IMPLEMENTATION REPORT OF THE

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

ON THE

ESTABLISHMENT OF A FORENSIC EVALUATION

TRAINING AND RESEARCH CENTER

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 9

COMMONWEALTH OF VIRGINIA
RICHMOND
1983

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I. HOUSE JOINT RESOLUTION

HOUSE JOINT RESOLUTION NO. 22

Requesting the Commissioner of Mental Health and Mental Retardation, to establish a Forensic Evaluation Training and Research Center.

Agreed to by the House of Delegates, March 8, 1980
Agreed to by the Senate, March 8, 1980

WHEREAS, data provided by the Department of Mental Health and Mental Retardation demonstrates that a substantial proportion of criminal defendants committed to the Forensic Units of the State Hospitals for forensic evaluation do not require inpatient evaluation and do not need hospitalization; and

WHEREAS, the provisions of § 19.2-169 of the Code of Virginia now permit, but do not require, the courts to order the performance of forensic evaluations at appropriate community facilities; and

WHEREAS, the experiences of other states demonstrate that forensic evaluations of criminal defendants can be efficiently and competently performed by appropriately trained clinical personnel in community mental health clinics on an outpatient basis at less expense than in inpatient setting; and

WHEREAS, the personnel of the community mental health clinics have not been adequately trained to perform forensic evaluations; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Commissioner of Mental Health and Mental Retardation (hereinafter referred to as the Commissioner) is requested to establish or contract for the establishment of a Forensic Evaluation Training and Research Center (hereinafter referred to as the Training and Research Center) for the following purposes:

1. To develop a plan for training community mental health professionals to perform forensic evaluations and to certify their qualifications and competency to do so;
2. To provide forensic training services for teams of community mental health professionals in jurisdictions selected by the Commissioner;
3. To develop clinical protocols and procedures for use by appropriately trained community mental health professionals to enable them (i) to efficiently screen and assess the competency of criminal defendants to stand trial, and (ii) to provide other appropriate psychological evaluations for the court; and
4. To compile the necessary information for evaluating the success of this program; and, be it

RESOLVED FURTHER, That the Commissioner shall make appropriate arrangements with selected community services boards:

1. To establish demonstration service projects in forensic evaluation; and
2. To work with the Training and Research Center to implement the objectives specified in the preceding paragraph.

These demonstration service projects shall:

1. include participation by designated mental health professionals in the training program developed by the Training and Research Center;
2. be coordinated with the courts to develop the necessary procedures for referring appropriate defendants for forensic evaluation;
3. conduct competency-to-stand trial evaluations for the courts as requested and without fee; and
4. conduct other forensic evaluations under conditions arranged with the Department of Mental Health and Mental Retardation and the courts; and, be it

RESOLVED FINALLY, That on or before September thirty, nineteen hundred eighty-two, the Commissioner shall prepare a report for the General Assembly describing the impact of this program. The report shall include a plan for providing community-based forensic evaluation and consultation services on a Statewide basis, as well as any necessary proposals for the revision of § 19.2-169 and other relevant sections of the Code of Virginia.

PREFACE

This implementation report concerning the establishment of a Forensic Evaluation Training and Research Center and the development of a community based system for outpatient forensic evaluations is submitted to the Governor and the General Assembly by the Department of Mental Health and Mental Retardation. It utilizes and is based upon the 1982 Annual Report of the Forensic Evaluation Training and Research Center which was designed and intended to represent a final report by the Center concerning the implementation of House Joint Resolution No. 22 of the 1980 Session of the General Assembly. References to an appendix contained herein refer to the appendix of the aforementioned Annual Report in its entirety, a copy of which will be made available by the Forensic Evaluation Training and Research Center or by the Department upon request.

EXECUTIVE SUMMARY

Prior to the 1980 session of the General Assembly, there were numerous indications that a substantial proportion of criminal defendants committed to state inpatient facilities for forensic evaluation did not need hospitalization and could be adequately and more economically evaluated on an outpatient basis at community mental health clinics. It was believed that what was needed was the training of teams of mental health professionals at the clinics to do forensic evaluations on an outpatient basis.

On March 8, 1980, the General Assembly agreed to House Joint Resolution No. 22 which in essence requested the Commissioner of Mental Health and Mental Retardation to establish a Forensic Evaluation Training and Research Center for training professionals in the skills of forensic evaluation, to establish related demonstration service projects and to report to the General Assembly describing the progress and the impact of this program.

In order to implement the subject resolves of the General Assembly, the Department developed a contract with the University of Virginia, Institute of Law, Psychiatry and Public Policy to establish the Forensic Evaluation, Training and Research Center. The requested demonstration projects were targeted for six jurisdictions to receive training, Radford, Roanoke, Charlottesville, Alexandria, Richmond and Portsmouth, and for six other jurisdictions to serve as controls, Arlington, Chesapeake, Norfolk, Petersburg and Suffolk.

Summary of the salient features of the program is as follows:

Protocols for both outpatient forensic evaluation and screening relative to mental status at the time of the alleged offense were developed as was a 350 page training manual and curriculum for the program. Teams of community mental health professionals at the target areas were trained between October, 1980 and May, 1981. This was followed by close follow-up, continuing education and evaluation of the results and impact during the first year of operation of the program.

It was not possible to conduct the competency to stand trial evaluations for the courts without fee as had been desired. A reasonably equitable fee schedule, however, was developed through the office of the Executive Secretary of the Supreme Court.

To assist judges, prosecutors and defense attorneys, educational meetings were held, and a 20-page informative booklet was developed and distributed.

The Center also developed an Advisory Committee of select judges, Commonwealth's attorneys and defense attorneys to resolve issues which arose concerning trainees and the performance of forensic evaluations.

There was coordination between the Forensic Unit at Central State Hospital and the Center, both in the training itself and in the subsequent follow-up of trainees for purposes of assessment and continuing education.

Collection of data to determine impact included information relative to state hospital admission of criminal defendants for evaluation, comparative costs, level of knowledge of trainees, evaluation of forensic report quality, use of screening evaluation pertinent to mental status at the time of the alleged offense and assessment by members of the legal profession.

Prior to the pilot project, during fiscal year 1979 through 1981, the annual number of inpatient forensic evaluations had remained relatively constant. During the operational year of the project, the in-hospital evaluations required by trained localities dropped by 46% whereas the community based outpatient forensic evaluations of the trained areas increased from an average of 193 evaluations per year to 291 evaluations during the year of the project, an increase of close to 50%. The control areas showed no comparable change.

Estimated costs for inpatient forensic evaluations were determined to be $2,745 per evaluation of each hospitalized patient as compared with $455 for each community based outpatient forensic evaluation. Implementation of the community based forensic evaluation in the demonstration project was determined to reduce the overall costs for forensic evaluations by 32%.

