An Evaluation of the Toledo Court Diagnostic and Treatment Center: an Experiment in Community Based Forensic Psychiatric Services

by

Nancy J. Beran, Ph.D.
Harry E. Allen, Ph.D.

April 18, 1974

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AN EVALUATION OF THE TOLEDO COURT DIAGNOSTIC AND TREATMENT CENTER: AN EXPERIMENT IN COMMUNITY BASED FORENSIC PSYCHIATRIC SERVICES

by

Nancy J. Beran, Ph.D.
Harry E. Allen, Ph.D.

THE OHIO STATE UNIVERSITY

LETTER OF TRANSMITTAL

April 28, 1974

Mr. Guy C. Nicholson, Acting Commissioner
Division of Forensic Psychiatry
Ohio Department of Mental Health and
Mental Retardation
431 E. Broad Street
Columbus, Ohio 43215

Dear Mr. Nicholson:

In accordance with our contract to provide evaluation services for the Federal Grant Number 2896-00-F4-72, "Expansion of Court Diagnostic and Treatment Center, Toledo, Ohio," we are pleased to submit this Final Report.

Our report, entitled "An Evaluation of the Toledo Court Diagnostic and Treatment Center: An Experiment in Community-Based Forensic Psychiatric Services," details the history, organization and operations of the Toledo unit; the clients served; their follow-up statuses; and the cost-effectiveness of services rendered.

A brief supplemental report will be submitted under separate cover, and will contain the more detailed cost analyses figures requested.

Thank you for allowing us to help in serving the citizens of Ohio.

Yours very truly,

Harry E. Allen

Harry E. Allen, Ph.D.
Director

HEA:fms

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Introduction

Recent years have witnessed an accelerated interest in the mental health and criminal justice fields, respectively, and especially in their common ground which is known most widely as "forensic psychiatry". Particularly noticeable have been the following developments:

1. A growth in research and theoretical debate surrounding the definition and management of criminal insanity, incompetency, and sexual psychopathy. While insanity statutes have been in existence in the United States since the introduction of the M'Naghten Rule in 1843 (and indeed were preshadowed by an irresistible impulse clause introduced into Ohio law in 1834), it was not until the mid-20th century that dissatisfaction with the variants of M'Naghten-Irresistible Impulse rules resulted in the development of new tests of criminal responsibility. In 1954, Judge David Bazelon announced the Durham Rule in the United States Court of Appeals for the District of Columbia, which was closely followed by the American Law Institute Model Penal Code test in 1962. But perhaps the best indicator of the intensity of the dilemma is the fact that the Durham Rule survived only 18 years, being struck down in June, 1972. (See Appendix A.1 for bibliographical listings re: criminal insanity.)

While rules for criminal incompetency originated in common law and have come down through the years almost wholly unchanged, critical analysis of their definition and use has recently emerged. A good deal of criticism has been directed toward many issues ranging from the misuse of criminal incompetency proceedings for avoidance of trial or for finding an "easy way in" to institutions, to the development of checklists for determining incompetency. (See Appendix A.2 for bibliographical listings re: criminal incompetency.)

The sexual psychopath laws are relatively recent on the national scene, gaining general support in America during the middle and late 1930s. Like the Durham Rule, however, sexual psychopath statutes were not in existence very long before they came under serious criticism. Debates have often focused on the definition of psychopathy, the relationship between psychopathy and sexual deviance, and the indeterminate commitment to institutions for the criminally-insane incumbent upon conviction under sexual psychopath laws. (See Appendix A.3 for bibliographical listings re: sexual psychopathy.)

2. The emergence in the 1960s of a strong interdisciplinary emphasis in the social and behavioral sciences. Psychologists, sociologists, social workers, and others have since been stressing the importance of crossing over into one another's field in both "pure" theorizing and "applied" research and fieldwork. Especially visible in the literature is the conceptualization of both criminality and mental illness under the rubric of deviance". Students of deviance have been devoting a great deal of attention to identifying commonalities and differences among the various "deviance definition and management systems", especially the mental health and criminal justice systems. These latter two systems interface in the arena of forensic psychiatry, and thus it is not too surprising that emerging studies in deviance have often focused on this arena. A recurrent theme coming out of this work is that the philosophies and practices of the mental health and criminal justice sytems are frequently contradictory. (See Appendix A.4 for bibliographical listings re: deviance.)

3. The progressive movement of the criminal justice system away from a punitive approach and toward a rehabilitative orientation. A two-sided coin is now evident: on the one hand, efforts have been directed toward "decriminalizing" and "medicalizing" various forms of deviant behavior (including drug and alcohol abuse, prostitution, and homosexuality). On the other hand, clinical personnel are finding increasing representation in the process of administering criminal justice. The most extreme variant of this theme is the proposal for a two-part "trial" system in which guilt or innocence is determined by a jury of peers, but disposition of the convicted by a panel of experts (mainly clinical).

4. The increasingly frequent suggestion that "dangerousness" and "probability of repeating" should be the state's main barometers in defining and managing deviants. Disenchantment with the results of previous corrective and curative efforts, plus growing social-legal concern with constitutional rights led in the 1960s to a focus on the deviant's "threat to the community". This turning of attention from intrapsychic to behavioral variables in large part gained momentum with recent court decisions guaranteeing the "right to treatment". (See Appendix A.5 for bibliographical listings re: dangerousness.)

5. The crystallization in the 1960s of a deep disenchantment with institutionalization as a deviance management technique, and the subsequent espousal of community-based services as a viable alternative. The community mental health movement has been the vanguard of short-term intensive care hospitalization and only as a last resort to treatment in the community. Similarly, community-based corrections has advocated the replacement of incarceration, whenever feasible, by halfway houses, furlough programs, and, of course, probation and parole.

In line with these developments (indeed to many

professionals the most significant development of all) is the recent emergence of court clinics or forensic psychiatric centers. In various sectors of the nation, clinical services have been designed to meet the mental health evaluative and treatment needs of the criminal justice system, from pretrial through presentence to probation and parole. While such programs germinated as early as 1909[1], they have only become widespread in the last few decades. The latest (and perhaps the only) national survey of court psychiatric clinics that could be located by the Program for the Study of Crime and Delinquency was conducted by the eminent forensic psychiatrist, Dr. Manfred Guttmacher. Guttmacher published his findings in 1966, and at that time identified approximately 30 court clinics in the United States. (See Appendix B for more detailed information on the organization and activities of the clinics studied by Guttmacher, and Appendix A.6 for bibliographical listings re: court clinics.) An indicator of developments between 1966 and the present is the fact that, by 1974, the State of Massachusetts alone had 30 court clinics in operation.[2]

The Ohio Experience

In line with national trends, the Ohio Department of Mental Health and Retardation, division of Forensic Psychiatry, has recently inaugurated a program of forensic psychiatric centers. In February, of 1974, centers have been opened in Akron, Cincinnati, Columbus, Dayton, Hamilton, Springfield, and Toledo. Like their counterparts across the nation, Ohio's forensic psychiatric centers have been designed to ease many of the problems in the articulation of mental health and criminal justice systems discussed above. More specifically, it is anticipated that the forensic psychiatric centers will:

1. supplement the evaluative and treatment services of Lima State Hospital (LSH);
2. improve the quality of evaluations and treatment conducted at LSH by virtue of lightening its caseload;
3. provide evaluations to the court in a shorter period of time than required by LSH;
4. provide more thorough and comprehensive evaluation reports than can be provided by LSH by virtue of greater accessibility to offenders' families, friends, employers, and other social agencies;
5. prevent the negative impact upon the offender and his family of institutionalization at LSH;
6. prevent the need to reintegrate offenders released from institutional care;
7. negate the costs incumbent upon institutionalization at LSH;
8. prevent the social, psychological, and economic disruption to the offender, his family, and the community incumbent upon uprooting him from his home and job;
9. ease the time and monetary problems incumbent upon expert testimony in court;
10. provide evaluations, recommendations, and outpatient treatment for probation and parole departments;
11. provide emergency intervention and consultation services for local detention facilities;
12. educate and train local social agents in the identification and management of mentally disordered offenders;
13. identify dangerous or potentially dangerous offenders for the criminal justice system; and
14. reduce recidivism via accurate evaluations and appropriate recommendations and treatment.

These are ambitious demands, but ones that the forensic psychiatric centers were designed to meet in Ohio's continuing efforts to improve the management of the mentally disordered offender.

The Evaluation of Ohio's Forensic Psychiatric Centers

The Ohio Division of Forensic Psychiatry has contracted with the Ohio State University Program for the Study of Crime and Delinquency to evaluate the Toledo, Dayton (and thus also the Springfield) Forensic Psychiatric Centers. The Program for the Study of Crime and Delinquency has agreed to:

1. develop a computer-based record keeping system allowing direct transfer to data cards and statistical analysis and manipulation. After an initial shake-down, this system will be recommended as a "standard" for use at all centers, and center personnel will be trained in the use of the system.
2. gather data at key periods and conduct statistical analyses to determine cost effectiveness, patient profiles, and dispositional information. These analyses will be provided for the center Director's use and for evaluation of the project for the Law Enforcement Assistance Administration.
3. correlate the data from LSH and from other community-based centers in order to determine relative effectiveness of these programs.
4. prepare an annual report on the systems analysis, indicating recommendations for improvement and modification to intake, treatment, and disposition procedures.
5. provide liason to the Ohio State University Federation of Faculty in order to assist development of the community-based center concept.
6. provide general advice and assistance as required to meet the goals of the center.

This document is the annual report on the Program for the Study of Crime and Delinquency's evaluation of the Toledo forensic center, known as the Toledo Court Diagnostic and Treatment Center (CDTC). While the contract period for the fulfillment of the responsibilities outlined above with regard to Toledo dated from March 1, 1973 to February 28, 1974, the Program for the Study of Crime and Delinquency was involved in activities prior to that time that have direct relevance to the Toledo evaluation. In the Autumn of 1972, the Program for the Study of Crime and Delinquency staff and the staff of the Dayton Forensic Psychiatric Center developed a computer-based data collection instrument for use at the Center. The Program for the Study of Crime and Delinquency originally intended to use a slightly modified version of this instrument in its evaluation of the Toledo Center, but shortly after the commencement of that contract period in March of 1973, the Department of Mental Health and Mental Retardation requested that a uniform instrument be developed that could be of use in all divisions of the Department. In response to this request, a series of meetings were held in which staff members of the Program for the Study of Crime and Delinquency coparticipated with representatives of the State Bureau of Statistics, the Division of Forensic Psychiatry, the Dayton Forensic Psychiatric Center, and the Columbus Southwest Mental Health Center. These meetings were designed to take the best of both the Program for the Study of Crime and Delinquency-Dayton Center instrument and the comparable instrument then employed in the Division of Mental Health in arriving at a uniformly applicable instrument.

Five such meetings were held in the Spring and early Summer of 1973. While much valuable interchange occurred, the instrument was still on the drawing board as Summer was coming to an end. At this point, the Program for the Study of Crime and Delinquency had contributed its basic input and withdrew from the larger effort to proceed with what appeared to be the version of the instrument best adapted to the evaluation of the Toledo CDTC, for a full six months of that contract period had elapsed. Indeed, the Program for the Study of Crime and Delinquency contributed to that effort as long as it did in the belief shared with other members of the group than an inordinate amount of subjective confusion can be prevented and extremely valuable data generated by an objective instrument painstakingly constructed with a judicious eye toward all relevant input, and which is also valid and reliable statistically.

The instrument finally employed in data collection at Toledo is reproduced in its entirety in Appendix C. Its purpose was to gather basic information on clients serviced at the Center along the following dimensions: demographic; status within the criminal justice system (current charge, court status, prior juvenile and adult record); history of involvement in the mental health system; referral source and reason for referral (Ascherman, sanity, competency, etc.); processing within the Center (types of evaluations, e.g. psychometric testing, psychiatric interviews, social case histories); evaluations and recommendations of the Center; and court disposition. These data were gathered from the files of the CDTC and from municipal, and county police and court records for every criminal justice system client referred to the Center since its opening in July of 1971 who had at least two contacts with the Center and whose case had been terminated by December of 1973 (N = 433). In addition and for comparative purposes, a similar instrument was developed for gathering data from the files of LSH. (See Appendix D). These data were gathered on a 50% sample of first admission referrals from the same area served by the CDTC (Lucas and Wood Counties) to LSH from 1968 through 1973 (N = 95).

Objective and attitudinal data were also gathered through interviews and questionnaires. Three separate schedules were developed for tapping Center staff, judges, and probation officers, respectively (see Appendices E, F, and G). The CDTC staff schedule gathered information on length of employment at the Center; distribution of times devoted to administration, evaluations and recommendations, and treatment; and perceptions of the goals and performance of the Center, of working relations with referral agents, of typical referrals, of the relation of the Center to LSH, of the strengths and weaknesses of the Center, and so on. The schedules used with judges and probation officers focused largely on perceptions of the goals and performance of the Center. These schedules were used in personal interviews with eight of the 14 Center staff members, three judges, and four probation officers (the latter two groups representing Toledo Municipal and Lucas County Courts and Probation Offices). The questionnaire version of the schedule was mailed to all but two of the remaining Center staff members and to every other Municipal and Common Pleas judge and probation officer in Lucas County (N of mailed questionnaire = 35). In addition, questionnaires were mailed to every member of the Center's Board of Directors (N = 17). The latter schedule solicited information regarding why the individual chose or consented to being a Board member, and perceptions of the Center's goals and performance (see Appendix H).

The balance of the hard data collected includes various reports compiled by the Center and monthly budgetary statements from the opening in July 1971 through November 1973.

Costs.

It should go without saying that the gathering, coding, computerizing, and analyzing of all this data involved large expenditures of time, money, and manpower. The Project Director and a staff of from one to three graduate research assistants made a total of nine trips to Toledo, six of which were overnight trips for one or two consecutive nights, plus four trips to LSH, for a total of 59 full 10-12 hour working days in the field. Besides hard-data collection, the trips to Toledo included numerous conferences with the Director of the Center and his staff. A staff psychologist at the Center worked especially closely with the Program for the Study of Crime and Delinquency team, for an estimated 100 hours. In addition, two students from Toledo University were hired for a total of 40 hours to assist in drawing data from police and court records. The Program for the Study of Crime and Delinquency also hired a computer consultant for 53.8 hours at $8 per hour.

The graduate research assistants with the Program for the Study of Crime and Delinquency who worked on the project included: one MPA student at half-time since the start of the project, one MSW student at three-quarter-time since Autumn 1973, one Ph.D. public administration student at half-time for all but two months since Autumn 1973, and one undergraduate SW student at half-time since mid-January 1974. The Project Director for the first four months of the study is a Ph.D. candidate research associate with the Program for the Study of Crime and Delinquency who devoted 23% of his time to the study; the Project Director for the duration is a Ph.D. research associate with the Program for the Study of Crime and Delinquency who was technically responsible for the project on a half-time basis. In actual fact, the latter Project Director increased time devoted to the study to three-quarter time in October 1973 and to 95% time in December 1973 through this writing. And finally, the Director of the Program for the Study of Crime and Delinquency has been involved in a total of 13 meetings or trips related to the Division of Forensic Psychiatry since the beginning of the current fiscal year, and all of these related either directly or indirectly to the Forensic Psychiatric Centers project. The total cost of this project is at least $29,569.

The History, Organization and Operation of the Toledo Court Diagnostic and Treatment Center

The Toledo Court Diagnostic and Treatment Center was established in April of 1971 through the combined efforts of the Ohio Law Enforcement Planning Agency, the Lucas County Mental Health and Retardation Board, the Adult Courts of Lucas and Wood Counties, and their respective Probation Department heads. The local 648 Board, which administered the creation of the Center, was firmly committed to the development of an autonomous organization. As a result, a 20 member Board of Directors was formed to rule on all major policy and funding decisions, and the agency was incorporated in September of 1972.

Funding for the first fiscal year of operation (1971-72) was distributed on a 60% - 40% basis between OLEPA (AJD) and the Lucas County 648 Board, and totaled $82,500. The Ohio Division of Forensic Psychiatry began funding the Center in 1973, contributing three percent of the total $169,500 for the fiscal year 1972-73. The balance was distributed on a 71% - 26% basis between AJD and the 648 Board. Funding for fiscal year 1973-74 totals $225,400, of which 51% is from AJD, 23% from the 648 Board, and the remaining 27% from the Division of Forensic Psychiatry.

The CDTC's November 1973 Long Range Planning Report states that the goal of the agency is "to reduce the incidence of reoccurring anti-social behavior through proper evaluation and treatment of the adult offender; as well as to assist the courts in identifying those offenders who are of increasing or continuing danger to the community" (p. 1). Correlatively, the function of the agency is "to provide, or make available through referral to other agencies, the full range of mental health services that are designed to meet the specialized needs of the adult offender" (p. 1). These services are offered not only to all adult criminal courts of Lucas and Wood Counties, but also to local detention facilities. (Toledo is located in Lucas County; Wood County is the adjacent county to the south.)

Table I (see p.6) presents statistics on the Center's caseload from July 1971, when clients were first received, through December 1973. A rapid and steady expansion is indicated, from 77 cases processed in the last six months of 1971 to a total of 491 in 1973. In all, the Center has managed 869 cases in its two-and-one-half years of operation. The November 1973 Long Range Planning Report states that approximately 50 cases per month (or 600 per year) appears to be the maximum caseload feasible if standards of performance are to be maintained with current staff.

It is important to note that the Center, since its inception, has served not only the criminal justice system but also the Lucas County civil Probate Court. While 10% of operting time was originally allocated to conducting mental status evaluations for the Probate Court, the figures in Table I suggest that greater percentages of time have in fact been devoted to these cases. A total of 152 probate referrals, or 17% of the total caseload of 869, have been seen at the Center since its opening. Furthermore, the number has steadily incresed, from six (8%) in 1971 to 113 (23%) in 1973. While the Center staff report that a probate referral takes

less evaluation time on the average than a criminal justice system referral, they nevertheless concur that probate cases are occupying an excess of 10% of their time. Indeed, the question of how many probate referrals should be accepted was found by the Program for the Study of Crime and Delinquency team to be a topic of discussion among some of those involved with the CDTC.

In any event, the number of criminal justice system cases handled at the Center has also risen sharply over time, from 71 in 1971, to 268 in 1972 and 378 in 1973, for a total of 717. The Director estimates that, on the average, approximately 50% of these referrals have come from Toledo Municipal Court, 45% from Lucas County Common Pleas Court, and 5% from outlying areas in Lucas County and from Wood County, the latter reportedly representing very few cases.

The CDTC staff has grown from the Executive Director, one psychiatric consultant, one psychologist, one psychological consultant, one social worker, one accounting clerk (half-time) and one clerk typist in 1971 to the Director, an administrative assistant, two psychiatric consultants, four psychologists (one half-time), three social workers, one social work consultant, a vocational rehabilitation counselor, and an outreach worker, plus an accounting clerk and three clerk typists at the time of this writing. The psychologists on the staff currently include two Ph.D.s, one ABD, and one MA (with a year's graduate work in psychology and the MA in rehabilitative counseling). The social workers (excluding the Director who is an MSW) include one MSW (with further education), two MSWs, and one BA. The rehabilitation counselor is an M.Ed. and the outreach worker has three years toward a college degree.

The Program for the Study of Crime and Delinquency team personally interviewed eight of the 14 Center staff members (the Director, the administrative assistant, one psychiatric consultant, two psychologists, two social workers, and one rehabilitation counselor) and obtained mailed questionnaires from three others (the other psychiatric consultant, one of the other two psychologists, and the other full-time social worker), for a total of eleven. The remaining psychologist was not querried since he had only been on the staff since September of 1973; the social work consultant's questionnnaire was misaddressed by the Program for the Study of Crime and Delinquency team and the error was not discovered in sufficient time to obtain his input; and the outreach worker (who was terminating his affiliation with the CDTC the week of the interviewing) missed two interview appointments with the Program for the Study of Crime and Delinquency team. The 11 from whom the Program for the Study of Crime and Delinquency obtained information ranged from five months to two and one-half years (the maximum possible) of inservice time at the CDTC, for a mean of 18.4 months. Those who were not full-time employees ranged from 5-20 hours/week of time devoted to the Center. The ten staff members for whom demographic data are available are predominantly male, between 21-40 years of age, with post-graduate work or degrees, and with prior experience in the mental health and/or criminal justice systems.

The 11 staff members questioned were asked how much time they spend in an average week on administration, evaluation, treatment, staff training, and research (see Table II, p.6). Nine reported at least some time devoted to evaluations, eight to administration and to treatment, three to staff training, and one to research. Based on these figures, total-house time investments range from evaluation (52.7%), to administration (26.5%), to treatment (11.8%), to staff training (7.7%), and finally to research (1.2%). If, however, the predominately administrative duties of the Director and the administrative assistant are deleted from these figures, the time investments for the remainder of the professional staff are 64.4% time in evaluation, 13.9% in treatment, 10.8% in administration, 9.4% in staff training, and 1.4% in research. Staff training is quite logically engaged in by those with higher professional qualifications and/or greater experience and is directed toward those with lower professional qualifications and/or lesser experience. Research is being conducted by a staff psychologist who is evaluating the Center as her dissertation topic at Toledo University.

The Director of the CDTC has developed a client flow chart which depicts procedural movement through the Center (see Figure 1, p. 7 . The Center accepts referrals from Municipal, Common Pleas, and Federal Courts, and defines probation, parole, and detention cases as coming officially under the aegis of the courts. Criminal justice system referrals thus include pretrial, presentence, and post-sentence cases. Reasons for referral cover the gamut, though they can be roughly categorized into two groups: evaluation and treatment. Referrals for evaluation include evaluation of competency to stand trial; of sanity at the time of alleged commission of the act; of Ascherman candidacy as mentally ill, mentally retarded, or psychopathic; of dangerousness; of probability of repeating; of amenability to treatment; of probation risk; plus many others. Referrals for treatment are court orders or requests to enroll the individual in a CDTC treatment program.

In a written statement in the Spring of 1973, the Director of the CDTC stated the following priorities of the Center:

"1. To evaluate all offenders, e.g. Ascherman Act cases, whose crimes are blatantly anti-social, since these represent the greatest and most immediate threat to the community.

2. To encourage referral by adult court personnel of the more routine offender who exhibits a strong potential for increasingly assaultive or anti-social behavior. Identification of this type of client is currently accomplished by

TABLE I

Court Diagnostic and Treatment Center Population By Year

	Total Pop. N	Probate Pop. N	Probate Pop. %	CJS Pop. N	CJS Pop. %
7/71-12/71	(77)	(6)	8	(71)	92
1972	(301)	(33)	11	(268)	89
1973	(491)	(113)	23	(378)	77
7/71-12/73	(869)	(152)	17	(717)	83

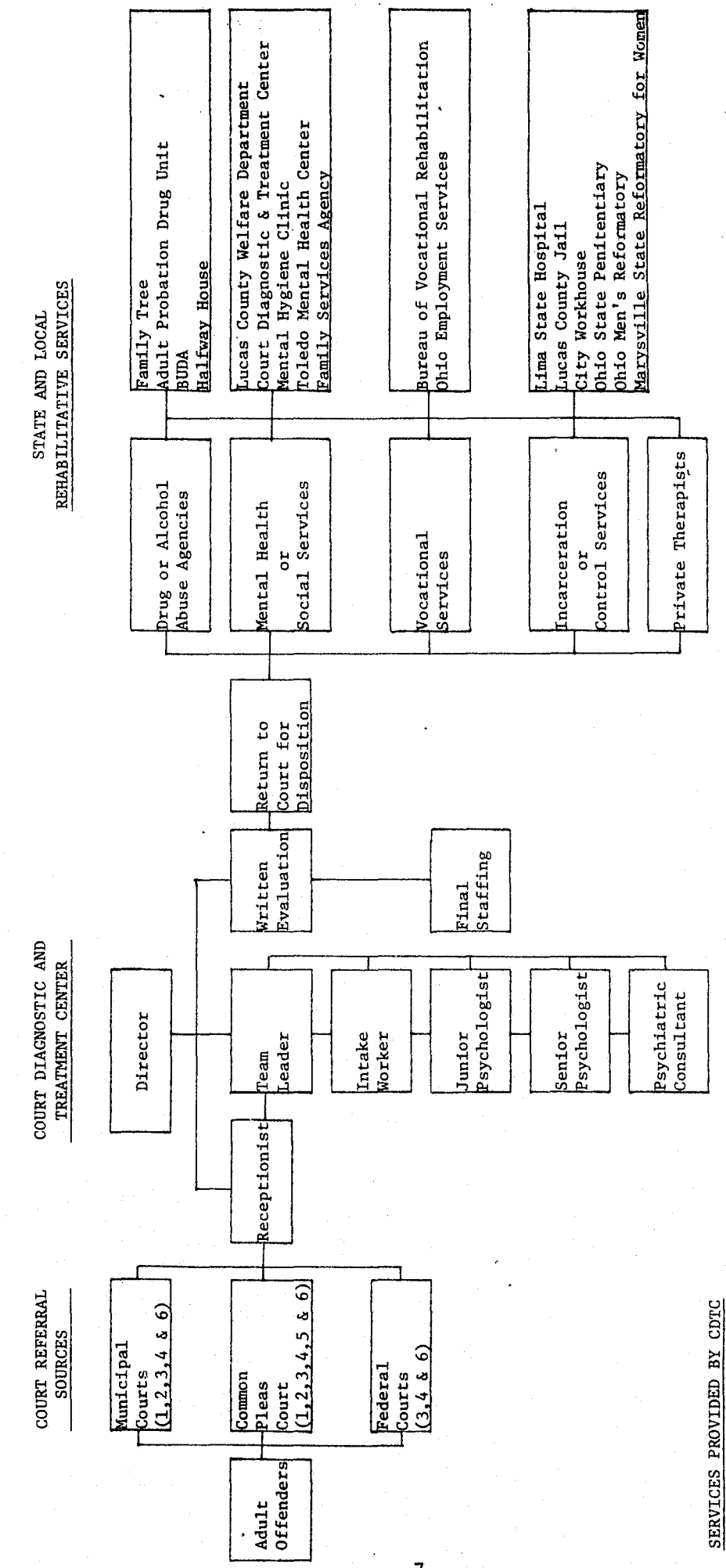
TABLE II

CDTC Staff: Percent of Time Devoted to Various Activities

	Total House		Without Director and Admin. Assistant	
	%	N	%	N
Administration	26.5	(8)	10.8	(6)
Evaluation/ Recommendations	52.7	(9)	64.4	(9)
Treatment	11.8	(8)	13.9	(7)
Staff Training	7.7	(3)	9.4	(3)
Research	1.2	(1)	1.4	(1)

FIGURE 1

CLIENT FLOW CHART



SERVICES PROVIDED BY CDTC

1. Pre-trial sanity evaluation
2. Post conviction complete psycho-social medical evaluation & treatment recommendations
3. Post probation differential evaluation & treatment recommendations
4. Treatment planning consultation
5. Non-criminal sanity evaluations for Probate Court
6. Short term individual, marital, family, or group therapy

broad circulation to all Court personnel of the following criteria -

'Special attention will be given those clients whose offenses reflect any or all of the following:
(a) Crimes against people, where actual or threatened bodily injury occurs.
(b) Offenses which manifest an increasing progression of severity, e.g. from shoplifting to burglary to assault.
(c) A routine appearing offense which contains an incongruent or totally irrational element, i.e., the client compounds the initial minor offense by becoming assaultive or by exhibiting some form of bizarre behavior.'"

