ Escorted Community ______________________________

☐ Unescorted Community (not overnight) __________

☐ Unescorted Community (up to 48 hrs) __________

☐ Conditional Release __________ Type: __________

☐ Unconditional Release __________ Type: __________

☐ REVOKE Conditional Release ____________________

☐ RESUME Conditional Release ____________________

☐ Annual Review ______________________________

☐ Consultation ______________________________

☐ REVOKE Approved Privileges ____________________

☐ RESTRICTED Privilege ______________________________

PRIVILEGE HISTORY: *(Date Approved)*

☐ Transfer to Civil: ______________________________

☐ Escorted Grounds: ______________________________

☐ Unescorted Grounds: ______________________________

☐ Escorted Community: ______________________________

☐ Unescorted Community (not overnight): ______________________________

☐ Unescorted Community (up to 48 hrs): ____________________

☐ Conditional Release: ______________________________

☐ Unconditional Release: ______________________________

☐ Annual Review: ______________________________

☐ Other: ______________________________

PACKET CONTENTS: *(Check all that apply)*

☐ FRP Report
☐ UPDATED Analysis of Risk (ARR)
☐ Initial Analysis of Risk (IARR)
☐ Temporary Custody Evaluation(s)
☐ Risk Management Plan(s)
☐ Annual Report
☐ Conditional Release Plan
☐ Discharge Plan (Unconditional Release)
☐ Other

DECISION: *(check)*

Yes ☐	**No** ☐	**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** ☐	**HAS THE TREATMENT TEAM DEVELOPED A RISK MANAGEMENT PLAN THAT ADEQUATELY MANAGES THE ASSESSED RISK?**
Yes ☐	**No** ☐	**IS THE INCREASED FREEDOM REQUESTED JUSTIFIED BY THE TREATMENT TEAM'S ASSESSMENT OF RISK AND PLAN FOR RISK MANAGEMENT?**

☐ APPROVED
☐ APPROVED PENDING REVISION, FURTHER REVIEW REQUIRED BY: ☐ COMMITTEE ☐ CHAIR
☐ DEFERRED FOR REVISION OR MORE INFORMATION; ANOTHER REVIEW REQUIRED BY: ☐ COMMITTEE ☐ CHAIR
☐ DISAPPROVED
☐ REMARKS *(See Comments on page 2)*

_______________________________	_______________
CHAIR, Forensic Review Panel	**Date**

INTERNAL FORENSIC PRIVILEGING COMMITTEE DECISION NOTICE

FACILITY:

Last Name: ____________ **First Name:** ____________ **Reg. No:** ____________

Date Request Received: ____________ **Date Reviewed:** ____________

Privilege Requested:

☐ Transfer to Civil (Facility:)

☐ Escorted Grounds

☐ Unescorted Grounds

☐ **Escorted Community:

☐ **Unescorted Community (not overnight):

☐ **Restricted Privilege:**

☐ ** Unescorted Community (up to 48 hrs)

☐ **Conditional Release:

☐ **Unconditional Release:

☐ Annual Review:

☐ Consultation:

****Privileges allowing access to the community require notification to Commonwealth Attorney (VA Code δ19.2-182.4c)**

Yes ☐ **No** ☐ **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** ☐ **HAS THE TREATMENT TEAM DEVELOPED A RISK MANAGEMENT PLAN THAT ADEQUATELY MANAGES THE ASSESSED RISK?**

Yes ☐ **No** ☐ **IS THE INCREASED FREEDOM REQUESTED JUSTIFIED BY THE TREATMENT TEAM'S ASSESSMENT OF RISK AND PLAN FOR RISK MANAGEMENT?**

DECISION:

☐ **APPROVED**
☐ **APPROVED PENDING REVISION, FURTHER REVIEW REQUIRED BY: COMMITTEE / CHAIR**
☐ **DEFERRED FOR REVISION OR MORE INFORMATION; ANOTHER REVIEW REQUIRED BY: COMMITTEE / CHAIR**
☐ **DISAPPROVED**
☐ **REMARKS (SEE COMMENTS ON PAGE 2)**

PRIVILEGING COMMITTEE MEMBER SIGNATURES:

____________ ____________

____________ ____________

____________ ____________

FACILITY DIRECTOR (or Designee)

____________ ____________ ____________

CHAIR, Internal Forensic Privileging Committee **Date** **Facility**

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 A REQUEST FOR A PRIVILEGE INCREASE HAS BEEN DISAPPROVED.

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 Behavioral Health and Developmental 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, DBHDS
Acquittee's Attorney
Judge
CSB NGRI Coordinator

CHAPTER 5

Planning For Conditional Release
(§ 19.2-182.7)

I. Legal parameters of the Conditional Release planning process.

Virginia Code § 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. When this occurs, the procedures outlined here apply to all courts having jurisdiction over the acquittee. In order for an acquittee to be released on conditional release or unconditional release, all courts in which the acquittee was found NGRI must approve either conditional or unconditional release.

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 conditional release from the committing NGRI court.

B. A recommendation for conditional release as a result of an evaluation pursuant to Virginia Code § 19.2-182.2 or §19.2-182.5 (acquittee petition).

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

Regardless of the reason for the request, the hospital must submit all requests for conditional release to the FRP for review and recommendations to the court.

III. Petitions for Release (§ 19.2-182.6.A)

A. By Commissioner, pursuant to § 19.2-182.6.A

1 On behalf of the Commissioner, the FRP 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 FRP 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 CSB or BHA.

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 CSB or BHA serving the locality to which the acquittee has been proposed for conditional release (and the original CSB or BHA if these are not the same).
e. Administrative Coordinator of the FRP.

4. Appointment of evaluators

a. Upon receipt of a petition for release from the Commissioner, no

further evaluations are required unless deemed necessary by the court, in which case the court shall order the Commissioner to appoint two persons to assess and report on the acquittee's need for inpatient hospitalization (§19.2-182.6.B.2).

(1) See Table 3.4: Petition For Release Hearing Evaluation
(2) The Deputy Director of the Office of Forensic Services (or designee), 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 do not require the approval of the FRP 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. Acquittee Petition for Release pursuant to Virginia Code §19.2-182.6.B.1

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 an acquittee’s petition for release, the court shall order the Commissioner to appoint two persons (§ 19.2-182.6.B.1), to assess and report on the acquittee's need for inpatient hospitalization.

(1) See Table 3.4: Petition For Release Hearing Evaluation
(2) The DBHDS 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 do not require the approval of the FRP 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 or Unconditional Release by an evaluator

If either Commissioner appointed evaluator recommends conditional or unconditional release, the treatment team must develop a conditional release plan or discharge plan with the appropriate CSB or BHA, and submit the plan(s) to the FRP. The FRP will, in turn, review and submit the conditional release and/or discharge plan to the court of jurisdiction, with the Panel's 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 should notify the CSB or BHA 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 has a mental illness or intellectual disability and continues to require inpatient hospitalization based on consideration of the factors set forth in § 19.2-182.3.

b. Place the acquittee on conditional release if

(1) He or she meets the criteria for conditional release (§19.2-182.7), and

(2) The court has approved a conditional release plan prepared jointly by the hospital staff and appropriate CSB or BHA; 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 CSB or BHA.

IV: Victim notification (§ 19.2-182.6(B), §19.2-182.4)

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 at the last known address, provided the person submits a written request for such

notification to the Commissioner. Section § 19.2-182.4.B requires the Commissioner to give notice of the granting of an unescorted community visit to any victim of a felony offense against the person punishable by more than five years in prison that resulted in the charges on which the acquittee was acquitted or the next-of-kin of the victim at the last known address, provided the person seeking notice submits a written request for such notice to the Commissioner.

B. Victims interested in receiving notification of these hearings shall write the Commissioner expressing their interest and provide their names and addresses, or other means of contacting the individual in a timely manner.

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

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

2. Write the individual requesting notification informing the individual of the contact information for the facility in which the acquittee is receiving treatment.

3. Send a copy of the letter to the Forensic Coordinator of the facility in which the acquittee is receiving treatment.

D. The Forensic Coordinator shall

1. Work closely with the treatment team and the court to monitor the acquittee's hearings pursuant to § §19.2-182.5 & 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) or §19.2-182.5.

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 or unconditional release must be reviewed and approved by the FRP.

B. General guidelines used by the FRP 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 and compliance with risk management plans 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 CSB or BHA

1. Virginia Code §§ 19.2-182.2, 19.2-182.5 (C), and 19.2-182.6(C) explicitly require CSBs or BHAs 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 CSB or BHA 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 or BHA is a member of the treatment team for the acquittee. It is important for the CSB or BHA 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/BHA provider involvement in conditional release plans:

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

2. Non-CSB/BHA staff providing components of the conditional release plan may be asked by the CSB/BHA to provide written confirmation of their willingness to provide specific components of the plan, regular progress updates to the supervising CSB/BHA, 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/BHA 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/BHA 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 CSB or BHA in the area of the acquittee's conditional release residence is responsible for implementing the conditional release plan and providing appropriate services.
b. The CSB or BHA from the original jurisdiction may provide consultation or collaboration, if appropriate.
c. The CSB or BHA 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 DBHDS.

4. When the CSB or BHA changes, the original CSB or BHA should remain involved until the new CSB or BHA has accepted the transfer and the responsibilities for case management.

D. Community Resource Planning

It is important that the CSB/BHA meet with the acquittee as soon as possible upon hospitalization in order to begin the planning process for the 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 F**. (Electronic files 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 CSB. The understanding that, pursuant to § 19.2-182.15, he or she shall be guilty of a class 6 felony if he or she leaves the Commonwealth of Virginia without court permission.
   d. Agreement not to use alcoholic beverages.
   e. Agreement not to use or possess any illegal drugs or other medication not prescribed for the acquittee.
   f. Agreement not to possess or use weapons.

3. Examples of specific rehabilitative components of community care that are

typically focused upon in treatment and service provision with acquittees:

a. Substance use counseling and monitoring
b. Alcoholics Anonymous or Narcotics Anonymous groups, or other substance use treatment
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 CSB 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.
      (4) An acquittee may also be subject to restrictions or reporting requirements required by other law enforcement entities such as the US Secret Service or Homeland Security.

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/BHA staff. It is critical that the hospital staff notify the CSB/BHA of each community visit once the acquittee has reached the privilege level of unescorted, not overnight. This notification procedure will facilitate the coordination necessary for the conditional release planning process, and help to maximize integration with community resources.

B. Acquittee's agreement to the conditions of release

1. It is recommended, but not 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. CSB/BHA agreement to the conditions of release

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

2. A separate section of the conditional release plan is provided to give the CSB/BHA staff an opportunity to make independent recommendations and/or comments to the FRP and/or court regarding the proposed conditional release plan. All documents submitted to the FRP should be signed and dated.

VIII. 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 provide 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 CSB(s), and the Director of Forensic Services noting

      (1) The date of final discharge;
      (2) The name, address, and phone number of the CSB 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 (such as those unusual instances where an acquittee is released by the judge directly from the courtroom), the CSB or BHA where the acquittee was released shall be immediately notified by the facility staff.

2. 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.

IX. 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 F**.

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/BHA 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 Risk Report. 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 Risk Report, along with other risk assessment instruments and documents, to the NGRI Coordinator for the CSB/BHA.

CHAPTER 6

Conditional Release and Release Without Conditions

I. Community Services Board/Behavioral Health Authority (CSB/BHA) NGRI Coordinator

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

1. Oversee compliance of the CSB/BHA 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/BHA 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, DBHDS facility Forensic Coordinators and staff from the state mental health facilities, Office of Forensic Services, 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. Virginia Code §19.2-182.7 requires the CSB/BHA serving the locality in which the acquittee will reside upon release to

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

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

1. Progress, and

2. Adjustment in the community.

III. Assistance from the DBHDS Office of Forensic Services

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

B. Copies of the following should be sent to the DBHDS Office of Forensic Services in a timely fashion

1. Monthly reviews of conditional release (See format and instructions at end of this chapter), for the first twelve months following release

2. Six month reports to the court (See format and instructions at end of this chapter), for the duration of conditional release

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 Virginia Code §19.2-182.7, by the CSB/BHA 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/BHA 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/BHA staff person supervising the 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 signed copy of the six month court report should be submitted to the judge holding jurisdiction over the acquittee (or judges if multiple courts are holding jurisdiction). 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. DBHDS Office of Forensic Services.