Study of the forensic knowledge of community mental health professionals trained in the project showed a mean test score of 75% compared to 50% for a comparable group who had not received the training.

As rated by judges, Commonwealth's attorneys and defense attorneys as a measure of the trainees' competence, the quality of their forensic evaluation reports was determined to be of high quality.

Utilizing the Center developed protocol for screening pertinent to mental status at the time of the alleged offense, 44% of the defendants were determined not to be in need of such an in-depth MSO evaluation, further decreasing the need for hospitalization.

A survey of the legal profession's assessment of the forensic evaluations produced by the trained clinics of the project indicates that it was quite satisfied with the overall quality of the community based forensic evaluation services being rendered by the clinics of the trained jurisdictions.

Certification of evaluators by the Forensic Evaluation Training and Research Center has been made an integral part of the Center's operation.

Significant progress has been made in establishing a statewide community based mental health forensic evaluation system and plans have been made for further statewide development of a graduated three-tiered system which will integrate and coordinate community based outpatient services, with services rendered by regional civil hospitals and the Central State Hospital Forensic Unit.

Pertinent revisions of Sections 19.2-169 of the Code of Virginia were accomplished and enacted by the 1982 session of the General Assembly. Additional legislative suggestions for consideration, contained in this report, relate to the reimbursement of forensic evaluators, the qualification of clinical social workers to perform competency evaluations for the courts, and the competency of defendants to plead guilty.

INTRODUCTION

The Forensic Evaluation Training and Research Center came into being as a result of House Joint Resolution No. 22, which was passed by the Virginia General Assemby on March 8, 1980. (App. 2). In this resolution, the General Assembly called upon the Department to establish a "Forensic Evaluation Training and Research Center" for the following purposes:

1. To develop a plan for training community mental health professionals to perform forensic evaluations and to certify their qualifications and competency to do so;

2. To provide forensic training services for teams of community mental health professionals in jurisdictions selected by the Commissioner (of Mental Health and Mental Retardation).

3. To develop clinical protocols and procedures for use by appropriately trained community mental health professionals to enable them (i) to efficiently screen and assess the competency of criminal defendants to stand trial, and (ii) to provide other appropriate psychological evaluations for the courts, and

4. To compile the necessary information for evaluating the success of this program.

In connection with the Center's second function, the Resolution also directed the Department to set up "demonstration services projects" in selected jurisdictions.

The Department, in turn, contracted with the University of Virginia's Institute of Law, Psychiatry and Public Policy to create the Center, train community professionals, and assist in implementing the demonstration program (App. 1). By July 1, 1980, the Institute had selected the Center's professional staff, comprised of one lawyer, who serves as the Center's director, one doctoral level clinical psychologist, who is the Center's research director, a clinical social worker, and two consulting psychiatrists (App. 3).

The impetus behind House Joint Resolution No. 22 was primarily financial. Prior to 1980, most criminal defendants who required assessment of their condition were sent to one of Virginia's two maximum security forensic units at Central State and Southwestern State Hospitals. According to a 1977 study (McCall, p., 1977), these defendants spent, on the average, over 30 days in the institution before being returned to court for trial. When the expense of housing over 700 defendants a year

for this long, at a per diem rate of between $60 to $100 a person, was added to the transportation and communication costs associated with evaluating defendants at distant forensic units, the total annual expenditures connected with Virginia's forensic evaluation system was well over 1.2 million dollars.

The General Assembly and the Department believed that these costs could be reduced significantly through the initiation of an outpatient evaluation system based in the communities. According to the study cited above, at least 70% of the defendants committed to Virginia's hospitals did not require prolonged inpatient observation or treatment. Moreover, several other states (Tennessee, Massachusetts, Ohio and Missouri, for instance) had reduced the number of hospital-based inpatient evaluations through the addition of a community-based, outpatient evaluation component to their forensic service systems. (See, e.g., App.4).

An additional factor motivating passage of House Joint Resolution 22 was the imminent shutdown of the forensic unit at Southwestern State in July, 1980, due to budgetary constraints. With the loss of this unit, Virginia required additional evaluation capacity which could not be provided solely by Central State Hospital. (Final Report, Commissioner's Committee on Mental Health and Mental Retardation Forensic Services, pp. 4-7, issued April, 1982).

A final reason for establishing a community-based system was the hope that unnecessary hospital confinement of criminal defendants would thereby be avoided. A defendant's rights to bail, speedy trial, and treatment in the least restrictive manner are more likely to be respected when local evaluations are available.

The pilot project described in the first two sections of this report was an attempt to investigate whether a community evaluation system would in fact reduce hospital admissions and the related costs in Virginia, while maintaining the quality of the evaluations provided the courts. Section I summarizes the principal steps taken to establish the project; Section II describes the results of the research conducted by the Center to examine the feasibility and efficacy of an outpatient forensic service system. Section III describes the several activities of the Center which grew out of the pilot project, both during and after the experimental phase of the program. Finally, Section IV offers some observations and recommendations concerning Virginia's forensic evaluation system and the future of the Center.

SECTION I. ESTABLISHING THE PILOT PROJECT

Between July 1, 1980 and February 28, 1982, the Forensic

Evaluation Training and Research Center designed and implemented an experimental outpatient forensic evaluation system and attempted to assess its efficacy through six evaluation strategies. This section summarized the implementation of the project, which involved the following initiatives: (1) arranging for the court system to pay, on a per-evaluation basis, the community mental health professionals trained by the Center; (2) selecting and training mental health professionals from six experimental or "target" communities; (3) educating members of the bench and bar in the target jurisdictions about the pilot project; (4) establishing an advisory committee to provide recommendations as to how the pilot project could best meet the needs of the legal system; and (5) monitoring the progress of the project by providing, as needed, continuing education of and consultation with the trainees.

1. Compensation. Under the original proposal for the pilot project, evaluations performed in the community were to be financed by the Department (See App. 2). However, the General Assembly's 1980-82 appropriation did not provide funds for such reimbursement. Thus the first job of the Center was to find a source of funding for the evaluations; without compensation, community professionals were unlikely to participate in the project.

The court system seemed the logical funding source, since judges and lawyers are responsibile for requesting most psychological evaluations. Although Virginia law (Section 19.2-175) provided that private clinicians who perform evaluations for the courts are entitled to up to $200 per evaluation and report, reimbursement under this statute varied from judge to judge and frequently was not forthcoming. Thus, in July, 1980, the Center approached the Executive Secretary of the Supreme Court, Robert Baldwin, in an effort to guarantee fiscal stability for the pilot project's evaluations.