Services provided at the Center can be roughly grouped into "evaluation" and "treatment". Evaluative techniques include medical and/or neurological examinations, individual clinical interviews, social case history compilations, and psychometric testing. The latter includes assessments of intellectual functioning (WAIS), personality tests (Rorschach, MMPI/CPI[3], TAT, DAP, Rotter), measures of neurological dysfunctioning (Bender-Gestalt, Graham-Kendall, Halstead, Wescher Memory), and vocational tests (Edwards). Treatment provided at the Center includes individual psychotherapy, marital counseling, and various group therapies, including a couples/sex offender group, a group for severely anti-social individuals, a group for mildly anti-social individuals, a general resocialization group for drug/alcohol abusers, a slow learners group, and a group conducted at the local workhouse. The Center states as one of its objectives: "To complete all evaluations within 30 days and, if probated, their enrollment in an appropriate treatment program (if needed) within two weeks following the court hearing."

The staff members who conduct evaluations and treatment (largely psychologists and social workers) are divided into two teams. While a given client is primarily the responsibility of one team member, every case has both an initial and final "staffing", at which time all team members discuss the case and arrive at a group decision re: evaluation, treatment and recommendation. One of the Center's objectives reads, in part: "To increase the active participation and informational input of probation officers in the evaluation and treatment process by . . . inviting and encouraging their regular attendance at final staff meetings involving their respective clients."

Based on the conclusions of the final staffing, a final report is compiled and forwarded to the referral agent. This report summarizes the CDTC's evaluation and includes any recommendations requested or offered. Recommendations range from incarceration to enrollment in a community treatment program.

The Program for the Study of Crime and Delinquency team interviewed three Toledo Municipal and Lucas County probation officers, and mailed questionnaires to every other Toledo Municipal and Lucas County probation officer (N = 19). Nine (47%) of the latter returned the questionnaire, for a total of 12 successfully contacted. Interviews were also conducted with three, and questionnaires mailed to every other Toledo Municipal and Lucas County judge. Three of fourteen (21%) returned the questionnaire, for a total of six successfully contacted. The probation officers questioned averaged 4.1 years as probation officers in the area, and the judges averaged 10 years (N = 3) on the Common Pleas bench and 4.3 years (N = 3) on the Municipal bench.

For comparative purposes, variations of the same questions were asked of all three samples (CDTC staff, probation officers, and judges). While the judges and probation officers indicated to the Program for the Study of Crime and Delinquency team an accurate understanding of the goals and purposes of the Center, CDTC staff indicated some disenchantment in this regard. When asked to rank how well the various referral agents understand the purposes of the Center on a scale from 1 (Very well) to 5 (Not well at all) the ten Center staff responding gave an average rank of 2.7. The Program for the Study of Crime and Delinquency sees four possible explanations for the discrepancy: (1) three CDTC staff members discriminated between Common Pleas and Municipal probation officers, ranking the former well and the latter not well, and therefore averaging out in the middle; (2) three CDTC staff members ranked non-criminal justice system social agencies poorly, pulling the overall mean in that direction; (3) some references were made to improvements over time, suggesting a mean rank may have pulled down current status; and (4) the probation officers and judges responding may represent those more positively oriented toward and most well-informed about the Center.

All three samples were then asked to rank their working relations with one another on a scale from 1 (Very good) to 5 (Very bad). The judges and probation officers ranked their relations with the Center 1.3 and 1.8 respectively. The Center staff again ranked their relations with the various referral agents lower, at 2.3. The same possible explanations for the discrepancies cited in the previous paragraph are applicable here. In both instances, of course, the suggestion remains that CDTC staff are less satisfied with the current state of affairs than are the judges and probation officers.

The Clients and Their Movement Through the System: Comparisons of the CDTC and LSH

Caseloads

As mentioned above, the Program for the Study of Crime and Delinquency (PSCD) team gathered extensive data from the files of the CDTC and from municipal and county police and court records on every CJS client referred to the Center since its opening in July of 1971 who had at least two contacts with the Center and whose case had been terminated by December of 1973 (N = 433).[4] As Table III (see p.10) indicates, the PSCD-CDTC sample of 433 represents 85% of the 1971 CJS cases, 82% of 1972, and 41% of 1973.[5] The missing cases in 1971 and 1972 are clients who had only one contact with the CDTC (one visit, one telephone call, etc.) and were therefore not evaluated or treated. The missing cases in 1973 are one-contact clients and/or those whose cases had not been terminated by December of 1973 (evaluation or treatment procedures still underway at that time).

Data were also gathered on a 50% sample of first admission referrals from Lucas and Wood Counties to LSH from January 1, 1968 through December 31, 1973 (N = 95). The sample was restricted to first admissions in an attempt to screen out indefinite commitments who could not be meaningfully compared with the CDTC sample. The total number of new referrals received at LSH from the two counties within this time frame was 190. Since 81 of the sample of 95 (85%) were admitted to LSH prior to July 1, 1971, it is a fair estimate that 162 total cases were received from Lucas and Wood Counties the three-and-one-half years prior to the opening of the CDTC. Likewise, approximately 28 were admitted to LSH during the first two-and-one-half years of the Center's operation. The sample of 95 contained 26 cases admitted in 1968; it is therefore likely that 52 total cases were received in 1968. If these 52 are deleted from the total 162 likely seen at LSH between 1968 and July 1971, it is possible to compare the first 2 1/2 years immediately prior to its opening. The comparison reveals that LSH was receiving an average of 44 new cases a year from Lucas and Wood Counties the 2 1/2 years before the CDTC opened, compared to 11 new cases a year during the first 2 1/2 years the Center has been in operation.

Attention should also be directed to the fact that the CDTC served 3.9 times as many new cases from Lucas and Wood Counties in its first 2 1/2 years of operation than LSH did in the 2 1/2 years immediately prior to the Center's opening. Thus the CDTC is apparently providing services not only for most of the clients who would previously have gone to LSH but also for a large number of individuals who would previously have received no forensic psychiatric services at all.

It is interesting to note further that only nine cases or 9% of the LSH sample of 95 were referred from Wood County. By the same token, Wood County referrals constituted only 3% (11 of 428) of the CDTC sample. Five of the nine Wood County-LSH cases were referred in the 2 1/2 years prior to the opening of the CDTC and three in the 2 1/2 year period after. Thus it is clear that Wood County reduced its first admission referrals to LSH by 40% since the CDTC opened, and has referred more new cases to the Center in 2 1/2 years than it did to LSH in six years. While this is a finding of import, denoting greater confidence in the CDTC than in LSH on the part of Wood County courts, of greater significance is the fact that Wood County courts make very few referrals to either agency.

Demographic Characteristics

Table IV (see p.11) summarizes the demographic characteristics of the CDTC and LSH clients. Males far outnumber females in both samples, though even more so in the LSH group, 93% of whom are male, compared to 84% of the CDTC sample. Both groups are relatively young; each has their greatest representation in the age bracket 21-30 (CDTC = 46%, LSH = 41%), their second greatest in the category under 21 (CDTC = 31%, LSH = 23%), and their third greatest between 31-40 (CDTC = 11%, LSH = 22%). Whites outnumber blacks three-to-one in both samples (CDTC = 75%, LSH = 74%). Similarity is equally evident with regard to marital status. The modal category in both groups is occupied by those never married, who constitute 48% of the CDTC sample and 44% of the LSH sample. If the divorced and separated are added to those never married, 65% of each sample fall into the category of "deviant" marital statuses. Thirty-two percent of the CDTC sample and 31% of the LSH sample are married or remarried.

Occupationally, the modal group in both samples is composed of laborers. While the CDTC's 58% is considerably lower than LSH's 86%, the number of people for whom occupational information was available in the Toledo sample was relatively low. With regard to education, 52% of the CDTC sample has not completed high school, compared to 77% of the LSH group. Correlatively, 29% of the CDTC sample and only 20% of the LSH sample have a high school education, but no additional degree. Twelve percent of the CDTC clients has some post-high school educational achievement, compared to only 3% of the LSH sample.

In summary, the average client of both the CDTC and LSH is a young, white, unmarried male, who has not completed high school and who is employed as a laborer. The CDTC client, however, is more likely than his LSH counterpart to have received, at the least, a high school diploma, and to be employed in a nonlabor capacity.

History in the Criminal Justice and Mental Health Systems

Table V (see p. 12) indicates the status of both samples with regard to juvenile record. Only

TABLE III

CDTC and LSH Populations and PSCD Samples

	CDTC Total Pop. N	CDTC Probate Pop. N	CDTC Probate Pop. %	CDTC CJS Pop. N	CDTC CJS Pop. %	PSCD-CDTC Sample N	PSCD-CDTC Sample %	PSCD-LSH 50% Sample N	LSH Lucas-Wood Cty Projected Pop. N
1968	-	-	-	-	-	-	-	(26)	(52)
1/69-6/71	-	-	-	-	-	-	-	(55)	(110)
1/68-6/71	-	-	-	-	-	-	-	(81)	(162)
7/71-12/71	(77)	(6)	8	(71)	92	(60)	85	-	-
1972	(301)	(33)	11	(268)	89	(219)	82	-	-
1973	(491)	(113)	23	(378)	77	(154)	41	-	-
7/71-12/73	(869)	(152)	17	(717)	83	(433)	60	(14)	(28)

TABLE IV

Demographic Characteristics of CDTC and LSH Samples

		CDTC		LSH		Total	
		%	N	%	N	%	N
Sex	Male	84	(364)	93	(88)	85	(452)
	Female	15	(67)	7	(7)	14	(74)
			(431)		(95)		(526)
Age	Under 21	31	(135)	23	(22)	30	(157)
	21-30	46	(260)	41	(39)	45	(239)
	31-40	11	(49)	22	(21)	13	(70)
			(384)		(82)		(466)
Race	White	74	(322)	75	(71)	74	(393)
	Black	23	(101)	25	(24)	24	(125)
			(423)		(95)		(518)
Mar. St.	Mar./Remar.	32	(141)	31	(29)	32	(170)
	N. Mar.	48	(207)	44	(42)	47	(249)
	NM, Div, Sep.	65	(282)	65	(65)	66	(347)
			(423)		(94)		(517)
Occ.	Labor	58	(253)	86	(82)	63	(335)
	Pr./Semi-Pr.	5	(20)	4	(4)	5	(24)
			(273)		(86)		(359)
Ed.	0-11	52	(227)	77	(73)	57	(300)
	HS/GED	29	(124)	20	(19)	27	(143)
	Post HS	12	(52)	3	(3)	10	(55)
			(403)		(95)		(498)

TABLE V

Juvenile Record for CDTC and LSH Samples

	Yes		No	
	%	N	%	N
CDTC	25	(109)	75	(325)
LSH	56	(53)	44	(42)
Total		(162)		(367)

TABLE VI

Prior Arrests For CDTC and LSH Samples

	Total						Collapsed					
	CDTC		LSH		Total		CDTC		LSH		Total	
	%	N	%	N	%	N	%	N	%	N	%	N
Sexual	13	(45)	14	(15)	13	(60)	20	(43)	23	(15)	20	(58)
Nonsexual Pers.	13	(45)	12	(12)	12	(57)	16	(36)	17	(11)	17	(47)
Property	29	(101)	40	(43)	31	(144)	32	(71)	47	(30)	36	(101)
Drug	17	(61)	3	(3)	14	(64)	9	(20)	2	(1)	7	(21)
Public Order	17	(61)	15	(16)	17	(77)	14	(31)	5	(3)	12	(34)
Other	12	(41)	17	(18)	13	(59)	9	(19)	6	(4)	8	(23)
Total		(354)		(107)		(461)		(220)		(64)		(284)

25% of the CDTC sample has a juvenile record compared to 56% of the LSH sample. Furthermore, 67% of the LSH group and only 51% of the CDTC group has at least one prior arrest as an adult;[6] Table VI (see p. 11) depicts prior arrests for both samples by crime category. A total of 220 clients within the CDTC sample have been arrested for a total of 354 offenses, or a mean of 1.6 prior offenses per offender. This compares with 64 in the LSH sample who have been arrested for 107 total offenses, or a mean of 1.7 prior offenses per offender.

It will be noted that Table VI contains not only an offense category breakdown for all prior arrests, but also a "collapsed" breakdown in which each offender with a prior arrest record (single or multiple arrests) appears in only one offense category. The data were collapsed to enhance their interpretive value by placing offenders with multiple prior arrests into the category which includes the most serious offense for which they have been arrested in the past. The PSCD team is fully cognizant of the fact that definitions of relative seriousness are at best value judgements and at worst arbitrary. But it is necessary nevertheless ss to develop some hierarchy of seriousness if analysis of the client's progression or regression over time is to move beyond a mere simplistic statement of whether or not he recidivated. Measures of relative adjustment, while sometimes far from sophisticated, at least identify some gradations between categorical success and categorical failure, and thus enable some assessment of the relative impact of ameliorative programs.

With the aim of at least attempting to measure relative adjustment of clients and relative effectiveness of forensic psychiatric centers, offense categories were ranked from most serious to least serious as follows:

1. sexual
2. nonsexual personal
3. property
4. drug
5. public order
6. other

The PSCD team is not without reservations regarding this rank-order. Voyeurism is ranked higher than murder, and assault and battery higher than burglary or grand larceny. But the consensus of opinion was that, generally speaking, prevailing public attitudes rank the body as a sexual object higher than the body as a non-sexual object, which in turn is ranked higher than material possessions or claims. While the drug problem is of heightened concern on the contemporary scene, much of this behavior falls within the "victimless or willing victim" category. Public order offenses, such as vagrancy and loitering, are perceived to have minimal threat value, and indeed are often visible only to the the arresting officer. "Other is a miscellaneous category for all offenses not clearly under one of the preceding rubrics.

Returning to the discussion of prior arrests within the CDTC and LSH samples, Table VI reveals that when offenses are collapsed, 87% of the LSH clients with prior arrests fall into the three most serious offense categories, compared to 68% of the CDTC's prior offenders. Correlatively, the latter group is more highly represented in the drug, public order, and "other" categories. The modal category of prior arrests in both groups is property offenses, followed by nonsexual personal and sexual offenses, respectively.

Comparing the collapsed data with the total data reveals that the LSH sample still has a higher percentage in the top three categories than does the CDTC sample (66% to 55%), but while the LSH percent representation declines 21%, Toledo's declines only 13%. While the modal category for both groups remains property offenses, second and third place shift to less serious offenses. And finally, the CDTC sample moves ahead of LSH in nonsexual personal offenses, comes within one percent of LSH in sexual offenses, and takes an even greater lead than before in drug offenses. In summary, the LSH sample consistently exhibits a more serious prior arrest record overall, though the total data exercises an equalizing effect over the collapsed data.

Data were also gathered on prior incarcerations in the CJS. Twenty-two percent of the CDTC sample has at least one prior incarceration compared to 36% of the LSH sample. Table VII (see p. 14) displays the breakdown of prior incarcerations, and indicates that the modal category in both samples is misdemeanor incarcerations. The LSH sample, however, has a larger percentage of prior felony incarcerations than does the CDTC sample (38% to 23%).

Table VIII (see p.14) summarizes the data on histories of involvement in the mental health system for both samples. A rank ordering of seriousness was again imposed on the data to facilitate further analysis, and proceeds from most serious to least serious as follows:

1. inpatient, institution for mentally disordered offenders
2. inpatient, civil mental institution
3. outpatient
4. unclassifiable treatment

There were no multiple histories to collapse in the LSH sample, so Table VIII presents collapsed data only for the CDTC sample, but uses these figures as the basis for comparison since they correspond to the "one prior per person" characteristic of the LSH uncollapsed data.

Thirty-four percent of the CDTC sample (N = 148) has a mental health history of at least one series of treatments, compared to only 25% of the LSH sample (N = 24). But 96% (all but one) of the latter group fall into the inpatient category and none fall into the outpatient category. Toledo, on the other hand, has 34% of its clients with mental health

TABLE VII

Prior Incarcerations for CDTC and LSH Samples

	CDTC		LSH		Total	
	%	N	%	N	%.	N
Felony	23	(22)	38	(13)	27	(35)
Misdemeanor	53	(51)	44	(15)	51	(66)
Fel. & Misd.	7	(7)	15	(5)	9	(12)
Unclass. prior	17	(16)	3	(1)	13	(17)
Total		(96)		(34)		(130)

TABLE VIII

Prior Incarcerations for CDTC and LSH Samples

	CDTC				LSH		Total	
	Uncollapsed		Collapsed[a]		Uncollapsed[b]		a & b	
	%	N	%	N	%	N	%	N
Inpt. MD eff.	10	(16)	11	(16)	-	-	9	(16)
Inpt. Civil	41	(69)	43	(63)	96	(23)	50	(86)
Outpt.	38	(63)	34	(51)	-	-	30	(51)
Unclass. Treat.	12	(20)	12	(18)	4	(1)	11	(19)
Total		(168)		(148)		(24)		(172)

histories in the outpatient category (and only 43% in inpatient). What this suggests is that LSH officials may restrict their compilation of mental health histories to prior inpatient treatments. If this were the case, then a more accurate comparison would be obtained by deleting the CDTC clients with prior outpatient treatments. This brings the total of those with mental health histories in the CDTC sample down to 22%, and boosts the prior inpatient up to 65%. The LSH sample, coincidentally, by definition has no priors in the mentally disordered offender category since the sample drew only from first admissions to LSH. (Of course a client could have had a history of institutionalization as a mentally disordered offender in another jurisdiction, but this did not occur.) The uncollapsed data for the CDTC sample indicates that the 148 clients with mental health histories accounted for a total of 168 prior treatment episodes.

Data on juvenile record, prior arrests, prior incarcerations, and history of involvement in the mental health system for both samples are summarized in Table IX (see p.16). The LSH sample clearly exceeds the Toledo sample in percentages with juvenile records, prior arrests, and prior incarcerations. Only in mental health treatment history does the CDTC sample exceed the LSH sample, and these figures are subject to serious qualifications just discussed. In essence, the data strongly suggest that LSH receives a more chronic mentally disordered offender than does the CDTC, and one whose mental disorder and whose offense are both more serious than those of his Toledo counterpart.

This is a difficult finding to interpret given the sharp decline in referrals to LSH from Lucas and Wood Counties when the CDTC opened and the subsequent probability that the Center has been receiving the clients who would previously have been LSH candidates. There is the distinct possibility that LSH's records are more thorough with regard to prior involvement in the criminal justice system and that the difference between the samples are thus more apparent than real. But the most obvious hypothesis is that the differences are very real yet attributable to the fact that LSH's referrals are exclusively Ascherman and competency/sanity evaluations while the CDTC receives many more less serious cases along with its Ascherman and competency/sanity evaluations. The earlier observation that the CDTC served 3.9 times as many cases from Lucas and Wood Counties in its first 2 1/2 years of operation than LSH did in the 2 1/2 years immediately prior to the Center's opening certainly suggests that the CDTC is accepting clients who previously would have received no referral anywhere. These are likely the less serious cases, and they would serve to load the sample statistics toward less serious prior records.

Table X (see p. 16) depicts the relationship of Toledo's Ascherman and competency/sanity referrals to both the LSH sample and the total CDTC sample with regard to prior record. The CDTC's Ascherman and competency/sanity population has a lower percentage of both juvenile records and prior arrests, an identical percentage of prior incarcerations, and a greater percentage of mental health histories than the LSH sample. The 15 who have mental health histories total 19 previous series of treatments, and 74% of these were inpatient treatments. On the other hand, the CDTC's Ascherman and competency/sanity population has a greater percentage of prior arrests, prior incarcerations, and prior mental health treatments than the total CDTC group, and an identical percentage of juvenile records. Thus in the final analysis, Toledo's Ascherman and competency/sanity referrals are more serious cases than the CDTC group as a whole, but slightly less serious than the LSH sample.

Current Status

Data on current offense for both samples are presented in Table XI (see p. 17). "Current offense" is defined as the most recent offense; in some cases the individual has only been charged with the offense, in others he has been convicted of the offense. As with prior arrests, current offenses have been collapsed by placing each offender in the offense category which includes the most serious offense in his current incident on a rank-order scale from sexual through "other" offenses.

An examination of data in Table XI reveals that 94% of the LSH clients fall into the three most serious offense categoires (sexual, nonsexual personal, and property), compared to 69% of the CDTC sample. The modal category for the LSH sample is property offenses (39%), followed by nonsexual personal (32%) and sexual (23%). The Toledo sample, on the other hand, has a tie for first position between sexual and property (26% each), with drug offenses occupying the second position (19%) and nonsexual personal third (17%). While LSH's percentages exceed the CDTC sample in both property and nonsexual personal categories, Toledo is ahead of LSH in sex offenses, and far ahead in drug offenses (indeed, the LSH sample does not include a single drug case).

When the data are uncollapsed, the LSH sample adds only one offense (a nonsexual personal). This suggests that LSH officials do not record multiple offenses, particularly in light of the fact that the CDTC data increases by 35 offenses, or a total of 440 for the 405 clients for whom information on current offense was available. The relative percentages change very little, however. So in summary, current offenses display a mixed picture, with property and nonsexual personal offenses highest among the LSH sample, and property, sexual, and drug offenses highest among the CDTC sample.

