Guidelines for Forensic Evaluations

December, 2004

(Federal Bureau of Prisons - Clinical Practice Guidelines)

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Purpose

The purpose of the Federal Bureau of Prisons Clinical Practice Guidelines for Forensic Evaluations is to provide recommendations for the psychiatric, psychological, and medical management of inmates committed to the custody of the Attorney General of the United States under the statutes in Title 18, United States Code, Sections 4241-4247, and housed in Federal Bureau of Prisons facilities.

Introduction

Certain legal aspects concerning the evaluation and management of inmates with mental diseases or defects are covered by statutes in Chapter 313 of Title 18, United States Code (USC) in §§4241-4247 (see *Appendix 1, General Overview of Federal Statutes* and *Appendix 2, Summary of Federal Statutes*). The statutes cover:

- Pretrial, presentenced inmates
- Post trial, presentenced inmates
- Inmates serving provisional sentences
- Inmates found Not Guilty Only by Reason of Insanity (NGRI)
- Sentenced inmates with severe mental disease or defect requiring involuntary hospitalization
- Sentenced inmates due for release who may be dangerous due to a mental disease or defect

All Bureau of Prisons (BOP) mental health clinicians should be familiar with these statutes, regardless of their duty station and usual clinical duties.

These guidelines set **minimum** standards for the evaluation process for forensic study cases and include standards for data collection, testimony, documentation, and supervision, as well as provide guidance on the use of psychological testing for forensic purposes. These guidelines cover forensic studies done in any of the BOP institutions. While these guidelines will specifically address each of the statutes in Chapter 313, Title 18, USC, they cannot address every possible question the courts may ask. However, the forensic clinician can be guided by the general principles and procedures outlined here, and adapt them as necessary for those rare cases that do not fall under §§4241-4247.

For simplicity's sake, the examiner will be identified as the staff person performing the tasks outlined in these guidelines. However, there is no attempt in these guidelines to direct which staff members (or how many) will participate in the forensic evaluation process (other than the requirement that the primary examiner must be a licensed doctoral level psychologist or psychiatrist with the necessary forensic experience or subspecialty training), as this will vary from institution to institution, and from case to case, depending on the resources available and the resources needed to complete the evaluation.

Because of the time-sensitive nature of forensic evaluations and the need for comprehensive assessment, coordination of care with corrections, health care staff, executive staff, nursing, pharmacy, and mental health staff is crucial. The examiner is responsible for ensuring that necessary medical and psychological studies are completed in a manner consistent with the statutory time frames. This will usually require close collaboration between the forensic examiner and the clinical director or primary care provider responsible for the inmate's medical care.

The BOP currently maintains forensic examining sites at several facilities throughout the United States. Inpatient study sites are located at selected Medical Referral Centers (MRCs) and provide forensic services when the increased resources available in a hospital setting are clinically or statutorily required. Outpatient study sites include some Federal Detention Centers, Federal Correctional Institutions, and MRCs.

Principles of Practice

The practice of forensic psychiatry and psychology is unique in clinical practice within the BOP. It requires the clinician to recognize that while performing forensic work, his or her obligation is to the justice system, specifically the court, and not to the United States Attorney's Office, the defense attorney, or even the inmate. It also requires that the clinician maintain a balanced, though empathic, scepticism regarding the information provided by the inmate and others. The inmate may have any number of reasons for wanting to appear something other than he or she is, for example as suffering from a mental illness when he or she isn't, or covering up the presence of a mental illness (common among individuals with delusional disorders), or exaggerating real symptoms.

Those individuals engaged in forensic work should be familiar with the potential ethical conflicts associated with practicing forensics, especially as it relates to being employed by the Department of Justice in a correctional setting. The reader is referred to the ethical guidelines published by the American Psychological Association, the American Psychiatric Association, and the American Academy of Psychiatry and the Law.

It is incumbent upon the clinician to attend carefully to his or her own subconscious and conscious motivations in his or her work on a particular case, and ensure that he or she is able to maintain objectivity. Requesting supervision, peer review, and/or a second opinion is not only encouraged, but imperative (at least on an intermittent basis) for the professional to maintain and improve his or her skills and to prevent the acting out of counter-transference issues. Whenever the examiner has a concern that he or she may have some bias or loss of objectivity in a case, supervision should be sought. In some cases, the examiner may decide that he or she cannot render an objective opinion. Under no circumstances should the examiner continue to work with the inmate, but should immediately seek supervision and refer the case to another evaluator.

All applicable ethical guidelines will not be repeated here; however the following basic

principles apply:

- **Every effort should be made to maintain impartiality (in substance and appearance) throughout the forensic process.** There is always the danger of the appearance of bias in one direction or another. Among other things, this means that both parties to the case (the defense attorney and the United States Attorney or Assistant United States Attorney) have equal access to information both in terms of content and timeliness.

- **It is not the evaluator's job to make a determination as to guilt or innocence, competence or incompetence, or to determine an appropriate punishment.** Such determinations are made during the legal proceedings in the courtroom by the trier of fact. The clinician provides an informed opinion on the questions posed by the court, based on observation, interaction with the inmate, and other data, and within the sphere of his or her expertise.

- **The evaluator should confine the evaluation, report, and testimony to those questions specifically raised by the court and to those areas in which he or she maintains expertise.**

- **The evaluator should always assume that the inmate is confused about his or her role, and should inform the inmate at the first contact** (and periodically thereafter) **as to the nature of the relationship and the purpose of the evaluation.**

- **The evaluator should complete the evaluation and report within the statutory time frames.**

Procedures

Designations

All forensic designations are managed through the Office of Medical Designations and Transportation (OMDT) in accordance with BOP policy. All court orders received by individuals outside of OMDT should be forwarded to OMDT for processing and disposition prior to any study being undertaken. OMDT staff will attempt to clarify the statutory intent of the court order prior to designating the inmate. Generally, any evaluations that by statute and policy are permitted to be done in an outpatient setting are designated to one of the BOP's outpatient forensic sites. Those that by statute, policy, or clinical condition require inpatient evaluation are designated to one of the BOP's inpatient forensic sites.

If the designation requires that the inmate be moved, the United States Marshals are usually responsible for transportation. The movement may be accomplished within days of the order, or may not occur for weeks. Because all of the statutes (except §4205) have statutory time

frames associated with them, it is quite possible that the inmate will not arrive at his or her designated institution until the end of the time frame noted in the court order. It is imperative that the court be notified of the inmate's arrival and request permission for the study to be extended to account for the time of the inmate's arrival at the designated forensic site (not the date of the order).

Once OMDT has entered the designation data into Sentry, staff at the forensic site can access the information and proceed to gather data prior to the inmate's arrival (see next section).

Evaluation

The evaluation process can be divided into several steps: initial review, ongoing assessment and preparing the report.

Initial Review: The initial review process can be divided into:

- court contact
- attorney contact
- notification of the inmate
- initial mental health assessment
- medication issues
- history and physical

The first two processes can be started prior to the inmate's arrival at the forensic site. However as previously noted, it is likely that the court will also need to be contacted once the inmate arrives at the institution.

Court Contact

As noted in the section on designations, the staff at the designated site can begin gathering information as soon as the inmate is designated. Obtaining a copy of the court order and clarifying it is an important step. Individual judges may order a forensic study only rarely, and their familiarity with the statutes may be limited. Often one of the attorneys in the case may have written the order for the judge. In either case, the order may not conform in verbiage or intent to the language in the statutes. Therefore a careful review of the order is necessary prior to undertaking the evaluation. If the order has a date or time frame specifically noted that either does not conform to the statute, or to the reality of the situation (e.g., the inmate will not arrive at the institution until late in the time frame), contact with the court to clarify these issues should be made as soon as possible. If an extension of the time frame is necessary, it should be requested at this time. The request should be sent from the Warden to the court.

Attorney Contact

It is likely that multiple contacts with the Assistant United States Attorney (AUSA) and defense attorneys will be necessary throughout the forensic evaluation. As with the

court, initial contact can be made prior to the inmate's arrival at the institution. The attorneys should be asked to provide you with all court orders, copies of indictments, police/investigative reports, criminal complaints, mental health and medical records, names and telephone numbers of family members, employers, and any other records that will facilitate the evaluation. The attorneys' names and numbers will be on file with the Clerk at the Federal Court where the order was written.

Notification of the Inmate

The inmate will be seen by a health care provider upon arrival at the institution and screened for any acute medical or psychiatric conditions that need immediate attention, such as acute psychosis, suicidal ideation, acute intoxication, or the potential for substance withdrawal problems. Within 24 hours of arrival at an inpatient site, an initial mental health evaluation should be conducted. At other sites, the evaluation should occur by the end of the first business day following arrival. The guidelines for the initial evaluation are contained in the Federal Bureau of Prisons Clinical Guidelines for Psychiatric Evaluation. Notification of the inmate must precede the initial evaluation. This will include notifying the inmate of the purpose of the forensic evaluation, the content of the court order, the expected time frame of the study, and a full explanation of the limits of confidentiality. Any questions the inmate has about the evaluation should be answered. A copy of the order may be given to the inmate in cases where this will not create a mental health or security issue.

Every attempt should be made to engage the inmate's cooperation in the evaluation process. The defense attorney can often be enlisted in facilitating the inmate's cooperation. However, in the event the inmate refuses to cooperate, or cannot fully comprehend the nature or purpose of the study, the evaluation can proceed, as the inmate's consent is not necessary to perform the court-ordered evaluation.