V. Acquittee non-compliance 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 Risk Report.

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 DBHDS facility treatment team that 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 DBHDS Office of Forensic Services should also be consulted or notified when modification of the conditional release plan or revocation is being considered

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 is 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/BHA case manager must monitor the entire conditional release plan (all general and special conditions). When the CSB/BHA case manager determines that the conditional release plan needs to be modified, it is incumbent upon the CSB/BHA 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/BHA 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 of conditional release.

C. Procedures for modification

1. The court of jurisdiction may modify conditions of release upon its own motion based upon reports of the supervising CSB/BHA, or upon petition

of any of the following entities:

a. Supervising CSB/BHA;
b. Attorney for the Commonwealth; or
c. The acquittee; who may petition only once annually commencing six months after the conditional release is ordered (see VA Code 19.2-182.11.A).

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

    a. In cases where the supervising CSB/BHA is requesting the modification, the petition should be accompanied by a written report specifying the request and providing a 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 DBHDS Office of Forensic Services.

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 CSB or BHA,
    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 CSB/BHA have an opportunity to present evidence challenging 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 the conditional release plan,
   c. Degree of compliance with psychotropic medication,
   d. Risk factors identified in the Analysis of Risk Report
   e. Acquittee's understanding of the criminal penalty for escape from conditional release (i.e., § 19.2-182.15),
   f. The availability of support systems, 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/BHA, 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 DBHDS hospital for revocation admission.

An acquittee in need of inpatient treatment may elect voluntary admission to a DBHDS facility. In those cases, discharge to conditional release from the hospital within 60 days does not require FRP review. If the treatment team is recommending revocation of conditional release for acquittees voluntarily admitted who were unable to resume conditional release within the initial 60 days, then FRP review is required.

Once the acquittee is revoked, the NGRI Coordinator of the CSB/BHA 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/BHA 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 CSB/BHA in requesting a response from the court.

3. The evaluator must 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 is no longer a proper subject for conditional release based on application of the criteria for conditional release, and
    b. Has a mental illness or intellectual disability 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 district court judge or special justice as defined in § 37.2-100 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, 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 person designated by the CSB/BHA 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 eight 8 hours.

3. A judge or special justice 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 seventy-two (72) hours prior to a hearing (if the 72-hour period expires on a Saturday, Sunday, or legal holiday, the 72 hours shall be extended to the next business day), 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, and
b. Requires inpatient hospitalization.

4. The committing court or any judge or special justice 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; and
(2) has a mental illness or intellectual disability and is 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 facility that serves the region to which the acquittee was conditionally released, thus facilitating continuity of care. In cases where the acquittee was discharged directly from the CSH Forensic Unit, consideration should be given to placing the acquittee at the facility serving the region to which the acquittee was conditionally released.

2. The decision to place the revoked acquittee in the Maximum Security Unit of Central State Hospital or another unit 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 DBHDS 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 DBHDS facility and the Forensic Coordinator of the Secure Forensic Unit, the DBHDS Office 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.

D. Based on a risk assessment conducted by the CSB/BHA, an acquittee can be admitted to a local psychiatric hospital on a temporary detention order or could remain on a voluntary admission, or can be voluntarily admitted to a DBHDS facility. 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)

Under Virginia Code § 19.2-182.7, after a finding by the court that the acquittee has violated the conditions of his release but does not require inpatient hospitalization, the court may hold the acquittee in contempt.

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

A. Required admitting court orders:

When an acquittee is involuntarily admitted back into the state hospital following conditional release, the acquittee's conditional release 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.

1. 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.

2. 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 thirty (30) days of revocation. The Forensic Coordinator should designate a due date to accommodate IFPC review prior to FRP review.

If the recommendation to the FRP is conditional release, the previous conditional release plan will need to be reviewed and updated/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 thirty (30) 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 60 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 CSB'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.

B. An account of the NGRI offense

C. An updated Analysis of Risk;

D. The results of a current mental status exam;

E. Copy of sanity evaluation (if available);

F. Appropriate risk management plan(s) if recommending continued hospitalization;

G. Current diagnosis;

H. Treatment team’s support for the request;

I. Current list of treatment activities and medication orders;

J. 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 60 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/biennial 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 (§§ 19.2-182.3, 19.2-182.6, 19.2-182. 11)

Acquittees can be released without conditions by the court of jurisdiction from conditional release, or directly from the custody of the Commissioner. An individual who is released without conditions is no longer under the jurisdiction of the court. The responsibility of the DBHDS and of the CSB for reporting to the court regarding acquittee status, ceases with unconditional release.

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 the criteria for conditional release set forth in § 19.2-182.7.

   2. The CSB may recommend removal of conditions to the court through the 6 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 by the CSB.

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 may 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 CSB,
   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. DBHDS Office of Forensic Services.

THE MONTHLY REVIEW OF CONDITIONAL RELEASE REPORT INSTRUCTIONS FOR COMPLETING THE FORM:

I. GENERAL GUIDANCE:

A. 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.

B. 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.

C. The 6-month report to the court does NOT substitute for the monthly report.

D. The reporting form is available in an electronic format for your convenience**.**

II. SPECIFIC INSTUCTIONS FOR THE FORM:

A. NAME OF ACQUITTEE – Complete the full name of the acquittee.

B. 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.

C. DATE OF HOSPITAL DISCAHRGE

D. SUPERVISING CSB

E. MONTH OF REVIEW– Complete the Month/Year being reviewed.

F. 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.

1. Check off "never compliant", "sometimes compliant", or "always compliant" to describe the acquittee's compliance with each general

condition of their release.

2. Write/type in comments as needed to describe the acquittee's compliance with the general conditions of their release.

3. 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".

G. 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.

1. Check off "never compliant", "sometimes compliant", or "always compliant" to describe the acquittee's compliance with each special condition of their release.

2. Write/type in comments as needed to describe the acquittee's compliance with each special condition of their release.

3. 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".

H. 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. This is also the place to indicate the dates and results of any substance abuse screening.

I. SIGNATURE – 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.

J. PHONE, FAX, EMAIL– Print/type the phone number and the fax where the case manager can be reached.

III. OTHER INFORMATION:

A. 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 2020 report is due on December 10, 2020.

B. Only email (preferred), fax or mail the Monthly Review of Conditional Release report. Do not send both faxed and mailed copies.

Mailing address:
Department of Behavioral Health and Developmental Services
Office of Forensic Services
P.O. Box 1797
Richmond, Virginia 23218-1797
Fax number: 804-786-9621
Email: csb.ngri@dbhds.virginia.gov

Monthly Report to the Department of Behavioral Health & Developmental Services Reviewing Conditional Release of an Insanity Acquittee

Email to:
csb.ngri@dbhds.virginia.gov

OR

Fax to:
804-786-9621

OR

Mail To:
Office of Forensic Services
DBHDS
P.O. Box 1797 Richmond, VA 23219

AcquitteeName:

Court Name:

Date of Hospital Discharge:

Supervising CSB Name:

Month and Year of Review: *Select Month* *Select Year*

This is the calendar month and year for which you are reporting, not the month you are submitting the report.

GENERAL CONDITIONS OF RELEASE

	Condition	Compliance	Comments
1)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
2)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
3)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
4)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	

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Monthly Report to the Department of Behavioral Health & Developmental Services Reviewing Conditional Release of an Insanity Acquittee

GENERAL CONDITIONS OF RELEASE

	Condition	Compliance	Comments
5)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
6)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
7)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
8)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
9)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	

Monthly Report to the Department of Behavioral Health & Developmental Services Reviewing Conditional Release of an Insanity Acquittee

GENERAL CONDITIONS OF RELEASE

	Condition	Compliance	Comments
10)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
11)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
12)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	

Additional Comments on Acquittee's Progress - GENERAL CONDITIONS OF RELEASE:

Monthly Report to the Department of Behavioral Health & Developmental Services Reviewing Conditional Release of an Insanity Acquittee

SPECIAL CONDITIONS OF RELEASE

	Condition	Compliance	Comments
1)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
2)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
3)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
4)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
5)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	

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Monthly Report to the Department of Behavioral Health & Developmental Services Reviewing Conditional Release of an Insanity Acquittee

SPECIAL CONDITIONS OF RELEASE

	Condition	Compliance	Comments
6)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
7)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
8)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
9)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
10)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	

Monthly Report to the Department of Behavioral Health & Developmental Services Reviewing Conditional Release of an Insanity Acquittee

SPECIAL CONDITIONS OF RELEASE

	Condition	Compliance	Comments
11)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
12)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
13)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
14)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
15)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	

Monthly Report to the Department of Behavioral Health & Developmental Services Reviewing Conditional Release of an Insanity Acquittee

SPECIAL CONDITIONS OF RELEASE

	Condition	Compliance	Comments
16)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
17)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
18)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
19)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	
20)		☐ Always Compliant ☐ Sometimes Compliant ☐ Never Compliant	

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Monthly Report to the Department of Behavioral Health & Developmental Services Reviewing Conditional Release of an Insanity Acquittee

Comments on acquittee's progress and adjustment in the community this reporting period (including the results of SA testing):

Staff completing the form:

Signature:

Phone:

Fax:

Email:

Rev. 3/2020

SIX-MONTH REPORT TO COURT
REVIEWING CONDITIONAL RELEASE OF INSANITY ACQUITTEES
INSTRUCTIONS FOR COMPLETING THE FORM:

I. GENERAL GUIDANCE:

A. 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.

B. The report should be completed and submitted every 6 months after the acquittee is placed on conditional release.

C. 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.

D. Do not 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.

E. The 6-month report to the court does NOT substitute for the monthly report.

F. The reporting form is available electronically for your convenience.

II. SPECIFIC INSTUCTIONS FOR THE FORM:

A. DATE – Complete the date that the report is written.

B. TO – Complete the name(s) of the NGRI judge(s) of jurisdiction and their address (es).

C. RE– Complete the full name of the acquittee, the court case number and the date of the conditional release order.

D. CONDITIONS OF RELEASE – Complete all the general and special conditions of release in this section.

E. 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 compliant", "sometimes compliant", or "always compliant" 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".

F. 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 compliant", "sometimes compliant", or "always compliant" 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".

G. 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.

H. 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 share your recommendation with the acquittee.

I. 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".

J. 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.

K. NAME – The case manager should print/type their name.

L. ADDRESS – Print/type the name of the CSB and the mailing address of the case manager.

M. PHONE, FAX, EMAIL – Print/type the phone number, email address, fax number where the case manager can be reached.

N. CC - The acquittee's attorney, the attorney for the commonwealth and the Forensic Office of DBHDS 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.