With regard to the specific reason for referral to the CDTC or to LSH, Table XII (see p. 18) indicates that 70% of the LSH sample was referred for Ascherman 60-day presentence evaluations, and that 18 of these 70% were then returned as post-sentence indefinite commitments. Eight percent were

TABLE IX

Overview of Prior Records for CDTC and LSH Samples

	CDTC				LSH				Total			
	Yes		No		Yes		No		Yes		No	
	%	N	%	N	%	N	%	N	%	N	%	N
Juv. Rec.	25	(109)	75	(325)	56	(53)	44	(42)	31	(162)	69	(367)
Arrests	51	(220)	49	(214)	67	(64)	33	(31)	54	(284)	46	(245)
Incar	22	(96)	78	(338)	36	(34)	64	(61)	25	(130)	75	(399)
MH Treat.	34	(148)	66	(286)	25	(24)	75	(71)	33	(172)	67	(357)

TABLE X

Prior Records of CDTC Ascherman and Competency Referrals Compared With Prior Records of Total CDTC and LSH Samples

	Total CDTC				CDTC Aschs. And Comp/Sans.				LSH			
	Yes		No		Yes		No		Yes		No	
	%	N	%	N	%	N	%	N	%	N	%	N
Juv. Rec.	25	(109)	75	(325)	25	(9)	75	(27)	56	(33)	44	(42)
Arrests	51	(220)	49	(214)	56	(20)	44	(16)	67	(64)	33	(31)
Incars.	22	(96)	78	(338)	36	(13)	64	(23)	36	(34)	64	(61)
MH Treat.	34	(148)	66	(286)	42	(15)	58	(21)	25	(24)	75	(71)

TABLE XI

Current Offense for CDTC and LSH Samples

	Total						Collapsed					
	CDTC		LSH		Total		CDTC		LSH		Total	
	%	N	%	N	%	N	%	N	%	N	%	N
Sexual	24	(106)	23	(22)	24	(128)	26	(106)	23	(22)	26	(129)
Nonsex. Pers.	17	(73)	32	(31)	19	(104)	17	(68)	32	(30)	20	(98)
Property	26	(113)	39	(37)	28	(150)	26	(105)	39	(37)	28	(140)
Drug	18	(81)	-	-	15	(81)	19	(77)	-	-	16	(78)
Public Order	4	(18)	-	-	3	(18)	3	(12)	-	-	2	(12)
Other	11	(49)	6	(6)	10	(55)	9	(37)	6	(6)	9	(43)
Total		(440)		(96)		(531)		(405)		(95)		(500)

TABLE XII

Reason for Referral for CDTC and LSH Samples

	CDTC		LSH		Total	
	%	N	%	N	%	N
Asch. 60 day	5	(20)	52	(49)	13	(69)
Asch. Pre-Post	-	-	18	(17)	3	(17)
Asch. Indef.	-	-	8	(8)	2	(8)
				(74)		(94)
Comp/San. 30 day	4	(16)	17	(16)	6	(32)
Comp/San. Pre-Post	-	-	4	(4)	1	(4)
Comp/San. Indef.	-	-	1	(1)	-1	(1)
				(21)		(37)
General Eval.	57	(244)	-	-	46	(244)
Treatment Eval.	24	(104)	-	-	20	(104)
Treatment Admin.	11	(46)	-	-	9	(46)
		(430)		(95)		(525)

indefinite commitments when they first entered the sample of first admissions drawn by the PSCD team. These eight cases were either (1) incorrectly recorded by LSH as first admissions, or (2) evaluated elsewhere than at LSH in the presentence phase of their processing. In any event, a total of 78% of the LSH sample were referred under the Ascherman Act. Another 21% were referred for 30-day competency/sanity evaluations, and 4 of these 21% were returned as incompetent/insane. (One of the competency/sanity cases was later returned for an Ascherman evaluation.) As with the Ascherman referrals, one competency/sanity case was a first-admission indeterminate commitment, bringing the total percentage of competency/sanity referrals to 22%.

In sharp contrast to LSH, though in part due to selective sampling procedures and to the fact that Ascherman and competency/sanity referrals were not formally accepted prior to funding by the Division of Forensic Psychiatry in early 1973, only 5% of the CDTC referrals were for Ascherman evaluations and only 4% for competency/sanity evaluation. The modal category of referrals (57%) were for "general evaluations" which typically represents an evaluation for probation candidacy . A total of 89% of the CDTC's referrals were for evaluation and 11% for treatment administration. If the treatment evaluation referrals (in essence evaluations for CDTC treatment candidacy) are added to the 11%, a total of 35% of the CDTC's cases are treatment related. By the same token, 90% of LSH's referrals were for evaluation, 22% of which were later returned for treatment administration. If the 9% first admission indefinite commitments are added to the 22%, a total of 31% of LSH's cases are treatment related. It must be again remembered, however, that the LSH sample was restricted to first admissions and is thus biased toward evaluation as opposed to treatment (indefinite commitment).

LSH received 12 competency/sanity evaluation referrals from Lucas and Wood Counties in the 2 1/2 years immediately preceding the opening of the CDTC; it has since received only five. The CDTC has received 16 such referrals in the first 2 1/2 years of operation. These figures reveal not only that the CDTC is apparently reducing referrals to LSH but also that total competency/sanity evaluation referrals rose from 12 in the first period to 21 in the second. It seems reasonable to entertain the possibility that referral agents are more willing to raise the question now that the evaluation can be performed at the CDTC rather than LSH.

The Evaluation Procedure

Psychometric testing was administered to 80% of the CDTC sample and to 98% of the LSH sample. Table XIII (see p. 20) demonstrates the percentages of each sample that received the most frequently employed batteries of tests. Fifty-eight percent of the CDTC sample receiving testing was administered one of the seven most standard batteries, compared to 40% of the LSH sample receiving one of the five most standard batteries. (All other batteries were administered to only 2.1% or fewer of each tested population.)

The 346 CDTC clients who received testing were given a total of 917 tests, or a mean of 2.7. The 93 LSH clients who were tested took a total of 312 tests, or a mean of 3.4. Data in Table XIII indicate the percentage of each tested population that were administered the most frequently employed individual instruments. Each test is labelled as a personality measurement (P), a test of intellectual functioning (IF), or a measure of neurological dysfunctioning (ND). Both facilities clearly use all three types of tests.

In summary, LSH's psychometric testing is more extensive than the CDTC's in three senses: (1) 98% of the LSH clients received testing, compared to only 80% at the CDTC; (2) the mean number of tests administered is 3.4 at LSH compared to 2.7 at Toledo; and (3) the most frequently employed battery consists of four tests at LSH, compared to only one at the CDTC. On the other hand, all testing at the CDTC is either directly administered or analyzed and interpreted by a Ph.D. psychologist or an ABD psychologist. In contrast, the 10 psychologists who performed psychometric evaluations for the 95 LSH clients included six BAs and four MAs. Thus, LSH's psychometric testing is found to be more extensive than the CDTC's, but the latter's testing is performed by psychologists with higher professional degree attainment.

Psychiatric evaluations via clinical interviews were conducted for 21% of the 344 CDTC clients for whom the PSCD team was able to obtain information. While every LSH client in the sample of 95 was evaluated by a physician, only two of the 11 physicians who saw the 95 were board certified or board eligible psychiatrists, and only two others were licensed medical doctors. Again, fewer psychiatric interviews are performed at the CDTC than at LSH, but the latter's interviews are performed by more professionally qualified physicians.

Social histories were compiled for every case in the CDTC sample and for 93% of the LSH sample. The three social workers who compiled case histories for the 95 LSH clients included two MSWs and one BA. At the CDTC, these histories are compiled by an MSW, an MA+, an M.Ed., a BA, an ABD psychologist, and a Ph.D. psychologist. Toledo has developed a system wherein for every three case histories conducted by a social worker, a junior psychologist does two, and a senior psychologist one. The net effect is that more social histories are compiled by individuals with higher professional degree attainments at the CDTC than at LSH.

The PSCD team attempted to compile an estimate of average "exposure time" per client to the total gamut of evaluation procedures. All medical/neurological examinations, individual clinical interviews (psychiatric and nonpsychiatric), psychometric testing sessions, and social work consultations

TABLE XIII

Psychometric Testing for CDTC and LSH Samples

CDTC N	CDTC %	CDTC Battery	LSH N	LSH %	LSH Battery
(89)	26	MMPI/CPI	(12)	13	Rorschach, Beta, Bender-Gestalt, DAP
(24)	7	MMPI/CPI, Rorschach, WAIS, Bender-Gestalt	(10)	11	Rorschach, Beta, Bender-Gestalt
(23)	7	MMPI/CPI, WAIS, Bender-Gestalt	(5)	5	Rorschach, Corsinie
(21)	6	MMPI/CPI, WAIS	(4)	4	Rorschach, Corsinie, Bender-Gestalt
(14)	4	MMPI/CPI, Rorschach	(3)	3	Rorschach, Beta, Bender-Gestalt, Rotter, Lykken, GPPT
(14)	4	WAIS			
(14)	4	MMPI/CPI, WAIS, Bender-Gestalt, Graham-Kendall	(3)	3	Rorschach, Bender-Gestalt, DAP
(199)	58	Total	(37)	39	Total

Total Tests*

N	%	Test	N	%	Test
(288)	31	MMPI/CPI (P)	(71)	23	Rorschach (P)
(184)	20	WAIS (IF)	(65)	21	Bender-Gestalt (ND)
(118)	13	Rorschach (P)	(47)	15	Beta (IF)
(153)	17	Bender-Gestalt (ND)	(45)	14	DAP (P)
(62)	7	Graham-Kendall (ND)	(18)	6	Corsinie (IF)
(48)	5	TAT (P)	(19)	6	Rotter (P)
(853)	93	Total	(14)	4	Lykken (P)
			(279)	89	Total

*Excludes all other tests as infrequently administered to less than 2.1% of the populations.

were added together for each client to arrive at a total number of "interview sessions". Ninety-five percent of the total CDTC sample received at least one interview session for a mean of 2.7 sessions. From the estimates by current staff members who perform these evaluations of the length of time each procedure takes, the PSCD team computed an average length of time for a medical/neurological examination to be 80 minutes, an individual clinical interview at 78 minutes, a psychometric test at 75 minutes, and a social case history compilation at 143 minutes. These averages yield a total mean time of 86.7 minutes or 1.4 hours per interview session. Thus the average CDTC client receives 2.7 interview sessions at 1.4 hours per session or a total of 3.8 hours per evaluation.

Evaluation Results, Recommendations, and Dispositions

Table XIV (see p. 22) depicts the results of both LSH's and the CDTC's evaluations of their respective clients. Fifty-three percent of the CDTC's Ascherman referrals were found by the Center to be Ascherman commitable compared to 47% of LSH's Ascherman referrals. The weight of negative findings shifts to LSH with regard to competency/sanity evaluations; the latter facility found 20% of its competency/sanity referrals to be incompetent/insane compared the the CDTC's 12%, though the Ns are quite low in both cases. Two points are evident: (1) there is no substantial difference between the two facilities with regard to findings in Ascherman and competency/sanity evaluations, and (2) an Ascherman referral runs a 50% chance of being found mentally ill, mentally retarded, or psychopathic, while a competency/sanity referral runs at least a four to one chance of being found competent/sane.

It is also interesting to note that, of the nine CDTC Ascherman candidates evaluated as commitable for whom a specific designation was obtainable, 67% were found psychopathic (as opposed to mentally ill or mentally retarded). By the same token, 97% of the 30 LSH Ascherman candidates for whom information was available were found psychopathic.

A statement to the effect that the client is dangerous, "a menace to the public,"or likely to repeat was made regarding 6% of the CDTC referrals and 43% of the LSH referrals. Furthermore, 9% of the CDTC sample was reported by the Center to have a drug or alcohol problem compared to 18% of the LSH sample. These discrepancies could reflect the differences in seriousness of cases discussed above, though they could just as readily reflect differential orientations of evaluators at the two facilities.

The CDTC does not record diagnoses in terms of the American Psychiatric Association's Diagnostic and Statistical Manual as does LSH. Diagnoses were obtained for 97% of the latter sample. Eighty-two of the the clients were accorded single diagnoses, and the remaining ten were accorded multiple diagnoses. Of the single diagnoses, 55% were for personality disorders (especially "antisocial personality"), 12% for drug or alcohol disorders, 10% for sexual deviations, and 4% for mental retardation. Nine of the 10 multiple diagnoses were various combinations of personality disorders, drug or alcohol disorders, and mental retardation.

The data regarding the recommendations for disposition that the two facilities forwarded to the courts are contained in Table XV (see p. 23). It should first be noted that the CDTC made a total of 500 recommendations for 353 clients out of the total 434 (81%) or a mean of 1.4 recommendations per client receiving a recommendation. By comparison, LSH forwarded only singular recommendations, and for only 41 (43%) of the 95 cases. The PSCD team learned that there is considerable debate concerning whether or not Ascherman and competency/sanity evaluations should be accompanied by recommendations; some courts and clinicians define the purpose of evaluators to simply report whether or not the client is Ascherman commitable or incompetent/insane, others believe the clinicians should additionally forward their professional opinions regarding appropriate court disposition.

In any event, of the recommendations that were made to the courts for the clients under consideration, 10% of the CDTC recommendations were for incarceration in a correctional facility, compared to 34% of LSH's recommendations. A close examination of Table XV reveals that a categorization of recommendations beyond this first step proved difficult. LSH records contained such statements as "needs treatment", "needs institutionalization", and "doesn't need LSH". Similarly, CDTC records contained such statements as "needs assistance of BVR", and "needs further evaluation". While these are rather vague dispositional suggestions, it still appears feasible to group most under either "institutionalization" or "return to the community". Table XVI (see p. 25) indicates the resulting comparative recommendations for the CDTC and LSH.

If "probation", "mental health outpatient", "drug or alcohol treatment", and "social life intervention" recommendations are added together, then a total of 324, or 65% of the CDTC recommendations are for the client to be returned to the community. If "probation", "mental health outpatient", and "not LSH", are added together, then a total of seven, or 17% of the LSH recommendations are for the client to be returned to the community. On the other hand, if "incarceration" and "mental hospitalization" are added together, then a total of 94, or 19% of the CDTC recommendations are for the client to be institutionalized. If "incarceration", "mental hospitalization", "unclassifiable institutionalization", and unclassifiable treatment" are added together, then a total of 31, or 76% of the LSH recommendations are for the client to be institutionalized. To the degree this categorization is legitimate, LSH recommends institutionalization (as opposed to a return to the community) in 76% of its recommendations, compared to only 19% of the CDTC recommendations.

TABLE XIV

Evaluation Results for CDTC and LSH Samples

	CDTC		LSH		Total	
	%	N	%	N	%	N
Ascherman	53	(9)	47	(31)	48	(40)
Not Asch.	47	(8)	53	(35)	52	(43)
		(17)		(66)		(83)
Incomp/Insane	12.2	(2)	20	(4)	17	(6)
Comp/Sane	87.5	(14)	80	(16)	83	(30)
		(16)		(20)		(36)
Dangerous	6	(27)	43	(41)	13	(68)
Not Dang.	3	(13)	3	(3)	3	(16)
		(40 of 434)		(44 of 95)		(84 of 529)
Dr/Al. Prob.	9	(41)	18	(17)	11	(58)
No Dr/Al. Prob.	1	(3)	0	(0)	1	(3)
		(44 of 434)		(17 of 95)		(61 of 529)

TABLE XV

Recommendations for CDTC and LSH Samples

	CDTC		LSH		Total	
	%	N	%	N	%	N
Incarceration	10	(52)	34	(14)	12	(66)
Mental Hosp.	8	(42)	5	(2)	8	(44)
Unclass. Inst.	-	-	5	(2)	-1	(2)
Unclass. Treatment	-	-	32	(13)	2	(13)
"Not LSH"	-	-	5	(2)	-1	(2)
MH Outpt.	39	(193)	10	(4)	36	(197)
Probation	12	(60)	2	(1)	11	(61)
Dr/Al. Treatment	5	(23)	-	-	4	(23)
Social Life Interv.	10	(48)	-	-	9	(48)
Further Eval.	5	(25)	-	-	5	(25)
Other	11	(57)	7	(3)	11	(60)
		(500 for 353 of 434)		(41 for 41 of 95)		(541)

If "unclassifiable treatment" recommendations are shifted from the "institutionalization" category to the "return to community" category, the ratio of institutionalization/noninstitutionalization recommendations for LSH is still 49/44. And if the "drug or alcohol treatment" recommendations are shifted from the "return to the community" category to the "institutionalization" category, the ratio of institutionalization/noninstitutionalization for the CDTC is still 62/22.

The PSCD team was able to obtain court dispositions on only 47% (N = 202) of the CDTC sample and 69% of the LSH sample (the latter percentage excludes the nine first admission indefinite commitments). Not surprisingly, dispositions were much less varied than recommendations, as data in Table XVII (see p. 25) indicates. The only collapsing was of eight "mental health outpatient", "drug or alcohol treatment", and "social life intervention" dispositions into "probation" and of one "further evaluation" into "other" in the CDTC data. Forty-one percent of the LSH dispositions were for incarceration, another 41% for mental hospitalization, and only 19% for probation. This contrasts with 57% of the CDTC dispositions for probation, 28% for incarceration, and 2% for mental hospitalization. The data in Table XVIII (see p. 26) reveal that 81% of the court dispositions for the LSH sample were for institutionalization compared to only 30% of the CDTC's court dispositions.

Of significance with regard to Ascherman and competency/sanity evaluations is not just the court disposition but also the court decision of whether or not the client is Ascherman commitable or incompetent/insane. Unfortunately, police and court records only reported on disposition. If it is assumed that a court order to return the client to LSH constitutes a legal finding of Ascherman commitable, then 41% (20 of the 49 Aschermans for whom a disposition was available) of LSH's Ascherman evaluation referrals were declared Ascherman commitable by the courts. If it is further assumed that a sentence to a correctional facility constitutes a finding of not Ascherman commitable, then 39% (19 of the 49) of LSH's Ascherman evaluation referrals were declared not Ascherman commitable by the courts. Twenty percent (10 of the 49) of LSH's Ascherman referrals were placed on probation, which is a statutorily-endorsed disposition (an alternative to commitment to LSH) for those found mentally ill, mentally retarded, or psychopathic (i.e. Ascherman), and it is therefore impossible to categorize these 10 as either "Ascherman" or "not Ascherman".

Forty percent (four of the 10 LSH competency/sanity cases for whom a disposition was available) were returned to LSH and can therefore be presumed to have been declared incompetent/insane. Sixty percent (6 of the 10) were either incarcerated or probated, and thus presumed to have been declared competent/sane. Dispositions were only obtained on five of the CDTC Ascherman and competency/sanity referrals, and it is therefore impossible to make any statements about court decisions regarding the Toledo sample of Ascherman and competency/sanity cases.

Time Involved in Moving Through the System

Table XIX (see p.26) depicts the average number of days between the various stages of the evaluation and treatment process for both the CDTC and LSH. It is evident that the CDTC averages one day longer than LSH on the number of days between (1) court order (or referral) and admission, and (2) admission and release (or date of final report for Ascherman evaluations. On the other hand, the CDTC averages significantly fewer days than LSH between (3) admission and release/final report for competency/sanity evaluations (25 to 46 days), (4) release/final report and court disposition (22 to 40 days), and (5) admission for treatment and release/final report (2.4 months to 16.9 months).

While a difference of one day is negligible, one of the purposes of the CDTC was to reduce the length of time between referral and admission and between admission and release, and thus far this goal has apparently not been attained. Correlatively, only 50% of the Toledo area judges and probation officers questioned by the PSCD team responded in the affirmative when asked if the CDTC performed their evaluations within the length of time suggested or imposed by law, though some said they would rather have a good report that takes time than a poor report quickly.

With regard to point (3) above, it is significant that the average length of time for a competency/sanity evaluation at LSH (45.8 days) exceeds the statutory 30-day limit, while the CDTC's 24.7 days is comfortably within the limit. Furthermore, with regard to point (4) above, the shorter period of time between release and disposition characteristic of the CDTC as opposed to LSH is very important from the "speedy justice" point of view.

It must of course be recognized in interpreting point (5) above that LSH likely receives more serious cases for inpatient care than the CDTC receives for outpatient care. But in any event, the 25 Ascherman indefinite commitments in the LSH sample (eight first admission indefinites and 17 pre-post cases) spent an average of 16.6 months at LSH, and the four competency/sanity indefinite commitments spent an average of 18.3 months there. By comparison, the 77 of the 86 CDTC cases on record as in treatment for whom time data were available were under the Center's care an average of 73 days, within which time they spent an average of 22 hours in therapy.

Intrasample Comparison of Variables: CDTC

The preceding discussion of client movement through the evaluation and treatment procedures compared frequency distributions for the CDTC and LSH samples on each respective variable. The discussion

TABLE XVI

Recommendations for CDTC and LSH Samples

	CDTC		LSH		Total	
	%	N	%	N	%	N
Return to Community	65	(324)	17	(7)	73	(331)
Institution-alization	19	(94)	76	(31)	27	(125)
		(418)		(38)		(456)

TABLE XVII

Court Dispositions for CDTC and LSH Samples

	CDTC		LSH		Total	
	%	N	%	N	%	N
Incarceration	28	(56)	41	(24)	31	(80)
Mental Hospit.	2	(4)	41	(24)	11	(28)
Probation	57	(115)	19	(11)	48	(126)
Other	13	(27)	-	-	10	(27)
		(202)		(59)		(261)

TABLE XVIII

Dispositions for CDTC and LSH Samples

	CDTC		LSH		Total	
	%	N	%	N	%	N
Return to Community	57	(115)	19	(11)	54	(126)
Institution-alization	30	(60)	81	(48)	46	(108)
		(175)		(59)		(234)

TABLE XIX

Time Comparisons for CDTC and LSH Samples

	CDTC		LSH	
	$\bar{x}$ No. Days Between	N	$\bar{x}$ No. Days Between	N
Ct. order/ref. & admission	9.6	(383)	8.5	(86)
Ad. & release or final report:				
-Total Evals	41.5	(320[a])	41.4	(86[b])
-Asch. Evals	40.5	(19)	39.5	(66[b])
-C/S Evals	24.7	(15)	45.8	(20[b])
Release & Disposition	21.7	(141)	39.8	(58)
Treatment ad. & rel/final rep.	2.4 mths.	(77)	16.9 mths.	(29)

[a]Excludes treatment administration cases.

[b]Excludes first admission indefinite commitments, and only counts "pre" time for pre-post cases.

which follows reports on the findings of cross-tabulations of selected variables both within and between samples. Variables were first grouped under general headings, including demographic characteristics; prior involvement in the criminal justice and mental health systems; current status; evaluation processing; evaluation results, recommendations, and dispositions; and treatment processing. All of the variables in each group were then cross-tabulated with all of the variables in every other group, producing an extensive computer printout of comparative data.

The next three sections of this report discuss the cross-tabulations that produced significant comparative findings. The first section deals with intrasample comparisons of variables for the CDTC data, the second with intrasample comparisons of variables for the LSH data, and the last with inter-sample comparisons of variables for the CDTC and LSH samples. Scores of cross-tabulations were run and analyzed that are not discussed, either because they revealed no significant relationships or because the sample Ns were too small, or, on some occasions, because of both reasons. For ease in identification and thus comparative interpretation, all cross-tabluations are labelled and indexed.

A.1 - Current Offense/Referral Source (CDTC)

Sixty percent of the sexual offenders were referred by the Toledo Municipal Court compared to only 32% by Lucas County Common Pleas Court. Also, 75% of the drug offenders were referred by Toledo Municipal Court compared to only 13% by Lucas County Common Pleas Court. On the other hand, 53% of the property offenders were referred by Lucas County Common Pleas Court compared to only 19% by Toledo Municipal Court, and 54% of the nonsexual personal offenders were referred by Lucas County Common Pleas Court compared to only 27% by Toledo Municipal Court. Apparently most sexual and drug offenders are not felonious, and this concurs with CDTC reports that exhibitionists and marijuana smokers are the modal categories in the respective groups. On the other hand, more than half of the property and nonsexual personal offenses are apparently of a felonious degree.

A.2 - Current Offense/Age (CDTC)

There is a progressive increase with age categories in the percent of offenses which are sexual, from 15% in the "Under 21" category to 53% in the "41-50" category. In contrast, there is a steady decrease with age categories in the percent of offenses which are drug related, from 30% in the "Under 21" category to 3% in the "41-50" category.

A.3 - Current Offense/Marital Status (CDTC)

More of the "never married" committed property offenses than any other category (36%), followed by drug offenses (25%). The modal category of offenses for the married was sexual offenses (39%), and the second and third most frequent categories contained only 19% each. It seems that the young and single are responsible for drug offenses, and the middle-aged and married for sexual offenses.

A.4 - Current Offense/Prior Offense (CDTC)

Table XX (see p. 28) presents the cross-tabulation of current offense and prior offense. The rate of correspondence between prior and current offense is found to be highest for sexual offenses (62%) and lowest for nonsexual personal offenses (27%). Drug offenses and property offenses are in between with correspondence rates of 58% and 54% respectively.

Twenty-two percent of those with prior property offenses are charged with nonsexual personal, or a more serious offense. But 36% of those with prior nonsexual personal offenses are charged with property offenses, and 21% of those with prior sexual offenses are charged with nonsexual personal offenses, the total 57% having shifted to less serious offenses.

Of those with no prior offenses, 33% are charged with sexual offenses, 25% with drug offenses, 17% with property offenses, and 15% with nonsexual personal offenses. One of the more significant findings, therefore, is that the percentage order of first offenses is identical to the percentage order of recidivism: sex, drug, property, and nonsexual personal. That is, first offenses are increasingly occuring in those categories in which recidivism rates are increasingly higher. While this could be a most ominous sign, it could also represent an awareness of relative recidivism rates on the part of referral agents, and subsequent attempts to thwart future recidivism of the first offender by referral to the CDTC.