The parameters of the relationship of the examiner to the inmate is unique in the experience of most inmates. It is easy for the inmate to become confused as to the nature of the relationship and begin to interact with the examiner as if he or she is a personal therapist. It is important to periodically review the purpose of the evaluation and the role of the examiner in the evaluation, as well as the limits of confidentiality. While there may be occasion for the examiner to provide crisis intervention or some psychological support, the primary relationship is not a treatment relationship in the classic sense.

Inmates may be committed to an institution for hospitalization and treatment under §§ 4241(d), 4243(e), 4244(d), 4245(d), or 4246(d). In these cases there is even greater potential for role confusion. The examiner and inmate need to remain aware of the purpose of the treatment (e.g., restoration of competence) which may be something less than the usual therapeutic goal of optimizing a patient's functioning.

The inmate should be asked to sign releases of information for any outside medical and psychiatric records. If the inmate refuses to sign releases for relevant information from

outside sources (such as medical and/or psychiatric records), the court should be promptly notified and asked to issue an order for release of those records.

Releases are not absolutely necessary to obtain verbal information from attorneys, family members, or other individuals. The inmate should be informed that collateral information will be gathered from relevant sources. However the examiner cannot reveal any information about the inmate or the case to sources other than the attorneys, court, or United States Parole Office (USPO) without a signed release from the inmate.

It is not uncommon for the inmate to frequently ask for feedback regarding the evaluation and request that the examiner inform him or her as to the likely conclusions the examiner will draw. This should be avoided for several reasons. Most importantly the examiner should never be boxed into a final opinion, because it is always possible that additional material may be discovered that would cause a change in that opinion. Therefore, the inmate should be directed to his or her attorney for this information and regarding requests for a copy of the report.

Initial Mental Health Assessment
As noted above, the inmate will initially be screened (usually in Receiving and Discharge) by a health care provider. Within 24 hours of arrival at an inpatient site (**including** weekends and holidays), a mental health professional (either a licensed psychologist or psychiatrist, or a mental health professional directly supervised by a licensed psychologist or psychiatrist) will perform an initial mental health assessment. At all other sites, the evaluation should occur within 24 hours, **excluding** weekends and holidays. The assessment should conform to BOP policy and the BOP Clinical Guidelines on Psychiatric Evaluations, as applicable.

Medication Issues
Any inmate admitted as a study case to the institution on psychiatric medication, should be seen by a psychiatrist or other physician as soon as possible, but at least within 24 hours, excluding weekends and holidays. In the interim, the medication should be continued, and an informed consent for the medication should be documented according to policy. Inmates on potentially addictive, mind-altering medications, such as tranquilizers, barbiturates, or others, should usually be informed by a physician or psychologist as to the addictive nature of the medications and the cognitive impairments associated with them. In general, they should be tapered off of these medications (see the BOP Clinical Guidelines on Detoxification), time permitting within the study period.

During the evaluation period, if psychiatric medication is deemed clinically appropriate, and the inmate gives informed consent, then medication may be started. The attorneys and court should be notified however. If emergency medication is administered (see the program statements on Administrative Safeguards for Psychiatric Treatment and Medication, Health Services Manual and Psychiatric Services), the court should be notified within 1 working day. Notification of the attorneys can then be made. Staff

should consider the need for involuntary commitment for hospitalization and treatment whenever emergency medication is administered. In cases in which the inmate is housed in an outpatient setting and his or her clinical condition is such that hospitalization is required, the court, defense attorneys, and AUSA should be notified and given 24 hours to respond to the information. Rarely the court may prohibit a transfer to an MRC. If transfer is pursued, the institution staff should submit a transfer request to OMDT.

History and Physical

A medical evaluation is essential to a forensic study. Organic conditions can cause any number of psychiatric symptoms, including psychosis and dementia. Due to the time-sensitive nature of forensic studies, a complete history and physical should be completed within 7 days at an outpatient site and within 24 hours at an inpatient site. This evaluation should include relevant laboratory and radiologic studies. While the specific tests and diagnostic studies performed will be guided by the history, physical, and mental health evaluation, the following tests should be completed on any inmate undergoing a forensic study:

- CBC with differential
- Fasting chemistry panel
- Urinalysis
- HIV testing
- TSH

Females should also receive pregnancy testing. Additional studies may be indicated in inmates with specific medical or psychiatric findings, or from areas where certain significant conditions are endemic (such as cysticercosis, or syphilis).

Any abnormal findings should be immediately addressed. **The examiner is responsible for coordinating the medical care of the inmate such that any essential evaluations and treatments are completed prior to the end of the study period.** Ensuring continuity of care upon discharge from the institution, particularly as it pertains to any need for further medical or psychiatric evaluations and treatments, is also the responsibility of the examiner in collaboration with the clinical director or primary care provider responsible for the inmate's medical care.

Ongoing Assessment: The ongoing assessment will include:

- serial interviews of the inmate
- behavioral observations
- review of collateral information
- medical review
- psychological testing
- legally-focused interviews

Serial Interviews of the Inmate

The frequency of inmate contacts will be dictated to some extent by the inmate's

clinical presentation, need for treatment interventions, etc. Ordinarily the inmate should be seen at least weekly, but depending on circumstances and the condition of the inmate, daily contacts may be necessary. Clinical contacts with the inmate will always include a mental status examination, including assessment of any risk of harm towards self or others, and ongoing diagnostic assessment. The clinician will also frequently review with the inmate the purpose of the evaluation, as well as assess previous clinical findings or psychiatric symptoms. If the inmate is on psychiatric medication, response to the medication (benefits and side effects) should also be reviewed.

Serial interviews are likely to increase the accuracy/reliability of the clinical findings, and are more sensitive at uncovering inconsistencies in presentation (which may be due to any number of factors), than one-time interviews.

As collaborative data is collected and reviewed, contradictory information may come to light. The serial interview should be used to clarify any inconsistencies and contradictions that the examiner discovers.

Behavioral Observations

The examiner should take opportunities to observe the inmate in surroundings other than the office or cell in which the clinical interviews take place. The examiner should also interview other staff as to their observations, including correctional staff, recreation staff, other health care providers, pharmacy staff, etc. Log books, incident reports, and any other written documentation generated during the inmate's study period should also be reviewed.

A review of taped telephone conversations and written correspondence (other than communication with the inmate's own attorney which is privileged information) can also provide significant insight into the inmate's thought processes and level of functioning.

Review of Collateral Information

It is imperative to collect and review as much collateral information as possible. As previously noted, this includes law enforcement records, outside medical and mental health records, education and military records, criminal history, interviews with the opposing attorneys, family, employers, and others. Repeated efforts may be necessary to obtain the material in a timely manner. Some of the documents may not arrive until after the departure of the inmate from the institution. Whenever possible, any conflict between the information provided by the inmate and other sources should be explored and resolved to the satisfaction of the examiner.

Medical Review

The examiner will need to periodically review the progress and results of the medical and laboratory evaluations. This review may best be done in collaboration with the primary care provider and/or clinical director. The purpose of the review is to ensure that any abnormal findings are appropriately documented and addressed as clinically

indicated consistent with the inmate's length of stay, and BOP policies and procedures as outlined in the Program Statement on Patient Care (Check name of this and need to reference). Follow-up may consist of further studies, interventions, or monitoring. The examiner, usually in collaboration with the clinical director, may need to contact the inmate's receiving institution or outside physician (in cases in which the inmate is released from custody) and the inmate's attorney to ensure that appropriate follow-up is provided. If abnormal results are obtained after the inmate has left the BOP facility, contact with the inmate's attorney and receiving institution or outside physician should also be made by the examiner.

All relevant medical findings will be included in the final report to the court.

Psychological Testing

The use of specific psychological tests in forensic evaluations will be driven by several factors:

- the question(s) posed by the court
- the provisional diagnosis
- the reliability and validity of the test(s) for the inmate being evaluated
- the defensibility/admissibility of the test results in court
- staff expertise with various psychological tests
- if no testing is done, the defensibility of this decision

Testing should never be used in lieu of in-depth clinical interviews and behavioral observations, and review of collateral data. Psychological testing should support the clinical findings, not take their place, and the findings of the test should be directly relevant to the question(s) posed by the court.

There is no specific minimum or maximum number or type of tests that should be used in a forensic evaluation. However, most forensic examiners do have the inmate perform some psychological testing, typically some measure of intellectual function and some personality testing. For inmates being evaluated for competency to stand trial, it is common for standard tools, such as the Competency Screening Test, to be administered.

Many of the available psychometric tools have been validated on specific populations, cultures, and in specific languages. Please see *Appendix 3 (Overview of Psychometric Tools)*, for a list of some of the psychometric tools available. Any psychological testing utilized should be valid for the person being tested. Care should be taken in the selection of psychological tools in individuals in any of the following categories:

- Primary language other than English
- Limited formal education
- Presence of serious, chronic medical illness
- Cognitive impairment

Legally-Focused Interviews

The type of legally-focused interview will be directed by the type of study. Typically, legally-focused interviews are more formal interviews in which specific information is explored and recorded. Such interviews may occur multiple times during an inmate's study period. For example, an inmate being evaluated for competency to stand trial may have some assessment of his or her competency done in the initial mental assessment, and again part way through to assess progression to or regression from competency, as well as just prior to completion of the study.

Preparing the Report

The forensic report will be submitted to the court and the attorneys involved. It will likely be shared with the defendant, and if a jury is involved, they will also see it. It will become part of the permanent court record, and may or may not be sealed. As such, it will be read by individuals with varying medical or mental health expertise. Therefore it is essential that the report be written in concise, clear, jargon-free language. Most importantly, the report should address only those questions posed by the court.