After prolonged negotiation with Mr. Baldwin and the Attorney General's office, which became involved to insure legal technicalities were observed, a Memorandum entitled "Outpatient Forensic Evaluations for Adult Criminal Evaluations" was issued on November 21, 1980, to all judges, probation officers and sheriffs. (App. 5). Signed by Mr. Baldwin, the Commissioner of Mental Health and Mental Retardation, and a representative from the Attorney General's office, the Memorandum described the pilot project and established the following fixed fees to be paid by the judiciary:

Competency and MSO screening evaluation*	$100
Comprehensive MSO evaluation	$200
Pre-Sentence evaluation (if no prior eval.)	$200
Pre-Sentence evaluation (if prior eval.)	$100

2. Selection and Training and Mental Health Professionals. In selecting mental health professionals for the pilot project, the Center focused its efforts on community clinics, rather than individual private clinicians. It was assumed that the former are generally more committed to community service and are less transient than the latter, and thus are more likely to establish a permanent, ongoing relationship with the court system. From July through September, 1980, the Center contacted several community clinics and informed their directors about the pilot project. Specifically, the directors were told that participation in the pilot project would involve sending, at the clinic's expense, a "team" of from three to five professionals, including one psychiatrist or doctoral level clinical psychologist, to attend a training program at the Center's facilities in Charlottesville. The clinic would also be asked to provide various types of data to the Center once evaluations for the courts began. In "exchange," the staff would be "certified" to perform forensic evaluations reimbursable at rates currently being negotiated with the Supreme Court.

By October 1, 1980, six community clinics had agreed to participate in the experimental program. They were located in Alexandria, Charlottesville, Portsmouth, Radford, Richmond and Roanoke, thus providing a geographically diverse group of clinics serving both rural and urban populations. Each clinic sent at least one psychiatrist, one doctoral level clinical psychologist and one clinical social worker to the training. Altogether, 30 professionals became involved in the pilot project.

The training of these professionals took place between October, 1980 and March, 1981. To insure personalized classes, the six clinics were divided into two groups of three and trained in two phases separated by over a month. The complete course consisted of a total of eight days instruction on the topics listed in Appendix 6. Each trainee received a 350 page training manual containing outlines and relevant background materials (see App. 7 for table of contents), 30 hours of didactic lecture and videotape viewing, and seven hours of supervised evaluation

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*A mental state at the time of the offense (MSO) screening evaluation is a short (1-2 hour) evaluation designed to "screen out" those defendants who clearly do not have a legal defense based on mental abnormality.

experience. Those who attended this course and passed an 80 question forensic evaluation (See p. 10, this report) received a certificate indicating that they had completed the requirements for forensic training in the state of Virginia (App. 8).

3. Education of the Bar. To be successful, the pilot project required the full support and understanding of the legal profession. In January and February of 1981, before the trainees began performing evaluations for the courts, meetings were held in each target jurisdiction to which the appropriate judges, prosecutors and defense attorneys were invited. Those who attended these meetings received a 20 page booklet containing H.J.R. 22, the Memorandum from the Supreme Court, and model court orders and reports, as well as a verbal explanation of how the project was expected to operate. A secondary objective of these meetings was to begin the process of educating the legal profession about the nature of clinical assessment, a process which the community professionals would continue once they began performing evaluations.

4. Advisory Committee. The meetings held in each target jurisdiction alerted the Center's staff to the need for more information concerning the legal system's use of clinical expertise. Lawyers and judges at these meetings often made useful suggestions about the content of the training and how the evaluation process might be structured. In order to obtain such legal expertise in a more formal manner, the Center invited a select group of judges, commonwealth's attorneys and defense attorneys to sit on an advisory committee to the Center (App. 9). This committee met for the first time in May, 1980, after the trainees had been performing evaluations for over two months, and again in September, 1981. Several issues which had arisen with respect to the pilot project were discussed and resolved at each session, leading to some changes in the design of the pilot project. (App. 10).

5. Continuing Education and Monitoring. Throughout the pilot project's term, the Center's staff stayed in close contact with the trainees, through a variety of mechanisms. Over the phone, the Center provided consultation on specific problems and kept track of the project's day to day progress. The staff also visited each clinic at least twice between March, 1981 and March, 1982, to discuss how the program was working. During the visits, the clinics were asked to provide random samples of their evaluation reports, which were reviewed and critiqued by the Center's staff.

In addition, each clinic team spent one day at Central State Hospital in May, 1981, performing three evaluations utilizing

the outpatient evaluation protocols developed by the Center. Dr. James Dimitris and his staff critiqued these evaluations. Finally, the first semi-annual Forensic Symposium, to which all the trainees were invited, took place on November 19, 1981. During this gathering, Center staff apprised the pilot project group of new developments and provided additional training. (See App. 11).

This brief description of the pilot project summarizes how the project was conceived and implemented. The next section of this report describes the Center's analysis of the project's efficacy.

SECTION II

EFFICACY of the PILOT PROJECT

In order to assess the efficacy of the pilot project, the Center collected data regarding:

1. the impact of the pilot project on the number of defendants admitted to the state's four major mental hospitals for forensic evaluation;

2. the comparative costs of a hospital-based forensic evaluation system and a community-based forensic evaluation system;

3. the level of forensic knowledge achieved by community mental health professionals participating in the pilot project, as measured by a forensic examination validated by national experts;

4. a comparison of the quality of reports prepared by the trainees with those prepared by state hospital forensic experts, as measured by ratings obtained from a panel of judges, Commonwealth's attorneys, and defense attorneys;

5. the efficacy of the mental state at the time of the offense screening evaluation (an evaluation protocol developed by the Center to aid mental health professionals in performing outpatient evaluations of mental state at the time of the offense); and

6. the initial assessment of the legal profession regarding the quality of services provided by the staff of the six pilot community mental health centers.

The first and third studies involved comparisons between

data obtained from the six Experimental (i.e., pilot) jurisdictions and six "matched" control jurisdictions. Each Control jurisdiction was selected based upon its similarity to one of the Experimental jurisdictions. Determinations of "similarity" were based upon ratings provided by members of the staff of the Assistant Commissioner for Community Services familiar with the state's community mental health centers. These staff members matched the centers according to variables identified by the Center, including: catchment population size; clinic philosophy (i.e., nature of services offered, service goals, degree of outreach and "community orientation"); quality of clinic services (i.e., effectiveness and responsiveness to community needs); level of training and experience of staff; availability of outpatient mental health services in the private sector; and size of staff. The Control clinics selected were located in: Arlington, Chesapeake, Newport News, Norfolk, Petersburg and Suffolk.