A.5 - Current Offense/Reason for Referral (CDTC)

Table XXI (see p. 29) depicts the cross-tabulation of current offenses and reason for referral. Forty-five percent of the Ascherman referrals were charged with sexual offenses and another 45% with nonsexual personal offenses. Thirty-eight percent of the competency/sanity cases were charged with nonsexual personal offenses, 31% with property offenses, and another 19% with sexual offenses. While the Ns are quite small in these two groups, it is not surprising that Ascherman and competency/sanity cases have been charged with the more serious offenses.

Forty-three percent of the treatment administration referrals are charged with drug offenses, as are 20% of the treatment evaluation referrals (though 29% and 28% of the latter referrals were charged with property and sexual offenses, respectively). It may be recalled that the CDTC has ongoing group therapy for drug/alcohol problem offenders and for sex offenders, and this could account for their high representation in treatment-related referrals.

TABLE XX

Prior Offenses by Current Offense for CDTC Sample

Prior Offense	Current Offense: Sexual	Non Pers.	Property	Drug	Public Order	Other	Row Total
Sexual	61.9[a] (26.0)[b]	21.4 (13.6)	9.5 (4.0)	4.8 (2.8)	-- --	2.4 (3.1)	42
Nonsexual Pers.	6.1 (2.0)	27.3 (13.6)	36.4 (12.1)	9.1 (4.2)	3.0 (8.3)	18.2 (18.8)	33
Property	5.9 (4.0)	22.1 (22.7)	54.4 (37.4)	5.9 (5.6)	1.5 (8.3)	10.3 (21.9)	68
Drug	5.3 (1.0)	5.3 (1.5)	31.6 (6.1)	57.9 (15.5)	-- --	-- --	19
Public Order	13.7 (4.0)	20.7 (9.1)	24.1 (7.0)	17.2 (7.0)	17.2 (41.7)	6.9 (6.3)	29
Other	41.2 (7.0)	5.9 (1.5)	17.6 (3.0)	17.6 (4.2)	5.9 (8.3)	11.8 (6.3)	17
None	32.6 (56.0)	14.5 (37.9)	17.4 (30.3)	25.0 (60.6)	2.3 (33.3)	8.1 (43.8)	172
Column Total	100	66	99	71	12	32	380

[a] = row percent; [b] = column percent

TABLE XXI

Current Offense by Reason for Referral for CDTC

Current Offense	Reason for Referral: Ascherman	Comp/San.	Gen. Eval.	Treat. Eval.	Treat. Admin.	Row Total
Sexual	8.6[a] (45.0)[b]	2.9 (18.8)	58.1 (26.6)	26.7 (27.7)	3.8 (10.8)	105
Nonsex. Pers.	13.2 (45.0)	8.8 (37.5)	52.9 (15.7)	20.6 (13.9)	4.4 (8.1)	68
Property	1.0 (5.0)	4.8 (31.3)	59.0 (27.1)	27.6 (28.7)	7.6 (21.6)	105
Drug	-- --	-- --	53.2 (17.9)	26.0 (19.8)	20.8 (43.2)	77
Public Order	-- --	-- --	58.3 (3.1)	33.3 (4.0)	8.3 (2.7)	12
Other	2.7 (5.0)	5.4 (12.5)	62.2 (10.0)	16.2 (5.9)	13.5 (13.5)	37
Column Total	20	16	230	101	37	404

[a] = row percent; [b] = column percent

Twenty-seven percent of the "general evaluation" referrals are charged with sexual offenses, and another 27% with property offenses. The third highest category, at 18%, are charged with drug offenses.

A.6 - Current Offense and Reason for Referral/ Number Interview Sessions and Percent Psychiatric Evaluations

Table XXII (see p. 31) reveals that both the highest mean number of interview sessions and the greatest percentage of psychiatric evaluations were received by those charged with nonsexual personal offenses, followed by those charged with sexual offenses. Thus the CDTC staff is expending the most time overall and the greatest percentage of their "most expert" time on the two most serious offense types. It will be recalled from A.5 above that these two offenses are those most typical of Ascherman referrals.

Table XXII also indicates that the greatest mean number of interview sessions are accorded to Ascherman evaluations as opposed to any other reason for referral, and that 95% of all Ascherman evaluations receive a psychiatric evaluation. While competency/sanity referrals are third in the mean number of interview sessions, a full 100% of the competency/sanity referrals receiveda psychiatric evaluation. The fact that treatment administration referrals receive the lowest mean number of interview sessions suggests that they are moved out of the evaluation phase and into treatment rather quickly.

A.7 - Psychiatric Evaluation/Mental Health History (CDTC)

Twenty-nine percent of those with a history of mental health outpatient care received a psychiatric evaluation, compared to 26% of those with a history of inpatient care. Moreover, the highest percentage of psychiatric evaluations (44%) were of those clients having no history of mental health care at all. While this is a somewhat striking finding, it strongly suggests that "previous history" is not a determining factor in according psychiatric evaluations, and, when coupled with the findings in A.5 and A.6 above, further suggests that reason for referral and offense are the most important considerations.

It should be added that 50% (four of eight) of those with a history of inpatient care in an institution for mentally disordered offenders did receive a psychiatric evaluation.

A.8 - Reason for Referral/Psychological Testing (CDTC)

Table XXIII (see p. 32) presents a cross-tabulation of reason for referral and psychological tests received. Seventy-five percent of the Ascherman referrals received a series of tests in common with at least one other client. This compares with 47% of the treatment evaluation referrals, 42% of the general evaluation referrals, 26% of the treatment administration referrals, and 18% of the competency/sanity referrals. Seventy-three percent of the 15 Ascherman referrals who received these most frequently administered batteries received all three types of measurements--personality, intellectual functioning, and neurological dysfunctioning. This compares with 22% of the general evaluation referrals and 16% of the treatment administration referrals. Furthermore, all 20 Aschermans received testing, though 56% of the treatment administration referrals did not, nor did 36% of the competency/sanity referrals, 14% of the treatment evaluation referrals, and 13% of the general evaluation referrals. Thus it appears that, in line with the findings discussed in A.6 above, Ascherman cases are those most uniformly and extensively tested. And while 100% of the competency/sanity referrals receiveda psychiatric evaluation, 36% receivedno psychological testing. While the Ns with regard to competency/sanity cases are very low, the modal category (2) of those receiving testing was administered, quite logically, a test of intellectual functioning.

A.9 - Treatment Recommendation/Current Offense and Demographics (CDTC)

In line with the findings reported in A.5 above, the cross-tabulation of current offense with whether or not the CDTC recommended treatment at their agency reveals that the highest percentage of treatment recommendations are for sex offenders and the second highest are for drug offenders.

While 80% of the total treatment recommendations were for males, 31% of the females compared to 24% of the males were recommended for CDTC treatment. It is possible that sexual and drug offenses are disproportionately represented among females, though it is equally possible that females are generally considered more responsive to treatment.

With regard to marital status, 63% of those for whom treatment at the CDTC was recommended were never married, divorced, or separated, while only 37% were married or remarried. The deviant marital statuses account for 65% of the total sample, and the marrieds/remarrieds 32%; thus the married are slightly more likely than the nonmarried to be recommended for treatment.

Sixty-four percent of the CDTC treatment recommendations were for those with at least a high school degree, though only 41% of the total sample have achieved this educational level. It seems that the CDTC treatment recommendations are biased toward those with higher educational levels. Only two of the many possibilities that could account for this are that better educated people are more amenable to treatment or that clinicians are more comfortable treating better educated people.

TABLE XXII

Current Offense & Reason for Referral By Interview Sessions and Psychiatric Evaluation for CDTC

Current Offense	$\bar{x}$ Number Interview Sessions		% of Psychiatric Evaluations Received	
	$\bar{x}$ No.	N	%	N
Sexual	2.94	(106)	29.1	(25)
Nonsex. Pers.	3.07	(68)	36.0	(68)
Property	2.46	(105)	18.6	(16)
Drug	2.59	(77)	2.3	(2)
Public Order	2.67	(12)	3.5	(3)

Reason for Referral	$\bar{x}$ Number Interview Sessions		% Receiving Psychiatric Evals.	
	$\bar{x}$ No.	N	%	N
Gen. Eval.	2.49	(244)	17.0	(39)
Treat. Eval.	2.97	(104)	12.6	(13)
Treat. Admin.	2.09	(46)	2.2	(1)
Ascherman	4.32	(20)	95.0	(19)
Comp./San.	2.56	(16)	100.0	(16)

TABLE XXIII

Reason for Referral by Psychological Testing for CDTC

	Reason for Referral %	N	Psychological Testing: MMPI/CPI (P)	WAIS (IF)	Rorschach (P)	Bender-Gestalt (ND)	Graham-Kendall (ND)	Halstead (ND)
	20	(49)	x					
	5	(13)	x	x				
	5	(11)	x	x	x	x		
Gen.	4	(10)	x		x			
Eval.	4	(9)	x	x		x	x	
	3	(7)	x	x		x		
	1	(2)	x	x				x
	13	(31)						
	26	(27)	x					
Treat-	10	(10)	x	x		x		
ment	6	(6)		x				
Eval.	5	(5)	x	x				
	14	(14)						
Treat-	26	(12)	x					
ment	56	(26)						
Admin.								
	35	(7)	x	x	x	x		
Ascher-	10	(2)	x	x	x	x	x	
man	10	(2)	x	x		x		
	10	(2)	x	x	x			
	10	(2)	x		x			
Comp/	18	(2)		x				
San.	36	(4)						

A.10 - Recommendation/Disposition (CDTC)

Table XXIV (see p. 34) contains the cross-tabulation of recommendations and dispositions. Eighty-one percent of those recommended for probation received probation, 69% of those recommended for incarceration received incarceration, and 16% of those recommended for mental hospitalization received mental hospitalization. Thus the CDTC and the court were in fairly good agreement regarding probation and incarceration, but in very little agreement regarding mental hospitalization. The court placed 47% of those recommended for mental hospitalization on probation, and the remaining 37% recommended for mental hospitalization were incarcerated. And while the court placed 19% of those recommended for probation in a correctional institution, it placed 31% of those recommended for incarceration on probation. Thus, on balance, the court responded more leniently than the CDTC recommended, more often placing cases on which there was not court-Center agreement in the community than in an institutional environment.

A.11 - Race/Multiple Variables (CDTC)

Table XXV (see p. 35) contains data on a cross-tabulation of race and eight other variables. Reading across this table, it will be noted first that 36% of the blacks were referred by Toledo Municipal Court and 54% by Lucas County Common Pleas Court. This compares with 48% of the whites from Toledo Municipal Court and 34% from Lucas County Common Pleas Court. The modal category of blacks in the CDTC sample have thus been charged with felonies and the modal category of whites with misdemeanors. Furthermore, while there was little difference between the races with regard to sexual and property offenses, 27% of the blacks were charged with nonsexual personal offenses (compared to 14% of the whites), and 22% of the whites were charged with drug offenses (compared to 8% of the blacks).

The portion of the table addressing reason for referral reveals that 11% of the blacks were Ascherman referrals, compared to only 3% of the whites. That is, while blacks comprise only 25% of the total sample, they represent over half of the Ascherman referrals. Competency/sanity referrals were 81% white, though 4% of the total sample of whites and 3% of the total number of blacks were competency/sanity referrals. On the other hand, only 3% of the blacks were referred for treatment administration compared to 13% of the whites. By the same token, 93% of the treatment administration referrals were white, and only 7% were black. And similarly, 85% of those recommended for treatment at the CDTC were white (28% of the whites) and only 15% were black (16% of the blacks).

The blacks received 3.03 interview sessions compared to 2.64 for the whites, and 30% of the blacks but only 20% of the whites received a psychiatric evaluation. These findings are likely due in part to the black Ascherman referrals, as well as the greater representation of felony charges among blacks.

Dispositions for both sexual and nonsexual personal offenses reveal some clear distinctions with regard to race. Forty percent of the white sex offenders were placed on probation compared to only 14% of the blacks. Only 18% of the white sex offenders were incarcerated compared to 29% of the black. Twenty-nine percent of the white nonsexual personal offenders were probated compared to only 12% of blacks. Only 20% of the white nonsexual personal offenders were incarcerated compared to 27% of the black.

There is no doubt that most of the findings in Table XXV could be interpreted in many ways. Social scientists have long been aware that it is impossible to control for all potentially contributory or confounding variables when attempting to explain a particular behavioral phenomenon. In the current instance, efforts to control for more suggestive variables (such as prior record) were hampered by unreasonably small numbers.

Intrasample Comparisons of Variables: LSH

B.1 - Current Offense/Demographics (LSH)

While one might predict that females committed to LSH would be the prototype "Lady Macbeth" offenders, five (71%) of the women in the LSH sample are charged with a property offense. With regard to race, the modal category of whites are property offenders (42%), while the modal category of blacks are nonsexual personal offenders (46%). And finally, the married were charged with sexual offenses more than any other category (48%), while the never married, divorced, and separated were charged most frequently with property offenses (47%), followed by nonsexual personal offenses (35%).

B.2 - Current Offense/Prior Offense (LSH)

Table XXVI (see p. 37) presents the cross-tabulation of current offense and prior offense. The rate of correspondence between prior and current offense is found to be highest for property offenses (73%) and lowest for sexual offenses (22%). Nonsexual personal offenses are in between with a correspondence rate of 67%. It will be recalled that the LSH sample does not contain a single drug offense as current offense.

Twenty-three percent of those with prior property offenses are charged with nonsexual personal, or a more serious offense. But 39% of those with prior sexual offenses are charged with nonsexual personal offenses, and another 22% with property offenses, a total of 61% of prior sexual offenders having shifted to less serious offenses. Of those with no prior offenses, 39% are charged with sexual

TABLE XXIV

Recommendation by Disposition for CDTC

Disposition	Recommendation			Row Total
	Probation	Ment. Hosp.	Incar.	
Probation	85[a] (81)[b]	8 (47)	7 (31)	113
Ment. Hosp.	-	100 (16)	-	3
Incar.	48 (19)	15 (37)	38 (69)	48
Column Total	119	19	26	164

[a] = row percent, [b] = column percent

TABLE XXV

Race by Multiple Variables for CDTC

	Race			
	White		Black	
	%	N	%	N
Referral Source:				
Tol. Muni.	48	(154)	36	(36)
L. Cty. C. Pl.	34	(110)	54	(54)
Other	18	(57)	11	(11)
Current Offense:				
Nonsex. Pers.	14	(41)	27	(27)
Drug	22	(65)	8	(8)
Other	64	(191)	65	(65)
Reason for Ref:				
Asch.	3	(9)	11	(11)
Comp/San.	4	(13)	3	(3)
Treat Ad.	13	(42)	3	(3)
Other	80	(257)	83	(84)
CDTC Treatment:				
Recommended	28	(66)	16	(12)
Not Rec.	72	(169)	84	(65)
Interview Sessions:	($\bar{x}$ #) 2.64	(322)	($\bar{x}$ #) 3.03	(101)
Psychiatric Eval.:				
Received	20	(60)	30	(29)
Not Rec.	80	(248)	70	(69)
Dispo. Sex Offs.:				
Proba.	40	(29)	14	(4)
Incar.	18	(13)	29	(8)
Other	42	(30)	57	(16)
Disp. NP Offs:				
Proba.	29	(10)	12	(3)
Incar.	20	(7)	27	(7)
Other	51	(18)	62	(16)

offenses, 32% with property offenses, and 23% with nonsexual personal offenses. There thus appears to be only a weak relationship between the order of first offense and the order of recidivism.

B.3 - Current Offense/Reason for Referral (LSH)

Table XXVII (see p. 37) depicts the cross-tabulation of current offense and reason for referral. The modal category of Ascherman 60 day evaluation referrals are charged with property offenses (49%). Forty-one percent of the Ascherman pre-postsentence referrals are chared with property offenses, and another 41% with nonsexual personal offenses. Fifty percent of the Ascherman indefinite commitments are charged with nonsexual personal offenses, as are 44% of the competency/sanity 30 day evaluation referrals. Though the competency/sanity pre-postsentence referrals are few in number, 67% are charged with nonsexual personal offenses. It appears that those referred to LSH are largely property and nonsexual personal offenders overall, but also that the nonsexual personal offenders are the ones more likely to be indefinitely committed.

B.4 - Reason for Referral/Prior Offense (LSH)

Seventy percent of the Ascherman pre-postsentence referrals have prior offense records, compared to only 44% of the Ascherman "60 day evaluation only" referrals. By the same token, all three of the competency/sanity pre-postsentence referrals have prior offenses, compared to 60% (9 of 13) of the competency/sanity "30 day evaluation only" referrals. As far as offense category is concerned, prior sexual offenses were twice as common among the Ascherman pre-postsentence cases than among the Ascherman 60 day evaluation only group (29% to 13%).

B.5 - Reason for Referral/Psychological Testing (LSH)

Table XXVIII (see p. 38) presents a cross-tabulation of reason for referral and psychological testing. Standard batteries were most commonly administered to Ascherman indefinite referrals (38%), followed by competency/sanity 30 day (31%), Ascherman pre-postsentence (28%), and Ascherman 60 day evaluations (13%). The Ascherman indefinites were the only group not receiving all three types of tests (personality, intellectual functioning, and neurological dysfunctioning); they received two types of tests (though the Corsinie is a brief and superficial measure of intellectual functioning). It is interesting to note that the Ascherman pre-postsentence referrals and the competency/sanity 30 day evaluation referrals often receive the same battery of tests (Rorschach, Beta, Bender-Gestalt, and Draw-a-Person).

B.6 - Reason for Referral/Diagnosis (LSH)

Table XXIX (see p. 38) presents a cross-tabulation of reason for referral and diagnosis. While the large number of diagnoses as "personality disorder" is again evident, some interesting variations appear among the small remaining groups of diagnoses. Fifteen percent of the Ascherman 60 day evaluations are diagnosed as drug/alcohol disorders, though there are no such diagnoses among the Ascherman pre-postsentence cases. On the other side of the coin, 38% of the Ascherman pre-postsentence referrals are diagnosed as sexual deviates, though there are no such diagnoses among the Ascherman 60 day evaluations. The very same pattern exists for the competency/sanity referrals, though the Ns are very low. It seems that those with drug/alcohol problems may get themselves into LSH for evaluations, but with good likelihood of getting out and not coming back. But those with sexual problems find themselves indefinitely committed. Other data support this impression. The cross-tabulation of diagnosis/LSH evaluation results found that 75% of those with diagnoses as sexual deviates were reported by LSH to be Ascherman commitable. Furthermore the cross-tabulation of diagnosis/disposition revealed that every one of the total seven clients diagnosed as sexual deviates was returned by the court to LSH. (See Table XXX, p. 39).

B.7 - Evaluation Results/Court Decision (LSH)

Table XXXI (see p. 40) compares evaluation results and court decision regarding whether or not the client is an Ascherman candidate or incompetent/insane. It will be recalled that the only way the PSCD team could determine this court decision was through the actual disposition (incarcerated or returned to LSH). If the Ascherman cases placed on probation are excluded, 49% of the referrals were found by the court to be not Ascherman committable, compared to 53% so evaluated by LSH. Obversely the court found 51% Ascherman committable compared to 47% so evaluated by LSH. If the cases placed on probation are assumed to be found not Ascherman committable, 59% of the referrals were found not committable by the court and 41% were found committable. Either way, the discrepancies between evaluation results and court decisions are rather small.

There was less agreement between LSH and the courts on competency/sanity referrals. Whereas LSH found only 20% incompetent/insane, the court found 40% incompetent/insane.

B.8 - Reason for Referral/Court Disposition (LSH)

Table XXXII (see p. 40) contains the cross-tabulation of reason for referral and court disposition. Thirty-nine percent of the 49 Ascherman 60 day evaluation and pre-postsentence referrals for whom dispositional information was available were

TABLE XXVI

Current Offense by Prior Offense for LSH

Current Offense	Prior Offense: Sex	Nons. Pers.	Prop.	Other	None	Row Total
Sex	18[a] (22)[b]	9 (17)	5 (4)	14 (38)	55 (39)	22
Nonsex. Pers.	23 (39)	27 (67)	20 (23)	7 (25)	23 (23)	30
Property	11 (22)	5 (17)	51 (73)	5 (25)	27 (32)	37
Other	50 (17)	-- --	-- --	17 (13)	33 (6)	6
Column Total	18	12	26	8	31	95

[a] = row percent, [b] = column percent

TABLE XXVII

Current Offense by Reason for Referral for LSH

Current Offense	Reason for Referral: Asch. 60 day	Asch. P-Post	Asch. Indef.	C/S 30 day	C/S P-Post	C/S Indef.	C/S Asch.	Row Total
Sex	50[a] (22)[b]	14 (18)	14 (38)	14 (19)	5 (33)	5 (100)	- -	22
Nonsex. Pers.	33 (20)	23 (41)	13 (50)	23 (44)	7 (67)	- -	- -	30
Property	65 (49)	19 (41)	3 (13)	14 (31)	- -	- -	- -	37
Other	67 (8)	- -	- -	17 6	- -	- -	17 (100)	6
Column Total	49	17	8	16	3	1		95

[a] = row percent, [b] = column percent

TABLE XXVIII

Psychological Testing by Reason for Referral for LSH Sample

Reason for Referral	%	N	Psychological Testing: Rorschach (P)	Beta (IF)	Bender-Gestalt (ND)	DAP (P)	Corsinie (IF)
Asch. 60 day	13	(6)	x	x	x		
Asch. P-Post	28	(5)	x	x	x	x	
Asch. Indef.	38	(3)	x				x
C/S 30 day	31	(5)	x	x	x	x	

TABLE XXIX

Reason for Referral by Diagnosis for LSH

Reason for Referral	Diagnosis: Person. Dis. (301)	Sex. Dev. (302)	Al/Dr. Dis. (303 & 4)	Reactions (307, 8, 16)	Retard. (310,11)	Row Total
Ascherman 60 day	67[a] (62)[b]	- -	15 (67)	10 (67)	8 (100)	39
Ascherman Pre-Post	63 (24)	38 (86)	- -	- -	- -	16
Comp/San. 30 day	55 (14)	- -	27 (33)	18 (33)	- -	11
Comp/San. Pre-Post	- -	100 (14)	- -	- -	- -	1
Column Total	42	7	9	6	3	67

[a] = row percent, [b] = column percent

TABLE XXX

Diagnosis by Court Disposition for LSH

Diagnosis	Court Disposition: Incarcerated	Probated	Returned to LSH	Row Total
Schiz. (295)	-	-	100 (13)	3
Neuroses (300)	75[a] (13)[b]	25 (9)	-	4
Personality Disorders (301)	37 (42)	15 (36)	48 (54)	27
Sexual Deviations (302)	-	-	100 (29)	7
Al/Drug Disorders (303 & 4)	57 (17)	29 (18)	14 (4)	7
Reactions (307, 8, & 16)	67 (8)	33 (9)	-	3
Mental Retardation (310 & 11)	67 (8)	33 (9)	-	3
Multiple Diagnoses	60 (13)	40 (18)	-	5
Column Total	24	11	24	59

TABLE XXXI

Evaluation Results and Court Decision for LSH

	Evaluation Results		Court Decision: With Probated		Court Decision: Without Probated	
	%	N	%	N	%	N
Not Asch.	53	(35)	59	(29)	49	(19)
Asch.	47	(31)	41	(20)	51	(20)
		(66)		(49)		(39)
Comp/San.	80	(16)	60	(6)	--	--
Inc/Insane	20	(4)	40	(4)	--	--
		(20)		(10)	--	--

TABLE XXXII

Reason for Referral by Court Disposition for LSH

Reason for Referral	Incar. %	Incar. N	Court Disposition: Probated %	Probated N	Ret. to LSH %	Ret. to LSH N	
Asch. 60 day	37	(19)	20	(10)	6	(3)	32
Asch. P-Post	--		--		35	(17)	17/49
Comp/San. 30 day	50	(5)	1	(1)	--		6
Comp/San. P-Post	--		--		40	(4)	4/10
Column Total		(24)		(11)		(24)	

incarcerated in a correctional facility, and another 41% were returned to LSH. Thus, 80% of the Ascherman evaluation referrals were institutionalized and only 20% were returned to the community. Fifty percent of the 10 competency/sanity 30 day evaluation and pre-postsentence referrals for whom dispositional information was available were incarcerated, and another 40% were returned to LSH. Thus, 90% of the competency/sanity evaluation referrals were institutionalized, and only 10% were returned to the community.

B.9 - Recommendation/Court Disposition (LSH)

Table XXXIII (see p. 43) compares recommendation and disposition. It is difficult to imagine a greater degree of agreement than appears to exist between LSH and the courts. LSH recommended institutionalization for 81.5%, and the court institutionalized 81.3%; LSH recommended a return to the community for 18.4%, and the court returned 18.6% to the community.

Intersample Comparison of Variables: CDTC and LSH

A.11 - B.1

While frequencies were well spread across current offense categories for both blacks and whites in the CDTC sample, a significantly higher percentage of blacks were charged with nonsexual personal offenses, and this was also the modal category for blacks in the LSH sample. Whether this and other racial differences identified are reflective of actual differential crime involvement or of discriminatory practices within the criminal justice system could not, in most instances, be ascertained by the study reported herein. But differences were clearly found, and suggest a need for additional analysis.