Every forensic report will follow the same basic format and include the same basic information as outlined in §4247 (see *Appendix 4, Format for Forensic Reports).* The report should stand on its own merit. In other words, the information in the report should be relevant and lead logically and naturally to the conclusions offered by the examiner. Report writing requires the examiner to carefully integrate the data from multiple sources in a way that provides ample support for the final opinion. Poorly worded or extraneous information is not only unhelpful, but can obscure and confuse the picture.

When additional reports on the same inmate are prepared for the same court, the writer can summarize the relevant findings in the previous reports and refer the reader to those reports for more in depth information.

The examiner should be careful not to include sensitive information about individuals other than the defendant in the report.

The report should specifically note any areas in which information was not available or could not be corroborated. If records which contain substantive data do not arrive until after the report has been submitted, an amended report may need to be submitted. The examiner should not feel constrained by his or her initial opinion if information comes to light that changes that opinion. In fact, it would be unethical not to notify the court of that change in opinion and provide a report with the supporting data for that change.

The report may contain data, such as psychological test results, or medical evaluations and treatment, that is outside the examiner's area of expertise. The data should be carefully reviewed with someone with the appropriate expertise prior to submission of the report, and again prior to any testimony. The examiner may elect to have the individual with the appropriate expertise write this section of the report. If so, that person's name and signature will also need to appear on the report. If the examiner writes the section(s) then it should be reviewed by the appropriate person for accuracy prior to submission of the report.

If the conclusion of the examiner differs from conclusions of other examiners of the inmate, the report should reflect the process by which the examiner came to the conclusions and opinions offered in the report. This will include a discussion of the differential diagnosis, and the process by which a particular diagnosis was made versus that of another diagnosis. However, this should not include anything that may give the appearance of "sparring" with other examiners.

The timeliness of the report is as essential to the process as the timeliness of the evaluation. Court orders will often stipulate a date by which the report should be submitted to the court. The report should ordinarily be completed and sent to the court within 2 weeks from the conclusion of the study (e.g., for a 30 day study, the report should be sent to the court by day 44).

The report should be filed with the court, and distributed as stipulated in the court order, or if not specifically stated in the order then according to §4247, Title 18, USC. The burden is on the defense attorney to restrict access to the report by making a request to the court.

Documentation

The importance of thorough, timely documentation cannot be overemphasized in forensic work. Years may pass from the time an examiner prepares a report and the final legal outcome of the case. It is imperative that the examiner understand that memory cannot be relied upon to support testimony or reports filed with the court. It is equally important to recognize that all documentation is discoverable. Finally, because the documentation may be reviewed in court, all entries must be legible. If the judge or jury can't read it, then it is of little, if any, value and can reflect negatively on the credibility of the author.

In essence, the principles guiding documentation on forensic cases are no different from those that guide documentation on medical or psychiatric patients. The reader is referred to the Program Statement on Health Information Management (HIM) for complete information on the policies governing the health record. See *Appendix 5 (Documentation / Filing Guidance for Forensic Psychological Evaluations).*

- **All documentation will be contained in the inmate health record**, including outside records, collaborative data, clinical contacts, results of psychological testing (other than raw data which is filed in the Central File), and forensic reports. The examiner is not to set up "personal" or "private" records. All records are discoverable and as previously noted, become a permanent part of the inmate's health record or Central File. The examiner may wish to keep copies of logs, test data, and forensic reports; however, these should not be the originals, and must be managed as any other confidential material would be managed.

- **If clinical contacts, forensic reports, or other data are documented in the**

Psychology Data System (PDS), these notes should be printed and filed in the inmate health record within 72 hours of the event prompting the entry. Any documentation in PDS will conform to requirements of documentation as outlined in the Program Statements on Health Information Management, and Psychology Services Manual.

- **All contacts with the inmate will be documented as soon as possible in the inmate health record or PDS**, generally within minutes to hours, but no later than 24 hours after the contact. Any documentation entered at a time other than the time of contact, should be titled "Late Entry" and include the date and time of entry, as well as the date and time of contact, as per the Program Statement on HIM. If the contact is documented in the PDS, the documentation should be printed and filed in the inmate health record within 72 hours.

- **All contact with other sources will be documented in the inmate health record or PDS,** and as noted, if placed in PDS, should be printed and filed in the inmate health record within 72 hours.

- **All information documented in the record will also include the source of that information** (though in the case of an individual, not necessarily the individual's name, e.g., "nursing staff," "correctional staff," "family member," etc.).

- **Documentation of any treatment will include type of treatment, response to treatment, any side effects of treatment** (including those which may impact inmate's ability to fully participate in the trial process), as well as documentation of presence or absence of informed consent and competency to give consent for treatment.

- **All court orders will be placed in the inmate health record.**

- **The examiner is encouraged to keep a log of time, date, and type of contact for all communication and correspondence related to the case**, such as calls to attorneys, family members, letters to or from the court, faxes requesting information, etc. This log will help facilitate tracking of important information. However, it is not a substitute for documentation in the record, nor is it the personal property of the examiner, but should be considered part of the permanent record.

- **All discussions with the inmate regarding the limits of confidentiality, the examiner's role in the evaluation, as well as the level of the inmate's understanding should be thoroughly documented** in the health record (or PDS and placed in the health record) and in the forensic report.

Treatment

As has already been discussed, it is common for inmates to misinterpret the relationship with the examiner as being a treatment relationship in the clinical sense. The Bureau does not prohibit a forensic examiner from also being the treating clinician. In some cases it may be necessary or appropriate for the examiner to provide treatment (such as crisis intervention or medication for an inmate committed under §4241(d)). However it is the examiner's responsibility to ensure that neither party loses sight of the true nature of the relationship.

In cases in which a clinician has established a treatment relationship (outside of the context of a forensic order), and a situation arises in which a court requests a forensic evaluation (other than those under §4243, §4244, §4245, or §4246), the treating clinician cannot ethically provide that evaluation, but must refer the inmate to another clinician. If all potential BOP examiners at that site have been involved in the treatment of the inmate prior to the court-ordered study, it may be necessary to ask the court to allow for an independent examiner from the community to perform the evaluation, or to submit a transfer request through OMDT.

An inmate being evaluated under §4241(b) may be suffering from a mental illness that requires immediate or urgent treatment. In such a case, it is important to provide the court with a report summarizing the findings and request that the court issue an order for a 4241(d) study. If the inmate is unwilling or unable to give consent for treatment, the report and order will have to conform to the criteria set forth in the Sell v. USA case. See *Appendix 6 (Guidance on Involuntary Medication Post Sell v. USA), Appendix 7 (Dangerousness Flow Chart),* and *Appendix 8 (Sample Letter Requesting Sell Hearing).*

Additional guidance for psychiatric treatment for inmates committed to the custody of the Attorney General for an evaluation or treatment can be found in the program statements on Psychiatric Services, and Administrative Safeguards for Psychiatric Treatment and Medication, as well as in relevant Federal Bureau of Prisons Clinical Practice Guidelines.

Testimony

It is not unusual for the court and attorneys to accept the report into the record and not request that the examiner testify. However, in contested cases, it is highly likely that the examiner will be called upon to testify either in person, or through video or telephone testimony. Testifying can provoke some anxiety even in the most experienced examiners. Careful preparation, including exhaustive review of the records, not only is necessary for accurate testimony, but does much to mitigate the examiner's anxiety.

The examiner may be requested to testify by either of the attorneys, or by the court. Regardless as to which party has made the request, the examiner is not testifying on "behalf" of any party, but is testifying as to his or her informed, clinical opinion on the questions posed in the court order. Testimony is based on the data collected in the study **and** the examiner's clinical expertise. At all times, the examiner must remember that he or she is not an expert on

criminal or moral matters, but only on clinical matters in which he or she possesses expertise, and it is only in this realm that he or she can offer an opinion.

As at other times, it is important for the examiner to maintain a non-biased approach to the case. This does not mean that the examiner does not advocate for his or her opinion, but it does mean that the examiner refrains in appearance and substance from any behavior that might be interpreted as biased. Therefore, regardless as to which attorney has requested the appearance of the examiner, the examiner should take care to treat both attorneys equally. There should be no "secret" looks or other nonverbal communication between the examiner and either of the attorneys. Under no circumstances should the examiner sit at either of the attorney's tables. The examiner's duty is to provide truthful and accurate testimony based on the data that he or she has reviewed.

It should go without saying that the court room is a solemn place, and professional attire and behavior is required. The use of humor in testimony is to be discouraged as this can often be interpreted as arrogance or a lack of seriousness/credibility on the part of the examiner.

Testimony should be clear, concise, and free from jargon. The examiner should tell a "story" that proceeds logically from the data to his or her conclusion. The opinion offered is one of "reasonable medical certainty," typically meaning "more likely than not." (For additional information on testifying, the reader is referred to outside resources, such as The Psychiatrist as Expert Witness, by T. G. Gutheil, published by American Psychiatric Press, Inc, 1998.)

The examiner must always remember that he or she is presenting an informed opinion, not a fact. He or she should not be invested in any particular outcome of the case, but only as to his or her ability to be truthful, objective, and fair.

Supervision

Supervision and mentoring are integral to the development and maintenance of expertise in any clinical practice, but are especially important in the practice of forensics. The examiner's ability to maintain objectivity, and to keep abreast of changes in case law are paramount to producing impartial, high quality, credible work. See *Appendix 9 (Supervision Checklist for Forensic Psychological Evaluations)*.