O. OTHER INFORMATION:

1. Only email, 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: DBHDS, Office of Forensic Services
   P.O. Box 1797
   Richmond, Virginia 23218-1797
   Email: csb.ngri@dbhds.virginia.gov; Fax number: 804-786-9621

Six Month Report to Court
Reviewing Conditional Release of an Insanity Acquittee

DATE OF REPORT:

MAIL TO: The Honorable:

Court Name:

Court Address:

RE: AcquitteeName:

Court Case No(s).:

Date of Conditional Release Order:

GENERAL CONDITIONS OF RELEASE

	Condition Description	Level of Compliance	Comments
1)		☐ Never ☐ Sometimes ☐ Always	
2)		☐ Never ☐ Sometimes ☐ Always	
3)		☐ Never ☐ Sometimes ☐ Always	
4)		☐ Never ☐ Sometimes ☐ Always	

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Six Month Report to Court
Reviewing Conditional Release of an Insanity Acquittee

GENERAL CONDITIONS OF RELEASE

	Condition Description	Level of Compliance	Comments
5)		☐ Never ☐ Sometimes ☐ Always	
6)		☐ Never ☐ Sometimes ☐ Always	
7)		☐ Never ☐ Sometimes ☐ Always	
8)		☐ Never ☐ Sometimes ☐ Always	
9)		☐ Never ☐ Sometimes ☐ Always	
10)		☐ Never ☐ Sometimes ☐ Always	
11)		☐ Never ☐ Sometimes ☐ Always	
12)		☐ Never ☐ Sometimes ☐ Always	

Six Month Report to Court
Reviewing Conditional Release of an Insanity Acquittee

SPECIAL CONDITIONS OF RELEASE

	Condition Description	Level of Compliance	Comments
1)		☐ Never ☐ Sometimes ☐ Always	
2)		☐ Never ☐ Sometimes ☐ Always	
3)		☐ Never ☐ Sometimes ☐ Always	
4)		☐ Never ☐ Sometimes ☐ Always	
5)		☐ Never ☐ Sometimes ☐ Always	
6)		☐ Never ☐ Sometimes ☐ Always	
7)		☐ Never ☐ Sometimes ☐ Always	

Rev. 11/2019

Six Month Report to Court
Reviewing Conditional Release of an Insanity Acquittee

SPECIAL CONDITIONS OF RELEASE

	Condition Description	Level of Compliance	Comments
8)		☐ Never ☐ Sometimes ☐ Always	
9)		☐ Never ☐ Sometimes ☐ Always	
10)		☐ Never ☐ Sometimes ☐ Always	
11)		☐ Never ☐ Sometimes ☐ Always	
12)		☐ Never ☐ Sometimes ☐ Always	
13)		☐ Never ☐ Sometimes ☐ Always	
14)		☐ Never ☐ Sometimes ☐ Always	

Six Month Report to Court
Reviewing Conditional Release of an Insanity Acquittee

SPECIAL CONDITIONS OF RELEASE

	Condition Description	Level of Compliance	Comments
15)		☐ Never ☐ Sometimes ☐ Always	
16)		☐ Never ☐ Sometimes ☐ Always	
17)		☐ Never ☐ Sometimes ☐ Always	
18)		☐ Never ☐ Sometimes ☐ Always	
19)		☐ Never ☐ Sometimes ☐ Always	
20)		☐ Never ☐ Sometimes ☐ Always	

Six Month Report to Court
Reviewing Conditional Release of an Insanity Acquittee

Comments on acquittee's progress and adjustment in the community this reporting period (including results of SA testing):

<u>CSB Recommendation to the Court:</u>

- ☐ Continue conditional release
- ☐ Modify current conditional release order
- ☐ Revoke conditional release
- ☐ Remove conditions of release

Six Month Report to Court
Reviewing Conditional Release of an Insanity Acquittee

If making a request for modification or removal of conditions, provide specifics of request and rationale:

If the individual completing this report is not the CSB NGRI Coordinator then both signatures are required, otherwise only the NGRI Coordinator must sign below:

Staff Completing Form:		**NGRI Coordinator**	
Signature:		Signature:	
Name:		Name:	
Agency:		Agency:	
Phone:		Phone:	
Fax:		Fax:	
Email:		Email:	

CC:

Acquittee's Attorney:

Attorney for the Commonwealth:

DBHDS Office of Forensic Services: Fax: 804-786-9621 or
Email:csb.ngri@dbhds.virginia.gov or
Mail: P.O. Box 1797, Richmond, VA 23219

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 ____________________

DATE OF BIRTH___________________ FELONY ____________________________
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_____________

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
DBHDS Office of Forensic Services

CHAPTER 7

Procedures for the Management of Persons Found Not Guilty by Reason of Insanity of a Misdemeanor Offense, Pursuant to VA Code § 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. VA Code 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.

A. 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 date of acquittal.

B. 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); emergency custody pursuant to § 37.2-808; temporary detention pursuant to § 37.2-809; or involuntary civil commitment pursuant to § 37.2-814 *et seq.*:

1. The Commissioner shall petition the committing court for such.

2. The Commissioner's duty to file such a petition does not preclude the ability of any other person who meets the requirements defined in §37.2-808 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 has a mental illness or intellectual disability and is in need of inpatient hospitalization. The court consider the following factors, in rendering its decision:

1. The extent to which the acquittee has mental illness or intellectual disability;

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, and the completion of the Analysis of Risk Report, are applicable to misdemeanant acquittees.

2. Verification by the Forensic Coordinator 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 Forensic Coordinator, or designee, 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 date shall be recorded in the Forensic Information Management System (FIMS).
e. The verified date of acquittal 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 DBHDS 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 DBHDS 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 DBHDS 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 FRP and the 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 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 acquittee's 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, if such evaluations are ordered by the court.
   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 DBHDS 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 FRP within 30 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 FRP approves that request, the Panel must notify the court within sixty (60) 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, 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 FRP, following the revocation of the acquittee.

g. If the FRP 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.

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 Forensic 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 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 jurisdiction indicating it is the treatment team's recommendation that the misdemeanant acquittee be civilly committed.
   c. Copies of these documents shall be sent to the Commonwealth's Attorney in the case, the acquittee's 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 order shall also be forwarded to the Chair of the FRP, the DBHDS 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 AVATAR system is changed to a civil AVATAR 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 Risk

I. The Analysis of Risk Report (ARR) 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 ARR 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 and risk management,

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. Release planning, and

5. Community aftercare.

B. The ARR 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 ARR 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 ARR focuses on containment of future aggression rather than strictly static predictions of dangerousness.

1. The ARR 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 violent 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). Consider precipitating factors such as mental status, substance use, stress, and destabilizing events.

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 and violence.

C. Records of previous hospitalizations should be reviewed for incidents of aggression and violence 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.

F. Past instances of times when the patient did not become aggressive or violent, despite circumstances being similar to previous acts of violence.

G. The ARR evaluator may request additional information not provided in the admission packet.

III. Once the data on past violence episodes are collected from multiple sources (collateral sources, self-report from the acquittee and structured interview), 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 dysregulation related to mood disorders;

4. Impairment in impulse control due to neurological or developmental disorder (e.g. seizure disorder, brain injury or disease, intellectual/developmental disability).

B. Common characteristics or patterns across violent episodes should be identified, including (but not limited to)

1. Time (month, year, time of day)

2. Nature of violent 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), instrumental or reactive aggression

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 ARR completed during Temporary Custody

A. The Analysis of Risk 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 ARR on each new acquittee, may not have an Initial ARR. If this is found to be the case, an Initial ARR 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 DBHDS facility housing an acquittee in temporary custody) shall make efforts to obtain the relevant Analysis of Risk Report information and complete the Initial ARR within 30 days after admission. (In cases wherein Commissioner Appointed Evaluators have been assigned to complete the Initial ARR, 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 ARR)

1. Attempts to obtain information should

    a. Begin immediately upon admission or upon appointment of the evaluators by the Commissioner (outpatient temporary custody) by requesting 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 CSB/BHA and other treatment providers, family members, and significant others, and
    e. Be well documented.

2. Information gathering is an extremely important aspect of the ARR and the process of assessing risk.

3. A suggested format and hypothetical cases are included later in this chapter.

C. The ARR 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. ARR information available during the first 30 days after admission and before completion of the temporary custody evaluations shall be immediately provided to the appointed evaluators. If emailed, the ARR

should be transmitted in PDF format.

2 In cases where the ARR 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 complete the report and document

a. Contacts made,
b. Why information is not available, and
c. How the missing information may have an impact on the Analysis of Risk Report
d. Attempts to obtain this information shall continue even after the Initial ARR is completed and submitted to the Temporary Custody evaluators
e. If important information is obtained after submission of the Initial ARR, an Updated ARR should be submitted

V. Format for Initial Analysis of Risk

A. Identifying Information

B. Purpose of Evaluation

C. Statement of non-confidentiality

D. Sources of Information

E. Relevant Background Information

F. NGRI Offense

G. Acquittee's Account of the NGRI Offense

H. Collateral Accounts of the NGRI Offense

I. Behavioral Observations and Mental Status Examination

J. Psychological Testing Results (if completed)

K. Diagnostic Impression and Formulation

L. Patient Strengths Which Mitigate the Probability of Future Aggressions

M. Analysis of Risk Report

1. Narrative description of current risk factors

a. Include past instances of occurrence of that factor
b. Frequency of occurrence
c. Intensity
d. Conditions under which factor is exhibited
e. Dates of occurrence(s) if available
f. Any other relevant information regarding why this factor represents a risk for this particular acquittee

2. Current status of risk factors

a. Indicate whether or not the acquittee has exhibited recent behavior relevant to the risk factor
b. Indicate whether the acquittee demonstrates insight into the factor or any gains or losses towards managing the risk factor

3. Means of addressing risk factors

a. 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.
b. Strategies for managing risk factors may be extensive and could involve medications, different forms of therapy, sanctions, etc.
c. Some management strategies will apply to more than one risk factor, and some risk factors will require more than one management strategy.

4. Factors which Mitigate the Probability of Future Risk

a. 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 Risk

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).

VII. Updates to the Initial ARR

A. The acquittee's treatment team shall update the ARR within 30 days prior to the submission of any requests to the FRP, or to the IFPC 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 unescorted visits (48 hours maximum),
5. Conditional release,
6. Conditional release from temporary custody, and
7. Release without conditions.

B. The Initial ARR 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 ARR Updates demonstrate progress or lack thereof for each risk factor reported, providing a continuity of risk assessment.

C. Risk factors identified in the Initial ARR, 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.

D. 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

E. The ARR 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 ARR 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,
   d. Escape attempts/escapes, and
   e. 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.

F. Each categorical risk factor should be labeled and described specifically for the individual acquittee.

G. The ARR-Update is generally part of another comprehensive report, e.g., FRP or IFPC Submission Report or Annual Continuation of Confinement Report. When the ARR-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 ARR. If the ARR-Update is required to be a stand-alone report this additional information should be included.

VIII. General Risk Factors to be considered in Assessing Risk

A. HISTORY OF VIOLENCE IS THE STRONGEST SINGLE PREDICTOR OF FUTURE VIOLENCE.

1. Great care should be given to documenting a complete history of violence across the acquittee's lifespan. Clinicians should take into account the acquittee's history of violence in the roles of Perpetrator, Victim, and Observer.

2. Acquittee's violent 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 violent behavior if it is relevant.

B. SUBSTANCE ABUSE: RISK IS HEIGHTENED CONSIDERABLY WHEN A DIAGNOSIS OF SERIOUS MENTAL ILLNESS IS COMBINED WITH A DIAGNOSIS OF SUBSTANCE ABUSE.

IX. Historical Clinical Risk-20 Checklist (HCR-20) (Douglas, Hart, Webster, & Belfrage, 2013)

A. The DBHDS requires the use of the HCR-20 in Initial Analysis of Risk Reports. Currently, the HCR-20 is in its third version (HCR-20:V3). The HCR-20:V3 will be replaced by future versions as published and trainings provided by the DBHDS and/or the University of Virginia, Institute of Law, Psychiatry and Public Policy (ILPPP).

B. The HCR-20 is a Structured Professional Judgement measure which allows for the assessment of risk factors for future violence in a population with mental illness. The identified factors are rated by their presence as well as their relevance to the individual assessed.

C. The HCR-20:V3 requires training and/or supervision to use. Training should be completed through the ILPPP or DBHDS. Forensic Coordinators and/or Psychology Directors may provide supervision, as needed.