A.3 - B.1

In both samples, those occupying deviant marital statuses were charged with property offenses more than any other single category, while the married were charged most often with sexual offenses. The affinity between property offenses and deviant marital statuses is partially explained, of course, by the fact that each is the highest frequency in its respective variable breakdown in both samples. The relationship between sexual offenses and the married, however, is much more suggestive of significant social-psychological problems which, while they are far beyond the scope of the present investigation, should receive some impetus for examination by the findings contained herein.

A.4 - B.2

For the CDTC sample, the rate of correspondence between prior and current offense was found to be highest for sexual offenses, while sexual offenses had the lowest rate of correspondence in the LSH sample. In both samples, a greater percentage of those with a current offense different from their prior offense shifted to a current offense that is less serious than their prior offense. Also the same in both samples was the ordering of current offenses for those with no prior offenses (excluding drug): sex offenses were highest, followed by property offenses and then by nonsexual personal offenses.

A.5 - B.3

CDTC Ascherman evaluation referrals were charged most often with sexual and nonsexual personal offenses. The Ascherman referrals at LSH, on the other hand, were charged most often with property and nonsexual personal offenses. The competency/sanity referrals in both samples were most often charged with nonsexual personal offenses.

There is obviously neither a clear nor a categorical relationship between offense and involvement in the forensic psychiatric system in Lucas and Wood Counties. This is a finding, of course, which the positivistic criminologist will applaud and which the classical criminologist will abhor.

A.10 - B.9

While there was greater agreement between LSH recommendations and court dispositions than between CDTC recommendations and court dispositions, the former agreement was essentially perfect and thus rather difficult to match. Complete agreement is not, of course, inherently desirable and may in fact represent both a failure to consider or propose alternatives and noncritical "rubber-stamping".

Follow-Up Status

To many, the most important variable in any deviance definition and management system is the performance of the individual after his departure from the system. There can certainly be no accurate measurement of the impact of a program without an evaluation of the follow-up status of those who moved through the program. The PSCD team therefore attempted to gather follow-up information on all 433 cases in the CDTC sample and all 95 cases in the LSH sample.

Of the 433 CDTC clients, follow-up data could not be obtained for 108. Sixty-eight of these 108 were referred after January 1, 1973 (including 80% of the Ascherman referrals and 81% of the competency/sanity referrals), and the balance represent unavailable or incomplete records. Of the 325 for whom follow-up information was obtained, 32 were referrals from outlying areas of Lucas County and from Wood County, and time did not permit visits to all these jurisdictions.

Table XXXIV (see p. 43) summarizes the follow-up status for the remaining 293 cases. Seventeen of the 293 were incarcerated, and two more were hospitalized from the time of disposition of their current offense through early February 1974 (when follow-up data were gathered). A total of 274 were thus potential recidivists. One of the major findings of this study is that only 22% (N = 61) of the potential recidivists in the CDTC sample had in fact repeated by February of 1974. As before, it was impossible to separate arrests from convictions, so these and the following recidivism figures may represent arrests only.

While this is a most encouraging finding, it is tempered somewhat by a finer breakdown of the data. Clients were placed into follow-up interval categories of six, 12, 18, and 24 months by computing the number of months that had elapsed between either the date of court disposition for their current offense, the date of the Center's final report on their current case, or the approximate date of their release from incarceration for the current offense. If the number of months was anywhere between six and 12, the client was in the six month follow-up interval; if the number of months was anywhere between 12 and 18, the client was placed in the 12 month follow-up interval, and so on through the 24 month interval. Table XXXIV reveals that, while only 22% of the total 274 potential recidivists in fact repeated, the percentage of potential recidivists who in fact repeated increased steadily as the follow-up interval increased in months. That is, four percent of the potential recidivists in the six month follow-up interval in fact repeated, 22% of those in the 12 month follow-up interval, 28% of those in the 18 month follow-up interval, and 32% of those in the 24 month follow-up period.

To further enhance the interpretive value of the follow-up data, a weighting system was developed to reciprocally account for both time of new offense and seriousness of new offense by attaching a numerical score to each and then simply adding the two scores together. More specifically, a score of 5 was given to an individual in the six month follow-up interval, a score of 4 to one in the 12 month interval, a score of 3 to one in the 18 month interval, and a score of 2 to one in the 24 month interval.[7] In addition, a score of 4 was given to an individual who was arrested for a more serious offense, a score of 3 to one who repeated in the same offense category, a score of 2 to one who was arrested for a less serious offense, and a score of 1 to one who had no new arrests. Those individuals with new offenses were scored on their first new arrest and in the follow-up interval in which that offense occured. Total scores could thus range from nine, an arrest for a more serious offense in the first six month interval, to three, or no new arrests through the 24 monch interval. Scores four through seven could obviously be obtained by more than one combination of time status plus offense status, but that is not a problem since the entire purpose of the weighting system is to consider each in relation to the other and thus depict a less serious offense after only 12 months as relatively equal in gravity to a more serious offense after 24 months.

In any event, the mean weighted follow-up score for the total 274 potential recidivists is 5.43. The breakdown of cases by referral date is presented in Table XXXV (see p. 44). It must be remembered that the follow-up intervals in months do not necessarily correlate with referral dates since the follow-up period for those incarcerated for their current offense does not begin until release from that incarceration; a total of 37 of 14% of the 274 were incarcerated for a portion of the time between disposition for their current offense and February 1974. Bearing this in mind, the probable follow-up interval for the remaining majority of those referred between July and December 1971 is 24 to 30 months, for those referred between January and June 1972 18 to 24 months, for those referred between July and December 1972 12 to 18 months, and for those referred between January and June 1973 6 to 12 months. The range of possible scores within each bracket, plus the midpoint of each range are listed in Table XXXV, and a comparison of the actual weighted scores with the range midpoints reveals that (1) there is less difference between actual scores over time than there is between predicted scores, and (2) actual scores progress steadily from 1.05 below the predicted score in the January-June 1973 bracket to .17 above the predicted score in the July-December 1971 bracket; that is, weighted scores, and thus the recidivism problem, increase over time.

Table XXXVI (see p.44) clarifies these findings by comparing the actual weighted scores with crime-free scores, or scores based solely on time intervals. When the crime-free scores for each follow-up interval are subtracted from the actual weighted scores for each referral date bracket, it is clear that recidivism has steadily increased over time. It should also be noted, however, that the differences between crime-free scores and actual weighted scores are not very large, and therefore not very suggestive of high frequencies of more serious offenses.

Table XXXVII (see p.45) provides more elaborate information on the 61 recidivists among the 274 potential recidivists. Only 18% of the recidivists were arrested for more serious offenses, compared to 41% each for less serious offense categories and the same offense category. Table XXXVIII (see p. 45) cross-tabulates new arrest and current offense to present an even clearer picture of recidivism. Excluding the "other" offenses, sexual offenses have the lowest rate of correspondence between current offense and first new offenses. Non-sexual personal and drug offenses have the highest rates of correspondence at 57% and 56% respectively. Most striking, however, is the finding that 76% of the new less serious offenses were in public order or other (miscellaneous) categories.

TABLE XXXIII

Recommendation by Court Disposition for LSH

	Recommendation		Disposition	
	%	N	%	N
Return to Community	18.4	(7)	18.6	(11)
Institutionalization	81.5	(31)	81.3	(48)

TABLE XXXIV

Recidivism Statistics for CDTC Sample

Follow-Up Interval Months	Total N	Incar. or Hosp.	Potential Recidivists	Recidivists N	Recidivists % of Potents.
6	(56)	7	49	(2)	4
12	(104)	9	95	(21)	22
18	(94)	2	92	(26)	28
24	(39)	1	38	(12)	32
Total	(293)	19	274	(61)	

TABLE XXXV

Weighted Follow-up Scores for CDTC Sample

Referral Date	Probable Follow-up Int.-Mths.	Possible Score Range	Predicted Score (Range Midpoint)	Actual Score	Act. Score-Pred. Score
7/71-12/71	24	6-3	4.5	4.67	+.17
1/72-6/72	18-24	7-3	5	5.14	+.14
7/72-12/72	12-18	8-4	6	5.80	-.20
1/73-6/73	6-12	9-5	7	5.95	-1.05

TABLE XXXVI

Actual Score and Crime-free Score for CDTC Sample

Referral Date	Probable Follow-up Int.-Mths.	Actual Score	Crime-free Score	Actual Score-Crime-free Score
7/71-12/71	24	4.67	3	1.67
1/72-6/72	18-24	5.14	4.5	.64
7/72-12/72	12-18	5.80	5.5	.30
1/73-6/73	6-12	5.95	6.5	- .55

TABLE XXXVII

Offense and Follow-up Interval Data for CDTC Recidivists

Follow-up Interval - Months	New Arrest: More Serious	Same	Less Serious	Row Total
6	--	--	100	2
WS = 7.00	--	--	(8)	
12	19[a]	38	43	21
WS = 6.76	(36)[b]	(32)	(36)	
18	23	50	27	26
WS = 5.96	(55)	(52)	(28)	
24	8	33	58	12
WS = 4.50	(9)	(16)	(28)	
Column Total	11	25	25	61

[a] = row percent, [b] = column percent

TABLE XXXVIII

Current Offense by First New Arrest for CDTC

Current Offense	First New Arrest: Sexual	Nonsex. Pers.	Property	Drug	Public Order	Other	Row Total
Sexual	50[a]	--	33	--	--	17	6
	(38)[b]	--	(20)	--	--	(7)	
Nonsex. Pers.	10	40	--	--	10	40	10
	(13)	(57)	--	--	(8)	(29)	
Property	16	5	26	21	11	21	19
	(38)	(14)	(50)	(44)	(15)	(29)	
Drug	--	7	20	33	27	13	15
	--	(14)	(30)	(56)	(31)	(14)	
Public Order	--	--	--	--	86	14	7
	--	--	--	--	(46)	(7)	
Other	25	25	--	--	--	50	4
	(13)	(14)	--	--	--	(14)	
Column Total	8	7	10	9	13	14	61

[a] = row percent, [b] = column percent

In summary, while various forms of data manipulation consistently demonstrate that the recidivism problem becomes more serious over time, the CDTC sample recidivism rates at their worst remain well below national averages, and, furthermore, over 40% of new arrests were for a less serious offense than first brought the client to the attention of the Center.

One of the major reasons for developing the weighted follow-up scoring system was to compare Ascherman and competency/sanity referrals with general evaluation referrals, and it is indeed regrettable that insufficient follow-up data were available on the former types of referrals to permit this comparison. Another reason was to compare the scores of those who received treatment with those who did not, and this was accomplished. The 66 of the 86 clients who received treatment at the CDTC for whom follow-up data were available produced a mean weighted follow-up score of 4.92 compared to a score of 5.59 for those who did not receive treatment.

The PSCD team was not able to obtain follow-up information on 61% (N = 58) of the LSH sample. These 58 break down as follows: two were too recent to permit even a six month follow-up; three were still in LSH at the time follow-up data were gathered; two were from Wood County and time did not permit pursuing them; 16 were incarcerated (as the disposition for their current offense) for an unspecified period of time so that follow-up interval could not be established, and the records of the remaining 35 were either unavailable or incomplete.

The 37 follow-ups obtainable included 15 clients (or 41%) with no new arrests since their release from LSH. Thus 59% of the LSH clients have recidivated compared to only 22% of the CDTC sample. Table XXXIX (see p. 47) compares the LSH and CDTC recidivists on seriousness of first new arrest. Twenty-seven percent of the LSH recidivists were arrested for more serious offenses compared to only 18% of the CDTC recidivists. On the other hand, 41% of the CDTC clients repeated in less serious offense categories compared to only 27% of the LSH repeaters. Thus the LSH recidivists repeated in greater proportion and in more serious offense categories than the CDTC recidivists.

Cost Effectiveness

Equal in importance to the follow-up status of clients who have been processed through the CDTC and LSH is the financial cost involved in the evaluative and treatment services provided by each agency. A variety of types of budgetary data were obtained from the Director of the CDTC and from the November 1973 Long Range Planning Report. These data were used in conjunction with staff interviewee estimates of time expenditures to arrive at approximate costs for various activities. Cost data regarding LSH were obtained directly from the Division of Forensic Psychiatry.

Mean salaries by professional affiliation were computed for all clinical personnel employed by the CDTC from July 1971 through December 1973. Psychiatrists have cost the Center $25/hour, psychologists $6.12/hour, social workers $6.09/hour, and vocational rehabilitation workers $5.10/hour. (Parenthetically, administrative assistants, secretarial, and clerical personnel have an average salary of $3.69/hour.) The mean salaries of professional personnel were then compared with the mean length of time each evaluative and treatment procedure takes to arrive at a partial cost for each procedure. The lengths of time involved in the administration of each procedure were obtained by averaging the time reported by all staff members interviewed in January 1974 who engaged in the particular procedure.

Table XL (see p. 47) presents the mean times and costs of the various evaluative and treatment procedures conducted at the CDTC. The first and most important observation that should be made is that the cost figures are based solely on salaries of professional personnel and therefore do not include any of the gamut of indirect costs (salaries of nonprofessional personnel, supplies, equipment, contract services, travel, retirement and compensation, and miscellaneous expenses). With this serious qualification in mind, it is nevertheless clear that, of all four evaluative techniques, social case history compilation takes the most time and psychometric testing the least. While the latter also costs the least, the former is second to the cost of a medical/neurological examination which is clearly higher by virtue of its performance by the more highly paid psychiatrists. Individual clinical interviews are conducted by members of all four professional affiliations, social work histories by psychologists, social workers, and vocational rehabilitation workers, and psychometric tests by psychologists and social workers, though the latter are restricted to objective test administration and scoring.

All three types of treatment are conducted by psychologists, social workers, and vocational rehabilitation workers (no psychiatrists are involved in direct treatment). These three groups average $5.34/hour in salaries if the MSW-Director is excluded and $5.79/hour if he is included. Since the Director leads some group therapy, the latter figure is used to compute the cost of $13.90 for group therapy. It is important to note that treatment times and costs are means and not totals for an average treatment week, and thus might be somewhat easily misinterpreted. For example, while each therapist spends an average of 2.4 hours/week in group therapy, a total of six groups meet each week, each under the guidance of one or two therapists.

Table XLI (see p.49) summarizes the caseloads and cost/client by year at the CDTC. Both caseloads and total expenditures have risen sharply

TABLE XXXIX

New Arrests by Seriousness for CDTC and LSH Recidivists

New Offense	CDTC %	CDTC N	LSH %	LSH N
More Serious	18	(11)	27	(6)
Same Category	41	(25)	45	(10)
Less Serious	41	(25)	27	(6)

TABLE XL

Professional Staff Time and Cost
In Evaluation and Treatment, CDTC

Evaluation	$\bar{X}$ Time-Hrs	Dollar Cost
Med/Neuro.	1.3	32.0
Ind. Cl. Int.	1.3	7.7
Soc. Case Hist.	2.4	13.3
Psychometric	1.2	6.8
Grand Mean	1.4	8.3

Treatment	$\bar{X}$ Time-Hrs/wk	Dollar Cost
Ind. Psycho.	4.3	23.0
Marital	1.4	7.5
Group	2.4	13.9
Grand Mean	2.1	12.16

over the three year period. Cost/client has steadily decreased over time, and the Director attributes this not only to the increase in numbers of clients served, but also to increasing staff efficiency and decreasing overhead costs. Table XLII (see p. 49) breaks down professional salaries and indirect costs by year. While professional salaries have constituted a greater percentage of the total expenditures each year, indirect costs have constituted a lesser percentage each year. Though the indirect cost/client has also steadily decreased over time, the professional salaries cost/client was highest in 1972, second highest in 1973, and lowest in 1971.

Table XLIII (see p. 49) presents data on professional and indirect costs broken down by evaluation and treatment each year. The percent distribution between evaluation and treatment was obtained by taking the mean percents of time reported by all interviewees to be devoted to evaluation and treatment, respectively, and converting these to a 100 point scale. That is, staff members who are engaged in evaluations reported an average of 52.7% of their time devoted to evaluation, and staff members who are engaged in treatment reported an average of 11.8% of their time devoted to treatment. On the basis of the fact that evaluation and treatment are the major (if not the sole) purposes of the CDTC, times devoted to these activities were converted to a 100 point scale, resulting in an 82% - 18% distribution between evaluation and treatment. Then, on the assumption that all other costs are indirectly supportive of these two major activities, indirect costs were distributed on the same percentage basis between evaluation and treatment. While the independent grand totals of professional costs and indirect costs do not correspond to those presented in Table XLII, the main concern is with their combined totals for each year for both evaluation and treatment, which figures do accurately total to the annual expenditures for each year. Thus, however distributed between professional costs and indirect costs, the percentage distribution between evaluation and treatment reported by the staff remains intact. These figures are then used to arrive at evaluation and treatment cost/day and cost/client presented in Table XLIV (see p. 50).

As Table XLIV indicates, a total of 869 clients were seen at the CDTC between July 1971 and December 1973. One-hundred-fifty-two of these clients were civil probate evaluations and 717 were CJS referrals. Of the PSCD team's sample of 433 cases from the 717 CJS referrals, 86 received treatment. These 86 represented 20% of the sample of 433, and it is thus a fair estimate that 20% of the total 717, or 144, received treatment. Thus 573 CJS cases and 152 probate cases, or a total of 725 cases were "evaluation only" referrals.

The evaluation only referrals from the PSCD sample averaged 42 total days, or about 30 working days on the CDTC's records between referral or admission date and date of final report, and this figure is generalized to all evaluation referrals in Table XLIV. Based on a five-day work week, the CDTC was in operation for 650 working days between July 1971 and December 1973; based on an eight-hour day, this represents 5200 working hours. Table XLIII indicates that the total evaluation cost for the 2 1/2 year period was $386,958. Simple calculations with all of these figures reveal that an average evaluation day at the CDTC costs $595.36 or $17.51/client for the average 34 clients in the process of evaluation on an average working day. If the total evaluation cost is divided by the total number of evaluations performed, the resulting cost is $533.74/evaluation.

The same sorts of calculations with regard to treatment reveal that an average treatment day at the CDTC costs $130.72 or $10.89/client for the average 12 clients in the process of treatment on an average working day. If the total treatment costs for the 2 1/2 year period ($84,942) are divided by the 144 treatment cases likely processed, the resulting cost is $589.88/series of treatments per client. The treatment clients in the PSCD sample of 433 averaged 73 total days, or 2.4 months, on Center records between referral or admission date and date of final report. Within that period of time, the 86 averaged 10.41 sessions at 2.1 hours each, or a total of 22 hours of therapy. Thus, an outpatient treatment series at the CDTC takes an average of 2.4 months and costs an average of $590. Ascherman indefinite commitments to LSH average an 18 month inpatient stay at a cost of $6,587.

Table XLIV also indicates that, when evaluation and treatment are combined, a total of 46 cases were being processed at the CDTC on an average day, at a total cost of $726 or a client cost of $15.78. The client cost is $10.16 less than the $25.94 expended on keeping a client at LSH for one day. If the total expenditures for all three years at the CDTC are divided by the total number of cases, the resulting cost is $543.04/client.

While the PSCD team did not obtain an absolute count, it is estimated that two-thirds of the total number of Ascherman and competency/sanity referrals were terminated cases and thus within the sample of 433. It is thus further estimated that 30 Ascherman and 24 competency/sanity referrals were made to the CDTC during the first 2 1/2 years of operation. Since 80% of the 20 Ascherman cases that were terminated were referred in 1973, there were probably approximately 24 total Ascherman cases seen in 1973. Likewise, since 81% of the 16 competency/sanity cases that were terminated were referred in 1973, there were probably approximately 19 total competency/sanity cases seen in 1973. In any event, given the fact that Ascherman and competency/sanity referrals were not formally accepted by the CDTC prior to the inflow of funds from the Division of Forensic Psychiatry in the early part of 1973, the cost analysis of these referrals is restricted to that year.

Table XLV (see p.50) summarizes the costs for the various types of evaluations performed by the

TABLE XLI

Caseloads and Costs by Year for CDTC

	Total N	Probate %	Probate N	CJS %	CJS N	Total Expenditures	Cost/Client
7/71-12/71	77	8	(6)	92	(71)	82,500	1071.43
1972	301	11	(33)	89	(268)	164,000	544.85
1973	491	23	(113)	77	(378)	225,400	459.06
Total	869	17	(152)	83	(717)	471,900	

TABLE XLII

Professional Salaries and Indirect Costs by Year for CDTC

	Professional Salaries			Indirect Costs		
	Total	% Tot. Expends.	Cost/Client	Total	% Total Expends.	Cost/Client
7/71-12/71	16,480	20	214	66,020	80	857
1972	80,085	49	266	83,915	51	279
1973	123,943	55	252	101,457	45	207
Total	220,508			251,392		

TABLE XLIII

Professional and Indirect Costs for Evaluation and Treatment by Year, CDTC

	Evaluation (82%)			Treatment (18%)			
	Prof. Costs	Indirect Costs	Total	Prof. Costs	Indirect Costs	Total	Grand Total
7/71-12/71	43,973	23,678	67,651	9,653	5,198	14,851	82,500
1972	87,412	47,068	134,480	19,188	10,332	29,520	164,000
1973	120,138	64,690	184,828	26,372	14,200	40,572	225,400
Total	251,523	135,435	386,958	55,212	29,730	84,942	471,900

TABLE XLIV

Evaluation and Treatment Cost/Day for CDTC

	N	Days on Records	Working Days on Records	Number Cases/Day	Total Cost/Day	Client Cost/Day
Evaluation	705	42	30	34	595.36	17.51
Treatment	144	73	53	12	130.72	10.89
Total	869			46	726.08	15.78

TABLE XLV

Costs for 1973 Evaluations by Type for CDTC

	N	%	Total Cost By Caseload	Cost/Client By Caseload	Percent Eval. Time	Total Cost By Time	Cost/Client By Time
Ascherman	(24)	6	11,090	462	9	16,635	693
Comp/San.	(19)	4	7,393	389	4	7,393	389
Other CJS	(279)	64	118,290	424	66	121,986	437
Probate	(113)	26	48,055	425	21	38,814	343
Total	(435)		184,828			184,828	

CDTC in 1973. The estimated 56 treatment referrals have been subtracted from the total 491 cases seen resulting in a total of 435 evaluation-only cases. On the basis of absolute caseload numbers, Ascherman referrals constitute 6% of all evaluations, but cost the most per client, or $462. Competency/sanity referrals constitute the lowest percentage of all evaluations, 4%, and cost the least, or $389/client. While the other CJS referrals (largely "general evaluations") constitute 64% of the total and the probate referrals constitute only 26%, their per-client cost is almost identical at $424 and $425, respectively.

The difficulty with these figures is that they fail to account for the fact that the various types of evaluations take varying lengths of time to process, and therefore the last half of Table XLV indicates the differential costs based on differential professional staff time investments. The Ascherman referrals in the PSCD sample averaged 6 hours of evaluation time, the competency/sanity referrals averaged 3.6 hours, and the CJS referrals as a total group averaged 3.8 hours. Staff reports were that probate referrals took less time, and these referrals were therefore estimated at 3 hours per case. On the basis of these figures, the Ascherman referrals rose to 9% of the total evaluation time in 1973, the competency/sanity cases remained at 4%, the other CJS referrals rose to 66%, and the probate referrals dropped to 21% of total 1973 evaluation time. The result in terms of cost is that Ascherman referrals remain the most expensive, but at $693/evaluation, and the probate referrals drop to the least expensive slot, or $343/evaluation. Competency/sanity evaluations remain at $389/evaluation, and the other CJS referrals rise to $437/evaluation.

These figures gain significance when compared to those characteristic of LSH. An Ascherman presentence evaluation at LSH costs $2011, therefore the CDTC Ascherman evaluation is at best $1549 (or 77%) less and at worst $1318 (or 66%) less than the LSH Ascherman evaluation. A competency/sanity evaluation at LSH costs $1095; therefore, the CDTC competency/sanity evaluation is $706, or 64% less than the LSH competency/sanity evaluation.

Summary and Conclusions

Strengths of the Toledo CDTC

The findings presented above leave little doubt that the anticipated benefits of forensic psychiatric centers listed early in this report are in large measure being realized by the Toledo CDTC. The reduction in referrals to LSH since the opening of the Center in 1971 coupled with the caseload size of significantly greater proportions than served by LSH prior to the Center's opening are clear testimony that the CDTC is (1) supplementing the evaluation and treatment services of LSH, (2) lightening LSH's caseload from Lucas and Wood Counties, and (3) preventing the institutionalization of some individuals and thus the disruptive influence on the client, his family, and the community of such institutionalization, not to mention the easing of the reintegration problem. Cost effectiveness analyses demonstrated that the CDTC negates a sizable proportion of costs incumbent upon institutionalization at LSH, and follow-up studies indicated that CDTC recidivism rates are both lower and less frequently a move to a more serious offense. A measure of the Center's treatment efficacy is the finding that weighted follow-up scores were lower (and thus less recidivistic) for those referrals who were treated at the CDTC than for those who were not. The CDTC is performing competency/sanity evaluations in a significantly shorter span of time than that typical of LSH, and the period between Center release and court disposition is also much shorter for the CDTC referrals.