Supervision in the BOP is typically both clinical and administrative, and may be done by one, or more than one, individual. Administrative supervision is an ongoing process and may vary in intensity based on the institution, the staff involved, and the nature of the forensic study. Clinical supervision/mentoring is more focused and should occur on a regular basis, as well as be available on an as-needed basis. Ideally, the clinical supervisor/mentor will be at the same institution as the examiner, however when this is not possible, use of video or telephonic conferencing can provide some of the components of a supervisory/mentoring relationship.

Clinical supervision and mentoring should involve:

- formal and informal case presentations
- review of the case, including corroborative documentation and test results
- individual and joint interviews of the inmate on selected random cases, and especially on high profile cases (e.g., death penalty cases)
- review of the written report
- discussion of transference and counter-transference issues
- review of testimony before and after court
- recommendations for continuing professional education in areas in need of improvement

An objective clinician should review the report. In the review, the clinician should specifically look for signs of partiality or bias, exclusion of important supporting data, inclusion of extraneous information, and the relevance of the report and conclusions to the questions posed by the court.

Forensic examiners are also strongly encouraged to provide clinical supervision and mentoring to other forensic examiners, and to regularly present cases to other mental health and medical colleagues at the institution and across institutions.

Informal supervision and critique of testimony can also be (and should be) sought from the attorneys involved in the case. Immediate feedback on the examiner's demeanor, impartiality, professionalism, credibility, and clarity can all be very helpful, even to the veteran examiner.

Role of Students/Interns/Fellows/Residents

Trainees of various disciplines and levels of expertise may be involved in the evaluation and/or treatment of inmates undergoing forensic studies. Very close clinical supervision and mentoring by a licensed doctoral level staff psychologist or staff psychiatrist is necessary throughout the study process. The forensic report should clearly reflect the role of the trainee in the study. If the trainee contributed substantially to the report and/or treatment, (e.g., more than psychological testing and review of the history) his or her name should appear along with the supervisor's name as authors of the report.

The trainee should document in the health record according to the direction provided in these guidelines, as well as in the Program Statements on HIM, Psychiatric Services, and Administrative Safeguards for Psychiatric Treatment and Medication, as well as any relevant BOP Clinical Guidelines. All notes must be cosigned and dated by a licensed doctoral level staff psychologist or staff psychiatrist.

Special Populations

BOP staff perform forensic evaluations only when ordered by the court, and only on inmates in BOP custody. Any requests for forensic evaluations outside of these parameters should be directed to the Chief Psychiatrist of the BOP for further review and disposition.

Juveniles
Rarely, the courts may request that BOP staff perform a forensic study on a juvenile. The Bureau does not normally house juveniles. These individuals are usually being held at a juvenile contract facility. For that reason, studies on juveniles are typically done in the local community by contract forensic evaluators.

Any requests by a court or attorney for evaluation of a juvenile should be directed to the Chief Psychiatrist of the BOP for further review and disposition.

The psychiatric/psychological evaluation and/or treatment of adolescents differs in significant ways from that of adults. Examiners who are not fellowship-trained in adolescent psychiatry or psychology should refrain from performing forensic evaluations on juveniles.

For further information on the management of juveniles in the Federal Bureau of Prisons, the reader is referred to the Program Statement on Juvenile Delinquents.

Death Penalty Cases
Individuals facing the death penalty as a potential sentence may be court-ordered for a forensic study at any time during the judicial process: pretrial, presentence, and/or up to the time of execution. Some examiners may find their abilities to maintain impartiality and empathy tested to the limit on these cases. There may be significant media attention focused on the case, as well as significant interest from the Department of Justice or political entities, further complicating the management of the case.

As a rule, examiners should always seek clinical and administrative supervision on these cases. Counter-transference issues should be regularly explored with the clinical supervisor throughout the study period. In cases which involve determining competency to be executed, or restoring competency to be executed, the examiner may elect not to be involved in the study. (Title 28, USC, §26.5, "No ... employee of the Department of Justice [who] is a medical professional who considers such participation or attendance contrary to medical ethics" "shall be required to ... participate in any execution.")

Military Prisoners, District of Columbia Code Offenders, Bureau of Immigration and Customs Enforcement (formerly INS) detainees
See the Program Statements on Administrative Safeguards for Psychiatric Treatment and Medication, and Psychiatric Services.

Data Collection and Reporting

A web-based data collection and reporting process for forensic cases is currently being developed. Ongoing work on data base development, coordination of forensic services between Correctional Programs Division (CPD) and Health Services Division (HSD), and refinement of the designation process and data base are all essential components for meaningful

statistical analyses. In the interim, responsibilities for collecting and publishing data are divided between Psychology Services Branch and the Health Services Division (particularly the Office of the Medical Director).

Appendix 10 (Forensic Case Data Form) lists the minimum data that should be collected on each study. These sheets should be faxed or mailed to the Medical Director quarterly. Additional recipients may include the Regional Psychology Administrators and the Psychology Services Branch in the Central Office.

Definitions

Examiner: A licensed, doctoral level psychologist or psychiatrist. This term is used interchangeably with "evaluator," "clinician," "forensic professional, practitioner, or clinician."

Forensic Clinician: A subspecialist in psychiatry (forensic psychiatrist) or psychology (forensic psychologist) in which "scientific and clinical expertise is applied to legal issues in legal contexts." (American Academy of Psychiatry and the Law).

Inmate: Any individual committed to the custody of the Attorney General at any point during the legal process, i.e., pre-trial, pre-sentence, sentenced, found not guilty only by reason of insanity, etc.

Section: The smallest, distinct numbered subdivision of a code, statute or other juridical writing.

Statute: A law enacted or established by the legislative branch of government. See *Appendix 1 (General Overview of Federal Statutes, Title 18, United States Code,* §§4241-4247) and *Appendix 2 (Summary of Federal Statutes).*

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Appendix 1. General Overview of Federal Statutes Title 18, United States Code, §§4241-4247

(See Chapter 313–Offenders with Mental Disease or Defect in Federal Criminal Code and Rules, West Group; 2003)

Statutes (paraphrased below) governing the evaluation, treatment, and confinement of defendants with possible mental illness are contained in Title 18, United States Code (USC), §§4241-4247. All individuals committed to the custody of the Attorney General for mental health evaluation or treatment are still accorded due process prior to the administration of involuntary medication.

§4241(b): Determination of mental competency to stand trial

At any time prior to sentencing, the defendant or Government "may request an evaluation to determine if the defendant is suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense."

§4241(b) is an outpatient evaluation that does not require placement in a BOP facility, with a statutory time frame of 30 days. An extension may be requested not to exceed 15 days.

The standard for competency to stand trial is a two prong test:
1. The individual has the ability to understand legal proceedings
2. The individual has the ability to work with an attorney

In order to be found not competent, an individual must fail to meet either (or both) of the above criteria, and the failure to meet the criteria is due to the presence of a mental disease or defect. Several tools are available to help assess an individual's competency to stand trial (see *Appendix 3, Overview of Psychometric Tools*).

If the examiner's opinion is that the inmate is incompetent to proceed, and the examiner is a psychiatrist with expertise in treating the type of disorder from which the inmate suffers, it may be appropriate to specifically address the clinical issues under Sell v. USA in the report. It is not appropriate for the examiner to address the issue of the government's interest in the report. See *Appendix 6 (Guidance on Involuntary Medication Post Sell v. USA)*.

Competence or incompetence is determined by the court based on a preponderance of evidence.

§4241(d): Restoration of competence

"If"..."the court finds by a preponderance of evidence that the defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his

defense, the court shall commit the defendant to the custody of the Attorney General. The Attorney General shall hospitalize the defendant for treatment" for a "reasonable period of time"... "to determine whether there is a substantial probability that in the foreseeable future" he will regain competency.

§4241(d) is an inpatient evaluation, and must be done in a BOP Psychiatric Referral Center with an inpatient unit. The initial commitment cannot exceed 4 months; however additional time can be ordered if the individual is not restored to competence within 4 months, but a substantial probability remains for the individual to be restored to competence in the foreseeable future. There is no specific time limit on the extension(s), however, the court must receive an update at least semi-annually on all individuals committed under §4241(d).

If an examiner opines that the individual is not substantially likely to be restored to competence, whether by failure to meet the Sell criteria or for clinical reasons, then a risk assessment should be completed prior to the expiration of the commitment. Should the assessment reveal that the individual poses a substantial risk of bodily harm to others or serious damage to the property of others due to the presence of a mental disease or defect, a petition under §4246 should be filed with the Federal Court having jurisdiction where the inmate is hospitalized, at the same time as the §4241(d) report is filed (which will be to the court which has jurisdiction over the offense).

§4241(d) does allow for involuntary hospitalization, but in the absence of dangerousness or grave disability, does not allow for involuntary treatment without meeting the requirements set forth in Sell v. USA. See *Appendix 6 (Guidance on Involuntary Medication Post Sell v. USA)* and *Appendix 7 (Dangerousness Flow Chart)* for further guidance. If the inmate refuses to accept treatment voluntarily, then the institution will need to notify the court and request consideration for a hearing on the Sell criteria. See *Appendix 8 (Sample Letter Requesting Sell Hearing)*.

Competence or incompetence is determined by the court based on a preponderance of evidence.

§4242: Determination of the existence of insanity at the time of the offense

Upon notification to the court that "the defendant intends to rely on the defense of insanity, the court... shall order that a psychiatric or psychological examination of the defendant be conducted to determine" ... "whether the person was insane at the time of the offense..." If the issue of insanity is raised, the jury, or in a nonjury trial the court, shall find the defendant: guilty, not guilty, or not guilty only by reason of insanity.

§4242 is an outpatient evaluation and does not require placement in a BOP facility. The statutory time frame for ths examination is 45 days, with allowances for an extension not exceed an additional 30 days.