Study 1: Impact of Community-Based Pilot Project upon Admissions for Forensic Evaluations to the State's Mental Hospitals

Since a primary impetus for the establishment of the community-based forensic evaluation system was the expectation that it would reduce admissions to the state hospitals and thereby reduce evaluation costs, the Center's first study examined whether the pilot program actually reduced admissions. We began by obtaining data (primarily from the Department's automated hospital Management Information System[1*]) regarding the numbers of hospital admissions for forensic evaluations from both the Experimental and Control catchment areas. The data were collected for three one-year periods: a) March 1, 1979 through February 29, 1980; b) March 1, 1980 through February 28, 1981; and, c) March 1, 1981 through February 28, 1982. The last interval corresponds with the first year the community professionals trained by the Center performed evaluations for the courts.

The figures obtained are reported in Table 1 and Figure 1 (Apps. 12A, 12B). They indicate that prior to the onset of the pilot project, in the years 1979 - 80 and 1980 - 81, the total number of evaluation admissions to state hospitals from both the Experimental and Control areas remained relatively constant. The figures also reveal that the total number of hospital admissions for forensic assessment from the Experimental group versus the Control group during the pre-pilot project years were remarkably similar (suggesting that the Office of the Assistant Commissioner for Community Services had performed an excellent job of "matching" the Experimental and Control clinics). Most importantly, Table 1 indicates that during the year of the pilot project, the frequency of admissions to state hospitals for forensic evalua-

* Footnotes to Section II are found in Appendix 20.

tions in the Experimental jurisdictions *dropped by 46.38%*, whereas the frequency of admissions in the Control areas remained constant. This finding, which was statistically significant at the $p < .001$ level, suggests that the pilot project had a substantial impact on the rate of hospital admissions for forensic evaluations.

Concurrent with the above data collection, we also attempted to estimate the number of outpatient evaluations performed in the Experimental and Control jurisdictions during the three one-year periods. We based this estimation on: a) reports from the Experimental and Control clinics for the year of the pilot project (prior to the project year, the clinics did not keep separate forensic records); and b) records obtained from the Supreme Court of Virginia regarding the total expenditures by the state for outpatient forensic evaluations performed in the Experimental and Control jurisdictions during the relevant time periods. [2] It appears that a relatively constant number of community-based evaluations were conducted both in the Control catchment areas across the three year period (i.e., 215, 175 and 190), and in the Experimental areas during the two year period prior to the commencement of the pilot program (i.e., 198 in 1979-80 and 212 in 1980-81). During the 1981-82 pilot project year, however, the number of community based evaluations *increased* to 291. Thus, the presence of trained forensic professionals appears to have increased the use of community services.

However, the *total* number of evaluations associated with the Experimental areas in 1981-82 did *not* increase. The tabulations of total referrals for forensic *assessment* (including community-based evaluations, hospital inpatient evaluations, and hospital outpatient evaluations) are presented in Table 2 and Figure 2 (App. 13A, 13). These data indicate that the number of forensic evaluations (inpatient and outpatient) remained relatively constant over the *entire* three-year period for both the Control and the Experimental groups (averaging slightly over 400 per year for each). While, as noted above, community-based evaluations in the Experimental areas increased by close to 50% during the pilot project year, hospital admissions from those areas *decreased* by slightly greater percentage. Thus, the on-set of the pilot program seemed to cause a *redistribution* of forensic evaluations, not an increase in their number.

A careful perusal of the data from the individual catchment areas within the Experimental group suggests that the program was substantially more effective in certain jurisdictions than in others. For example, in Charlottesville, Radford and Roanoke, hospital admissions for forensic evaluations dropped dramatically (i.e., by over 80%) and Portsmouth evidenced about a 50% drop. By contrast, in Richmond and Alexandria, little change appeared

to occur from one year to the next. The relatively small decline in admissions from Richmond probably is due to the fact that, because of an administrative oversight, half of the 12 judges responsible for forensic evaluation referrals in that jurisdiction had not been informed about the pilot project until well into the 1981-82 year. We thus expect that the number of admissions from Richmond will drop substantially in 1982-83, which is quite significant, since Richmond accounted for almost 30% of the total admissions from the Experimental jurisdictions.

The absence of any decline in admissions from Alexandria appears to be due to a more complex set of factors. Two District Court judges, who are responsible for the bulk of forensic evaluation orders in that jurisdiction, have indicated in response to a survey conducted by the Center, (see Study 6), that they believe the reports from the Alexandria clinic contain irrelevant information and do not answer the courts' questions.[4] Thus, these judges have continued to use the hospital as an initial evaluation resource, as well as a "second opinion" after the clinic's reports are received. We believe this development explains why admissions from Alexandria have remained constant.

Despite these problems, the general conclusion suggested by our data is that the project substantially reduced hospital admissions for forensic evaluation. Moreover, assuming these implementation difficulties can be corrected, the 1982-83 drop in admissions from the pilot project jurisdictions should be even greater.

Study 2: The Cost-Effectiveness of Community-Based Versus Hospital-Based Forensic Evaluation Systems

In order to determine whether the above reductions in hospital admissions did, in fact, lead to reductions in overall evaluation costs, it was necessary to compare the pilot project's costs with expenditures associated with the hospital-based system in prior years. Our investigations revealed that it was not possible to obtain actual figures for each of the various expenses incurred in the provision of community-based and hospital-based forensic evaluation services. Therefore, we estimated the expenditures for each type of service and computed an approximate cost comparison (See Laben, Kashgarian, Ness & Spencer, 1977).

To approximate the cost of hospitalization for a forensic evaluation, we assumed an average 30-hospitalization[5], at a cost of $85.00 per day[6], an average of one lunch for the sheriff's deputy transporting the defendant ($5)[7], an average transport of the defendant to the state hospital and back to jail of 200 miles ($40)[8], and an average of 10 days in jail between return from the hospital and the first court appearance, at a cost of $15 per day

(i.e., $150)[10]. These figures were totaled to obtain the estimated cost of each inpatient evaluation ($2,745). To compute the cost of each community evaluation, we assumed an average $150 fee paid by the courts for the evaluation[11], an average of 20 days in jail between arrest and the first court appearance, at $15 per day (i.e., $300)[12], and an average cost per transport (of clinic staff to the jail or of the defendant to the clinic)[13] of $5[14]. We estimated that the cost of each community-based out-patient evaluation was approximately $455 or the total of these figures.

Using these cost figures, we estimated the expense to the state of providing forensic evaluation services both during the pilot program year and during the two immediately previous years. During 1981-82, the cost of conducting the 291 community mental health center evaluations performed in the Experimental jurisdictions was approximately $132,406, and the cost of conducting the 111 hospital evaluations of defendants from the pilot areas was approximately $304,695, suggesting a total evaluation expenditure of $437,101 associated with these six areas for the pilot project year. By contrast, in the immediately preceding years, 1979-80 and 1980-81, an average of 205 community evaluations were performed, and an average of 207 hospital evaluations were conducted. The former services cost an estimated $77,900 and the latter services cost an estimated $568,215. Thus, for approximately the same number of evaluations performed in 1981-82 (412 to 402), the total average yearly expenditure immediately prior to the pilot project is estimated at $646,115.