The PSCD team found the CDTC to be providing not only evaluations, recommendations, and treatment for probation and parole, and emergency interventtion and consultation services for local detention facilities, but also education and training services for local social service agents. Fifty percent (N = 6) of those responding to the PSCD team's questionnaire reported having attended therapy sessions with their clients at the Center. CDTC staff members reported an average of 2.6 hours per week devoted to consultation with local CJS personnel, & another 2.6 hours devoted to consultation with non-CJS personnel regarding client evaluation and treatment. Expert testimony in court was found to have occurred on only a single occasion in the first 2 1/2 years of the Center's operation, such is the rapport and personal communication between the Center and the courts, and such is the faith of the latter in the former's reports. The Center was indeed found to be allocating greater proportions of its budget each year to the salaries of professional personnel, and to be staffed by individuals with higher professional degree attainments than is characteristic of LSH. And finally with regard to the list of anticipated benefits, the CDTC was found to have returned reports claiming dangerousness of clients and recommending institutionalization on some occasions, though not nearly as frequently as LSH. Indeed, the majority of the CDTC's recommendations were for return to the community, and the majority of LSH's recommendations were for institutionalization. Since the courts generally followed recommendations, the result was that most of the CDTC clients were returned to the community and most of the LSH clients were institutionalized.

Given all this, it is not too surprising that, when asked how well they think the Center is doing in achieving its goals and purposes, the vast majority of probation officers, judges, staff members, and Board of Directors members responding specified either well or very well. Judges and probation officers ranked the overall quality of evaluations as good or very good, and were virtually unanimous in claiming the evaluations are helpful and address the specific questions posed by the referral agent. Referral agents also indicated

that CDTC recommendations carry a good deal of weight in their decision-making. Most importantly, there was unanimous agreement among those individuals who had some experience with LSH evaluations that CDTC evaluations were superior in quality.

The judges, probation officers, staff members, and Board members who responded to PSCD team questioning made reference to many of these findings when asked about the strengths of the CDTC. On numerous occasions throughout the study period, the PSCD research team was also told that the "young, bright, highly-motivated, multi-disciplinary" staff is one of the greatest assets of the CDTC. Particularly favorable plaudits were accorded the Director who was widely-reported to be unusually skilled in bringing together in a close working relationship individuals with often highly diverse orientations and interests, including more than just mental health and criminal justice professionals in the Toledo area.

Problems Associated with the CDTC

While the PSCD study found very strong evidence that the CDTC is in fact realizing the anticipated benefits of forensic psychiatric centers, some problems were nevertheless encountered. To date, the CDTC has not achieved its goal of completing most, if not all evaluations, within 30 days. Indeed, the CDTC sample evidenced one day longer than the LSH sample for both all evaluation taken as a whole and for Ascherman evaluations. The CDTC sample also averaged one day longer between court order or referral and admission than did the LSH sample. Time was the most frequently voiced complaint of referral agents, and CDTC staff expressed acute awareness of this problem. Efforts of the PSCD team to pinpoint the problem most often hit upon the large caseload demands upon staff members, the desire of staff to provide thorough evaluations, the perennial paperwork problem, and the difficulties frequently entailed in getting clients into the office for evaluations. With regard to the last, broken appointments were reported to be a frequent cause of breakdown in the smooth expediting of cases. The resultant lengthening of time involved in completing evaluations may be the price to be paid for community-based as opposed to institutional evaluations.

The PSCD is also concerned about the low return rate for questionnaires mailed to probation officers, judges, and Board of Directors members. Fifty-three percent of the probation officers (10 of 19), 79% of the judges (11 of 14), and 59% (10 of 17) of the Board members did not return the questionnaire. While mailed questionnaires have an infamously poor return rate, the extremely enthusiastic reception accorded the PSCD team by those who were interviewed left the expectation that returns in this study would be substantial. The concern of the PSCD is tempered somewhat by the fact that return was requested of very busy people within a week after receipt.

Mention must also be made of the finding that racial distinctions were found at various junctions of client processing through the Center and courts. While most could be as easily accounted for by genuine differential racial involvements in different crime categories as by discriminatory practices, court disposition of a few groups of clients controlled by offense indicated few alternative explanations to differential Center recommendation and/or court disposition by race.

The PSCD team also found some discrepancy between the Center's statement of referral priorities and referrals actually received. As mentioned earlier, the CDTC indicated to referral agencies that special attention would be accorded offenders who commit crimes against people and offenders whose offense careers are exhibiting progressively more serious offenses. The PSCD found, on the other hand, that two of the three most frequent charges were property offenses (which was tied for first place with sexual offenses), and drug offenses. By the same token, the greatest percentage of those whose current offense was different from their prior offense record had shifted to a less serious offense as their current charge, though most referrals with prior records overall had repeated in the same offense category. While most referrals who had prior records were charged with sexual, nonsexual personal, (and property) offenses, and while most property offenses were felonious (and most sexual and drug offenses not felonious), there is still reason to be concerned about discrepancies between priorities of the CDTC and priorities of referral agencies.

Correlatively, the PSCD also found that Center staff were less convinced than the probation officers and judges responding to questioning that the latter adequately understood the goals and purposes of the CDTC. Probation officers and judges were also more satisfied than Center staff with the quality of working relations between the Center and referral agencies. On the other hand, suggestions came from all four groups questioned that communication and interaction between the CDTC and all other agencies could use some improvement. Of the 21 references made to this problem, three focused on the need for progress reports from the Center to the courts, and one suggested that the court should report back to the Center on disposition. Five others represented pleas for more punctual return of evaluation results on the part of the Center. One suggested that the Center staff should attend court more often, and another, reporting difficulty in getting hold of staff because of their frequent involvement in meetings, proposed a "man of the day" to be available to receive calls at all times.

In the November 1973 Long Range Planning Report, the Director of the CDTC proposed four steps to improve Center working relations with all court referral sources:

"1. Annual meetings that combine as a forum for the presentation of leading correctional and treatment programming concepts. Those invited will be judges, members of the Toledo Area Association of Correctional Workers and Concerned Citizens.

2. Maintaining the current board practice of includings judges and key probation department staff on the Board of Trustees. (This provides a continuing liaison among agency, board, and correctional representatives).

3. Printing and distributing to all appropriate court personnel a CDTC brochure that clearly articulates the agency goals, services, and referral procedures.

4. Increase utilization of formal and informal meetings with court and probation staff that are designed to enhance mutual understanding and cooperation." (pp. 8-9)

The findings of the PSCD study suggest that these are both desirable and necessary steps for the CDTC to take.

Frequent turnover of personnel at the Center also emerged as a problem. Various explanations were offered to the PSCD team to account for this, including the heavy workload, insufficiently competitive salaries, the preference of clinicians for treatment as opposed to evaluation, the desire of many to return to the academic environment to further educational attainment, and various forms of intrastaff conflict. Whatever its cause(s), staff turnover was readily acknowledged as a problem. Coincidentally, the Center subsidizes the salaries of more experienced administrative and supervisory level staff so as to offset the Ohio Civil Service practice of compensating all new staff at the lowest level in each pay range.

Related to complaints about staff turnover were contentions that the CDTC is in need of more staff, especially of a psychiatric nature. A total of 22 references were made to one or both of these problems by those questioned. While the Center is committed to the interdisciplinary team approach (as opposed to the traditional medical model), there is general consensus that two part-time psychiatric consultants cannot meet the needs of the Center and that a Director of Psychiatric Services or a Medical Director would therefore be desirable. The Director of the Center is hoping to fill such a position on a half-time basis by fiscal year 1974-75. In the interim, contract arrangements have been underway with the Medical College of Ohio and with a local hospital. Some problems may be encountered in filling this position due to a reported shortage of certified psychiatrists in the Toledo area.

There is also general agreement among those contacted by the PSCD team that a third diagnostic and treatment team is advisable, and the Director is hoping to accomplish this by 1975. The main argument for this addition is the rapidly increasing caseload and therefore workload. At one point in 1973, the overflow became of such unmanageable proportions that the Center had to request a temporary cutback of referrals. The only alternatives the Director could reasonably entertain were to establish quotas for each court or probation officer or to notify referral agencies that deadlines could not be met. Expansion of the staff to a third team would be designed to better meet the needs of referral agencies.

Six of the 35 individuals questioned by the PSCD team volunteered the opinion that the Center needs an inpatient facility. In the 1973 Long Range Planning Report, the Director listed (under "Gaps and Liabilities Within the Community: Absence of Community Mental Health Services") the absence of short term inpatient care for observation and diagnosis, and for treatment, of the assaultive offender under maximum security conditions. Some of those interviewed complained vociferously about the inability to deal with the assaultive offender who is blatantly mentally disturbed--statements were made to the effect that local civil institutions "will not touch criminal cases with a ten-foot pole", and that "LSH is a very poor and last ditch alternative, and it has a waiting list". While there was general agreement that seriously assaultive cases are a minority of the total client population, they are those who pose the greatest threat to the community. Because local correctional institutions are deemed inappropriate settings for the seriously mentally disordered offender, support is emerging for an inpatient facility under the auspices of the CDTC.

Other reasons cited for the need of an inpatient facility include the contention of Center personnel that referrals with more serious problems are increasing in numbers over time as the Center continues to demonstrate its capabilities. The PSCD team attempted to measure this claim by comparing referrals in six month blocks over time on five indicators of seriousness: current offense, prior offense, prior incarceration, mental health treatment history, and juvenile record. Two of the five measures (current offense and mental health treatment history) clearly substantiated the claim of greater severity of clients over time, and one other (prior incarcerations) was suggestive of greater severity. One (prior offense) was mixed, and only juvenile record was slightly suggestive of less severity. Along these same lines, it will be recalled that the Ascherman and competency/sanity referrals were clearly more serious than the balance of the CDTC sample, and these referral types increased substantially in numbers when the Center began receiving funding from the Division of Forensic Psychiatry in 1973.

Many of the problems just discussed relate quite obviously to funding. The Director has projected costs through 1976 on the basis of maintaining present service levels and of adding a Medical Director, a third team, and an inpatient facility (see Table XLVI, p. 54). One of the most immediate and pressing problems the Center faces is the expiration of original three year commitments by both

TABLE XLVI

Projected Cost of Services, CDTC

	1974	1975	1976
Maintain present level of service plus 6% inflation	$238,000	$253,000	$270,000
Addition of Medical Director	253,000	268,000	300,000
Addition of Third Team	312,000	352,000	387,000
Addition of Inpatient Facility	530,000	572,000	618,000

the Lucas County 648 Board and by OLEPA-AJD at the end of the current fiscal year. The Director is attempting not only to obtain continuations of contractual agreements with these funding sources, but also to tap new funds from the Toledo City Council (Revenue Sharing), the Lucas County Court of Common Pleas (County Commissioners), and the Wood County 648 Board. Clearly, the uncertainty of long range funding is a most serious problem for the CDTC.

Other issues include the role of the CDTC in relation to the civil Probate Court. There was reportedly a good deal of debate among those involved in founding the Center over whether or not services should be provided to the Probate Court. The percentage of total caseload comprised by these cases has steadily increased over time, though unit cost has averaged less than the CJS evaluations. While the PSCD team did not gather data on probate referrals, the Director reported very positive reactions by the Probate Court officials and very large reductions in the number of civil commitments in the wake of the CDTC involvement in the system. Genuine ambivalence appeared to surround this issue: on the one hand, Center staff feel they're making an important contribution to the civil mental health system; on the other hand, they feel probate cases contribute to their excessive workload and detract from the performance of their duties for the CJS.

Related to this issue is the acute awareness on the part of Center staff of the many shortcomings in the overall criminal justice and mental health systems in the Toledo area. Among the problems listed by the Center Director in the Long Range Planning Report are the following:

- -Insufficient long-range or maintenance outpatient therapy for the chronically disturbed adult offender.
- -Lack of funding and insufficient personnel within other agencies to work with the offender.
- -Insufficient funding for additional probation officers to provide intensive supervision and counseling of probationers.
- -No centers to provide week-end 24 hour intensive therapy within a secure setting
- -Antiquated and overcrowded lock-ups with no facilities or appropriate staff to provide therapy.
- -Lack of widespread community understanding of locally based rehabilitation services.
- -Lack of clear definition of agency services within the correctional community.

It is the PSCD's impression that much of the CDTC's effort to provide multiple and far-reaching services represents a conscientious attempt to compensate for many of these shortcomings in related areas.

The 1973 Long Range Planning Report expressed intentions to begin discussions with the Division of Forensic Psychiatry relative to providing forensic services on a regional basis by 1976. It might facetiously be said that, if Wood County is any example of the additional caseload that can be expected, then there is little to fear. It remains unclear to the PSCD why Wood County sends so few referrals to either the CDTC or LSH. On the other hand, if it is assumed that Wood County is atypical, then consideration must be given to the fact that the CDTC has recently had to curtail services within Lucas County alone due to an imbalance between current supply and demand. Considerations of regionalism must also be advised that a strong commitment to maintaining independent agency status exists among Board members and staff members of the CDTC. Furthermore, when Board members were asked by the PSCD team: "In its future development, would you like to see the Center become more state-oriented or more deeply-rooted in the local community?", five of the seven responding opted for the local orientation and two replied "both". Said one of the two: "If funding is available at the State level, this should outweigh a rigid insistence on complete local control unless state requirements were so onerous as to preclude the performance of the Center's mission". One of those who chose the local orientation added, however, that the State should provide more funding since the CDTC is assuming some of the work of LSH.

A few problems relating to more general issues in forensic psychiatry were also identified by the PSCD team in the course of its investigation. CDTC staff members on numerous occasions expressed confusion regarding who "the client" really is--the offender or the referral agent. The question becomes significant in relation to confidentiality and various other situations involving conflicts of interests. Related to this issue is that of the efficacy of "treatment by force"--resistance is frequently encountered, according to Center personnel.

Last, but by no means least, the PSCD team found that eight of the nine staff members responding to questions regarding the content of Ohio's incompetency and insanity statutes displayed some confusion or misunderstanding, especially with regard to the test for criminal responsibility. One of the judges interviewed maintained that ignorance or misunderstanding of the statutes on the part of Center personnel was a problem in the early days of operation, but that improvements have occurred over time under the guidance and teaching of the court. While incompetency/insanity cases are a minority of the CDTC cases, they have increased substantially since the introduction of Forensic Psychiatry Division funds, and ignorance of the law on the part of those servicing the courts is surely a matter of serious concern.

Recommendations

In light of all the findings discussed above, the PSCD recommends that:

(1) Continued support be given to the development of forensic psychiatric centers in the State of Ohio by the Department of Mental Health and Mental Retardation. To the degree the accomplishments that have been made at the Toledo CDTC can be realized in other locales, forensic psychiatric centers promise to be community-based alternatives to LSH that are both more economical and more effective in stemming recidivism. Indeed, the vast majority of the benefits anticipated in Ohio's venture into the development of forensic psychiatric centers are being successfully achieved in the Toledo area as a result of the CDTC.

(2) Continued support, financial and otherwise, be extended to the CDTC by all relevant federal, state, and especially local agencies. The demonstrated success of the Center in achieving its goals and purposes renders it worthy of future investment and assistance by all concerned with the problems involved in managing the mentally disordered offender.

(3) The CDTC and referral agencies make a renewed effort to decrease the length of time elapsing between court order or referral and admission to the Center. Similar efforts should be made by the Center to reduce the time involved in completing evaluations. If however, the choice is ever between time and quality, responses of referral agencies and the inclinations of the PSCD suggest that quality should be maintained.

(4) The CDTC reaffirms the priority-ranking of referrals in terms of personal offenses and increasingly serious offenses, and perhaps exercise some screening of referrals along these lines. Greater selectivity by both referral agencies and the Center should make some contribution to easing excess caseloads.

(5) The CDTC and referral agencies seek to improve communication and interaction with one another. While extensive formal and informal communication and interaction is already evident, complaints of participants at all levels of the system suggest there is still considerable room for improvement. The CDTC should work especially diligently toward seeing that referral agencies clearly understand the goals and purposes of the Center, with an eye toward reducing inappropriate expectations and increasing staff efficiency.

(6) The CDTC makes every effort to stabilize the staffing situation by reducing excessive turnover. Funding agencies should be encouraged to increase the subsidizing of salaries, for turnover is very costly not only in terms of orientation and training but also in terms of morale, and a vicious circle is easily generated.

(7) The CDTC continues its efforts to add a Medical Director and a third diagnostic and treatment team to the staff, but abandon plans to open an inpatient facility. The PSCD is acutely aware of the fact that inpatient treatment is sorely needed but strongly recommends alternatives to the CDTC opening its own facility. Capital expenditures, maintenance, and staffing with high quality personnel are inordinately costly. It must be remembered that one of the basic advantages of the CDTC is its lower costs for handling clients. If the inpatient facility were achieved, these costs will increase. Furthermore, there is evidence on the national scene that the group most often presenting problems--the young--will be decreasing in numbers as the "baby boom" subsides. To the degree the need for inpatient care is related to drug abuse, there is also evidence that a decline in the drug problem has begun to occur in the United States (especially heroin). In other words, unless it is anticipated that additional heavy industry will be attracting large groups of migrants, no community should be advised to open new inpatient facilities at this time if some such facilities are already in operation in the area.

The CDTC, of course, has a problem in the unwillingness of civil facilities to accept CJS clients, and this is a problem not unique to Toledo. The PSCD encourages the Department of Mental Health and Mental Retardation and the CDTC to negotiate arrangements between civil facilities in the area and the CDTC whereby short-term hospitalization of CDTC clients can be accomodated. Failing this, the PSCD recommends that, in instances where assaultive or otherwise dangerous behavior appears to be closely-related to mental health problems, the client be diverted into the civil probate procedure and committed to a local mental health facility.

(8) The CDTC continues to appraise its arrangements with the civil Probate Court. While the PSCD has insufficient information to address the question of whether or not probate cases should continue to be served by the CDTC in the future, time and cost investments in this area have clearly been steadily increasing since the opening of the Center. On the other hand, the PSCD strongly endorses the removal of barriers between the mental health and criminal justice systems implied in the very concept of forensic psychiatry, and in this sense the CDTC is a forensic psychiatric center in the fullest sense of the terms.

(9) An examination into the reasons behind the minimal referrals from Wood County to either the CDTC or LSH be conducted by the CDTC and the Department of Mental Health and Mental Retardation.

(10) The CDTC makes every effort to maintain its independent status as a private contractual agency, but conduct negotiations with the Department of Mental Heath and Mental Retardation to provide regional services in the foreseeable future. To this end, the PSCD again recommends that the CDTC make every possible effort to screen out clients

with minimal mental health problems. It is further recommended that the CDTC reconsider its efforts to expand beyond specific mental health services to vocational rehabilitation and other forms of outreach work. While the PSCD is very aware of needs in this area, and indeed endorses the orientation that seeks to break out of traditional narrow conceptualizations of problems, the energies of the Center should be directed first and foremost toward the unique contribution that can be made in evaluation and treatment. Probation officers and other social agencies should be relied upon to provide complimentary services. These adjustments seem to hold promise not only for increased efficiency in conducting evaluations and treatment, but also for a reduction in territorial jealousies and subsequent improvements in working relations among the components of the larger system.

(11) The CDTC considers increasing the time devoted to treatment as compared to the time devoted to evaluations. Follow-up scores suggest that treatment at the CDTC has an effect in reducing recidivism, and the Center should capitalize upon this finding. An increase in treatment should also function to ease the portion of staff turnover attributable to frustration of treatment aspirations.

(12) The CDTC and the Department of Mental Health and Mental Retardation address more specifically the dilemmas involved in confidentiality and other issures regarding "hierachies of allegiance" as they operate in the forensic psychiatric setting. Of equal concern is the issue of "treatment by force"--current national concerns with the right to treatment may obscure very legitimate questions concerning the right to refuse treatment.

(13) The CDTC and the court acquant every staff member with the exact statutory criteria for criminal irresponsibility and criminal incompetency. Correlatively, the PSCD recommends that immediate and serious attention be given by the Department of Mental Health and Mental Retardation to revisions in the Ohio statutes covering these matters. Indeed, these statutes are so ambiguous and confused that it is little wonder that CDTC staff displayed uncertainty and misunderstanding. In the course of preparing this report, the PSCD was working on a proposal for statutory amendment. These efforts were ceased when the comments contained in Appendix I were presented to the Division of Forensic Psychiatry's Seminar on Incompetency and Insanity in Cleveland in February of this year. The comments were compiled by a staff attorney for the Mental Health Legislative Guide Project at the request of the Division of Forensic Psychiatry. Ms. Compton was kind enough to forward a copy of her comments to the PSCD with the request that the inclusion in this report be underscored by the fact that the text is not yet finalized and is not presented in a format intended for reading (as opposed to being heard). The PSCD strongly recommends that the Department of Mental Health and Mental Retardation study this document.

(14) The Department of Mental Health and Mental Retardation seek to clarify the relationship between forensic psychiatry and community mental health. The charter of community mental health centers specifies involvement in consultation and education, and the question can be raised as to why forensic psychiatric services are not provided under this arm of community mental health. While the criminal justice **and** mental health sytems have recently been bifurcated in the State of Ohio, there is reason to appraise the sometimes ambiguous division of responsibilities between the two systems. Although the PSCD is not prepared at this time to offer speific recommendations, it seems highly advisable for the Department of Mental Health and Mental Retardation to take a total overview of mental health related activities in the State with an eye toward the development of a coordinated and logically coherent service delivery system. It may seem an insignificant point to those not acquanted with studies of language behavior, but one of the most frustrating aspects of conducting the investigation reported herein was to grapple with whether the individuals processed through forensic psychiatric facilities are best conceptualized as "offenders", or as "criminal offenders", or as "patients", or as "mentally disordered offenders", or as "offensive mental patients", or whatever, not to mention the issues generated by such terms as "criminally insane" or "insanely criminal". The term "client" was deliberately employed in this report as the most neutral of alternatives. The PSCD does not intend this as a humerous quip to cap off a lengthy and tedious report. Language confusion too often reflects conceptual confusion, and the PSCD suspects that the latter may be the most onerous problem confronting forensic psychiatry.

FOOTNOTES

[1]It was in 1909 that Dr. William Healy opened an advisory court clinic in the Cook County Juvenile Court of Chicago. The first adult court clinic was established in the magistrate's court of Chicago in 1914. See M. Guttmacher and H. Weihofen: Psychiatry and the Law, N.Y., 1952, p. 261.

[2]Remark in address of Dr. Paul Lipsett, Regional Director for Legal Medicine, Massachusetts Department of Mental Health, "The Screening and Assessment of Competency to Stand Trial", delivered to a Seminar on the Mentally Ill Offender: Incompetency and Insanity, sponsored by the Division of Forensic Psychiatry, Ohio Department of Mental Health and Mental Retardation, Cleveland, February 8, 1974.

[3]The MMPI/CPI was copyrighted in 1966 by Dr. David A. Rodgers, Chief Psychologist at Cleveland Clinic. The instrument is in essence a condensed version of both the Minnesota Multiphasic Personality Inventory and Gough's California Personality Inventory.

[4]Some of the findings reported below are based on an N of 434. Data on one of the clients was inadvertently duplicated on IBM code sheets in the early stages of tabulation. The error was not discovered until most of the computer analysis had been completed, and since an N of one can have but negligible impact on statistics for a sample of 433/434, it was deemed unnecessary to rerun the entire analysis.

[5]Year seen at the Center is based upon date of referral or admission. Eighteen of the 433 cases were not dated and could therefore not be forthwith placed within the appropriate year. To facilitate analysis, these 18 were distributed over the 2 1/2 year period in proportion to those with dates, and thus three were placed in the 1971 category, nine in 1972, and six in 1973.

[6]It was impossible in many cases to clearly distinguish between arrests and convictions from the information on file at both the CDTC and LSH. Therefore all prior citations are recorded as arrests even though some are known to represent convictions.

[7]The score of one was intended for those falling into the 30 month follow-up interval--that is, those who were referred to the CDTC in its first months of operation. As a result of either extended processing time, missing data, incarceration for a period of time for current offense, or new arrest within 24 months, no 30 month follow-ups were obtained.