D. The HCR-20 includes the following domains and risk factors:

1. Historical Factors: Historical factors are rated based on any past experiences throughout the individual's life-span, up to and including the day of the assessment. The presence of these risk factors may not go away and are typically more static; however, the relevance of each factor can shift and are more dynamic. Factors included in the Historical Factor domain include a history of problems in the following areas:

    a. Violence
    b. Other Antisocial Behavior
    c. Relationships
    d. Employment
    e. Substance Use
    f. Major Mental Disorder
    g. Personality Disorder
    h. Traumatic Experiences
    i. Violent Attitudes
    j. Treatment or Supervision Response

2. Clinical Factors: Clinical factors are rated based on the individual's current status. Choose a time frame and note in your assessment the time

frame used. Common time frames may be the last six months, the time period since the NGRI offense, time since admission to DBHDS, or time since last privilege level in cases of ARR Updates. Factors included in the Clinical Factors domain include recent problems with:

a. Insight
b. Violent Ideation or Intent
c. Symptoms of Major Mental Disorder
d. Instability
e. Treatment or Supervision Response

3. Risk Factors: Risk Factors require the clinician to make assumptions about situations the individual may face in the future. The clinician should choose a time frame and note that in the assessment. Six months into the future is a reasonable time frame anchor point for most individuals, but can be modified based on the person's acuity (shorter time frame for more symptomatic individuals, longer time frame for more stable patients). For Initial ARR's, the Risk Factor domain items should be scored "In" (if the acquittee is committed to the hospital) and "Out" (if the acquittee is conditionally released, discharged, or is permitted to remain in the community after outpatient temporary custody). For Updated ARR's, the clinician should determine if the Risk Factor domain items should be scored "In" or "Out" depending on the privilege level requested. Factors assessed in this domain include future problems with:

a. Professional Services and Plans
b. Living Situation
c. Personal Support
d. Treatment or Supervision Response
e. Stress or Coping

X. Base rates for re-arrest for insanity acquittee population

A. Ideally, clinicians should compare the individual acquittee's risk factors with base rate information describing the national insanity acquittee population.

B. "Failure" on conditional release can occur either with re-arrest for a new crime or violating conditions of release leading to revocation and readmission to a hospital.

C. 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

1. Generally, the closer the NGRI is monitored in the community, the lower the arrest rate, but the higher the re-hospitalization rate.

2. Acquittees who did well on conditional release

    a. were employed before the offense;
    b. were married;
    c. had committed a less severe offense;
    d. adjusted well to hospitalization;
    e. showed a general assessment score on the GAF of less than 50; and
    f. showed fewer than 7 symptoms on the SADS-C.

3. The first six 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.

D. 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 University of Virginia, Institute of Law, Psychiatry and Public Policy.

XI. Treatment teams, Forensic Coordinators, and staff completing the Analysis of Risk must remain current in the research and practice of assessing risk.

A. The DBHDS contracts with the Institute of Law, Psychiatry and Public Policy to provide

1. A wide range of forensic training programs including: basic forensic evaluation, risk assessment and management of NGRI acquittees;

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 CSB staff.

B. Ongoing training and review of the developing risk assessment literature is essential.

EXAMPLE

ANALYSIS OF RISK REPORT

Name:
Date of Birth:
Age:
Reg. No.:
NGRI Offense:
Case #:
Court:
Judge:
Date of NGRI Offense:
Date of NGRI Adjudication:
Date of Report:

PURPOSE OF EVALUATION:

[Acquittee] was adjudicated Not Guilty by Reason of Insanity (NGRI) pursuant to section 19.2-182.2. of the Code of Virginia. [Note if the acquittee was permitted to remain in the community, or was admitted to a hospital and the date of that admission]. This evaluation, the Initial Analysis of Risk Report, is a routine assessment protocol for new NGRI acquittees. This report will focus on the acquittee's current psychological functioning, risk factors for aggression, and treatment recommendations in order to help inform [his/her] temporary custody evaluations.

LIMITS OF CONFIDENTIALITY:

Prior to beginning the interview, the acquittee was informed of the purpose and nature of the evaluation. [He/She] was advised that [his/her] disclosures to the examiner and the results of psychological testing would be compiled into a report that would be included in files maintained by DBHDS. [He/She] was also told that this report would be reviewed by two Temporary Custody Evaluators, the court, [his/her] local CSB, and by various DBHDS personnel tasked with recommending that [he/she] either be committed to a DBHDS hospital or [allowed to remain in/be discharged to] the community, with or without mandated conditions. [He/She] was reminded that the usual doctor-patient confidentiality does not apply in this situation, and that if [he/she] discloses any thoughts of wanting to harm [himself/herself] or others, or reports child or elder abuse, these comments may need to be reported to others. The acquittee said [he/she] understood these conditions, was given the opportunity to ask questions, and agreed to participate.

SOURCES OF INFORMATION:

[List all records reviewed and collateral sources reviewed/consulted. If you requested records and they were not received, then include that information here as well.]

BACKGROUND INFORMATION: This background section is from the sources noted above.

Developmental/Family History:

Trauma history:

Academic History:

Employment History:

Legal History and Other Incidents of Violence: [Note the source of the criminal history. It may be important to contrast this with the acquittee's self-report. The acquittee may also be able to provide information about a juvenile delinquency history that may not be available for review or other instances of violence.]

Date	Offense	Jurisdiction	Disposition

Review of past violent behaviors: [Ask the acquittee about acts of violence across the lifespan. Discuss triggers and precipitants to violence, and explore possible patterns of behavior. Also discuss situations in which destabilizers and triggers were present, but the individual did not act violent. Include police reports if available.]

Substance Use History:

Medical History:

Psychiatric History:

NGRI Offense: [Remind the reader of the charge and date of offense.]

Collateral Accounts of the Instant Offense

[Divide separate collateral accounts if significantly different from one another. Include the account in the MSO report as a collateral source, too.]

Acquittee's Account of the Instant Offense
[Include the acquittee's current explanation of the NGRI offense. Probe for insight into the role of mental illness played in the offense, as well as the possibility of substance use. Discuss with the acquittee if she/thinks there is anything she could have done to avoid doing the NGRI offense.]

RECENT ADJUSTMENT: [Include information about behavior in jail and whether the individual was diagnosed with a mental illness and if he/she took prescribed medications. If the individual remained on bond, it is important to obtain information about the person's functioning in the community such as treatment adherence, violence, living situation, common stressors, things that may get in the way of following a conditional release plan such as lack of transportation, etc. If the evaluation is inpatient, include course of hospitalization.]

MENTAL STATUS EXAM & BEHAVIORAL OBSERVATIONS:

SUMMARY OF PSYCHOLOGICAL TESTING: [If completed]

Neurocognitive Functioning

[Summarize the results of any neurocognitive testing such as a mental status exam and/or intelligence test. Considering comparing to prior tests if you have the data.]

Personality Assessment

[Summarize the results of any personality testing completed such as the MMPI-2, MMPI-RF, or PAI. Considering comparing to prior tests if you have the data.]

DIAGNOSTIC IMPRESSIONS (DSM-5):

[Walk through your diagnostic formulation. Use the DSM-5 codes and names.]

[Code] [Name]

RISK ASSESSMENT:

The undersigned completed an evaluation of [Name's] violence risk based on all the information available at the time of the evaluation, including an interview with the acquittee and a review of collateral records. The purpose of a violence risk assessment is to identify factors which increase an individual's risk of violent behavior in the future – with consideration to the nature, severity, imminence, frequency, and likelihood of future violence – as well as to identify strategies for minimizing these risks. For the purpose of this report, violence is defined as actual, attempted, or threatened physical harm of another person, including intimidation or fear-inducing behavior that is nonconsensual.

To evaluate the acquittee's risk for violence, the undersigned used the *HCR-20-V3*, which utilizes a Structured Professional Judgement (SPJ) approach. A SPJ approach considers historical factors that may not change or be slower to change, as well as more dynamic factors that are often the focus of clinical interventions. The HCR-20-V3 provides a framework to assess risk of future aggression across three dimensions: historical, clinical, and risk management. Within each dimension, the examiner considers the presence of various specific risk factors, as well as the relevance of each factor to risk management planning.

Risk Factors

Historical Risk Factors
Historical factors are characteristics of an individual's background which tend to remain relatively stable over time. Research has identified several aspects of an individual's history which are useful in predicting risk over a longer period of time and in a broader context. For the HCR-20-V3, historical risk factors are considered up to the day of the assessment; so the relevance of these historical risk factors may change with interventions.

History of Problems with Violence (H1): [Describe each risk factor as it applies to the individual. At the end, in **bold**, note if you rate the factor's presence and relevance. Complete for each risk factor. If something is not present, then note that it is not present.]

History of Problems with Other Antisocial Behavior (H2):

History of Problems with Relationships (H3):

History of Problems with Employment (H4):

History of Problems with Substance Abuse (H5):

History of Problems with Major Mental Disorder (H6):

History of Problems with Personality Disorder (H7):

History of Problems with Traumatic Experiences (H8):

History of Problems with Violent Attitudes (H9):

History of Problems with Treatment or Supervision Response (H10):

Recent Clinical Risk Factors
The clinical factors assessed here capture the acquittee's functioning within the past [note time-frame]. These factors are most relevant to short-term risk for aggression.

Recent Problems with Insight (C1): [Describe each risk factor as it applies to the individual. At the end, in **bold**, note if you rate the factor's presence and relevance. Complete for each risk factor. If something is not present, then note that it is not present.]

Recent Problems with Violent Ideation or Intent (C2):

Recent Problems with Symptoms of Major Mental Disorder (C3):

Recent Problems with Instability (C4):

Recent Problems with Treatment or Supervision Response (C5):

Risk Management Factors
This risk factor was coded considering the risks [he/she] may face in the next [time frame] in [setting, either inpatient or outpatient].

Future Problems with Professional Services and Plans (R1): [Describe each risk factor as it applies to the individual. At the end, in **bold**, note if you rate the factor's presence and relevance. Complete for each risk factor. If something is not present, then note that it is not present.]

Future Problems with Living Situations (R2):

Future Problems with Personal Support (R3):

Future Problems with Treatment or Supervision Response (R4):

Future Problems with Stress or Coping (R5):

HCR-20: V3 Summary

HISTORICAL FACTORS: History of problems with…		
Factor	**Initial Assessment**	**Relevance**
H1. Violence		
H2. Other Antisocial Behavior		
H3. Relationships		
H4. Employment		
H5. Substance Use		
H6. Major Mental Disorder		
H7. Personality Disorder		
H8. Traumatic Experiences		
H9. Violent Attitudes		
H10. Treatment or Supervision Response		
OC-H. Other Considerations		
CLINICAL PROBLEMS: Recent problems with…		

Factor	**Initial Assessment**	**Relevance**
C1. Insight		
C2. Violent Ideation or Intent		
C3. Symptoms of Major Mental Disorder		
C4. Instability		
C5. Treatment or Supervision Response		
OC-C Other Considerations		
Risk Management Factors: Future problems with… *Context:* [Insert context and time frame]		
Factor	**Initial Assessment**	**Relevance**
R1. Professional Services and Plans		
R2. Living Situation		
R3. Personal Support		
R4. Treatment or Supervision Response		
R5. Stress or Coping		
OC-R. Other Considerations		

Risk Formulation
[Provide a narrative (1-2 paragraphs) of why this individual becomes violent. What are the most important risk factors, triggers, destabilizers, etc. that lead to aggressive and violent behavior. Does this person have one primary pathway towards violence or several that require different interventions and management? This tells the individual's violence story.]

Patient Strengths Which Mitigate the Probability of Future Violence: [Describe if any protective factors are present. They are: intelligence, secure childhood attachment, coping skills, self-control, resilient personality traits, empathy, employment, leisure activities/hobbies, strong commitment to school, motivation for treatment, medication adherence, financial management, positive attitudes towards authority, life goals, having a social network, professional care involvement, prosocial involvement, strong attachment and bonds, appropriate and supportive intimate relationships, and positive living circumstances.]

SUMMARY AND RISK MANAGEMENT PLANS/RECOMMENDATIONS:
[Provide an extremely brief summary of the acquittee's relevant history and what led to the current assessment.]

Given the results of the HCR-20 V3, as well as protective factors, it is my opinion that [Name's] overall risk for future violence, especially within the next [risk time frame], is [low, moderate or high. Explain reasoning].

The following risk management plan is offered for consideration:

1. [Strategy 1. Make sure you address all relevant risk factors. Some strategies may address multiple risk factors, and some risk factors may be addressed by multiple interventions. Consider the risk scenarios when developing risk management interventions]

The following recommendations are provided for the consideration of the Temporary Custody Evaluators, the court, treatment providers, and the Forensic Review Panel as possible ways to reduce the acquittee's risk of violence in the future. Conclusions and recommendations are limited by the information received. New information and a different context may change the assessment of risk and recommendations offered.