These data indicate an expected savings of $209,014 through the implementation of the community-based pilot program, or a drop in costs of 32.35%. As suggested with respect to Study 1, we expect that further reductions in admissions could be obtained through correction of some of the initial difficulties encountered by the program in two of the jurisdictions. Therefore, it is possible that even more substantial cost savings might occur if statewide implementation of the community-based forensic services program were to occur.

Study 3: Forensic Knowledge of Community Mental Health Professionals Trained in the Pilot Project

House Joint Resolution No. 22 recognized that in order to be effective, the community-based evaluation systems must provide "competent" services, as well as reduce evaluation costs. In order to evaluate the competence of those community mental health professionals trained in the pilot program, we examined their degree of forensic knowledge (discussed in this section) and the quality of their evaluation reports (See Study 4).

Forensic knowledge was evaluated using a "forensic examination," which was developed by Center staff and reviewed and validated by a panel of experts consisting of officers of

national organizations in forensic psychology, forensic psychiatry and mental health law, a Virginia trial judge, and three Virginia assistant attorneys general. The examination consists of 80 multiple choice questions divided equally among the following five topics: general forensic issues; competency to stand trial, mental state at the time of the offense; sentencing issues; and juvenile law. Each of these sections is itself divided into four equal sections: national law; Virginia law; clinical issues and research issues.

Center staff administered this examination to trainees from the Experimental clinics four to eight weeks after the completion of training. It was also administered to several "comparison" groups. Primary among these was a "director-designee" group, consisting of five staff members from the Control clinics (selected by the director) who probably would have been trainees had their clinic been involved in the forensic evaluation training. The "director designees" were thus comparable to the actual trainees from the Experimental clinics, except for their lack of specific forensic training. The 27 trainees from the Experimental clinics obtained a mean score of 75% on the test whereas the 28 director designees obtained a mean score of about 50%. (See Table 3, App. 14A). The differences between these groups was statistically significant at the $\underline{p} < .001$ level, indicating that the program trainees had a superior level of forensic knowledge.

The examination was also administered to mental health professionals at the Experimental clinics who had not taken the training, professionals at the Control clinics who were not "director designees," University of Virginia psychology and psychiatry residents, and Department of Behavioral Science and Psychiatry faculty. In all, 134 mental health professionals other than the trainees took the examination. Across <u>each</u> of these comparison groups, mean scores of about 50% were obtained. It thus appears that most groups of mental health professionals, whether working in a community mental health center or in an academic setting, obtain a certain basic level of forensic knowledge. Yet, as noted above, the <u>trainees</u> demonstrated a superior level of knowledge. Comparisons across groups within the specific sections of the examination revealed that this superiority existed across all categories.

The examination also was administered to 53 judges from a broad spectrum of jurisdictions across the United States who were attending seminars sponsored by the American Judicial College during the summer of 1981. The judges were administered a modified examination, with items on Virginia law excluded, since there was no expectation that non-Virginia judges would be familiar with local law. The responses of the judges were compared to those of the pilot program trainees, and with the control subjects. It was found that the trainees performed better than did the judges on each section of the examination, including the National Legal Issues section. These differences were statistically significant

at the $p < .001$ level. Other findings are not as surprising. The judges performed better than the other community mental health professionals (non-trainees) on the National Legal Issues section of the examination. By contrast, the control community mental health professionals performed more highly than the judges on the Clinical Issues section. (See Table 4, App. 14B).

We draw the following conclusions from these analyses: a) that the training provided by the Forensic Evaluation Training and Research Center substantially increases the knowledge base or community mental health professionals regarding forensic issues; b) that mental health professionals who are not trained by the Center, and who do not specialize in forensic practice, acquire a basic level of forensic knowledge which is relatively constant across groups (e.g., University Medical Center psychology and psychiatry faculty and community mental health center staff); and c) that trainees of the Center's programs acquire a level of forensic knowledge superior to that of a sampling of judges.

Study 4: Quality of Reports Prepared by Trainees of the Forensic Evaluation Training and Research Center

As a second measure of the trainee's competence (the first being the above-described test of their forensic knowledge), the Center studied the quality of the trainees' evaluation reports by comparing them to reports prepared by forensic experts at Central State Hospital's Forensic Unit. Since the courts of Virginia have long relied upon the reports submitted by Central State, it was deemed appropriate to use them as the standard against which to evaluate the trainees' efforts.[16]

The study was conducted as follows. First, we randomly selected reports from the clinics and from Central State Hospital forensic Unit. Identifying data in both sets of reports were altered, so that it would not be obvious whether the evaluation had been conducted in the hospital or a clinic; names, dates and locations were also changed. These reports were then sent to a group of expert raters, consisting of three judges, three commonwealth's attorneys and three defense attorneys. Each rater was sent eight competency to stand trial reports (one from each Experimental clinic and two from Central State Hospital); six mental state at the time of the offense reports (four from the four Experimental clinics performing such evaluations with regularity, and two from Central State); and six pre-sentence reports (four from the four Experimental clinics performing such evaluations with regularity, and two from Central State). The raters also received three different types of rating forms, corresponding to the different types of reports they had to rate (See Apps. 15A-15B). The rating forms were adapted from rating scales developed by Poythress (1979) in his study of reports by mental health professionals of various disciplines. The forms asked the raters to address a number of issues, such as whether the reports used

understandable language, whether they referred to the appropriate legal criteria, and whether they adequately explained the basis for their concluions.

For each item, the raters were asked to rate each report on a nine-point scale (where the score of "9" was the best score attainable). Across all three categories of report, the mean ratings of the clinic reports ranged between 6.29 and 7.82. Since a score of "5" is the mid-point between "poor" and "excellent," we can conclude that the raters perceived the reports as being above average. There did not appear to be any noticeable rating differences between the different groups of raters (i.e., judge, commonwealth's attorneys and defense attorneys) with respect to the Clinic reports. This would suggest that, according to raters representing the three primary groups of legal professionals in the criminal justice system in Virginia, the clinic reports are perceived to be of high quality. This result in turn suggests a high level of competence among the community mental health professionals involved in the reports' preparation.