APPENDICES

APPENDIX A

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APPENDIX B

TABLE I

ADULT PSYCHIATRIC COURT CLINICS*

Name of Clinic / Community Served / Year Established	Annual Case Load	Chief Sources of Referral	Time of Referral	Staff Personnel	Annual Budget	Reports Generally Admitted in Evidence	Reports Generally Furnished Court, Defense and Prosecutor	Approx. No. of Cases Personal Testimony Required	Availability of Hospital Beds for Observation by Clinic staff	Association of Juvenile Court Clinic with Adult court Clinic	Proportion of Cases given Psychological Tests	Teaching Activities of Clinic Staff	Research Activities of Clinic Staff	Treatment	Remarks
Psychiatric Institute of Municipal Court Chicago 1914	7,250	Courts, nearly 100%	Fitness for trial 85% Insanity plea 5% Pre-sentence 10%	2 Psychiatrists 10 Psychiatrists* 10 Psychologists 1 Psychologist* 11 Psych. Social Workers 1 EEG Tech. 17 Secretaries	$437,360	Yes	Yes	100%	None	Separate	100%	Residents in Psychiatry from all major cities. Social Service Trainees Loyola & Univ. of Chicago. Psychology Interne Univ. of Chicago	Psychological Research	Needs surveyed, treatment program to be started	3% have electroencephalograms
Clinic of County Court of Philadelphia 1918	Adults 894 Juveniles 242			7 Psychiatrists 7 Psychologists 2 Social Workers 12 Secretaries	Approx. $150,000	Yes	Yes	Less than 10%	No	Combined source	5%	Soc. Work Trainees Psychia. Residents & Sr. Med. Stud. from various schs. attend hearings & confer.	To a very limited extent	No	
Psychiatric Clinic Recorders Court Detroit 1919	3,376	Court, 95% Social Agencies 5%	Fitness for trial 5% Post-conviction 95%	3 Psychiatrists 10 Psychologists 10 Secretaries	$206,339 Quarters furnished	No	No	200	Yes	No	100%	Internes occa. rotated from 2 local hosps. Staff members teach at nearby university	Staff members do individual research	None	
Medical Office, Supreme Bench of Baltimore 1921	365	Crim. Ct. 55% Munic. Ct. 22% Prob. Dept. 5% Dom. Rela. 8% Jail 9% States Atty. 1%	Fitness for trial 30% Insan. plea 6%, Pre-sent. 58% Other 6%	4 Psychiatrists* 2 Psychologists 1 Psy. Soc. Worker 4 Secretaries	$ 80,000 Quarters furnished	Yes	Yes In all Cases	30	None	Associated but virtually autonomous	100%	Lectures at Johns Hopkins Univ. & Med. Sch. Lectures Univ. of Md. Med. Sch. Med. Stud. Univ. of Md. come to Clinic	Publication of Clinical Paper. No original research	None	Many of Court referrals at request of Defense Counsel. 5% have electroencephalograms
Psychiatric Clinic of Municipal and Criminal Courts Cleveland 1925	700	Mun. Ct. 66% Com. Pleas 34%	Fitness for trial 8% Insan. plea 2% Pre-sent. 90%	2 Psychiatrists* 2 Psychologists 2 Psy. Soc. Workers 1 Psy. Soc. Workers* 3 Secretaries	$ 68,000	Yes	No	150 (only in common plea)	None	Separate	90%	None	None	None	
Behavior Clinic of the Criminal Court of Cook County, Chicago 1931	380	Court 30% Defense Attys. 63% State's Atty. 7%	Pre-trial 95% Pre-sentence 5%	1 Psychiatrist 1 Psychiatrist* 3 Secretaries	In General Budget Dept. of Aid	No	Frequently	79	None	Separate	1%	None	None	None	All cases have blood tests for syphilis & smears for gonorrhea
Psychiatric Clinic, Sup. Ct. 1st Judicial Dist., N.Y. & Bronx Counties 1932	2,050	Supreme Court Judges 100%	Pre-trial 26% Pre-sent. 74%	3 Psychiatrists* 2 Psychologists 4 Secretaries	In budget of Psychiatric Div. Bellevue Hospital	No	No	20	None	None	25%	Senior law students New York University	Statistical studies and clinical papers	1%	
Allegheny County Behavior Clinic, Pittsburgh, 1937	550	District Atty. 90% Defense Attys. & Families of Defend. 10%	Pre-trial 99% Pre-sent. 1%	1 Psychiatrist 1 Psychiatrist* 1 Psychologist 2 Social Workers 1 Statistician 3 Secretaries	$ 72,000 (office space furnished)	No	No	5	Yes	No	25%	Residents from Western Psychintric Clinic	No	None	
Erie County Family Court Psychia. Clinic Erie County, Penn., 1951	113	Court (only source)	Pre-trial 100%	4 Psychiatrists* 3 Psychologists 1 Social Worker 4 Secretaries	$ 76,000	Yes	Yes	Twice a year	No	Combined source	95%	No	No	No	

*Unless so designated, full time.

*In Ralph Slovenko (ed), Crime, Law and Corrections, Chas. Thomas, 1966, pp. 479-93.

TABLE I (Continued)
ADULT PSYCHIATRIC COURT CLINICS *

Name of Clinic / Community Served / Year Established	Annual Case Load	Chief Sources of Referral	Time of Referral	Staff** Personnel	Annual Budget	Reports Generally Admitted Furnished in Court. Evidence Defense and Prosecutor
Suffolk County Superior Court Clinic, Mass. 1908	100	Court 65% Prob. 15% Dis. Atty. 15% Jail 5%	Fitness for trial 3% Insan. plea 7% Pre-sent. 90%	1 Psychiatrist	$ 18,000 Quarters furnished	No No
Quincy Court Clinic Quincy Massachusetts 1958	93	Probation Officers 100%	Post-conv. 100%	1 Psychiatrist 1 Social Worker* 1 Secretary	$ 27,000 Materials & quarters furnished	No No
Waltham Court Clinic, Waltham Massachusetts 1963	73			1 Psychiatrist 1 Social Worker	$ 26,000 Materials & quarters furnished	No No
Baltimore County Ct. Psychia. Clinic 1929	75 Adults 175 Juven.	Master Juv. Ct. Circuit Ct. Judges, St. Atty. Prob. Dept.	Pre-trial 30% Post-conv. 70%	1 Psychiatrist* 1 Psychologist 1 Research Asst. 1 Secretary	$ 21,700 Materials & quarters furnished	Yes Yes
Holyoke, Mass. Court Clinic 1960	125	Court and Police 99% Other 1%	Pre trial 50% Pre-sent. 50%	1 Psychiatrist 1 Secretary	Dept. Ment. Health, Div. Legal Med. Quarters furnished	Yes Yes
Roxbury, Mass. Court Clinic 1960	340	Hos. Ct. 75% Other Cts. 20% Community 5%	Pre trial 50% Pre-sent. 50%	1 Psychiatrist 6 Psychiatrists* 3 Social Workers 1 Secretary	$101,000 Dept. Ment. Health, Div. Legal Med.	No No
San Mateo County, Calif. Ment. Health Serv., Cts. & Corrections Unit 1961	308	Prob. Dept. 52% Court 13% Jail 25% Dist. Atty. 5% Other 5%	Pre-trial 20% Post-conv. 80%	1 Psychiatrist 1 Psychologist 1 Secretary	$ 39,000	No No
Behavior Clinic Probation Dept. Dayton, Ohio Municipal Court 1962	290	Court 10% Prob. Dept. 85% Corr. Farm 5% Other 2%	Pre-trial 85% Pre-sent. 15%	1 Psychiatrist* 1 Psychologist* 2 Social Workers 2 Secretaries	$ 34,000	Yes No
Norfolk County Mass. Ct. Clinic Stoughton, Sharon and Canton 1962	55	Court 30% Prob. Dept. 60% Police 10%	Pre-trial 5% Pre-sent. 95%	1 Psychiatrist*	$ 3,000	Yes No
Chelsea Court Clinic, Chelsea, Massachusetts 1962	235	Court 90% Police 10%	Pre-trial 95% Pre-sent. 5%	1 Psychiatrist 1 Social Worker	Dept. Ment. Health Div. Legal Medicine	No No

*Unless so designated, full time.

Name of Clinic / Community Served / Year Established	Approx. No. of Cases Personal Testimony Required	Availability of Hospital Beds for Observation by Clinic Staff	Association of Juvenile Court Clinic with Adult Court Clinic	Proportion of Cases given Psychological Tests	Teaching Activities of Clinic Staff	Research Activities of Clinic Staff	Treatment	Remarks
Suffolk County Superior Court Clinic, Mass. 1908	None	No	No	1%	Seminar for Soc. Workers. Teaching in Boston Univ. Law Med.	No	12% in treatment	
Quincy Court Clinic Quincy Massachusetts 1958	None	No	No	1%	Staff Conf. with Prob. Offs. and Judges	No	30% in treatment	
Waltham Court Clinic, Waltham Massachusetts 1963	None	No	Yes	None	Conferences with Prob. Officers	No	13% in treatment	
Baltimore County Ct. Psychia. Clinic 1929	2	No	Combined service	95%	No	No	Supported by outside funds	
Holyoke, Mass. Court Clinic 1960	None	No	No	1%	No	No	10% in treatment	
Roxbury, Mass. Court Clinic 1960	None	No	Yes	20%	Psychia. Residents Lectures & Seminar for Prob. Staff, Soc. Work students	Study of Identification Choice in Delinquent Adolescents, and child placement.	33 1/3% in treatment	
San Mateo County, Calif. Ment. Health Serv., Cts. & Corrections Unit 1961	1	No	Yes	25%	Course for Sheriff's Deputies	No	14% in treatment	All applicants for Sheriff's Deputies screened
Behavior Clinic Probation Dept. Dayton, Ohio Municipal Court 1962	None	No	Separate	20%	Seminary students attend Seminars	Studies of homosexual recidivism begun	20% in treatment	
Norfolk County Mass. Ct. Clinic Stoughton, Sharon and Canton 1962	None	No	Yes	25%	None	Study of Geriatric Offenders begun	20% in treatment	
Chelsea Court Clinic, Chelsea, Massachusetts 1962	None	No	Yes	3%	No	No	25%	

*In Ralph Slovenko (ed), Crime, Law and Corrections, Chas. Thomas, 1966, pp. 479-93.

APPENDIX C

TCDTC Code Sheet

Column	
7-9	PSCD Identification Number
10-12	Referral county, agency, agent. (Code A)
13-14	Current Charge. (Code B)
15	Conviction (Yes - 1, No - 2)
16-17	Court status. (Code C)
18	Incarcerated. (Yes - 1, No - 2)
19	Age (Code D)
20	Sex (Male - 1, Female - 2)
21	Race (Code E)
22	Marital Status. (Code F)
23	Education (Code G)
24-25	Occupation (Code H)
26-29	Reson for referral (Code I)
30	Juvenile record. (Yes - 1, No - 2)
31-32	Prior charge(s) or conviction(s). (Code J)
33-34	Prior incarceration(s). (Code K)
35-36	Prior mental health treatment. (Code L)
37-41	Psychological testing. (Code M)
42	Number of interview sessions
43	Psychiatric evaluation. (Yes - 1, No - 2)
44-46	Evaluation results: positive. (Code N)
47-49	Evaluation results: negative. (Code O)
50	Ascherman committable as: psychopath - 1, mentally ill - 2, mentally retarded - 3.
51-53	Recommendation (Code P)
54	Treatment at CDTC recommended. (Yes - 1, No - 2)
55	Court decision regarding statutory question. (Code Q)
56-58	Court disposition (Code R)
59	Treatment at CDTC ordered. (Yes - 1, No - 2)
60-61	Treatment at CDTC received: enter number of sessions, 98 if number unknown, 99 if no treatment received.
62-67	Date of referral
68-69	Number of days between referral and admission
70-71	Number days between admission (or referral) and date of final report

CODE A Referral County, Agency, Agent

100 - Toledo Municipal
 01 - 50: POs names
 51 - 99: Judges name
200 - Lucas County Adult
 01 - 50: POs names
 51 - 99: Judges name
300 - Perrysburg
 01 - 50: POs names
 51 - 99: Judges name
400 - Maumee
 01 - 50: POs names
 51 - 99: Judges name
500 - Oregon
 01 - 50: POs names
 51 - 99: Judges name
600 - Ohio APA or U.S. Probation
 01 - 50: APA: name
 51 - 99: U.S. Probation: name
700 - Detention Facility
 01 - 99: name of facility
800 - Multiple Referral Source
 01 - 99: Agency and agents names
900 - Other
 01 - 99: County, agency, agents names

CODE B Current Charge

01 - Property
02 - Nonsexual personal
04 - Sexual
08 - Drug related
16 - Public order
32 - Other
99 - None

CODE C Court Status

01 - Pretrial
02 - Presentence
04 - On probation/parole
08 - Sentenced
99 - None

CODE D Age

1 - Under 21
2 - 21-30
3 - 31-40
4 - 41-50
5 - 51-60
6 - 61-70
7 - Over 70

CODE E Race

1 - White
2 - Black
3 - Oriental
4 - American Indian
5 - Puerto Rican
6 - Mexican

CODE F Marital Status

1 - Married
2 - Never married
3 - Remarried
4 - Divorced
5 - Widowed
6 - Separated

CODE G Education

1 - 0-8
2 - 9-11
3 - HS or GED
4 - 13-15
5 - College Degree
6 - Postgrad. work
7 - Postgrad. Degree
8 - Voca., Tech., Bus. Certificate

CODE H Occupation

01 - Prof., semi-prof.
02 - Exec., upper admin.
03 - Managerial
04 - Self-employed
05 - Sales
06 - Clerical-sec.
07 - Civil serv.
08 - Labor
09 - Farm
10 - Domestic
11 - Housewife
12 - Student
13 - Retired
14 - Disabled
15 - None

CODE I Reason for Referral

0001 - General evaluation
0002 - Probation eval.
0004 - Treatment eval.
0008 - Prob. of repeating
0016 - Dangerousness
0032 - Drug/al. prob/dep.
0100 - Ascherman
0200 - Competency
0400 - Sanity
1000 - Emerg. interv.
2000 - Treatment admin.
4000 - Other

CODE J Prior Charges or Convictions

01 - Property
02 - Nonsexual personal
04 - Sexual
08 - Drug related
16 - Public order
32 - Other
99 - None

CODE K Prior Incarcerations

01 - Felony
02 - Misdemeanor
04 - Unclassifiable incarc.
08 - None

CODE L Prior Mental Health Treatment

01 - Outpatient
02 - Inpatient
04 - Inpt. inst. MD off.
08 - Other/unclass. treat.
16 - None

CODE M Psychological Testing

00001 - MMPI/CPI
00002 - Rorschach
00004 - WAIS
00008 - TAT
00016 - Bender-Gest.
00032 - Grah.-Kend.
00100 - Rotter
00200 - Weschler Memory
00400 - POI
01000 - Draw-a-Person
02000 - Halstead
04000 - Vocational
10000 - Lowens. Mosaic
20000 - Other
40000 -
99999 - None

CODE N Eval. Results: Positive

001 - Not mentally impaired
002 - Good probation risk
004 - Treatable
008 - Unlikely to repeat
016 - Not dangerous
032 - No drug/al. prob/dep.
100 - Not Ascherman
200 - Competent
400 - Sane

CODE O Eval. Results: Negative

001 - Mentally impaired
002 - Poor probation risk
004 - Not Treatable
008 - Likely to repeat
016 - Dangerous
032 - Drug/al. prob/dep.
100 - Ascherman
200 - Incompetent
400 - Insane

CODE P Recommendation

001 - Probation
002 - Further evaluation
004 - Social-life interv.
008 - Drug/al. treat. prog.
016 - MH outpt. treatment
032 - MH institution
100 - Due Proc/incarceration
200 - Other
999 - None

CODE R Disposition

001 - Probation
002 - Further evaluation
004 - Social-life interv.
008 - Drug/al. treat. prog.
016 - MH outpt. treatment
032 - MH institution
100 - Due Proc/incarceration
200 - Other
999 - None

CODE Q Court Decision Re Stat. Question

1 - Not Ascherman
2 - Competent
3 - Sane
4 - Not drug dep.
5 - Ascherman
6 - Incompetent
7 - Insane
8 - Drug dep.

APPENDIX D

TCDTC-LSH Code Sheet

Column	
7-8	PSCD identification number.
9	Race (Code A).
10	Sex (Male - 1, Female - 2).
11	Age (Code B).
12	Education (Code C).
13	Marital status (Code D).
14-15	Occupation (Code E).
16	Reason for referral (Code F).
17	Referral agent (Lucas County Common Pleas Court - 1, Wood City CP Court - 2, Lucas Cty. Juv. Ct. - 3, Toledo Municipal Ct. - 4)
18-19	Charge (Code G).
20-21	Prior mental health treatment (Code H).
22-26	Psychological testing (Code I).
27	Social history (Yes - 1, No - 2).
28-32	Diagnostic number (Enter number, None - 00000, Multiple diagnoses - 88888)
33	Ascherman committable as (psychopath - 1, mentally ill - 2, mentally retarded - 3).
34-36	Evaluation results: positive (Code J, identified as N -).
37-39	Evaluation results: negative (Code K, identified as O -).
40-42	Recommendation (Code L).
43	Juvenile record (Yes - 1, No - 2).
44-45	Prior charges or convictions (Code M).
46-47	Prior incarcerations (Code N).
48-53	Date of court order (or admission).
54-55	Number days between ct. order and admission.
56-58	Number days between admission (or ct. order) and release.
59-61	Number days between release and first return.
62-65	Number days between first return and second release.
66-71	Date of last release.
72-	If still at LSH, number days between admission through December 31, 1973.

Card Two

7-8	PSCD ID number.
9	Court decision on statutory question.
10	Court disposition (1 = incarcerated, 2 = probation, 3 = returned to LSH).

CODE A Race

1 - White
2 - Black
3 - Oriental
4 - American Indian
5 - Puerto Rican
6 - Mexican

CODE B Age

1 - Under 21
2 - 21-30
3 - 31-40
4 - 41-50
5 - 51-60
6 - 61-70
7 - Over 70

CODE C Education

1 - 0-8
2 - 9-11
3 - HS or GED
4 - 13-15
5 - College Degree
6 - Postgrad. Work
7 - Postgrad. Degree
8 - Voca., Tech., Busi. Certificate

CODE D Marital Status

1 - Married
2 - Never married
3 - Remarried
4 - Divorced
5 - Widowed
6 - Separated

CODE E Occupation

01 - Prof., semi-prof.
02 - Exec., upper admin.
03 - Managerial
04 - Self-employed
05 - Sales
06 - Clerical-sec.
07 - Civil serv.
08 - Labor
09 - Farm
10 - Domestic
11 - Dousewife
12 - Student
13 - Retired
14 - Disabled
15 - None

CODE F Reason for Referral

1 - 2945.37 (com/comp. 30 days)
2 - 2945.37 (com/comp. indef.)
3 - 2945.40 (com/comp. 30 days)
4 - 2947.25 (Asch., pres. 30 days)
5 - 2947.25 (Asch., posts. indef.)
6 - 2945.40 and .37 (com/comp. pres. and posts.)
7 - 2947.25 (Asch. pres. and posts.)
8 - 2945.40 and 2947.25 (com/comp. and Asch.)

CODE G Charge

01 - Property
02 - Nonsex. pers.
04 - Sexual
08 - Drug-related.
16 - Pub. order
32 - Other
99 - None

CODE H Prior MH Treatment

01 - Outpatient
02 - Inpatient
04 - Inpt. inst. MD offender
08 - Other/unclassifiable treat.
16 - None

CODE I Psychological Testing

00001 - MMPI
00002 - Rorschach
00004 - Corsini
00008 - Beta
00016 - Bet
00032 - PAT

00100 - DAH
00200 - DAT
00400 - Rotter
01000 - WAIS
02000 - TAT
04000 - Lykken

10000 - GPPT
20000 - Dep. Invent.
40000 - Other
99999 - None

CODE J Evaluation: positive

001 - no criminal tendencies
002 - good probation risk
004 - treatable
008 - unlikely to repeat
016 - not dangerous
032 - no drug/al. prob/dep.
100 - not Ascherman
200 - competent
400 - sane

CODE K Evaluation: negative

001 - criminal tendencies
002 - poor probation risk
004 - not treatable
008 - likely to repeat
016 - dangerous
032 - drug/al. prob/dep.
100 - Ascherman
200 - incompetent
400 - insane

CODE L Recommendations

001 - probation
002 - unclassifiable treat.
004 - unclassifiable inst.
008 - not LSH
016 - MH outpatient
032 - MH inpatient
100 - Due process/ incarc.
200 - Other
999 - None

CODE M Prior Charges/Convictions

01 - Property
02 - Nonsexual personal
04 - Sexual
08 - Drug related
16 - Public order
32 - Other
99 - None

CODE N Prior Incarcerations

01 - Felony
02 - Misdemeanor
04 - Unclassifiable incar.
08 - None

APPENDIX E

Note: The following questions refer solely to criminal cases seen at the CDTC; please exclude civil psychiatric probate cases from your responses.

Questionnaire for Staff of the

Toledo Court Diagnostic and Treatment Center

Position at Center _____

1. How long have you been employed by the Center? _____months, or _____years.

2. Is your position with the Center fulltime_____ or part time _____? If part time, how many total hours/week _____or hours/month _____ do you work for the Center?

3. What are the responsibilities accruing to your position at the Center? General description:

a. Administrative _____
b. Evaluations and/or Recommendations _____
(Include not only the administration of evaluation procedures but also time spent in analysis, report writing, staffing, and consultation regarding evaluations and recommendations.)
c. Treatment _____
d. Other (specify) _____

Enter approximate percentage of total time devoted to each activity.

If engaged in evaluations, which of the following procedures do you personally administer, and what is the average length of time it takes to administer, analyze, and write up each procedure?

a. Individual clinical interview _____mins. or _____ hour(s).
b. Compilation of social case history _____mins. or _____hour(s).
c. Psychometric testing:

MMPI/CPI	_____mins. or	_____hr(s).	Graham-Kendall	_____mins. or	_____hr(s).
Rorschach	_____mins. or	_____hr(s).	Rotter	_____mins. or	_____hr(s).
WAIS	_____mins. or	_____hr(s).	Weschler Memory	_____mins. or	_____hr(s).
TAT	_____mins. or	_____hr(s).	POI	_____mins. or	_____hr(s).
Bender-Gestalt	_____mins. or	_____hr(s).	Halstead	_____mins. or	_____hr(s).
Draw-a-Person	_____mins. or	_____hr(s).	Vocational	_____mins. or	_____hr(s).
Other(specify)_____					

d. Medical and/or neurological examinations _____mins. or _____hr(s).
e. Other (specify) _____, _____mins. or _____hr(s).

If engaged in treatment, which of the following are you involved in, and how many hours of an average week do you devote to each?

a. Individual psychotherapy _____hrs.
b. Marital counseling _____hrs.
c. Group therapy:
   Couples/sex offenders _____hrs. Slow learners _____hrs.
   General resocialization/drug-alcohol abusers _____hrs.
   Workhouse program _____hrs. Severely antisocial _____hrs.
   Mildly antisocial _____hrs. Other (specify) _____, _____hrs.
d. Other (specify) _____, _____hrs.

Would you estimate the amount of time you spend in an average week consulting with court, probation or other criminal justice system personnel regarding your clients?

Would you estimate the amount of time you spend in an average week consulting with families, friends, employers, or other non-court-related social agents regarding your clients?

4. What attracted you to your position at the Center?

5. What do you see as the major goals or purposes of the Center?

6. Generally speaking, how well do you think the Center is doing in achieving its goals or purposes?

Very Well 1 2 3 4 5 Not well at all

7. How well do you think the various referral agents understand the goals or purposes of the Center? More specifically, how well are the goals or purposes understood by:

a.	Probation officers	Very well	1	2	3	4	5 Not well at all
b.	Municipal judges	Very well	1	2	3	4	5 Not well at all
c.	Common Pleas judges	Very well	1	2	3	4	5 Not well at all
d.	Local detention facility personnel	Very well	1	2	3	4	5 Not well at all
e.	Parole officers	Very well	1	2	3	4	5 Not well at all
f.	Other (specify) _____	Very well	1	2	3	4	5 Not well at all
		Very well	1	2	3	4	5 Not well at all

8. How would you characterize your working relations with the various referral agents?

a.	Probation officers	Very good	1	2	3	4	5	Very bad
b.	Municipal judges	Very good	1	2	3	4	5	Very bad
c.	Common Pleas judges	Very good	1	2	3	4	5	Very bad
d.	Local detention facility personnel	Very good	1	2	3	4	5	Very bad
e.	Parole officers	Very good	1	2	3	4	5	Very bad
f.	Other (specify) _____	Very good	1	2	3	4	5	Very bad
		Very good	1	2	3	4	5	Very bad

9. From which agency do most of your referrals seem to come?

a. Probation _____
b. Municipal Court _____
c. Common Pleas Court _____
d. Other (specify) _____

10. What is the type of evaluation that appears to be most frequently requested by referral agents?

a. General evaluation _____
b. Evaluation for placing on probation _____
c. Evaluation for treatment _____
d. Ascherman status _____
e. Competency to stand trial _____
f. Sanity at the time of commission of the act _____
g. Other (specify) _____

11. Would you make some estimate of the percentage of referrals that request evaluation regarding the client's

a. dangerousness _____
b. amenability to treatment _____
c. probability of repeating _____

12. Would you estimate the percentage of referrals in which the referral agent suggests to you what he thinks your conclusions should be regarding evaluation and recommendation? _____

13. What do you understand Ohio's test of competency-to-stand-trial to be?

14. What do you understand Ohio's test of criminal responsibility ("sanity") at the time of commission of the criminal act to be?