A person is considered to be legally insane if the court determines, at the time of the offense, the individual suffered from a mental disease or defect and due to this defect was unable to appreciate the nature, quality, or wrongfulness of his or her conduct.

§4243: Hospitalization of a person found not guilty only by reason of insanity

If a person is found not guilty only by reason of insanity, then that person "shall be committed to a suitable facility until" he or she is eligible for release under subsection (e). If the crime involved

bodily injury to another, serious damage to the property of another, or the substantial risk of such injury or damage, the burden of proof lies with the person who must prove by clear and convincing evidence that he or she no longer poses such a risk. If the offense was of any other nature, the individual must prove by a preponderance of evidence that release to the community would not pose a substantial risk of bodily harm to another, or serious damage to the property of another.

§4243 requires that the individual be evaluated at a "suitable facility" (e.g., a BOP Psychiatric Referral Center inpatient unit) for a maximum of 45 days, with an extension permissible up to 30 days. Interestingly, this statute requires that the hearing occur in 40 days after the finding of not guilty only by reason of insanity (NGRI). Once committed under this statute as dangerous, the individual must be housed as an inpatient in a BOP Psychiatric Referral Center (PRC).

The court requires annual updates on inmates committed under §4243, and also requires that the Attorney General (the BOP) make efforts to have the State in which the person was domiciled or was tried to take custody of these individuals.

Release from this commitment can occur when the individual's mental condition is such that he or she no longer poses a substantial risk to others or the property of others, or when the State takes custody. Release may be conditional; that is, under a prescribed regimen of treatment, or unconditional.

§4244: Hospitalization of a convicted person suffering from mental disease or defect

If a defendant has been found guilty, prior to sentencing the court may request an evaluation to determine if the convicted person is suffering from a mental disease or defect for which he or she is in need of mental health care and treatment. If such an evaluation results in the court finding by a preponderance of evidence that the convicted person is suffering from a mental disease or defect for which he is in need of custody for mental health care and treatment, the court will commit the person to the custody of the Attorney General for hospitalization and treatment for a term equal to the maximum allowable time permitted by the sentencing guidelines. If the person recovers prior to expiration of the sentence, he will return to the court for final sentencing.

§4244 evaluations may take place on an outpatient basis. However, once the individual has been found in need of custody for care and treatment, the individual must be hospitalized in a BOP Psychiatric Referral Center inpatient unit.

The time frame allowed by statute for the evaluation is 30 days, with an extension up to 15 days. Once committed, the person will remain under the provisional sentence until the court finds that he or she has recovered to the extent that hospitalization is no longer necessary.

If the examiner opines that the individual does have a mental disease or defect, but is not in need of custody for care and treatment, then the report to the court must "include sentencing alternatives that could best accord the defendant the kind of treatment" he or she needs.
An annual report must be filed with the court on all individuals committed under §4244(d).

§4245: Hospitalization of an imprisoned (*convicted*) person suffering from mental disease or defect

This is essentially identical to civil commitment. If the court finds by a preponderance of evidence that an individual is "presently suffering from a mental disease or defect" for which he or she is in need of custody for care and treatment, that individual will be committed to the custody of the Attorney General for hospitalization and treatment until "he is no longer in need of such custody...or until the expiration of the sentence of imprisonment..."

There are no specific criteria in the statute as to what constitutes the need for custody for care and treatment, however case law in the Federal courts and in the States generally support commitment for dangerousness to self, others, or grave disability due to a mental disease or defect.

Although there is a limit of 30 days in which to complete the evaluation (with an extension up to 15 days allowed) once staff deems that it is appropriate to pursue commitment, there is no time frame in which a hearing must be held once a petition under §4245 has been filed. In some districts, the hearing may not take place for 3-6 months depending on the docket. However, in the case of a severely ill and unstable individual, an emergency hearing can be requested.

Annual reports to the court are required for all individuals committed under §4245. The commitment can be discharged upon certification by the Warden that the individual has recovered to the extent that hospitalization is no longer required, at which point the court will order the person be imprisoned until the expiration of his or her sentence.

§4246: Hospitalization of a person due for release but suffering from mental disease or defect

"[A] person in the custody of the Bureau of Prisons whose sentence is about to expire, or who has been committed" under "§4241(d), or against whom all criminal charges have been dropped solely for reasons related to" the person's mental condition, and whose "release would create a substantial risk of bodily injury to another" or "serious damage of property" due to a mental disease or defect, shall be committed to the custody of the Attorney General for hospitalization until he or she no longer poses such a risk, or until a conditional release can be arranged.

The examination period is not to exceed 45 days, with an extension permitted up to 30 days.

The burden of proof for commitment under §4246 is clear and convincing evidence. As in §4243, once the individual is committed the BOP must attempt to transfer custody to the State in which the person was domiciled or was tried. Also identical to the language in §4243 is the possibility of a conditional release under a prescribed regimen of treatment, if under that regimen the person no longer poses a substantial risk of bodily harm to another or risk of serious damage to property of another.

Annual reports to the court are required on all individuals committed under §4246.

§4247: General Provisions for chapter 313.

This statute reviews the statutory time frames, type of information that must be contained in study reports, and reporting requirements among other things.

Miscellaneous Statutes

§4205: Examination of an inmate eligible for parole.

This statute was repealed (along with others pertaining to parole) in 1987, however some inmates sentenced prior to 1987 ("old law") may be eligible for parole. The statute allows for the United States Parole Commission (USPC) to receive an evaluation from the BOP on an inmate's suitability for parole, including his mental and physical health, past criminal history, social background, etc.

§3552(b, c): Presentence study and report by the Bureau of Prisons, and psychological or psychiatric examination.

As part of the presentence investigative process the court may ask that the defendant undergo a psychological or psychiatric examination to provide information that will aid the court in determining an appropriate sentence. The court may ask any number of questions in its order, including questions about departure from the sentencing guidelines, mitigating circumstances, etc.

This evaluation can be completed in the community "unless the judge finds that there is a compelling reason for the study to be done by the Bureau of Prisons..." The statute allows for 60 days for the completion of the study, with an extension up to 60 additional days.

The format of the report should generally follow the format used in the other statutes, but should specifically address the court's question(s).

Appendix 2. Summary of Federal Statutes

Statute	Status	Purpose	Time Frame/ (extension)	Housing*	Reporting Requirement
4241 (b)	Pretrial to Presentence	Evaluate Competency	30 days (15 days)	Outpatient	N/A
4241 (d)	Pretrial to Presentence	Restoration of Competency	120 days (not specified)	BOP Inpatient	semiannual
4242	Pretrial	Evaluate Responsibility ("Insanity")	45 days (30 days)	Outpatient	N/A
4243 (b)	Found NGRI	Risk Assessment	45 days (30 days)	Not specified	N/A
4243 (e)	Found NGRI and Dangerous	Treatment	Indefinite	BOP Inpatient	Annual
4244 (b)	Presentence	Evaluation to determine presence of mental disease or defect & need for custody for care and treatment	30 days (15 days)	Outpatient	N/A
4244 (d)	Provisional sentence	Treatment	Maximum sentence allowed	BOP Inpatient	Annual
4245 (b)	Sentenced	Evaluation to determine need for hospitalization & treatment	30 days (15 days)	Outpatient	N/A
4245 (d)	Sentenced	Hospitalization and Treatment	Indefinite	BOP Inpatient	Annual
4246 (b)	Prerelease	Risk Assessment	45 days (30 days)	BOP Inpatient	N/A
4246 (d)	Prerelease	Treatment	Indefinite	BOP Inpatient	Annual
4205 (c)	Prerelease old law	Evaluation to help determine parole eligibility	not specified	Outpatient	N/A
3552 (b, c)	Presentence	Evaluation to help determine sentencing	60 days (60 days)	Outpatient Judge may require BOP	N/A

*In the case of some outpatients, the clinical condition of the inmate may warrant housing on an inpatient unit. For those inmates in BOP custody at an outpatient site, examiners should contact OMDT (Office of Medical Designations and Transportation) to discuss possible transfer to an inpatient forensic site.

Appendix 3. Overview of Psychometric Tools

(Taken from The Forensic Guidelines for BOP Psychologists)

Examiners are reminded to use the latest edition of psychometric tools, and to be prepared to defend use of a psychometric tool based on standardization, reliability, validity, and applicability to forensic populations and to the specific case.

Forensic Assessment Tests: Competency to Stand Trial

Competency Assessment Instrument (CAI)

This test was developed simultaneously with the CST and was designed to serve as a more comprehensive measure of trial competency. The instrument describes 13 functions identified as relevant towards trial competency. The clinician is required to rate the defendant along the 13 items. Overall validity evidence is sparse, but the instrument seems to correlate with other established measures of trial competency.
Administration Population: Pretrial Adults.
Administration Time: Approximately 60 minutes.
Language Requirement: English.

Competency Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)

This instrument is designed specifically for persons with mental retardation. It consists of 50 items in multiple choice or open-ended format. Initial validity study was well designed, but has only recently become more popular.
Administration Population: Mental Retarded persons with I.Q. ranging from 35 to 70.
Administration Time: 45 minutes.
Language Requirement: Limited English ability.

Competency Screening Test (CST)

One of the most popular instruments, comprised of 22 items in incomplete sentence format. Designed to be a screening measure so it suffers from higher false negative rates. Numerous validation studies are available and suggest very good levels of reliability and moderately good levels of validity.
Administration Population: Pretrial Adults.
Administration Time: 15 minutes.
Language Requirement: English.