In order to compare the ratings of the clinic reports with those of Central State Hospital, we focused on the final item of each rating scale, which deals with the "overall" quality of the report. The fourteen clinic reports (including all three categories of report) were compared statistically with the six Central State Hospital reports (across all three categories of report). The statistical comparisons were performed separately for each group of raters (i.e., judges, commonwealth's attorneys and defense attorneys). For each group of raters, the clinic reports were rated more highly than the Central State reports. These differences between the groups were statistically significant (See Tables 5-8, Apps. 16A-16D).

In reviewing the specific items on the rating scale, it appeared that Central State reports were seen as least helpful with respect to their presentation of "the factual basis of the clinician's conclusions" regarding the defendant's functioning. This finding reflects the fact that Central State traditionally has prepared conclusory written reports and transmitted the bulk of its information verbally, whereas the clinics were taught to provide background data in the report.

It is also interesting to note that while there were no significant differences between the three groups of raters with respect to the clinic reports, the Commonwealth's attorneys rated the Central State reports slightly more positively than did the defense attorneys, and both the Commonwealth's attorneys and the defense attorneys rated the Central State reports slightly more highly than did the judges.

In conclusion, our data suggest, at a minimum, that a community based system would not cause a decline in the quality of

forensic evaluation reports in Virginia.

Study 5: The Mental State at the Time of the Offense Screening Protocol

Protocols designed to assist mental health professionals in screening those referred for evaluations of competency to stand trial have already been developed (see, e.g., McGarry, A. L., et. al. 1977). These protocols have been shown effective in reducing hospital admissions for competency evaluations (Roesch & Golding, 1980). However, in serious cases, lawyers rarely ask for an evaluation of the defendant's competency along; they are also interested in his mental state at the time of the offense. If evaluations of mental state at the time of the offense could not be performed on an outpatient basis, the capacity to screen for competency may not reduce significantly forensic evaluation costs because defendants will still be referred to the hospital for the former type of assessment.

Given this problem, the Center's staff developed a mental state at the time of the offense screening evaluation protocol (see App. 17), or the "MSE," and tested its efficacy in a study conducted at Central State Hospital. The full study will appear in the January, 1983 issue of Law and Human Behavior. In that paper, we concluded that the MSE, when used by trained professionals, does have the potential for reducing unnecessary hospitalization and for reducing the cost of forensic evaluations. While using the Center's outpatient evaluation protocol, trainees "screened-out" (i.e., found no evidence of significant impairment due to mental disease or defect at the time of the offense) a sufficiently large number of defendants (44%) to suggest that an outpatient evaluation system can avoid a substantial proportion of inpatient evaluations of mental state at the time of the offense. Moreover, based on comparisons of the trainees' conclusions with those of Central State and the courts, the defendants whom the trainees "screened-out" did not have clinically supportable defenses (i.e., there were no "false negatives").

Study 6: The Legal Profession's Assessment of Evaluation Services Provided by the Six Community Mental Health Centers

In order to supplement the findings of the third and fourth studies, and obtain a more direct sampling of the pilot project's effectiveness, we surveyed all of the District, Circuit, and Juvenile Court judges and Commonwealth's attorneys in the six pilot jurisdictions, plus three defense attorneys from each pilot jurisdiction (total = 80). In June, 1982, approximately fifteen months after the pilot program was initiated, these professionals were requested to provide their assessment of the following: the

quality of the reports prepared by the pilot clinics; their relationship with the pilot clinic evaluators in their jurisdiction; and the general effectiveness of the outpatient evaluation system. They were asked to rate each item on a five-point scale, where a score of "one" represented "poor" and a score of "five" represented "excellent."

Forty-nine (or about 61.2%) of those surveyed responded. Of this total, seven respondents indicated that they had not had occasion to use the pilot program's services. The mean ratings of the legal professionals who did respond were as follows: 4.01 on report quality; 4.29 on relationship with the community evaluators; and 4.10 on overall effectiveness of the program (three being the mid-point of the scale). When viewed separately, certain of the community clinics were rated far above average on all three items. For instance, Charlottesville and Richmond uniformly received almost perfect scores from all raters. In most jurisdictions, there was consistent agreement among different legal professionals that the quality of services provided by the clinics is high. The one exception to this pattern was Alexandria, where two of the seven respondents rated the clinic quite poorly, while five of the respondents rated the clinics very highly. (See Table 10, App. 19).

This brief survey clearly demonstrates that, with the exceptions noted above, legal professionals from the pilot jurisdictions are quite satisfied with the overall quality of the community-based forensic evaluation services in the Experimental jurisdictions.

Summary of Research Findings Regarding the Efficacy and Cost-Effectiveness of the Pilot Program of Community-Based Forensic Evaluations

In summary, we interpret the findings described above as indicating that a community-based system of forensic evaluations is an effective and less expensive alternative to the current hospital-based system of forensic evaluations. Our research indicates that the availability of community-based forensic services reduces admissions to state hospitals for forensic evaluation, and consequently reduces costs, while providing services judged to be at least adequate, and often superior, by those who use them.

The explicit findings of this research are further summarized in the concluding section of this report. It should be mentioned here, however, that there may be other advantages to a community-based system that cannot be quantified. We have observed, for instance, that when evaluations are performed in the community rather than a distant state hospital, "communication costs" are reduced, background information is more easily obtained by the evaluators, and more "fluid" relationships are established

between legal professionals and mental health professional evaluators. Further, the existence of a community-based system of forensic evaluations probably will facilitate the efficient functioning of the state's inpatient forensic unit. The availability of community services should reduce or eliminate the long waiting lists for Central State's forensic evaluation services, and will thus expedite the provision of inpatient evaluation and treatment to those defendants for whom such services are truly essential.

SECTION III

OTHER ACTIVITIES of the CENTER

The staff for the Forensic Evaluation Training and Research Center has been involved in several activities which are directly related to the pilot project and community evaluations for the courts, but which are outside the literal mandate of House Joint Resolution No. 22. These activities fall into four general categories: (1) assisting in the planning, implementation, and requisite training for a statewide system of outpatient community evaluations; (2) participating in the drafting and sponsorship of legislation promoting community evaluations, and revising the law relating to the conduct of the forensic mental health evaluations generally; (3) providing consultation to the Executive Secretary's Office on model orders and related matters which guide the court system in making referrals for evaluation; and (4) providing consultation to various government agencies on management information and data collection systems.

1. Establishing a Statewide System. The drafters of HJR 22 contemplated expanding evaluation capacity statewide only after the final report on the pilot project was received on September 30, 1982. (App. 2). However, several developments led the Department to begin implementation of this system earlier than originally planned. Most significantly, by July, 1981, the shut-down of the Forensic Unit at Southwestern State Hospital and an overall increase in demand for evaluations had begun to put substantial strain on the staff at Central State. (Commissioner's Report, supra page 2, at 4-7.) Fortunately, the research findings after the first three months of the pilot project indicated that the project was reducing hospital admissions, (App. 21), providing preliminary evidence that a community-based system could eventually relieve the pressure on Central State Hospital once implemented statewide.