15. Would you please draw a general profile of the "average" client referred to the Center?

16. On the average, how much weight do you think the Center's evaluations and/or recommendations carry in the decision-making of:

a. Probation officers	A great deal of weight	1	2	3	4	5	No weight
b. Municipal judges	A great deal of weight	1	2	3	4	5	No weight
c. Common Pleas judges	A great deal of weight	1	2	3	4	5	No weight
d. Parole officers	A great deal of weight	1	2	3	4	5	No weight
e. Other (specify)							
_____	A great deal of weight	1	2	3	4	5	No weight

17. How would you compare the evaluations, recommendations and treatment programs of the Court Diagnostic and Treatment Center with those of Lima State Hospital?

18. What do you see as the major strengths and weaknesses of the Center?
First, strengths:

What about weaknesses?

19. If you could make any changes in any aspect of the Center's philosophy, structure, or operations, what would they be?

20. How has your experience with the Center affected your perception of:

a. criminal offenders?

b. the criminal justice system?

c. the helping professions?

21. Lastly, would you please complete the following items?

a. Circle the category appropriate to you:

1. Age: Under 21, 21-30, 31-40, 41-50, 51-60, over 60.
2. Sex: Male Female
3. Marital Status: Married, Never Married, Divorced, Separated, Widowed
4. Education: Under 12 yrs, HS, 13-15 yrs, College Degree, Work toward Masters, Masters Degree Work toward Ph.D., Ph.D. Degree, M.D. Vocation-Technical-Business Certificate

b. Briefly outline your professional career prior to assumption of your present position.

APPENDIX F

Questionnaire for Toledo Area Judges

Regarding Court Diagnostic and Treatment Center

1. How long have you been serving as a (Common Pleas/Municipal) Judge? ___yrs.
(circle appropriate)
2. Could you briefly outline your professional background prior to assumption of your present position?

3. To your understanding, what is the purpose of the Toledo Court Diagnostic and Treatment Center?

4. Generally speaking, how well do you think the Court Diagnostic and Treatment Center is doing in achieving its purposes?

Very well 1 2 3 4 5 Not well at all

5. How would you characterize your working relations with the Center?

Very good 1 2 3 4 5 Very bad

6. What are the statutes under which you are permitted or mandated to send an offender to the Court Diagnostic and Treatment Center for <u>evaluation</u>?

7. Could you give us an estimate of how many offenders you refer to the Court Diagnostic and Treatment Center for evaluation under each of these various statutes in, say, an average month?

8. What are the statutes under which you are permitted or mandated to send an offender to the Court Diagnostic and Treatment Center for <u>treatment</u>?

CONTINUED

1 OF 2

9. Could you give us an estimate of how many offenders you refer for treatment under each of these statutes in an average month?

10. Do Center personnel appear to understand the specific questions they are legally bound to answer with regard to sanity at the time of the offense, competency to stand trial, and Ascherman evaluations?

11. Besides these statutorily-mandated questions, what are the other sorts of questions you most frequently ask the Center to address, particularly in presentence examinations?

12. Under what circumstances do you ask the Center to couple their evaluations with recommendations?

13. Do you ever make suggestions to the Center of what you think their conclusions regarding evaluations and recommendations should be, based, perhaps, on your unique knowledge of the offender and surrounding circumstances?

14. We're particularly interested in your evaluation of the Center's performance and responsiveness to your needs.

    a. How would you rank the overall quality of their evaluations?

       Very good 1 2 3 4 5 Very bad

    b. Do their evaluations usually address the questions you posed in the referral?

       Yes ___No____ Other_____

    c. Do they generally complete their evaluations within the time limits suggested or imposed by either you or the law?

       Yes ___No _____ Other_____

    d. Are their evaluations helpful to you in your decision-making regarding the offender?

       Yes ___No____ Other_____

    e. How much weight do their evaluations carry in your decision-making?

       A great deal of weight 1 2 3 4 5 No weight at all

    f. How effective do you think their treatment programs are?

       Very effective 1 2 3 4 5 Not effective at all

15. How would you compare the evaluations, recommendations, and treatment programs of the Court Diagnostic and Treatment Center with those of Lima State Hospital?

16. Do you have any problems whatsoever with regard to the Court Diagnostic and Treatment Center or any suggestions for change or improvement.

17. Any other comments that would aid us in our analysis of the Center?

APPENDIX G

Questionnaire for Toledo Area Probation Officers

Regarding Court Diagnostic and Treatment Center

1. How long have you been working as a probation officer in this area?

_____months, or _____years

2. To your understanding, what is the purpose of the Court Diagnostic and Treatment Center?

3. Generally speaking, how well do you think the Court Diagnostic and Treatment Center is doing in achieving its purposes?

Very well 1 2 3 4 5 Not well at all

4. How would you characterize your working relations with the Center?

Very good 1 2 3 4 5 Very bad

5. Could you estimate how many referrals you make to the Center in, say, an average month? _____

6. Would you please draw a general profile of the "average" offender you refer to the Court Diagnostic and Treatment Center?

7. In your referrals, what are the questions you most frequently ask the Center to answer for you?

8. Do you ever make suggestions to the Center of what you think their conclusions regarding evaluations and recommendations should be, based, perhaps, on your unique knowledge of the offender and surrounding circumstances?

Yes ___ No ___ Other _____

9. We're particularly interested in your evaluation of the Center's performance and responsiveness to your needs.

   a. How would you rank the overall quality of their evaluations?

      Very good 1 2 3 4 5 Very bad

   b. Do their evaluations usually address the questions you posed in the referral?

      Yes ___ No ___ Other_____

   c. Do they generally complete their evaluations within the time limits suggested or imposed by either you or the law?

      Yes ___ No ___ Other_____

   d. Are their evaluations generally helpful to you in your decision-making regarding the offender?

      Yes ___ No ___ Other _____

   e. How much weight do their evaluations and/or recommendations carry in your decision-making?

      A great deal of weight 1 2 3 4 5 No weight at all

   f. How effective do you think their treatment programs are?

      Very effective 1 2 3 4 5 Not effective at all

   g. How would you compare the evaluations, recommendations, and treatment programs of the Court Diagnostic and Treatment Center with those of Lima State Hospital?

10. Have you ever attended any of the Court Diagnostic and Treatment Center's therapy sessions or programs?

    Yes ___ No ____

11. Have you ever made a referral to Lima State Hospital for <u>evaluation</u> (as opposed to treatment)?

    Yes ___ No ___

12. Do you have any problems whatsoever with regard to the Court Diagnostic and Treatment Center or any suggestions for change or improvement?

13. Any other comments that would aid us in our analysis of the Center?

14. Lastly, would you please complete the following items?

    a. Circle the category appropriate to you:

       1. Age: Under 21, 21-30, 31-40, 41-50, 51-60, Over 60
       2. Sex: Male Female
       3. Marital Status: Married, Never Married, Divorced, Separated, Widowed
       4. Education: Under 12 yrs, HS, 13-15 yrs, College Degree, Work toward Masters, Masters Degree, Work toward Ph.D., Ph.D. Degree Vocational-Technical-Business Certificate

    b. Briefly outline your professional career prior to assumption of your present position.

APPENDIX H

QUESTIONNAIRE FOR BOARD OF DIRECTORS

TOLEDO COURT DIAGNOSTIC AND TREATMENT CENTER

1. Please describe any role you played in the creation of the Court Diagnostic and Treatment Center.

2. Why did you choose or consent to be affiliated with the Court Diagnostic and Treatment Center as a Board Member?

3. How do you define the major goals or purposes of the Center?

4. Generally speaking, how well do you think the Center is doing in achieving its goals or purposes?

5. What do you see as the major strengths and weaknesses of the Center?

First, strengths:

What about weaknesses:

6. If you could make any changes in any aspect of the Center's philosophy, structure, or operations, what would they be?

7. In its future development, would you like to see the Center become more state-oriented or more deeply-rooted in the local community?

8. Do you have any other comments that would aid us in our analysis of the Court Diagnostic and Treatment Center?

APPENDIX I

Remarks at Ohio Seminar for Forensic Psychiatry

February 8, 1974 Ruby I. Compton

"New Approaches to Incompetency to Stand Trial"

I. Background Information on Mental Health Law Project and Legislative Guide Project

The Mental Health Law Project began as an integral part of the Center for Law & Social Policy, one of the first public interest law firms. In 1972, the Project was organized as a separate entity to fill the obvious need for the involvement of lawyers and mental health professionals in improving the plight of the mentally handicapped. The Project activities include test case litigation, an education program and some limited back-up assistance. The litigation has included the important cases of Wyatt v. Stickney (Alabama -- Right to Treatment) and Mills v. Board of Education (D.C. -- Right to Education) which were begun as Center cases and continued by Project attorneys after January 1972. Other important cases include Kaimowitz v. Department of Mental Health (Michigan -- Psychosurgery), Souder v. Brennan (D.C. -- Right to Compensation for Institution Maintaining Labor), Morales v. Turman (Texas -- Right to Treatment for Juveniles), and Donaldson v. O'Connor (Florida -- Right to Treatment/ Compensation for Confinement without Treatment).

In addition to its own litigation activities, the Project provides interested lawyers around the country with specialized back-up assistance by disseminating materials

and providing expert advice.

The Project is also keenly interested in developing a mental health bar. To facilitate this goal, the Project, in conjunction with the Center for Law & Social Policy, conducts a clinical education program for second and third year law students from selected law schools throughout the country. There are five or six participating schools. It is anticipated that these students who have received training with the Project will continue to be involved in the mental health field after law school.

As part of its public education program, the Project has produced a consumer handbook entitled "Basic Rights of the Mentally Handicapped." Also, Project staff participated in the planning and presentation of a conference on the legal rights of the mentally retarded sponsored by the President's Committee on Mental Retardation and have recently completed co-sponsoring a series of four Practising Law Institute Seminars on Legal Rights of the Mentally Handicapped.

The Mental Health Legislative Guide Project (partially owned subsidiary of the Mental Health Law Project) is being conducted by the Mental Health Law Project under a cost-sharing contract with the National Institute of Mental Health. As is obvious to everyone here, there is and has been a serious need for the reconsideration and revision of state mental health legislation to reflect the changes and advances in the medical and behavioral sciences, patients' rights litigation and new concepts for administering and financing

mental health care. The Guide project was initiated to fill this need. The Guide is not intended to be an all-encompassing "uniform code," but will be comprehensive in scope. The Guide will, in selected areas, set forth model acts such as a model commitment act, supported by extensive commentary, and in other areas such as financing, the Guide will, in treatise form, analyze problems and issues and present the best feasible approaches. Our goal is to present workable legislative approaches in a format useful to state legislatures and other agencies interested in drafting and proposing new legislation in this field.

II. The Legislative Guide Perspective of the Ohio Statutes

Next, I have been asked to present the Legislative Guide's "perspective" of the Ohio statutes. First of all, I will list what I consider serious short comings in all three sections and then describe in more detail our legislative suggestions for a more enlightened approach to the issues.

A. Incompetency -- Section 2945.38 falls far short of the precise language necessary to protect the rights of defendant's whose competency is in issue.

1. First of all, the statute does not define the word "sane" nor does it provide a clear standard for a finding of competency. The Ohio cases indicated that the basic Dusky standard is applied, but this standard should be stated in the statute in the place of the inappropriate term "sanity."

2. Secondly, upon a finding of "insanity" or incompetency the statute requires automatic commitment to a state hospital.

[a] There is no provision for treatment in a less restrictive facility or on an outpatient basis and,

[b] There is no provision requiring an individualized treatment plan nor,

[c] is there any requirement that the treatment facility have the resources to provide the defendant with the particular treatment recommended.

3. Also, there is no durational limitation on confinement pursuant to a finding of incompetency. Under this statute defendants could be confined indefinitely in conflict with the recent Supreme Court decision in Jackson v. Indiana.

4. Likewise, there is no provision for periodic judicial review of the necessity of the defendant's continued confinement.

5. And, lastly, this section of the code should provide for, what some authors have termed "partial postponement." Defense counsel should be able to make pre-trial motions, the fair disposition of which can be made without the participation of the defendant.

B. Effect of Verdict of Not Guilty by Reason of Insanity -- Section 2945.39

1. Obviously, the presumption that the defendant's insanity continues if he is found not guilty by reason of insanity is without factual basis and is factually irrelevant to the general question whether those acquitted by reason of insanity are dangerous and in need of treatment.

2. In support of that presumption, the statute inappropriately provides for mandatory commitment upon a finding of not guilty by reason of insanity.

3. As in the incompetency section, this section mandates automatic commitment to a hospital rather than providing for treatment in alternative facilities.

4. The release procedures are too restrictive. Release procedures should be no more burdensome than those applied to civilly committed patients.

5. The provision for annual review by the hospital superintendent is insufficient. Review should be by the court and at least every ninety days if not more frequently.

C. Expert Witnesses in Insanity Cases -- Section 2945.40

1. First of all, this section should include a means whereby the defendant can challenge the court or the prosecution's request for a mental exam. If he feels he is competent to stand trial and was not insane at the time of the alleged criminal offense, he may not want to be subjected to the burden and embarrassment of a mental examination.

2. Again, the statute provides for automatic confinement for the mental examination and does not allow for out-patient examinations or use of screening tests to prevent unnecessary institutionalization.

3. If the defendant for good reason must be confined for examination, it should be for a very short period, certainly no longer than 5 days. Thirty days confinement for a pre-trial examination is much too long.

4. In accordance, the statute should make clear that the defendant is entitled to pre-trial release if he is otherwise eligible even though he has been ordered to undergo a mental examination.

5. The defendants Fifth Amendment rights against self-incrimination are totally ignored in the statute.

6. Also, the statute is unclear as to whether examiners can make conclusory statements in their report or at the hearing. The examiners, of course, should be limited to medical and behavioral observations and the need for treatment.

7. The language is unclear as to what "qualified physicians" are other than specialists in mental diseases. It should more specifically state who is qualified to conduct a mental examination.

8. Finally, even though the experts are purportedly "impartial," the defendant should have the right to an independent medical expert at the expense of the state. Studies show that dubbing an expert "impartial" causes judges and juries to abdicate their fact-finding responsibilities to that expert. The issues are socio-legal and should be decided within the adversary context.

III. Suggested New Approaches

Next, I hope to, at a minimum, superficially introduce some new approaches to the issues concerning the mentally ill in the criminal process and in so doing will point out that the statutes' shortcomings are in fact that. I intend to devote a disproportionate amount of my time on incompetency

problems simply because the issue of incompetency to stand trial is far more frequently raised than the insanity defense (less than 1% of all felony dispositions -- Matthews). It affects thousands of persons who are committed each year to mental institutions for study and for treatment, but has received much, much less attention from legal scholars and forensic psychiatry.

I will briefly discuss seven different key aspects of the proceedings that we feel need particular attention: [A] pre-trial release, [B] use of a screening test, [C] out-patient examinations, [D] the examiner's report to the court, [E] the defendant's Fifth Amendment rights, [F] maximum treatment periods, and [G] disposition of permanently incompetent defendants.

A. Pre-Trial Release

1) A majority of jurisdictions today deny bail and other forms of release when a pretrial mental exam is ordered and revoke bail when mental exam is ordered after release.

2) These practices are inconsistent with the constitutional and statutory rights of the accused.

3) The Eighth Amendment and Due Process Clause read together permit the fixing of bail only upon standards relevant to the purposes of assuring the presence of the defendant at subsequent proceedings. Forty states and the federal government provide for release based on this standard.

4) The practice of denying release would be justified only if there were a reasonable basis in experience for the

automatic denial of release for all who are scheduled for an examination.

5) But, there is no such factual basis for suggesting that those for whom an examination is ordered are, as a class, more likely to flee or fail to appear than others.

6) The different standard reflected in courtroom practice, therefore conflicts with the Eighth Amendment prohibition on excessibe bail, the due process right to a bail hearing and the several state statutes.

7) Mention Marcey v. Harris -- statutory grounds, Bail Reform Act. The Court of Appeals for the District of Columbia held that a mental exam order is not sufficient basis for denial of bail or other form of pretrial release. 400 F.2d 772 (1968).

8) Also, to apply additional hardships on those suspected of mental impairment seems contrary to enlightened, humane values. They should be permitted to maintain supportive relationships in the community while they await trial as well as other defendants.

B. Screening Test

1) We do not propose to have the requisite knowledge and understanding necessary to dictate what form the screening test should take, but from our research, we have concluded that an accurate screening test is appropriate to the fair and prompt disposition or treatment of those defendant's whose mental competence to stand trial is in doubt.

2) Dr. Lipsett, who worked with the Harvard Medical

School's Laboratory of Community Psychiatry as they developed a Competency Screening Test and Competency Assessment Instrument, is better qualified to discuss the substantive context of such devices.

3) However, we do feel that the screening test is one useful and appropriate alternative to the unnecessary institutionalization and extraordinary expense of observational commitment for clearly competent defendants.

[a] Defendents are usually sent great distances to state maximum security hospitals for in-patient pre-trial mental examinations.

[b] Some statutes provide for confinement for such pre-trial examinations for up to 90 days. The Ohio statute limits this observational confinement to 30 days, but that length of time is also unnecessary.

[c] In addition, an extremely high percentage are found competent and returned to court, (only 6/501 in Massachusetts not returned in 1971).

[d] So, for the majority of these defendant's, the 90 or even 30 day confinement has been an unnecessary restriction on their personal liberty.

[e] Administration of the screening test by qualified examiners, preferably a Forensic Psychiatric Office should remedy this by enabling the clearly competent defendant to return to court. As a practical matter, this can occur within a few hours after the issue is raised.

The procedure in the District of Columbia Superior Courts is illustrative: If the issue of incompetency

is raised before or during the trial, the defendant is taken downstairs from the courtroom where the Forensic Psychiatric Office has a Field Unit. He is examined on-the-spot and either returned to court (2/3 of those tested) as competent -- or sent to the main office of the Forensic Psychiatry Office of St. Elizabeth's for a more extensive examination. So, for 2/3 of the cases where the issue is raised, the proceedings are interrupted for a short period of time.

C. Out-Patient Examinations

With or without the aid of the screening test, pre-trial mental examinations should be conducted on an out-patient basis whenever possible.

As the least restrictive alternative for evaluating competency, outpatient examinations pose the fewest due process problems and should be required and presumed appropriate unless it can be convincingly demonstrated to the court that such a procedure would be ineffective in an individual case.

Long periods of confinement are unnecessary for a medically thorough mental examination. Adequate diagnostic procedures can be completed very quickly if the state devotes sufficient personnel to the task. Even in the absence of sufficient personnel, patients typically spend the 90-day observational confinement period as any other patient and are examined for at most 1 or 2 hours. This extremely short interview, as well as the adequately staffed interview, of course, could take place on an outpatient basis, eliminating

the need for prolonged confinement.

The counter argument is that institutionalization provides the opportunity for prolonged periods of observation. Observing patients on a daily basis in an institutional environment, however, does not for the most part enlighten the examiner as to the defendant's competency to stand trial. The defendant needs a rational and factual understanding of the proceedings against him, and he needs to be able to aid in his defense by rationally consulting with his lawyer. These matters generally cannot be determined by observation of the defendant performing unrelated tasks, or none at all, in the institution.

Another reason put forward for state hospital examinations is that they permit a mentally-ill person to receive care and treatment promptly if it is needed. This consideration is clearly irrelevant. The accused has neither sought nor been committed for treatment at this stage. If the examination shows incompetence, the accused will promptly be ordered to undergo treatment. In fact procedures which leads to a speedy resolution of the competency issue would lead to more prompt treatment than the accused would be likely to receive during a lengthy observational period.

D. The Examiner's Report to the Court

Upon completion of a mental examination ordered by the court the examiner should make a detailed report to the court which includes a statement as to the nature and extent of the examination; a diagnosis and prognosis; a statement specifying and explaining the nature and extent of any

deficiency in or impairment of the defendant's ability to understand the proceedings or to consult rationally with counsel; a statement indicating whether the accused is in need of immediate treatment and if he needs treatment, how likely and to what extent he is likely to overcome any of the specified deficiencies or impairments within 90 days and what the least restrictive setting would be for the effective provision of that treatment.

In every case in which such a report is made, the court should make an independent judicial determination on the issue of competency to stand trial. Such determination may be based upon the examiner's report and other evidence introduced at the hearing.

At the present time, most state courts improperly rely upon the psychiatrists' opinion on the legal issue of competence and fail to obtain detailed information upon which to base an independent resolution of the question. Typically the examining psychiatrist or physician submits a form report in which he concludes whether the accused is competent or incompetent to stand trial. Competency is not an absolute characteristic but a matter of degree and its determination involves balancing the realities and uncertainties in each case for each individual as well as the facts of the particular trial situation.

Courts should request and insist upon factual reports and make their own decisions on the ultimate legal issue of competence.

An examination report such as the one proposed would

help ensure the usefulness of mental examination reports and testimony in pre-trial situations. Not only would the detailed factual information be more useful, but the examiner should be a more candid and helpful witness if he has not been required to take a position on the ultimate legal issue.

E. The Defendant's Fifth Amendment Rights

At the time of an order for a mental examination and before the examination begins, the defendant should be advised by the court that he may not be punished for refusal to cooperate with his examiners. The court should also advise him fully in open court of the privileged nature of any statements he makes during the course of the examination and of the consequences of any failure to cooperate (inadmissability of his own witnesses' testimony). The defendant should be represented by counsel before any examination is conducted.

Defendants who miss appointments because they are physically ill or simply forgetful or defendants who have difficulty communicating and answering questions because of language, sociological or fear-oriented barriers should not be tagged as failing to cooperate.

Any statement made by the accused in the course of pretrial mental examination or treatment should not be admissible in evidence against him in any criminal proceeding or civil commitment action on any issue. Any statement made by the accused in the course of mental examination or treatment relating to the crime charged or

any other criminal act should not be made available by the examiner to any other person without the informed, written consent of the accused.

F. Maximum Treatment Period

In an overwhelming majority of jurisdictions (41/50 Rock & Brakel, 1971), defendants found incompetent to stand trial are automatically committed typically to maximum security state hospitals for the criminally insane. Commitment is almost always for an indefinite period with release conditioned solely upon attainment of competence. This lack of a durational limitation for commitment is accompanied by a lack of treatment.

However, in light of Jackson v. Indiana, incompetency commitments can no longer be automatic and indefinite but must be reasonable, temporary and effective i.e., treatment provided in rehabilitating the defendant to competency. To meet the constitutional standard of reasonableness however the duration of treatment must be based on treatment realities. From the medical viewpoint, (several authors and experienced forensic psychiatrists) short term confinement for treatment to restore competency is adequate.

Based on the Jackson mandate [Jackson cite did not prescribe arbitrary time limits] and the treatment realities, we recommend [1] that the incompetent defendant, if diagnosed as treatable, should undergo treatment in accordance with an individualized treatment plan; [2] that such treatment be provided in the least restrictive setting in

which such treatment is practical, [3] that treatment in an institution not be ordered except in specified limited cases, [4] that the director of the training facility should report to the court every 30 days the status of the accused, the treatment which has been provided and the future treatment planned, and [5] that the order for treatment should not exceed 90 days with a possible extension upon a showing of good cause for an additional 30 days.

Confinement for greater lengths of time may have some treatment justification, but in a large number of cases, treatment can be provided within 90 days. Next I will briefly discuss possible disposition of those individuals who cannot be restored to competency within 90 or 120 days.

G. Proceeding to Trial

Norvell Morris of the University of Chicago Law School and Bo Burt of the University of Michigan Law School have collaborated on an article, 40 U. Chi. L. Rev. 66 (1973), with the misleading title of "A Proposal for the Abolition of the Incompetency Plea." Actually, the article does not call for an abolition of the plea, but instead recommends a system for the disposition of permanently incompetent defendants. The system contemplated, although not in finalized form, is worth introducing here. Basically, for permanently incompetent defendants the proposal recommends that the state should dismiss the charges or proceed to a trial which would be governed, where necessary by procedures designed to safeguard against an unfair trial by compensating for the incompetent defendant's particular trial disabilities.

Specifically, the court should where needed:

1) Order pretrial disclosure of evidence that would materially assist the defendant in overcoming his disabilities.

2) Demand from the prosecution a higher burden of proof than would obtain in an ordinary criminal case with respect to issues on which the defendant is likely to be prevented or hampered by his disability from effective rebuttal.

3) Instruct the jury that in weighing the evidence against the defendant, that it should take into account, in the defendant's favor, the disabilities under which he went to trial, including the inappropriateness of his demeanor.

4) Adopt any other procedures as it deems necessary.

END

7 Miscellaneous