____________________________________ ________________________

[Name] Date

ARR-UPDATE FORMAT

It is generally not necessary for an ARR-Update to have all the components of the Initial Risk Assessment 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 ARR-Update, when part of another submission/report, should minimally include the following:

Risk Factors for Aggression While Exercising Proposed Privilege Level Using HCR-20 V3.

To evaluate Ms. Doe’s risk for violence, the undersigned used the Historical Clinical Risk Management-20, Version 3 (HCR-20-V3) and the Female Additional Manual (FAM). Both tools utilize a Structured Professional Judgement (SPJ) approach and considers historical factors that may not change or be slower to change, as well as more dynamic factors, that are often the focus of clinical interventions. The HCR-20-V3 provides a framework to assess risk of future aggression across three dimensions: historical, clinical, and risk management. Within each dimension, the examiner considers the presence of various specific risk factors, as well as the relevance of each factor to risk management planning. The FAM, which is designed to be used in conjunction with the HCR-20-V3, is a complementary measure designed to assess factors specific to female-perpetrated violence. It is scored in the same manner as the HCR-20-V3 but also includes influencing someone else to commit violence or being accessory to violence carried out by another individual in the definition of violence. For the purpose of this report, Ms. Doe’s risk for violence will be explored and conceptualized using these tools.

Historical Factors:

Ms. Doe’s most salient historical risk factors for violence include a history of problems with: serious mental illness (H6), problems in relationships (H3), and parenting difficulties (FAMH12).

Ms. Doe is currently diagnosed with Bipolar I Disorder and has been experiencing symptoms since her

20's. She has a history of depressive and manic mood episodes, the latter of which presented with psychotic features during the NGRI offense (grandiose delusional beliefs that she was God, the president, or an agent of the CIA). Documentation indicates there may have been some limited experience of hallucinations. Ms. Doe has reportedly been hospitalized several times for symptoms consistent with her diagnosis of Bipolar Disorder and at the time of her NGRI offense, Ms. Doe was experiencing symptoms of mania. This item is rated Present and of High Relevance for her violence risk (History of Problems with Major Mental Disorder).

Ms. Doe's history of violence is limited and has almost exclusively been directed at her second ex-husband. Per her report, her infrequent bouts of violence have occurred in response to distress within a romantic relationship, though the NGRI offense was related to concerns about her youngest child (History of Problems with Relationships and Parenting Difficulties). Ms. Doe's descriptions of her prior romantic relationships have been notable for their emotional strain. Her first marriage was reportedly difficult given her husband's substance abuse problems and physical abuse towards her. The early years of her second marriage were reportedly characterized by reciprocal physical and verbal abuse. In 2003, Ms. Doe reportedly became suspicious that her second husband was having an extramarital affair and when reviewing contents of his computer, became aware of his possession of pornographic images of children. Ms. Doe noted there was subsequent legal action, following which, their marriage improved and reciprocal abuse stopped for many years. Ms. Doe incurred a charge of Assault and Battery against her second husband in 2014 and divorced him in 2015, reportedly due to renewed concerns about his possession of child pornography. Despite allegations made in court by Ms. Doe's eldest daughter, (the daughter with whom she currently takes passes) that he had sexually molested her during her childhood, he was awarded custody of their two children. Since her ESH admission, Ms. Doe's statements about her ex-husband are indicative of persistent distrust and negative emotions. Ms. Doe

has recently allowed the undersigned to communicate with her ex-husband for the purposes of discussing possible visitation with her youngest daughter in the community in the future. Though she continues to verbalize distrust toward him, this is considered a positive change in her approach to their co-parenting relationship.

Ms. Doe denies any history of aggression toward her children when asymptomatic. However, during prior periods of symptom resurgence, she has been noted to become verbally threatening toward them. Per her IAAB, there were "indications that she was accused of assaulting her older daughter and husband in 2014." However, in the description provided below, it appears the violence was largely directed at her ex-husband. At the time of the NGRI offense, Ms. Doe reported learning that her youngest daughter was being hit by her older sister (this is the middle of Ms. Doe's daughters, but the eldest of their union and not the daughter with whom Ms. Doe takes passes). not the sister with whom Ms. Doe currently takes passes). Ms. Doe reported she attempted to address this with her ex-husband, but that he was reportedly dismissive of her. She described becoming angry and upset with him following this and committed the NGRI offense the same day. Given the history of relational difficulties, mounting co-parenting tensions at the time of the NGRI offense, and the fact that her ex-husband and youngest daughter were the victims of her NGRI offenses, the risk factors for Relationships and Parenting Difficulties are considered Present and Highly Relevant.

Other less critical risk factors for Ms. Doe's violence include problems with: previous violence (H1), suicide/self-injurious behavior (FAM 14), medical issues (other), history of traumatic and adverse experiences (H8), employment (H4), and problems with treatment or supervision response (H10).
Ms. Doe's history of violence has been relatively brief and was largely directed toward her second ex-husband (History of Violence). Ms. Doe described this as sporadic and reciprocal domestic violence prior

to the NGRI offense. In 2014, Ms. Doe reportedly became violent toward him in the context of a "steroid rage" and was charged with Assault and Battery. She indicated she received a steroid injection as a treatment for pneumonia and approximately one week later, she hit and/or kicked her husband. She initially noted she was not clear why she was angry, but subsequently mentioned her husband had said something to do with money, following which she hit him. She denied causing him injury, but her oldest daughter called the police. Ms. Doe's only other instance of aggression toward him was the NGRI offense, which involved Ms. Doe driving her car into her ex-husband's home, making threats of wanting to kill him, and attempting to circle the house looking for him after crashing her car. Ms. Doe has consistently attributed her behavior to active symptoms of mental illness and frustration with her husband for his lack of concern in response to complaints that their youngest daughter was being assaulted by her older sister. Records indicate she previously had a protective order from threatening her ex-husband and for her two youngest children, but this has since been lifted.

As noted previously, Ms. Doe denies any history of aggression directed toward her children during periods when she was asymptomatic. However, records have indicated she has verbally threatened her children when ill and placed her youngest in danger during the NGRI offense when she crashed her car into the home of her ex-husband. Ms. Doe has consistently reported that her aggressive behavior toward her children has occurred during times of active psychiatric symptoms and when in her "right mind" she vigorously denies any historical bouts of aggression or aggressive ideation toward her children. Ms. Doe has not exhibited any aggressive behavior or reported any aggressive ideation during her hospitalizations at CSH and ESH. Taken together, this risk factor is considered Present and of Moderate Relevance.

Ms. Doe has a history of suicidal thinking and behavior to include suicidal ideation as part of her

depressive episodes and four suicide attempts (Suicidal thinking and behavior). Her first attempt occurred at age 20, in approximately 1989, when she attempted suicide by overdosing on her Prozac, which she reports induced some suicidal thinking. Her next attempt, another overdose, occurred approximately one year prior to the NGRI offense. She reported a final suicide attempt approximately one week later in which she took several Motrin. She clarified this attempt, unlike her prior attempt, was unplanned, but was prompted by ongoing relationship difficulties with her ex-husband. Finally, she attempted suicide on 5/XX/2019 by attempting to jump from her parents' moving car … due to hopelessness related to persistent pain. Though her suicidal acts have not historically been connected with acts of violence, her most recent attempt did endanger the lives of her parents and others on the road. Her history of suicide attempts have occurred during periods of increased stress and are understood to reflect a more pervasive loss of more adaptive coping strategies and impulsivity. As such, these are indirectly related to her risk for violence. As such, this is considered Present. However, given the intermittent relationship of her suicide history to her violence this is considered of Moderate Relevance.

Ms. Doe has a history of multiple medical issues, but has exhibited greatest disruption as a result of chronic gynecological pain (Medical Issues). While this issue has not played a direct role in her previous violence, it played a role in her most recent suicide attempt, which endangered the lives of her parents while transporting her and others on the road. This risk factor is considered Present and of Moderate relevance to her risk for violence as when present, it has taxed her coping resources and influences her impulsivity, putting herself and others at risk. At the time of the attempt, Ms. Doe reported feeling overcome with hopelessness that her pain would continue for the rest of her life and there would be no end to it. She denies any other precipitating stress and denies any awareness of her level of distress prior to going on pass. Since this event, Ms. Doe's medication regimen has been adjusted considerably

and she had surgery, which she reports has been quite effective in reducing her pain. With the resolution of her most acute pain, she exhibited some insight into the relationship between her stress and her pain, which was a critical area of intervention prior to her attempt. At this time, Mr. Doe reports persistent discomfort but minimal pain (ranging between a 1-2 out of 10) for the last several months. She denies any anxiety related to this pain along with suicidal ideation and hopelessness. As noted before, should she experience other physical complaints that tax her coping ability, this may make her more likely to engage in behavior that could endanger herself and those around her, but at this time, her pain appears to be well-managed.

Ms. Doe has a history of sexual assault as a child, being threatened with violence as a teen, and as an adult experiencing domestic violence and learning of her husband's sexual molestation of her child while under her care (History of Traumatic Experiences). This history of trauma likely affects Ms. Doe's difficulty coping with stress and it is possible they play some role in her current chronic gynecological complaints as well. Though her violence has not been enacted during times of traumatic events or recollection of such, it is likely that her experience of trauma has compromised her ability to cope with certain situations and in the presence of other more salient risk factors, may increase the likelihood of resorting to aggression as a situational response. As such, this is considered Present and of Moderate relevance.

Though Ms. Doe was reportedly compliant with her medication at the time of the offense, she reported altering her dosing schedule to accommodate her disrupted sleep/work schedule. Recently, Ms. Doe noted this was approved by a community provider, but this is uncorroborated. Ms. Doe reported some historical medication noncompliance in the community, but noted this paled in comparison to her longer periods of compliance. In the hospital, she has remained compliant with all medication and

treatment recommendations. However, she struggles with development of insight into specific domains of risk management. As such, this item (History of Problems with Treatment Supervision and Response) is rated as Partially Present. As it has been inconsistently related to her violence this item is considered of Moderate Relevance.

Risk factors that seem to have little, if any, relevance to Ms. Doe's history of violence include: a history of violent attitudes (H9), problems with other antisocial behavior (H2), having a personality disorder (H7), substance use (H5), employment problems (H4), prostitution (FAMH11), and pregnancy at a young age(FAMH13).

Ms. Doe has consistently denied a history of violent attitudes and while she engaged in reciprocal domestic violence for a period of time with her second ex-husband, the absence of violence in other relationships indicates she likely does not hold pervasive attitudes supportive of violence. She does not have a history of other antisocial behavior, prostitution, or a personality disorder. Ms. Doe has a history of alcohol consumption, but it has not been connected to her previous instances of violence and she has remained sober since her incarceration. While substance use in general increases the risk for violence and it is likely that consumption of alcohol or other substances would likely impair her ability to effectively deal with stress and in the presence of other risk factors, this is not considered of great relevance for her risk of aggression at this time. Finally, while she became pregnant at a young age, she denied any long lasting negative impacts from these experiences and they do not seem to have been implicated in her acts of violence.

Ms. Doe has a long history of employment as a nurse and reportedly enjoyed her vocation immensely. Her history of employment is not stereotypically problematic, but was a source of stress and a

precipitating factor prior to her NGRI offenses (History of Problems with Employment). Due to the nature of Ms. Doe's work, she was frequently changing her sleep schedule and attempted to alter her medication regimen to fit her needs. Rather than stop or change her work schedule, Ms. Doe persisted, although there was no reported disruption in her work. Ms. Doe wants to work and she has mentioned interest in renewing her nursing certification following her release. While working in general has been helpful for her and is generally a protective factor, Ms. Doe will need to remain mindful how to negotiate her work obligations and resultant distress in ways that protect her recovery. This risk factor is considered Not Present and of Low Relevance.

Clinical Factor Time frame: 90 days or since last privilege increase

Over the last 90 days, Ms. Smith's most salient clinical risk factors include lack of insight (C1), instability (C4), and treatment and supervision response (C5).