Thus, in July, 1981, the Director of the Center met with members of the Department and Central State Hospital to begin planning how the system was to be structured. It was decided that, after the completion of the pilot project's first year of implementation, in February, 1982, the Center would begin training additional community clinics. Additionally, to meet the

the demand for forensic evaluation services during the time it required to train a sufficient number of clinics to meet statewide requirements, professionals from the six civil hospitals (at Central, Eastern, Southwestern and Western State, Northern and Southwestern Virginia Mental Health Institutes) were to be trained. They would then be available to perform outpatient forensic evaluations (at the hospitals) of defendants from those jurisdictions which did not yet have trained clinics. For those jurisdictions with trained clinics, the hospitals would function as "backup" evaluation facilities. (App. 22).

To implement this system, the Center began a series of training programs. Staff from the six civil hospitals were trained in October, 1981 and began performing evaluations at the end of February, 1982. Since March, 1982, the Center has also trained nine clinics (in Abingdon, Culpeper, Madison, Nassawadox (Eastern Shore), Newport News, Norfolk, Orange, Virginia Beach, and Winchester) and has notified judges and lawyers in those jurisdictions that qualified professionals are available to perform outpatient evaluations. The Center plans to train an additional two or three clinics every two months between June 30, 1982 and March, 1984, so that by the latter date approximately 40 clinics will have been trained to perform outpatient evaluations.

The typical training program for a clinic will follow this chronology: (1) contact with clinic explaining nature of the training program (App. 23); (2) confirmation of clinic's participation in the training and designation of staff to be trained; (3) seven days of training, six days at Charlottesville and one day at Central State (4) administration of the forensic examination; (6) meeting with judges, Commonwealth's attorneys, and defense attorneys in clinic's jurisdiction (for outline of meeting, (See App. 24); (7) after evaluations begin, random sampling of three of the clinic's reports, occasional visits to clinic, other follow-up monitoring.

In addition, the Center plans to continue holding semi-annual forensic symposia. The Center held its second Symposium on May 18, 1982 (App. 25). Attendance at these symposia may be required of those who have "graduated" from the training program as part of a continuing "certification" process (See Section IV (3)).

Finally, the Center is continuing its efforts to educate the bench and the bar beyond the jurisdiction by jurisdiction meetings described above. Mr. Slobogin, former director of the Center, addressed the District Court Judges' Conference on May 24, 1982, and a Regional Circuit Court Judges Meeting in Petersburg on June 22, 1982. He is scheduled to address the annual Commonwealth Attorneys' Association meeting at Virginia Beach on August 7, 1982. In addition, Mr. Slobogin is a regular speaker at the Supreme Court's training sessions for new judges. Efforts are being made to schedule appearances at the Trial Lawyers Association meeting and

the Circuit Court Judges' meeting in the upcoming year. (App. 26).

2. Legislation. In March, 1982, the General Assembly passed Senate Bill 417, which significantly revises those sections of the Virginia Code dealing with psychological evaluations for the courts. (App. 27). Members of the Center participated on the Insanity Defense Plea Task Force, which was appointed by the Secretary of Human Resources and was instrumental in drafting the Bill and providing supporting testimony in the General Assembly. Dr. Showalter, consulting psychiatrist with the Center, was Chairman of the Task Force appointed to draft the Bill (App. 28), and Mr. Slobogin, who also was appointed to the Task Force, was its principal drafter and testified several times during the legislative session.

Effective July 1, 1982, the new statute, inter alia, requires the courts to utilize outpatient evaluation services whenever they are available (Section 19.2-169.1(B)), 19.2-169.5 (B), provides that certain types of background information be forwarded to the evaluators before they begin their evaluation (Section19.2-169.1(C)); 19.2-169.5(C)), requires the judge to consider ordering outpatient treatment for those defendants found incompetent to stand trial or in need of emergency treatment (Sections 19.2-169.2; 19.2-169.6), and authorizes psychologists as well as psychiatrists to perform evaluations of competency (Section 19.2-169.5(A)) and mental state at the time of the offense (Section 19.2-169.5(A)). The statute thus gives the outpatient evaluation system firm legal footing and should facilitate immensely the implementation of the outpatient evaluation system.

3. By-Products of the Statute. In May, 1981, the Office of the Executive Secretary of the Supreme Court requested the assistance of the Center in drafting court order forms incorporating the requirements of the new law. The Center helped draft an Order for Psychological Evaluation (App. 29), an Order for Treatment of the Incompetent Defendant (App. 30), and an Order for Emergency Hospital Treatment Pending Trial (App. 31). In addition, the Center helped draft instructions to court clerks concerning the proper use of these forms (App. 32). More so than the statute, the order forms and the instructions should promote the establishment of the outpatient evaluation system because they will be used everyday by those who run the court system.

Also as a result of the new statute's passage, the Executive Secretary's Office agreed to sign a new reimbursement Memorandum, extending the fixed fee schedule (with one change) to evaluations performed by any clinic trained by the Center (App. 33). Thus, effective July 1, 1982, the courts are obligated to pay for any competency, sanity, or pre-sentence evaluation which they order to be performed by the Center-trained professionals. The existence of this document should provide incentive for clinics and private clinicians to participate in the training and should stabilize reimbursement for forensic evaluations.

4. Data Management. Finally, as a result of its experience with the state's computer system during the pilot project, the Center has become involved in advising the Department and the Supreme Court on the proper coding of information concerning forensic evaluation and treatment. Lois A. Weithorn, Ph.D., the Center's Research Director, has been in contact with the government, and has provided some initial suggestions about the system. She continues to provide consultation as needed. (App. 34).

SECTION IV

SUMMARY and RECOMMENDATIONS

The agreement between the Department and the Institute establishing the Center, (App. 1), stipulates that the Center include in its final report: (1) an evaluation of the effectiveness and impact of the pilot project; (2) a plan for providing community-based forensic evaluation and consultation services on a statewide basis; (3) a plan for certification of forensic evaluators; and (4) any necessary proposals for the revision of §19.2-169 and other relevant sections of the Code of Virginia. By way of summary, these topics will be addressed in this final section of the report.

1. Evaluation of Pilot Project's Effectiveness. As detailed in Section II, the pilot project:

(a) reduced hospital admissions from the experimental jurisdictions by close to 50% while admissions from control jurisdictions remained the same or increased;

(b) reduced the overall cost of evaluating defendants from the experimental communities by a substantial margin, probably close to 30%;

(c) provided at least adequate, and often superior, evaluations for the courts; and

(d) operated in a manner satisfactory to those in the legal profession who referred defendants for evaluation.