Georgia Court Competency Test - Mississippi State Hospital (GCCT-MSH)

Another measure designed as a screening device. The revised version consists of 21 items designed to assess the defendant's knowledge in four areas. Factor structure is well documented, as are the psychometric properties. There is even one study available that contains normative data for malingerers.
Administration Population: Pretrial Adults.
Administration Time: 15 to 20 minutes.
Language Requirement: English.

Interdisciplinary Fitness Interview (IFI)

This instrument was designed as a comprehensive evaluation method. It is to be administered jointly by an attorney and mental health professional. The content is comprised of 16 areas covering both legal and psychopathological domains. Although reliability estimates have been reported as good, there are limited studies addressing the validity. Perhaps the greatest limitation is that an attorney needs to be available.
Administration Population: Pretrial Adult.
Administration Time: Approximately 60 minutes.
Language Requirement: English.

MacArthur Competence Assessment Tool - Criminal Adjudication (MaCAT-CA)

This is the latest instrument used in the area. It is another product from the MacArthur Foundation. Despite authors stressing that this is a tool and not a test, it has been well validated and is based on a comprehensive theory of legal competence. Perhaps the only instrument for competency to stand trial that addresses the decision-making construct discussed in the relevant research literature. National norms are available.
Administration Population: Pretrial Adults.
Administration Time: Approximately 60 minutes.
Language Requirement: English.
Other: This test does require the defendant to be able to think of legal scenarios in a more abstract manner than other instruments.

Forensic Assessment Test: Criminal Responsibility

Rogers Criminal Responsibility Assessment Scale (R-CRAS)

This instrument is designed to provide a comprehensive approach to the assessment of criminal responsibility. Essentially, this is a rating scale that allows the examiner to determine if the criteria have been met for insanity based on various legal standards. This instrument has been empirically derived and validated, although some criticisms have been made about the lack of standardized administration.
Administration Population: Pretrial Adults.
Administration Time: Variable as the ratings do not have to occur with the examinee present.
Language Requirement: None.
Other: Authors caution against use with organic or mentally retarded populations since initial validation studies had a restricted range of such populations.

Intelligence Tests

Comprehensive Test of Nonverbal Intelligence (C-TONI)

This is a test of nonverbal intelligence that minimizes biases due to gender or culture. Composed of six subtests. Instructions can either be given in English or pantomime for persons whose primary language is other than English, are deaf, or neurologically impaired. Similar to the Test of Nonverbal Intelligence-3 (TONI-3), but more comprehensive.
Administration Population: Ages 6 to 89.
Administration Time: Approximately 60 minutes.
Language Requirement: None.
Other: Computerized administration is available.

Kaufman Adolescent and Adult Intelligence Test (KAIT)

This is a comprehensive intelligence test based on the Cattell-Horn model of fluid-crystallized intelligence. Fine motor coordination and speed are de-emphasized compared to other comprehensive intellectual measures. The test is composed of 6 required and 4 optional subtests.
Administration Population: 11 to 85+ years.
Administration Time: 60 to 90 minutes.
Language Requirement: English, but nonverbal estimate can be used for non-English speaking persons.

Kaufman Brief Intelligence Test (K-BIT)

This test provides a brief estimate of intelligence for screening purposes. Consists of 2 subtests, and provides a verbal (2 parts) and nonverbal (1 part) estimate of intelligence. Nonverbal estimate is less culturally biased.
Administration Population: Ages 4 through 90.
Administration Time: 15 to 30 minutes.
Language Requirement: English, but nonverbal estimate can be used for non-English speaking persons.

Shipley Institute of Living Scale (SILS)

This measure provides a brief assessment of verbal intelligence. The psychometric properties (reliability and validity) are only moderate, and the results should be used with caution.
Administration Population: Psychiatric patients
Administration Time: 30 minutes.
Language Requirement: English.

Stanford-Binet Intelligence Scale - Fourth Edition (SB-IV)

This is a comprehensive intelligence test composed of 15 subtests. Based on g-factor model of intelligence, and second-level factors of crystallized, fluid, and short-term memory. The intelligence model continues to rely heavily on verbal abilities.
Administration Population: Ages 2 through Adults.
Administration Time: 60 to 90 minutes.
Language Requirement: English (vocabulary and chronological age determines start level for all other subtests).

Wechsler Adult Intelligence Scale - Third Edition (WAIS-III)

Most common intelligence test used in this country. Gives estimate of general, performance, and verbal intelligence through the assessment of several interrelated elements of intelligence as measured by 14 subtests. Administration of three subtests is optional. Allows pattern analysis of separate subtests and indices although the research on the utility of this is mixed.
Administration Population: 16 through 89 years.
Administration Time: 60 to 120 minutes depending in part on how many subtests are administered.
Language Requirement: English, although performance index may give an estimate of intelligence in persons whose primary language is not English.
Other: Full scale index range from 45 to 155.

Malingering Tests: Cognitive Functioning

Multidigit Memory Test (MDMT)

A computerized test designed to detect the malingering of memory deficits. Contains 72 items presented with 3 different levels of stimulus delay. This measure has available norms to detect malingering. The malingering norms include both naive and informed samples.
Administration Population: Psychiatric patients, controls, and neurologically impaired adults.
Administration Time: 30 minutes.
Language Requirement: English.

Test of Memory Malingering (TOMM)

A 50 item test that requires forced-choice responding over the course of 3 sections. Can be shortened to only 2 sections if needed. Useful in detecting motivational difficulties with respect to memory.
Administration Population: Validation sample include ages 18 to 84 of controls and various types of neurologically-impaired groups.
Administration Time: 15 minutes.
Language Requirement: English.

Validity Indicator Profile (VIP)

A measure designed to detect response style on cognitive tests. Provides an estimation of response approach on concurrently administered cognitive tests. Consists of 78 verbal and 100 nonverbal items, but sections can be administered independently of one another.
Administration Population: Ages 18 to 69.
Administration Time: 30 to 45 minutes.
Language Requirement: English for the Verbal section; the Nonverbal section has not be validated with non-English speaking populations.

Malingering Tests: Psychiatric Functioning

Structured Interview of Reported Symptoms (SIRS)

This is a structured interview with 172 items designed to detect malingering of psychiatric symptoms. Each of the 13 scales is designed to detect a different strategy of malingering. It has been validated on both criminal and noncriminal samples. A conservative cutoff is recommended either using a combination of scales in the probable malingering range or a total score.
Administration Population: Forensic and psychiatric populations. Adults, but some research is available for adolescent populations.
Administration Time: Approximately 45 minutes.
Language Requirement: English.
Other: Items are read to the subject thereby minimizing the reading requirements.

Neuropsychological/Cognitive Tests

Booklet Category Test (BCT)

A more portable variation of one of the HRNT subtests. Comprised of 208 visual stimuli designed to assess concept formation and abstract reasoning. It warrants a separate discussion since it includes various indices of malingering. The original Category Test is the second most sensitive index on the HRNT for the detection of overall neurocognitive impairment, and the most common single subtest. Research indicates that this version is comparable to the original.
Administration Population: Ages 15 through Adults.
Administration Time: 30 to 45 minutes.
Language Requirement: English.

Cognistat (Neurobehavioral Cognitive Status Examination)

A neuropsychological screening measure designed to assess functioning in five areas. While the research is mixed on the overall utility of this measure, it seems to be more valid than several other "mini-mental status" formats. This measure is also available in Spanish.
Administration Population: Ages 18 and older.
Administration Time: 20 - 30 minutes.
Language Requirement: English or Spanish.

Halstead Retan Neuropsychological Test (HRNT)

A comprehensive, widely used procedure to assess neuropsychological impairment. Composed of approximately 8 tests (depending on what are considered separate subtests) which can be administered independently. Some of the subtests have more subjective scoring criteria, but the combined test yields several indices of general and specific areas of impairment. The use of this test requires a high level of technical expertise especially for interpretation.
Administration Population: Adults (although there are modified versions for ages as low as 5)
Administration Time: 120 to 180 minutes.
Language Requirement: English.
Other: WAIS and WMS should be administered in conjunction.

Kaufman Short Neuropsychological (K-SNAP)

A neuropsychological screening measure. Comprised of 4 subtests and yields an overall impairment index score. Attempts were made to minimize cultural bias.
Administration Population: Ages 11 to 85.
Administration Time: 30 minutes.
Language Requirement: English.

Luria Nebraska Neuropsychological Battery (LNNB)

A comprehensive measure of neuropsychological functioning that contains 269 items divided into 11 content scales. This measure continues to experience mixed validation findings. In addition, it has been criticized due to its heavy language dependence.
Administration Population: Adults.
Administration Time: Approximately 120 minutes.
Language Requirement: English.

Wechsler Memory Scale - Third Edition (WMS-3)

A comprehensive test of learning, memory, and working memory. Comprised of 11 subtests, 6 primary and 5 optional subtests.
Administration Population: Ages 16 - 89.
Administration Time: 30 to 60 minutes.
Language Requirement: English.
Other: Contains 2 identical subtests as the WAIS-III, which can be used to assess consistency of responses if the WAIS-III was concurrently administered.

Wide Range Achievement Test - 3 (WRAT-3)

A measure of academic achievement in reading (recognizing and pronouncing words), spelling (writing words) and arithmetic (oral and written computations). Individual sections can be used separately. For example, reading section can be used to determine if level is sufficient for the administration of other tests such as the MMPI-2. This test is well normed and has good psychometric properties.
Administration Population: Ages 5 to 75.
Administration Time: Approximately 30 minutes.
Language Requirement: English.
Other: Contains alternate forms.