Ms. Doe's insight has been a critical area of intervention for much of her hospitalization (Problems with Insight). Her level of insight has varied depending on the area of inquiry and the level of distress she is currently experiencing. By and large, she accepts her psychiatric diagnosis and need for medication to effectively deal with symptoms. However, she has struggled to appreciate education about her risk factors and the notion that risk requires consistent management rather than some factors just being sufficiently managed because they are in the past. This has been a consistent observation of Ms. Doe across work with the undersigned and per report of her individual therapist. For example, Ms. Doe struggled to accept that her chronic pain may have affected her ability to tolerate stress and that this could be a risk factor for violence in that it compromised her overall ability to tolerate stress and manage impulsive decision-making. Only following her surgery has she become more receptive to discussing the relationship between her pain and her stress level recognizing that they may inform one another. Finally, following her suicide attempt in May 2019, she struggled greatly to even identify the

event as a suicide attempt, to develop additional insight surrounding this event, and generally use the experience for proactive relapse prevention. She has made recent improvements in this domain. Given this, the item is rated Partially present. However, because this deficit in insight has not been functionally related to any episodes of violence in the last 90 days, and months before that, it is considered to be of Moderate Relevance.

Ms. Doe is compliant with all treatment interventions and her most acute manic/depressive symptoms are well-managed with medication. She also reports decreased pain, consistent use of coping resources (i.e., latch hooking, talking with family, attending therapy), and has remained free of violence. However, she does exhibit some recurrent emotional and cognitive instability (Problems with Instability), despite her general psychiatric stability. Specifically, Ms. Doe frequently devolves into tears and when distressed and has frequently resorted to rather all-or-nothing problem-solving/ideation when immediately confronted with difficult or upsetting news. With intervention and time, she is redirectable, able to regain emotional stability, and engage with more balanced decision-making. There have been several examples of this recently and once given time to verbalize her frustration and calm down, she exhibited more reasonable thinking about the matter. She describes herself as a sensitive individual and notes that crying is often a helpful way for her to express her emotions. This presentation, characterized by emotional and cognitive impulsivity, is relatively common and such is rated as Present. That said, in the presence of these, she has not exhibited any behavioral impulsivity (i.e., aggression toward self or others, disengagement from treatment, refusal to take medication, etc.). Therefore, this instability is considered to be only moderately relevant to her risk for violence at this time. Though intermittently tearful and anxious, she has engaged her coping skills effectively. Finally, while she is a self-admitted worrier who cries often, she is otherwise pleasant and capable. As her insight and emotional regulation strategies remain a point of intervention, due to slow responsiveness, the risk factor Problems with Treatment and Supervision is also rated as Partially present and of moderate relevance.

The following risk factors have not been problematic over the last 90 days: symptoms of active mental illness (C3), covert and manipulative behavior (FAM C6), low self-esteem (FAM C7), and medical issues. Ms. Doe denies and has not exhibited any symptoms of mania, depression, or psychosis in the last 90 days. Ms. Doe has not exhibited any behavior that might be described as manipulative. Ms. Doe has not made statements suggestive of low self-esteem in the last 90 days. While she is frequently emotive, it is not clear that this is related to low views of herself, though it is quite possible that she feels considerable shame and guilt about the involvement of her daughter in the offenses given her the subsequent restrictions on their interaction. Finally, her medical issues appear to be adequately addressed at this time following her surgery. Though she reports some persistent low level pain (one out of ten), this is a considerable decrease from prior levels and she reports satisfaction with the surgery.

Risk Factor consideration: UC-48's Timeframe: Next 90 days

This privilege level, would allow Ms. Doe to take overnight passes at her independent apartment in the community, which is also her proposed discharge placement.

The following risk factors are considered present and relevant, to some degree for Ms. Doe's risk on the next level of privilege:

While on overnight passes, Ms. Doe's clinical needs will be addressed by therapeutic interventions available at ESH and XXX DAY TREATMENT CENTER. While in the hospital, she will continue attending PSR groups and individual therapy. While on pass, she will attend the XXX DAY TREATMENT CENTER one to two days per week, and will also attend a weekly AA meeting as well. Further, her medications will be administered by ESH staff when here and the XXX DAY TREATMENT CENTER will administer the majority of medication doses while on 48's. By virtue of staying in an independent apartment where PACT services will not be available until the point of

discharge, Ms. Doe will be expected to take some of her medications herself. As proposed, Ms. Doe will transport her medication to the XXX DAY TREATMENT CENTER and hand over to the nurse. The XXX DAY TREATMENT CENTER nurse will then be responsible for dispensing medications during the day while Ms. Doe is there. Before leaving XXX DAY TREATMENT CENTER for the day, Ms. Doe will be given her evening dose of medication by the XXX DAY TREATMENT CENTER nurse and is expected to call treatment team social worker (or designee) to verify she has taken her medication no later than 8pm. The following day, she will take the morning and midday doses at the XXX DAY TREATMENT CENTER. Again, the XXX DAY TREATMENT CENTER nurse will dispense evening medication to Ms. Doe before leaving for the day, in addition to the following morning medications. Ms. Doe will call the team social worker (or designee) to verify she has taken each dose. Though Ms. Doe has a remote history of medication noncompliance, the above plan ensures she will be monitored at several points to ensure compliance. Additionally, though Ms. Doe has a remote history of suicide attempts via overdose, she will not be given enough medication at any one point to pose lethal risk and will be searched on return to ensure she is not stockpiling medication. Taken together, this risk factor is considered Not Present and of Low Relevance to her risk for violence (Problems with Professional Services and Plans).

Ms. Doe reports having a very close-knit family to include her parents, children, and several friends. Her parents and eldest daughter have attended requested meetings with team, they visit Ms. Doe on a near weekly basis, and are highly responsive when contacted by team members. Her family members are supportive of treatment and she has taken between 5-10 family passes since regaining the privilege. She often relies on her daughter and father for emotional support and decision-making. While having the support of family is important, there is some concern that Ms. Doe is overly-reliant on them and less independent than would be hoped, in both her thinking and emotional resilience. For these reasons and the concern about the potential stressful home environment, the team is currently pursuing an

independent apartment rather than discharging her home to her parents, as was her preference. Ms. Doe intends to visit her parents in the evening hours, after treatment activities have concluded and with team approval, using this new privilege. As the family has been amenable to treatment intervention thus far, it is highly likely that they would be amenable to additional meetings with the team as needed. Taken together, this risk factor (Problems with Personal Support) is considered Partially Present and of Moderate relevance. Ms. Doe will be in her own apartment and thus have some distance from family, but will likely continue to experience some distress related to her ex-husband, though presumably less than renewing contact with him.

Given her history of compliance, Ms. Doe is highly likely to remain compliant with her psychiatric medication and recommended treatment interventions (e.g., groups and individual therapy) while on overnight passes. There are some remaining areas of treatment response, however, that will likely persist to some degree on overnight passes. Specifically, her emotional sensitivity and her difficulty with insight development have been slow to respond to treatment Nevertheless, she has exhibited some improvement and she has made considerable strides since her suicide attempt in May. Specifically, Ms. Doe has complied with several significant medication changes to address her mood dysregulation and impulsivity (added mood stabilizer and increased medication for anxiety). Following these, she has demonstrated behavioral stability through a gradual resumption of privileges and has used multiple unescorted community passes without issue. She had surgery in August to address her reports of chronic pain following which, her reported pain level has decreased and remained in the 1-2 range (out of 10). She has also kept a daily log identifying her pain level, suicidal ideation, and level of hopefulness, which is reviewed at regular intervals by the undersigned. While she is likely to have some difficulty with insight development, as this has been a chronic problem, she is not completely bereft of insight and has been using adaptive coping skills to manage her emotional distress while maintaining behavioral stability (Future Problems with Treatment and Supervision Response). As such, this risk factor is estimated to

be Partially Present and of Moderate Relevance.

Ms. Doe is likely to continue to experience stress on her next privilege level from both anticipated (e.g., holidays without family and freedom and ongoing struggles with her ex-husband) and unanticipated sources. While no longer in a relationship with her ex-husband, she remains connected to her ex-husband due to their shared children (two daughters). Ms. Doe continues to hold strong distrustful beliefs and negative emotions about her ex-husband and appears to be distressed at the notion of renewed communication with him, even with team support. She has agreed to allow the undersigned to communicate with him for the purposes of exploring potential visits with their daughter in the community, pending FRP approval. As has been her presentation here, she is likely to continue becoming tearful at intervals as well when confronted with stress. That said, Ms. Doe has a number of adaptive and effective coping skills she regularly employs which help her maintain behavioral stability. For instance, she engages in latch-hooking, coloring, meeting with her individual therapist, speaking with friends and family members, and treatment team members. Furthermore, her medications have been adjusted following her suicide attempt to address concerning aspects of her presentation, she has revised her WRAP plan, actively engages with providers, and has remained free of aggressive or self-injurious behavior. Finally, Ms. Doe is highly motivated to remain stable in an effort to resume contact with her youngest child, discharge from the hospital, and return to her life and work. Therefore, while she is highly likely to experience stress, her current motivation and management strategies (to include medication compliance and use of coping skills) have been effective for maintaining her stability over the last six months (Problems with Stress and Coping). Taken together, this risk factor is considered Present and of Moderate Relevance.

Ms. Doe is likely to experience distress at her limited enrollment in her children's lives on the next privilege level (Problematic Childcare Responsibilities). Specifically, she has reported an estranged

relationship with her adult son and considerable emotional upset over her limited role in the life of her youngest daughter (a victim of the NGRI offense). Ms. Doe has been pursuing a reconsideration of the FRP bar to visiting with her youngest daughter while in the community and has recently allowed the undersigned to speak with her ex-husband about this following his contact with the Forensic Coordinator and the undersigned. This risk factor is considered Present. At this time, the limited role in her youngest daughter's life is not new and during the six months since she was restricted from such contact with her daughter, she has remained free of violence and impulsive behaviors. Though childcare concerns were at the heart of her NGRI offense, she is considerably more stable at this time and additional stress from work and other familial stressors are no longer present. As such, this is considered to be of Moderate Relevance at this time.

Ms. Doe is currently involved in a romantic relationship with a hospital peer. Per her report, this is a healthy and supportive relationship, unlike her prior romantic relationships. There have been no reports of grossly inappropriate interaction between them At this time, there is no cause for concern that her current relationship will induce the same kind of destabilization as her prior relationships did, that Ms. Doe would be driven to domestic violence against her partner, or that together they would engage in offending behaviors. Therefore, the risk factor Problematic Intimate Relationships is rated Not Present and of Low Relevance.

Ms. Doe's will reside predominantly at the hospital during her next pass, but in an independent apartment when in the community. This was decided upon by the team because for several reasons. Primarily, it was reasoned that living independent of family would help in mitigating risk of decompensation posed by living with family in a highly emotive, potentially enabling environment. Additionally, given her history of functional independence and the daily observation by mental health providers that will be included in her structured activities, the level of supervision and restriction in a

group home was thought to excessive. Ms. Doe will continue to utilize her coping skills enumerated above while on pass, will be in contact with providers daily, and will be provided with emergency support contact information should she need them in the community. Despite her protests of this placement, Ms. Doe has exhibited intermittent contentment about going to her own apartment given her reports of frustration on the unit with multiple peers and the quiet and solitude afforded in the apartment. Additionally, she will be able to maintain contact with her parents. Ms. Doe will be working closely with the KEYs program to find a long-term apartment while on her next pass as she currently only has an interim apartment. Once identified, she can moved into the long-term apartment where she can demonstrate risk management in that setting as well before seeking release. She reported feeling somewhat unsafe about the surrounding neighborhood of her interim apartment, but that she would likely remain in the apartment rather than travel after certain hours. This is consistent with her behavior in the hospital when faced with a tumultuous unit as well and does not appear to increase her risk for violence. hospital. As such, the risk factor Future Problems with Living Situation is considered Partially Present, given the nature of the neighborhood surrounding her interim environment and her fears, but of Low risk for violence. Similarly, as her medical condition is currently sufficiently managed, this is considered not present and of low relevance to her risk for violence.