2. A Plan for Statewide Community Based Evaluations. In January, 1982, Dr. Joseph Bevilacqua, Commissioner of the Department of Mental Health and Mental Retardation, established a Committee on Mental Health and Mental Retardation Forensic Services and directed it to: "a) review the Department's current forensic system; b) examine specific issues of concern and c) provide recommendations for solving existing problems and projecting future forensic activities." Mr. Slobogin served on this Committee and helped draft the section on Forensic Evaluations in the Committee's Final Report, issued in April, 1982. These recommendations, which are listed in their entirety in Appendix 35,

are fully endorsed by the Center. Excerpts from the Committee's Executive Summary follow:

(a) By March, 1984, implement a graduated three-tiered statewide system for conducting <u>outpatient</u> forensic evaluations using community-based resources (Level I), regional civil hospitals (Level II), and the Central State Hospital Forensic Unit (Level III).

(b) By March, 1984, implement a graduated statewide system for conducting <u>inpatient</u> forensic evaluations using regional civil hospitals, at least one designated medium security forensic unit, and Central State Hospital Forensic Unit.

(c) Plan and implement multidisciplinary training strategies to establish and promote the three-tiered evaluation system.

(d) implement an interim training and operations plan pending the establishment of the three-tiered system.

(e) Develop a comprehensive forensic services fiscal plan to improve accountability and promote cost reimbursement.

(f) Establish a high-placed, adequately supported Central Office position with singular responsibility for directing the statewide forensic services system.

(g) Develop and implement a state facility and community based Management Information System (MIS) that addresses forensic services data needs.

As described in Section III, the Center has already taken steps toward implementing these recommendations to the extent it is within the Center's power to do so. It plans to continue following these recommendations until otherwise directed by the Department.

3. <u>Certification of Evaluators</u>. The Commissioner's Committee called for "multidisciplinary training" to promote the statewide forensic evaluation system. As outlined in Section III (1) of this report, the Center proposes to require that each mental health professional who enters the training program complete seven days of training, pass the forensic examination, and attend semiannual forensic symposia in order to be "certified" by the Center. Whether this certification should be a prerequisite to expert qualification by a court is a sensitive matter. Many clinicians who are currently providing evaluations and testimony for the Virginia courts are fully qualified to do so, even though they have not been trained at the Center. The Center proposes that the Department encourage these individuals to participate in the

Center's training program and that, at some later date, the possibility of requiring such training prior to performing forensic evaluations in Virginia be considered. In the meantime, the current procedure seems adequate.

4. Legislative Proposals. As noted in Section III, the Center was significantly involved in the passage of Senate Bill 417, which substantially revises §19.2-169 and related statutes. However, there remain at least three areas which could benefit from some additional legislative attention.

The first area involves reimbursement of forensic evaluators as provided for in §19.2-175 of the Virginia Code. Two aspects of this statute which should be examined carefully are its $200 maximum per-evaluation fee and its prohibition against permitting state employees to be compensated for evaluations they perform for the courts.

On the first issue, it must be recognized that to the extent $200 does not adequately reimburse evaluators from becoming involved in the outpatient evaluation system. At least one clinic has indicated reluctance to commit its staff to participation in the outpatient evaluation program on the grounds that such a step would not be financially worth while. (App. 36). As inflation raises costs generally, it may be that other clinics, as well as private clinicians, will react in a similar manner. If Virginia is to maintain a quality evaluation program, revision of the statutory cap should be considered. In this regard, the Center endorses the recommendation of the Commissioner's Committee that a survey of the time and resources require for comprehensive outpatient forensic evaluation be conducted.

Similarly, the prohibition against compensating state employees for their evaluations bears examination. Obviously, the employees themselves should not receive reimbursement beyond their state salaries. However, in light of the substantial benefit the legal system receives from hospital evaluations, it would seem appropriate for the courts to pay for services received. This approach would also remove any monetary incentive for the courts to use "free" hospital services rather than outpatient services. Parallelling the Committee's recommendation and the preliminary conclusions of the Task Force on Core Services' Implementation, Formula Funding and Facility Census Reduction (See Preliminary Report, June 10, 1982), the Center suggests that legislation authorizing local payment for all outpatient and inpatient forensic evaluations provided by state hospital personnel be pursued.

A second legislative priority is the qualification of clinical social workers to perform competency evaluations for the courts. As originally drafted, Senate Bill 417 permitted any mental health professional who was qualified by experience and training to perform such evaluations. This provision reflected the trend in

other states (e.g., New York, Tennessee, Michigan) toward allowing social workers to testify on competency. However, the General Assembly chose to limit expert qualification to psychiatrists and psychologists. Again, in line with a recommendation made by the Committee, the Center proposes that this issue be reconsidered in the next session of the General Assembly.

A third subject which merits investigation by the General Assembly is whether the new statutory Section 19.2-169.1 should be amended so as to recognize the fact that most defendants plead guilty and never go to trial, and thus should have their competency to plead guilty evaluated at the same time their competency to stand trial is assessed. The Center proposes to survey members of its advisory committee on this question and draft the necessary legislative revision, if one is deemed advisable.

Finally, the Center, through its contacts with judges, lawyers, clerks, and mental health professionals, will stay attuned to the system's response to the new statute and be prepared to propose statutory changes that seem necessary in view of feedback it receives from these groups.

The Department of Mental Health and Mental Retardation continues to fund the Forensic Evaluation Training and Research Center as the Center has proved to be most helpful in numerous issues and has demonstrated itself to be an effective instrument in developing a community based system for forensic evaluations and related services. The Center begins its third year with a new director, Mr. W. Lawrence Fitch who, as a lawyer working for the National Center for State Courts in Williamsburg, Virginia, is well acquainted with the issues addressed in this report. He and the rest of the Center's staff will continue to assist the Department in the implementation of Virginia's forensic evaluation system.

REFERENCES

Laben, J.K., Kasgarian, M., Nessa, D.B. & Spencer, L.D. Reform From the Inside: Mental Health Center Evaluations of Competency to Stand Trial, Journal of Community Psychology, 1977 5, 52-62.

McCall, P., Virginia Forensic Hospital Study, Masters of Law Thesis on file with the Institute of Law, Psychiatry and Public Policy, June, 1979.

McGarry, A.L., et al., Competency to Stand Trial and Mental Illness, Washington, D.C.: U.S. Government Printing Office, 1973.

Polythress, N.G. & Retrilla, R., The Quality of Forensic Examinations: An Interdisciplinary Study. Paper presented at the American Psychology-Law Society Biennial Convention, 1979.

Roesch, R. & Golding, S., Competency to Stand Trial, University of Illinois Press, 1980.