Personality / Psychopathology Tests

Millon Clinical Multiaxial Inventory-3rd Edition (MCMI-III)

Also a self-report measure of psychopathology and personality functioning. This measure remains controversial in the current research literature, especially in regard to validation within forensic populations. Contains 175 items.
Administration Population: 18 and older.
Administration Time: 30 minutes.
Language Requirement: English and Spanish.
Other: 6th grade reading level required.

Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

Most commonly used objective "paper and pencil" measure of psychopathology and personality functioning. Advantages of excellent standardization norms and research on specificity with various populations available. Includes multiple indices of dishonest responding. This measure is well accepted in the courtroom. Contains 567 items.
Administration Population: 18 and older.
Administration Time: 90 minutes.
Language Requirement: English or Spanish. Audio cassettes available in both languages. (Has been normed in approximately 40 languages).
Other: Reading requirements range from 5th to 8th grade depending on the source consulted.

Psychopathy Checklist - Revised (PCL-R)

This is a 20 item rating scale used to assess psychopathy. Requires the use of collateral records along with a recommended interview. The construct is useful in the prediction of general aggression, criminal recidivism, and treatment response. Disadvantages include the pejorative nature of the instrument's classification and that the construct must be explained to the courts since it is not part of the current psychiatric diagnostic system.
Administration Population: Normed on Criminal and forensic, nonminority adult males.
Administration Time: 120 to 180 minutes including collateral information review.
Language Requirement: Norms on English speaking samples.
Other: Requires collateral information.

Rorschach

A measure of personality functioning that is widely known. This test utilizes 10 ambiguous cards from which a person's perceptions are elicited and recorded. This test remains highly controversial, especially in the courtroom. Recent meta-analysis findings suggest that the psychometric properties are comparable to commonly used objective measures.
Administration Population: Ages 5 to Adult.
Administration Time: Approximately 60 minutes.
Language Requirement: English (for the Exner scoring system).

Risk Assessment Procedures

Assessing Risk for Violence (HCR-20)

An assessment guide for the prediction of violence towards others. Contains 20 items of historical, clinical, and risk management variables which requires the clinician to rate each item.
Administration Population: No age range is given in the manual.
Administration Time: Variable, requires record review and concurrent assessment of psychopathy.
Language Requirement: None.
Other: Requires the simultaneous assessment of psychopathy.

Appendix 4. Format for Forensic Reports

United States Department of Justice
Federal Bureau of Prisons
(Institution name)
(City, State, ZIP)

FORENSIC REPORT

Defendant Name: **Registration #:**

Case Number:

Date of Birth:

Dates of Evaluation:

Date of Report:

IDENTIFYING INFORMATION:

Defendant name, age, marital status, race/ethnicity, sex, referral source (court and district), name of institution, date of court order, date of arrival, court questions and statute(s), criminal charges.

Ex: Mr. John Jay Jones is a 34 year-old, twice married, white male referred by the United States District Court for the Western District of Anystate on Month, Day, Year, for an evaluation under the provisions of Title 18, US Code, Section 4241 (b) to determine his competency to stand trial. Mr. Jones is charged with a Felon in Possession of a Firearm. He arrived at FCI Institution on Month, Day, Year.

ASSESSMENT PROCEDURES:

Limits of Confidentiality
Interviews with defendant (dates, length of time of contacts, number of contacts, etc.)
Collateral Interviews
Collateral Information Reviewed
Observations by Other Staff
Physical Evaluation
Psychological Testing

BACKGROUND INFORMATION:

Describe sources of information, explain any contradictory information. Cover relevant information under appropriate sub-headings below. If nothing available or no history, note this under the heading (e.g., "Military History: No history of military service.")

Developmental History: Describe family of origin, criminal, psychiatric, and medical history of relatives, history of any abuse or trauma, and other relevant developmental history not covered under other headings.

Educational History:

Employment History:

Military History:

Marital History:

Medical History:

Psychiatric History:

Substance Abuse History:

Criminal History: Past history, including juvenile history

Description of Offense: This should include information gathered from collateral sources and the defendant, and any contradictions should be noted and explained.

EVALUATION FINDINGS:

Behavioral Observations:

Current Mental Status:

Medical Evaluation, Studies, and Treatment: Describe any positive results of physical examination, laboratory and other studies, and any medications (and their doses) and other treatments, and response to treatment. Any pending results should be noted here and also in the section on recommendations. Personal contact with the defense attorney and personnel at the receiving institution may be necessary to ensure continuity of care in the case of any significant medical or psychiatric concerns or need for ongoing follow-up or further studies.

Psychiatric Treatment: Describe any psychological or psychiatric treatment, medications, doses, side effects, and benefits of treatment. This section would also include any psychoeducational or psychosocial treatment, such as competency training, and the results of these interventions.

Psychological Test Results:

DIAGNOSTIC IMPRESSION: Diagnoses should be listed according to the current Diagnostic and Statistical Manual of Mental Disorders. This section includes a thorough description and

explanation of each diagnosis.

TREATMENT RECOMMENDATIONS: The complexity and scope of this section will be based on several factors, including the relevance to the court-posed questions, seriousness of the conditions present, need for follow-up, etc. When recommendations are made regarding specific medical or psychiatric conditions/treatment, the staff making those recommendations (if other than the examiner) should be noted in the report (e.g., *"The medical staff responsible for Mr. Jones' medical evaluation and treatment during this study period recommend that he continue his antihypertensive medication and have a repeat serum creatinine in 6 months."*) In cases in which urgent or significant follow-up of medical or psychiatric issues is necessary to protect the defendant's health or life, the examiner must ensure that this information is conveyed to the appropriate parties as soon as possible. This may require notification of the defense attorney by telephone, or preferably in writing, as well as medical staff at the receiving institution or jail.

In cases in which compliance with psychiatric treatment is necessary to maintain competence for legal proceedings, this should be noted in this section as well as in the next section, "Prognosis."

PROGNOSIS: This section can address prognostic issues related to relevant medical issues in addition to the psychiatric issues, especially as they pertain to the court-posed questions, and legal proceedings. Issues concerning compliance with medication should also be reiterated here.

OPINION ON THE ISSUE OF....(*add whatever questions were asked by the court, e.g., competency to stand trial, criminal responsibility, etc.*):
This section will contain the opinion of the examiner on the question(s) posed by the court. A separate heading for each specific question may be utilized, or one heading which lists all the questions, and then each opinion described and justified in the body. It is helpful to include specific behavioral observations, data, or defendant statements that support the opinion. The content should remain focused on the questions posed by the court, and should not extend into additional areas, nor should it extend beyond the expertise of the examiner.

SIGNATURE BLANKS:
This section should include the signature, printed name, and title of the primary evaluator, any secondary evaluators or contributors to the report, and the supervisor (or peer reviewer) of the primary evaluator, if relevant.

Example:

Signature	Printed Name	Title of Primary Evaluator
Signature	Printed Name	Title of Secondary Evaluator
Signature	Printed Name	Peer Reviewer

Appendix 5. Documentation / Filing Guidance for Forensic Psychological Evaluations

The following types of material may be collected or created during a forensic evaluation. Psychologists in outpatient study sites and MRCs may use the Psychology Data System as their primary documentation tool, with information printed and filed in the Health Care Record and Central File according to the table below.

Non-PDS Material

File Entry	Description	Medical File Location
Collateral Information	Material provided by external sources such as: arrest report, Pre-trial Services Report or PSI, verification of social history information.	Psychology Tab, Inmate Health Record
Correspondence	Letters to/from the Court or other parties related to the case.	Central File (primary); Psychology Tab, Inmate Health Record
Court Orders	As received from the Court.	Psychology Tab, Inmate Health Record
Psychological Test Data & Interpretive Reports	Raw test data and interpretive reports. Should be placed in the Central File upon completion of the forensic report.	Central File, Privacy Folder, Tab 2 (Not Medical File)
Treatment Records (non-BOP)	Records of treatment from sources outside the BOP.	Outside Medical Records Tab, Inmate Health Record

PDS Material

PDS Entry	Description	Medical File Location
Brief Counseling	Documentation of contact related to institution adjustment if needed.	Progress Notes, Inmate Health Record*
Crisis Intervention	Documentation of contact during a mental health crisis, description of evaluation and treatment rendered.	Progress Notes, Inmate Health Record*
Evaluation and Report: Clinical Contact	Documentation of any clinical contact including: informing the person of the nature of the study, confidentiality limits, order of the Court; history taking; mental status examination or periodic review; legally focused clinical interviews; assessment of risk of harm (unless documented as a formal suicide risk assessment is warranted).	Progress Notes, Inmate Health Record*

Appendix 5. Documentation / Filing Guidance for Forensic Psychological Evaluations (Page 2)

PDS Material

File Entry	Description	Medical File Location
Evaluation & Report: Collateral Contact	Documentation of contacts with attorneys, family, treatment providers, of staff.	Progress Notes, Inmate Health Record*
Evaluation & Report: Collateral Information	Documentation of receipt and/or review of collateral information.	Progress Notes, Inmate Health Record*
Evaluation & Report: Forensic Evaluation	The final report forwarded to the Court.	Psychology Tab, Inmate Health Record; Central File, Privacy Folder, Tab 2
Evaluation & Report: Summary of Psychological Testing	Notation that testing occurred on a specific date and time; observations of behavior during testing; summary of findings.	Progress Notes, Inmate Health Record*
Suicide Risk Assessment	Documentation of a formal suicide risk assessment if warranted by evidence, statements, or clinical presentation.	Progress Notes, Inmate Health Record*
Post-Suicide Watch Report	Documentation of conclusion of a suicide watch, changes in condition during the watch, plans for follow-up and monitoring.	Progress Notes, Inmate Health Record*

*On form SF 600, if an outpatient. On form SF509, if an inpatient.