Ms. Pierce has no history of arson or escape.

HCR-20 V3 Factor Current Presence

Current Relevancy: Last Presence, Last Relevancy

H1. Violence Present Moderate Present High

H2. Other Antisocial Behavior Partial Low Partial Low

H3. Relationships Present High Present High

H4. Employment No Low No Low

H5. Substance Use No Low No Low

H6. Major Mental Disorder Present High Present High

H7. Personality Disorder No Low No Low

H8. Traumatic Experiences Present Moderate Present Low

H9. Violent Attitudes No Low No Low

H10. Treatment or Supervision Response Partial Moderate Partial Moderate

FAM H11. Prostitution No Low No Low

FAM H12: Parenting Difficulties Partial High Partial High

FAM H13: Pregnancy at a young age No Low No Low

FAM 14: Suicidality/Self-Harm Present Moderate Present Low

OC-H Other: Medical Issues Present Moderate Present Moderate

C1. Insight Partial Moderate Partial High

C2. Violent Ideation or Intent No Low No Low

C3. Symptoms of Major Mental Disorder No Low No Low

C4. Instability Partial Moderate Partial Low

C5. Treatment or Supervision Response Partial Moderate Partial Moderate

FAM C6. Covert and Manipulative Behaviors No Low No Low

FAM C7. Low Self-esteem No Low No Low

OC-C Other: Medical Issues Partial Low N/A N/A

R1. Professional Services and Plans No Low No Low

R2. Living Situation No Low No Low

R3. Personal Support Partial Moderate Partial Low

R4. Treatment or Supervision Response Partial Moderate Partial Moderate

R5. Stress or Coping Yes Moderate Partial High

FAM R6. Problematic Child Care Responsibility Yes Moderate Partial Moderate

FAM R7. Problematic Intimate Relationship No Low No Low

OC-R Other: Medical Issues No Low N/A N/A

Recommended Reassessment Date/Marker: Next privilege request packet or 6 months from now, whichever happens first.

Risk Formulation (describe present factors and if they are currently relevant to the risk posed by utilizing the requested privilege): Ms. Doe has a limited history of violence. The bulk of her historical aggression has been directed toward her second ex-husband, though she has also threatened her daughters and put another at risk of injury in the commission of her NGRI offense. While Ms. Doe's history of psychiatric illness was directly involved in her NGRI offenses and the aggression directed towards her daughters, her violent behavior toward her second ex-husband has not consistently been related to her experience of psychiatric symptoms. Rather, the common factor in most of her instances of violence with him has been an underlying difficult relationship, exacerbated by other attendant risk factors. As such, her psychiatric illness can be thought of as a risk factor that destabilizes Ms. Doe and generally elevates her risk as it compromises her ability to cope and rationally select nonviolent coping methods. However, her interpersonal conflicts with romantic partners, parenting difficulties, and difficulties with emotional regulation are also critical to her risk of violence.

With regard to violence directed toward her husband, Ms. Doe described a period of reciprocal domestic violence in the early years of their relationship and noted that after a period of stability, nearly all instances of aggression were preceded by some sort of disagreement, whether about finances, suspicions of infidelity, or disagreements about parenting practices. Thus it seems the interpersonal

strife within this relationship acted as a contributing but steady factor that increased her violence risk. Ms. Doe, however, denies this and instead, attributed her violent behavior to the effects of steroid medication and need for self-defense during these instances.

At the time of the NGRI offense, Ms. Doe was contending with a number of risk factors. Her problematic relationship with her then husband was amplified as she was reeling from their bitter divorce in which prior evidence of her husband's sexual deviance resurfaced. In an attempt to provide financially, Ms. Doe had been working multiple shifts as a nurse with no consistent pattern of sleep or routine, in which she also rearranged her medications schedule in an attempt to accommodate her inconsistent schedule. The disruption in sleep and medication, in the presence of increased relational distress, likely contributed to her reemergence of symptoms. While symptomatic, Ms. Doe reported that her younger daughter told her she was being hit by her older sister. When Ms. Doe attempted to address it with her ex-husband the same day, she felt he dismissed and disregarded her concerns. Following this disagreement, Ms. Doe drove to her ex-husband's house and the NGRI offenses ensued. Therefore, her parental concerns and more specifically, the disagreement with her husband in an already compromised state appeared to precipitate the events of the NGRI offense.

Ms. Doe's brief history of aggression directed toward her daughters seem to all have occurred in the context of active psychiatric symptoms compounded by increased stress related to relationship dissolution. Ms. Doe denied any history of violence toward her children when not actively symptomatic and she noted that both instances were quickly followed by bizarre behavior (e.g., urinating on herself and making odd statements to police officers following her arrest), again supporting the notion that her psychotic thinking in the context of a bitter divorce precipitated her aggressive and uncharacteristic aggression toward her children.

Ms. Doe's most recent suicide attempt also endangered the lives of her parents and others on the road. While not intentionally violent, it was nevertheless a reckless act that could have caused injury. As outlined above, Ms. Doe has complied with several treatment interventions since that time and has exhibited behavioral stability. Further, she is no longer in the excessive pain she was at the time of the attempt and reports great relief in this. As the identifiable precipitant (i.e., pain) has been alleviated and the associated impulsivity appears to be well controlled at this time with medication and psychosocial intervention/support. She consistently denies suicidal ideation and verbalizes her motivation to remain stable and leave the hospital so as to carry on with her life.

At present, Ms. Doe's risk for violence is well-managed with consistent medication adherence and the provision of a structured setting to minimize stressors present at the time of the offense to include parenting difficulties, employment demands, and involvement in unhealthy romantic relationships. Ms. Doe's risk for violence is perpetuated by her mental illness, emotional reactivity, struggles with insight development, and co-parenting responsibilities. However, many of the risk factors present on the day of the NGRI offense have been mitigated. For instance, she has been consistently compliant with her medication which has resulted in successful management of her psychiatric illness. She has additionally participated in multiple groups that have focused on appropriate emotional expression and more appropriate relationship functioning. She participates in individual therapy and is developing more insight into her risk factors. Though she wants to work, she is not currently employed and will spend much of her time on this privilege engaged in treatment activities.

Risk Management Plan (add additional strategies as needed)

Management Strategy #1: As Ms. Doe's psychiatric stability is critical, her consistent compliance and responsivity to medication will be closely monitored on the next privilege level. She has remained

compliant with medication thus far and voices her intention to comply moving forward. As highlighted above, Ms. Doe will be responsible for some management of her own medication on this privilege level, but will be expected to check in with team members following each independently administered dose. Her compliance will be monitored with routine lab work. Nursing staff and treatment team members will closely monitor her mental status for changes in mood, sleep, thought disturbances and paranoia as well as suicidal or homicidal ideation prior to exercising new privileges (if approved) and address as needed. If her mental status worsens, the treatment team will suspend privileges pending further evaluation.

Management Strategy #2: Ms. Doe's history of violence has been circumscribed to those with whom she shares close relationships, specifically, her former romantic partner. She has refused to allow the team to help establish healthier and more productive communication between them for the sake of co-parenting. She has however, been receptive to sessions with other her parents and eldest daughter, which have gone well. Additional meetings with family will be held as necessary and the treatment team will revisit Ms. Doe's position on facilitating communication between she and her ex-husband in the future.

Management Strategy #3: Another important area of risk management for Ms. Doe involves her ongoing development of emotional regulation strategies and insight and for this, her individual therapy will continue. Additionally, the undersigned will continue to meet with her regularly to discuss her evolving risk management strategies. She has revised her WRAP plan and will be encouraged to update this as appropriate for the remainder of her hospitalization so that she might share it with family and community providers.

Future Violence/Case Prioritization: Low Moderate High

Serious Physical Harm: Low Moderate High

Imminent Violence: Low Moderate High

Check protective factors and how those factors help mitigate risk at this proposed privilege level.

Intelligent Secure childhood attachment Appropriate coping skills

Self-control Resilient personality traits Empathy

Employment Leisure activities/hobbies Motivation for treatment

Medication Adherence Financial management Positive attitudes towards authority

Future oriented Social network/attachments Pro-social involvement

Strong attachment and bonds Intimate Relationships

Other:

Ms. Doe has a number of protective factors that mitigate her risk for violence. Specifically, she has a history of advanced educational attainment and long periods of employment, periods of high level functioning in the community while appropriately managing her illness, multiple coping strategies (e.g., coloring, talking to support system, and latch-hooking among others), motivation for treatment, medication adherence, positive attitudes towards treatment providers, and goals for her life after discharge.

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APPENDIX B

Working With The Virginia courts

I. Understanding the Law

A. Constitutional law: Virginia and United States Constitutions establish principles of law

B. Statutory law: Virginia General Assembly enacts statutes that are collected in the Virginia Code

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

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. Virginia court of Appeals

a. No trials
b. Hears appeals on the record from circuit court decisions

4. Supreme court of Virginia

a. No trials
b. Hears appeals on the record from trial court decisions and decisions of the court of Appeals, in some cases

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 perform the duties required of a judge by Chapters 8 and 11 of Title 37.2 (civil commitment and judicial authorization of treatment)

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, egodytonic)
    c. Medication names (e.g., Seroquel, Risperidone)

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 a 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 C

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 Risk and ARR-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 CSB 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 CSB'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 intellectual disability 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 intellectual disability specified in Virginia Code section 37.2-100, and the criteria established by the American Association of Intellectual and Developmental Disabilities (AAIDD).

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 HAS A MENTAL ILLNESS OR INTELLECTUAL DISABILITYAND IS IN NEED OF INPATIENT HOSPITALIZATION

Based on my evaluation of Mr./Ms. ______________ as discussed in this report, it is my opinion that Mr./Ms.________________has a mental illness or intellectual disability and is in need of 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 FRP 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/psychiatric 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.

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 or acquittee requests release, pursuant to §19.2-182.5 (B), or

3. Petition for release evaluation, pursuant to §19.2-182.6 (A).

M. Date appointed by Commissioner to conduct 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 CSB)

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 (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 intellectual disability and need for inpatient hospitalization, based on factors described in § 19.2-182.3. court

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 HAS A MENTAL ILLNESS OR INTELLECTUAL DISABILITY AND IS IN NEED OF INPATIENT HOSPITALIZATION

Based on my evaluation of Mr./Ms. ______________ as discussed in this report, it is my opinion that Mr./Ms.________________has a mental illness or intellectual disability and is in need of 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 D

Reports to the Court

This appendix covers treatment team submissions of annual continuation of confinement (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 C**. 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 FRP.

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 Risk (see **Appendix A**). The outline suggests several factors that 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 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 intellectual disability should be based upon DSM criteria which require deficits in both level of intellectual functioning and adaptive capacity. See also the definition of intellectual disability specified in Virginia Code §37.2-1, 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 CSB's involvement in the development of the plan. Recommendations for either conditional release or release without conditions require prior review and approval by the FRP 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.

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 DBHDS

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 (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

D. 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 Violence Assessment

A. Summary of episodes of violence and brief description of each, including recent hospital violence

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 violence

VI. Summary Opinions/Recommendations

A. Assess mental illness and intellectual disability and need for inpatient hospitalization, based on factors described in § 19.2-182.3.

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 or recommitment to inpatient hospitalization,

2. Conditional release, or

3. Release without conditions.

C. 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 HAS A MENTAL ILLNESS OR INTELLECTUAL DISABILITY AND IS IN NEED OF INPATIENT HOSPITALIZATION

Based on my evaluation of Mr./Ms. ______________, as discussed in this report, it is my opinion that Mr./Ms. ______________ has a mental illness or intellectual disability and is in need of 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 E

Active Treatment Approaches for Insanity Acquittees

I. Treatment of Insanity Acquittees in DBHDS 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 Behavioral Health and Developmental Services (DBHDS) 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. 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 DBHDS facilities that provide treatment for insanity acquittees. Those individuals who are currently committed to the custody of the Commissioner of the DBHDS 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. 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 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 DBHDS 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 DBHDS facilities.

A. In accordance with departmental policy, 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, community reintegration (i.e., conditional or unconditional release from hospitalization) shall be a primary goal of treatment.