NOTE: PDS entries should be printed and forwarded to Health Services for inclusion in the Medical File within 72 hours

Appendix 6. Guidance on Involuntary Medication Post Sell v. USA

The Supreme Court's ruling in Sell v. USA in 2003 imposed additional standards on the use of involuntary medication for a non-dangerous, pretrial inmate committed to the custody of the Attorney General under §4241(d). Following Sell, Bureau Psychiatric Referral Center (PRC) staff are no longer authorized to administer involuntary antipsychotic medication to defendants committed under Title 18, USC, §4241(d) solely for the purpose of restoring competency to stand trial, absent appropriate court authorizations. For those inmates, the government must now meet a five-pronged test prior to medicating the inmate:

1. The government has an important interest in adjudicating the case that outweighs the defendant's liberty interest in avoiding unwanted medication.
2. The proposed treatment is medically appropriate (i.e., in the individual's best medical interest.)
3. The proposed treatment is substantially likely to restore the defendant to competence.
4. Less intrusive means of treatment are substantially unlikely to restore the defendant to competence.
5. Side effects from the treatment are substantially unlikely to interfere with the defendant's fair trial rights.

Nevertheless, Bureau PRC staff remain authorized to administer involuntary anti-psychotic medication to patients who are a danger to self, including by grave disability, and/or a danger to others, according to the Bureau's current due process procedures.

Appendix 7 (Dangerousness Flow Chart) is intended to assist PRC staff in understanding, analyzing, and documenting a patient's need for involuntary anti-psychotic medication. When PRC staff determine that a patient is a danger to self, including grave disability, and/or a danger to others, it is vitally important to document the examinations, observations, analysis, and conclusions in anticipation of close scrutiny by defense attorneys and federal courts. It is particularly important to avoid simply stating conclusions that a patient is in need of such treatment. Rather, PRC staff must carefully describe the specific behavioral observations and reasons which are the basis for concluding the patient is a danger to self, including grave disability, and/or a danger to others due to mental illness.

The Bureau's policy and procedures for involuntarily committing inmates to a mental health facility based on the Supreme Court's decision in Vitek v. Jones, 445 US 480 (1980), remain unchanged following the Sell decision.

Appendix 7. Dangerousness Flow Chart

DANGEROUSNESS

Bureau PRC staff may involuntarily administer antipsychotic medication to patients when they are a danger to self or others. The patient's dangerous behavior must exist, or is determined to be likely to exist, within the correctional setting. A prediction of such behavior occurring only in the community, or elsewhere, is not a sufficient basis.

DANGER TO SELF

DANGER TO OTHERS

Active Danger to Self

As a result of a mental disorder the patient actively engages, or is likely to engage, in conduct which is either intended, or reasonably likely, to cause physical harm to self or cause significant property damage, e.g., history of cutting self, threatening/attempting suicide; or significant destruction of property.

Passive Danger to Self (Gravely Disabled)

As a result of a mental disorder, the patient is in danger of serious physical harm to self by failing to provide for his/her own needs of health and/ or safety. The patient manifests, or will soon manifest, severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his/her actions.

Danger to Others

As a result of a mental disorder, the patient actively engages, or is likely to engage, in conduct which is either intended or reasonably likely to cause physical harm to others, or cause significant property damage, e.g., history of assaulting or threatening others.

Clear and Complete Documentation

Describe Observations - Behavior, appearance, actions, statements, responses, speech pattern, psychomotor activities, etc.

Provide Patient History - Prior documented history, especially as it pertains to diagnosis, treatment and treatment response, compliance history, history of behaviors dangerous to self or other, etc.

Explain Conclusions - Detailed explanation as to how prescribed treatment will benefit the patient and is, therefore, in his/her best medical interest.

Appendix 8. Sample Letter requesting Sell Hearing

Institution Letterhead

[Date]

The Honorable [Name]
United States District Court
District of _____
Address

RE: **[Inmate Name]**
Register Number:
Docket Number:

Dear Judge _____:

In accordance with your Court Order of **[Date]**, a psychiatric evaluation of **[Inmate Name]** has been completed.

[Inmate Name] was previously evaluated under the provisions of Title 18, United States Code, Section 4241(b). That report offered the opinion that he was not competent to stand trial. He was subsequently admitted to our facility under Section 4241(d) on **[Date]**. Although a psychiatrist has determined that antipsychotic medication would benefit **[Inmate Name]**, he has refused to voluntarily accept antipsychotic medication to treat his condition. As a consequence of his refusal, you may wish to consider conducting an involuntary medication hearing.

In Sell v USA, 123 S. Ct. 2174 (2003), the Supreme Court decided that the government's ability to involuntarily administer antipsychotic medication to a pretrial defendant solely to restore competence to stand trial is limited to those circumstances in which all of the following are proven in a hearing in a federal court: (1) The government has an important interest in adjudicating the case that outweighs the defendant's liberty interest in avoiding unwanted medication; (2) The proposed treatment is medically appropriate; (3) The proposed treatment is substantially likely to restore the defendant to competence; (4) Less intrusive means of treatment are substantially unlikely to restore the defendant to competence; (5) Side effects from the treatment are substantially unlikely to interfere with the defendant's fair trial rights.

Should you decide to proceed with a hearing, our clinical staff can participate through telephone or video conferencing.

If restoration of competence proves to be unsuccessful, either due to lack of medication, or unsuccessful treatment with antipsychotic medication after you order it, a final determination that the inmate is not competent and not restorable is required by Title 18, United States Code, Section 4241(d). If you make such a determination, an additional study is necessary to determine if the defendant may be subject to an indefinite commitment authorized by Title 18, United States Code, Section 4246. If after that study, the mental health professionals determine that commitment under Section 4246 should be pursued, the proceedings to commit the inmate would be initiated in the **[local]** District Court of **[State of confinement].**

If you have any additional questions or concerns, please feel free to contact me at **[phone number]**, or facsimile **[fax number]**.

Sincerely,

[Name]
Attorney
Institution Name
Address

Appendix 9. Supervision Checklist for Forensic Psychological Evaluations

Evaluator:	License #:	Expiration Date:
Reviewer:		Report Date:
Name:		Register No:

Report Check List

Element	Yes	No	N/A
Extensions appropriately filed			
Report completed by due date			
Report is dated and the reg. # is listed			
Charges or Instant Offense listed			
Referral Questions referenced			
Confidentiality statement noted			
Data base is clearly described			
Past medical/mental health records requested/reviewed			
Collateral Interviews attempted/conducted			
Defendant's history is appropriately reviewed			
Behavioral Observations and Mental Status detailed			
Medication, dosages, purposes, etc. are described			
Appropriate psychological tests are administered			
Psychological test results are explained			
Results of Medical evaluation are explained			
Diagnoses in DSM-IV format, including codes			
Diagnoses are explained and supported			
Prognoses are clearly addressed			
Immediate follow-up care needs are noted			
Court's questions are directly answered with wording of statute			

Intensive Case Review			
Element	**Yes**	**No**	**N/A**
Defendant interviewed			
Raw test data reviewed			
Collateral information reviewed			
Consults reviewed			
Attorneys interviewed			
Diagnoses accurate			
Diagnoses comprehensive			
Treatment recommendations accurate			
Treatment recommendations comprehensive			

Appendix 10. Forensic Case Data Form

1. Data Entry Date
2. Inmate Name
3. Inmate Reg. No.
4. Author
5. Institution (Sentry three letter code)
6. Date Study Completed
7. Type of Study
   a. 3552 (Sentencing recommendations)
   b. 4241 (Competency to proceed)
      i. Outcome
         (1) ☐ Competent
         (2) ☐ Not Competent
   c. 4241d (Restoration of competency)
      i. Outcome
         (1) ☐ Competency Restored
         (2) ☐ Competency not Restored
      ii. Court
         (1) ☐ Declined to order medication after Sell v. USA hearing
         (2) ☐ Ordered medication after Sell v. USA hearing
         (3) ☐ Input not needed, as Sell v. USA issue not raised
   d. 4242 (Mental state at time of offense)
      i. Outcome
         (1) ☐ Responsible
         (2) ☐ Not Responsible
   e. 4243 (Hospitalization due to NGRI and Dangerousness)
      i. Outcome
         (1) ☐ Substantial Risk due to Mental Illness
         (2) ☐ Not a Substantial Risk due to Mental Illness
   f. 4244 (Hospitalization of post-conviction/pre-sentenced person)
      i. Outcome
         (1) ☐ Hospitalization Needed
         (2) ☐ Hospitalization Not Needed
   g. 4245 (Hospitalization of sentenced inmate)
      i. Outcome
         (1) ☐ Hospitalization Needed
         (2) ☐ Hospitalization Not Needed
   h. 4246 (Dangerousness assessment of pretrial detainee)
      i. Outcome
         (1) ☐ Substantial Risk due to Mental Illness
         (2) ☐ Not a Substantial Risk due to Mental Illness
   i. 4246 (Dangerousness assessment of end-of-sentence inmate)

i. Outcome
   (1) ☐ Substantial Risk due to Mental Illness
   (2) ☐ Not a Substantial Risk due to Mental Illness

j. 5037 (General study & observation of juvenile)

8. Diagnoses:
   a. Axis I
   b. Axis II
   c. Axis III
   d. Axis IV
   e. Axis V
9. Tests and Structured Interviews (list all that apply and insert scores as appropriate).