C. Pre-discharge planning for acquittees shall be ongoing, as mandated by DBHDS policy, and shall involve the active participation of the representative to the acquittee's treatment team from the CSB that serves the jurisdiction to which the acquittee is likely to be discharged.

D. As soon as possible after the admission of an NGRI acquittee to a DBHDS 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 dynamic Risk Factors, 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 be 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 FRP or the IFPC shall be in the acquittee's Comprehensive Treatment Plan. Risk Management Plans developed to address changes in risk that are presented by increased levels of privilege, and also shall be incorporated into the acquittee's Comprehensive Treatment Plan.

H. Treatment of each acquittee shall be consistent with the biopsychosocial model of 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. 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 DBHDS 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 only as examples of the range of psychosocial interventions that is currently available at each DBHDS facility. These approaches to treatment for insanity acquittees may be useful in providing treatment/interventions in both the mental health facilities and community

settings. Not every acquittee will require every treatment modality. Treatment should be individualized based on risk and clinical need.

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

      (1) 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.
      (2) Behavioral repertoire of acquittee is identified and then divided into aggressive and non-aggressive behaviors.

   b. Stage 2-Building Alternative Responses to Aggression

      (1) Focus here is on increasing the number of available options for handling potentially aggression-inducing situations in a nonviolent way.
      (2) Possible alternatives
         i. avoidance
         ii. assertiveness
         iii. early warning and recognition
         iv. compliance and cooperation with "helping professionals"
         v. effective management of symptoms

   c. Stage 3-Development of Plans

      (1) Develop plan for handling important risk factors for aggression in a nonaggressive way, based on knowledge gained in first two stages
      (2) Develop written plan
      (3) Acquittee practices plan and discusses it sufficiently often

enough that he or she has a good working understanding of the plan

d. Stage 4-Relapse Prevention

(1) Unstructured group focused on
(2) work with relapse prevention plan developed in Stage 3
(3) implementing that plan on a daily basis
(4) preparing and fine-tuning plan for use during conditional release.
(5) 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

(1) Temporary custody
(2) Commitment to Commissioner
(3) Civil transfer
(4) 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

D. MRT (Moral Reconation Therapy)

MRT is an evidence-based practice that aims to change thought processes and decision-making associated with addiction and criminal behavior. MRT utilizes a combination of psychological practices to assist with egocentric behaviors and improve moral reasoning and positive identity. Studies suggest it is effective in reducing criminal recidivism after treatment.

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APPENDIX F

Conditional Release Plan

COURT-ORDERED CONDITIONAL RELEASE PLAN FOR [*Enter Name of Acquittee]*

The signatures at the end of this conditional release plan indicate that I understand that I have been found not guilty by reason of insanity for __, pursuant to Virginia Code Section 19.2-182.2, and I am under the continuing jurisdiction of the _____court as a result of that finding. Pursuant to Virginia Code Section 19.2-182.7, the __Community Services Board will be responsible for the implementation and monitoring of my conditional release plan. The undersigned parties and I have reviewed this conditional release plan and agree to follow the terms and conditions.

A. GENERAL CONDITIONS

1) I agree to abide by all municipal, county, state, and federal laws.

2) I agree not to leave the Commonwealth of Virginia without first obtaining the written permission of the judge maintaining jurisdiction over my case and the ___ Community Services Board (CSB). I further understand that, pursuant to § 19.2-182.15 *Code of Virginia*, I may be charged with a class 6 Felony if I leave the Commonwealth of Virginia without the permission of the court.

3) I agree not to use alcoholic beverages.

4) I agree not to use or possess any illegal drugs or prescribed medications unless prescribed by a licensed physician for me.

5) I understand that I am under the legal control of the judge maintaining jurisdiction over me and the under the supervision of the CSB (and/or CSB designee) implementing my conditional release plan. I agree to follow their directives and treatment plans and to make myself available for supervision at all reasonable times.

6) I agree to follow the conditions of my release and conduct myself in a manner that will maintain my mental health.

7) I understand that, even if it is not my fault or the result of any specific violation of conditions, I may be returned to a state hospital if my mental health deteriorates. I further understand that, if I am hospitalized in the custody of the Commissioner while on

conditional release, my conditional release is considered revoked unless I am voluntarily admitted.

8) I agree to pay for all treatment services on a fee schedule set by the CSB and/or other community providers.

9) I agree that I will not own, possess, or have access to firearms and/or other illegal weapons of any kind. I further agree not to associate with persons or places that own, possess, or have access to firearms and/or other illegal weapons of any kind.

10) Prior to and after discharge on conditional release, I agree to release all information and records concerning my mental health and my compliance with the conditions of release to the supervising CSB, other community providers, attorney, and other participating parties.

11) I agree to participate in 30-40 hours per week of structured activities while I am on conditional release. These weekly activities (and any changes) must be approved in advance by the CSB.

B. SPECIAL CONDITIONS

1) I agree to reside where authorized by the supervising CSB. Initially, I agree to reside at the following:

(Name of family member, name of placement, type of residential placement, or self)

Address

Phone

If, at any point during the conditional release, I choose not to live at the above location or am asked to move out, then the supervising CSB will evaluate the situation and recommend an alternative living placement. The supervising CSB will coordinate any changes in my residence. If I choose not to reside at the CSB recommended placement, I shall be considered to be in noncompliance with the conditions of release. Any change in residence requires notification to the court by the supervising CSB. I agree to be financially responsible for the cost of my living arrangements/residential placement(s).

2) I will receive approximately $___ per month in ___ benefit funds or earn a salary upon discharge from the hospital. I agree to apply for entitlements and health insurance for which I may be eligible in the community.

3) I agree that I will participate in structured daytime activities for the duration of my conditional release, i.e., employment, volunteer work, school, club house, AA, NA, other special groups, etc.

My   initial plan is the following:

Type of daytime activity/ies:
Frequency of daytime activity/ies:

4) Staff at the supervising CSB (or CSB designee) will provide case management for me. I agree to meet with my case manager for the purpose of monitoring compliance with the conditions of release. The name and phone number of my case manager is:

Name and phone number of case manager:_____

Duration of case management contacts: ________

Frequency of case management office visit contacts:

Frequency of case management home visits contacts: _______

5) In case of an afterhours or weekend emergency I can reach someone at the CSB at this number: _____

6) I agree to work with the CSB staff responsible for conducting ongoing assessments of my mental status and associated risk factors. I understand that this may be conducted as part of case management visits, individual therapy appointments or a separate meeting as directed by the CSB. The CSB will provide qualified staff persons for the purpose of conducting mental status and risk factor assessments. The responsible person is __and the frequency of my mental status assessment and risk assessment will be___.

7) When applicable, I agree to participate in individual therapy with treatment staff of the supervising CSB (or CSB designee). The initial schedule for my individual therapy is:

Duration of Therapy:

Frequency of Individual Sessions:

Location of Therapy Sessions:

8) I agree to take psychotropic medication as recommended by my treating psychiatrist. I agree to meet with my treating psychiatrist (or psychiatrist's designee) at the supervising CSB (or CSB designee) for the purposes of monitoring my psychotropic medications and to have my prescriptions renewed and refilled. I 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:

9) I agree to submit to periodic blood or urine analysis as directed by treatment staff of the supervising CSB for the purposes of monitoring psychotropic medication compliance and tolerance.

10) I agree to receive recommended medical treatment for the duration of my conditional release. My current medical conditions and providers are listed below:

My current medical condition(s) is:

Name and office location of medical provider(s):

11) I agree to be assessed by a substance abuse counselor at the supervising CSB (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:

12) I agree to submit to random and/or periodic breathalyzer, blood or urine analysis as directed by treatment staff of the supervising CSB for purposes of monitoring alcohol consumption, illicit drug use and/or other prohibited substances. Drug/alcohol screens will be given for the duration of conditional release or as otherwise indicated. When indicated, I agree to a full drug panel screening. I further agree to pay any lab fees associated with this screening. Detection of any illicit substances, detection of alcohol use, or refusal to participate in these screenings shall constitute noncompliance with the conditional release plan. The screening schedule is as follows:

Frequency of SA screening:

Duration of SA screening:

13) If applicable, I agree to be assessed by a vocational rehabilitation counselor and to follow the recommendations made from this assessment. The vocational assessment may be provided by treatment staff of the supervising CSB or can be conducted by another agency designated by the CSB.

14) I agree that, if cannot attend a meeting or session as required by this conditional release plan, I will provide advance notice by calling the person. If I am unable to contact that person, I must contact one of the following individuals:

Alternative contact #1:
Phone #:
Alternative contact #2:
Phone #:

15) I am responsible for arranging transportation between home and activities required under this conditional release plan. I 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.

16) I agree to additional special conditions that may be deemed necessary by the supervising CSB in the future.

[NOTE TO CSB: Other special conditions should be added here as appropriate to the individual acquittee and their special management needs in the community. Delete this note when you have completed the plan.]

** I have read or have read to me and understand and accept the conditions under which the court will release me from the hospital. I fully understand that failure to conform to the conditions may result in one or more of the following:

- Notification to the court of jurisdiction;
- Notification of the proper legal authorities;
- Modification of the conditional release plan pursuant to § 19.2-182.11;
- Revocation of conditional release and hospitalization pursuant to § 19.2-182.8;
- Emergency custody and hospitalization pursuant to § 19.2-182.9; or
- Charged with contempt of court pursuant to § 19.2-182.7

** I understand that my conditional release plan is part of a court document and could potentially be accessed by the public.

____ _______________
Signature of Acquittee Date

____ _______________
Signature of Witness for Acquittee's signature Date

____ _______________
Signature of NGRI Coordinator or designee for CSB Date

C. COMMUNITY SERVICES BOARD

1. The ____CSB will coordinate the conditional release plan. As of the beginning of the conditional release plan, the designated case manager is:

   Name:
   Title:
   Community Services Board:
   Address:
   City, State, Zip:
   Phone: ___ FAX:

2. The CSB 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
   DBHDS
   P.O. Box 1797
   Richmond, VA 23218

   PHONE: (804) 786-9084
   FAX: (804) 786-9621
   EMAIL: csb.ngri@dbhds.virginia.gov

3. The CSB shall provide Office of Forensic Services of DBHDS with monthly written reports for the first twelve consecutive months on conditional release. The monthly reports will address the acquittee's 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. Pursuant to § 19.2-182.11, the CSB understands that the court of jurisdiction must approve any proposed changes or deviations from this conditional release plan.

5. The CSB shall immediately provide copies of all court orders and notices related to the disposition of the acquittee to DBHDS, Office of Forensic Services, at the above address.

D. 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

E. 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. Please indicate the CSB's support for or against conditional release and an explanation for the CSB's position:

Signature/Print Name	**Title/CSB**	**Date**
______________________	______________________	__________
______________________	______________________	__________
______________________	______________________	__________

APPENDIX G

FORENSIC COORDINATOR RESPONSIBILITIES

Since 1987, the Commissioner has required that all DB HDS operated mental health facilities designate a Forensic Coordinator. The primary focus of the Forensic Coordinator is to improve the management of forensic patients in DBHDS 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 Division of Forensic Services, Forensic Services section.

Each facility shall 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 ae 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 attempt to obtain an appropriate court order, the Forensic Coordinator requires assistance, he or she shall contact the Director of Forensic Service in a timely manner to request technical assistance and support.

III Monitoring the management, progress, conditional release planning, and discharge planning for all forensic patients.

A. Notify the Director of Forensic Services of all admissions, transfer, and discharges of insanity acquittees (NGRIs) within one working day of the event.

B. Notify the Director of Forensic Services of ant 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 includes, but is 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 CSB/BHA 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 the report 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 FRP 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.

3. Ensure that reports are submitted to the court(s) on time.

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 appropriately 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.

XI Develop and maintain currency of facility NGRI legal and privileging files for each acquittee.

XII Provide comprehensive oversight of document production, transmission and receipt among facility treatment teams, the IFPC, the FRP, and the Office of Forensic Services, regarding the process of privileges granted by the facility IFPC.