Department of State Hospitals – Napa

**RE: ,**

Department:

Court Number:

CII:

Maximum Commitment Date:

*(enter optional text below if Max Date is expired)*

[Pending Court Order to Extend to ]

This report is pursuant to Penal Code Section 1026.5(b)(1).

**RECOMMENDATION**

**Pursuant to Penal Code section 1026.5(b)(1), it is my opinion to a reasonable degree of medical/psychological certainty that Mr. XX should be considered for an extension of commitment, as the data below support that by reason of a mental disease, defect, or disorder, he/she represents a substantial danger of physical harm to others and he/she has serious difficulty controlling his/her dangerous behavior.**

*[Make this distinction only if pertinent: Specifically, Mr./Mrs. XX’s risk of dangerousness is linked to components of his personality structure, rather than acute or active symptoms of SPMI].*

### IDENTIFICATION DATA

Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_ is a \_\_\_\_year-old (D.O.B.) male/female who was committed to the California Department of State Hospitals by \_\_\_\_\_\_\_County on [commitment date]. S/he was admitted to XXXX State Hospital on [admission date] pursuant to PC 1026—not guilty by reason of insanity. His/her committing offense is violation of [appropriate code and section, *e.g.*, PC245(a)(1)], [definition of section of code, *e.g.*, assault with a deadly weapon].

**CURRENT PSYCHOTROPIC MEDICATIONS**

*[List] Accurate list of ALL routine (psychotropic) medications with appropriate dosages, and indication.*

*Specify if Involuntary Medication Order is in place.*

**PSYCHIATRIC-LEGAL CRITERIA PERTINENT TO PC 1026.5(b)(1)**

**Mr./Ms. XX has/does not have a Mental Disease, Defect, or Disorder.**

### DSM-5 DIAGNOSES

*Please list diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5), including all specifiers and codes, with primary diagnosis listed first. Only include medical diagnoses if they affect mental status.*

*“Mental disease” denotes a condition that can improve or deteriorate. “Mental defect”” denotes a condition that cannot improve or deteriorate, and which may be congenital, the result of injury, or the residual effect of a physical or mental illness. (In re Ramon M. (1978) 222 Ca. app. 3d 419, 149 Cal.Rptr. 387.) A diagnosis of antisocial personality disorder alone cannot be a basis for the insanity defense (People v. Fields (1983) 35 Cal. App. 3d 1, 223 Cal. Rptr. 587). The court stated in this case, “Mental hospitals are not designed for this type of person; prisons are.” According to California Penal Code 25.5, “In any criminal proceeding in which a plea of not guilty by reason of insanity is entered, the defense shall not be found by the trier of fact solely on the basis of a personality or adjustment disorder, a seizure disorder, or an addiction to, or abuse of intoxicating substances.”* *Notwithstanding the latter definition of mental disease, defect, or disorder for purposes of the finding of insanity, case law has specifically found that antisocial personality disorder may qualify as a mental disorder for the purposes of extension of commitment.*

*Provide support (description of the specific evidence and rationale) that the individual meets diagnostic criteria for each mental disorder diagnosis using historical and/or current information as appropriate.*

*Discuss medical disorders* ***only*** *if they impact on cognitive or psychiatric status, otherwise state that there are no medical disorders that impact on cognitive or psychiatric status.* *Consider in particular: chronic illnesses (stable, critical or terminal), TBI’s, seizures, or MVA with loss of consciousness.*

**Mr./Ms. XX would/would not be a substantial danger of physical harm to others by reason of his/her mental disease, defect, or disorder.**

Historical Factors

1. *Psychiatric History (up to the time of the NGI Commitment).* 
   1. *Illness Prodrome, onset, and characteristic clinical presentation during decompensation. Workup / neuroimaging.*
   2. *Hospitalizations {Date/age of first hospitalization and last prior to current; total number of hospitalizations; longest period of consecutive hospitalization; main reason for hospitalization}*
   3. *Outpatient Treatments {adherence, treating outpatient team}*
   4. *Treatment trials {Mention past medication trials; trials of clozapine, meds on LAI; ECT trials; individual psychotherapy}*
   5. *Suicide: {Include magnitude, frequency, and triggering or precipitating event}.*
2. *Substance Abuse History.* 
   1. *Substances Used, Drug of Choice. {Specify age on onset, maximum amount used, route of administration (specify presence or absence of IV drug use)}*
   2. *Treatment {Specify longest period of sobriety and circumstances. Specify total number of detox attempts, longest rehab stay, medication-assisted treatment trials}*
   3. *Medical complications derived from acute intoxication, withdrawal, or chronic use.*
3. *Violence / Criminal History;*
   1. *Summary of offenses as included in RAP sheet*
      1. *;* *Include violent acts which occurred when the individual was a juvenile with age at which first known violent act occurred;*
   2. *Provide a detailed description of the instant offense; Please address the contributing factors to the instant offense including: psychiatric symptoms present before, during, and after instant offense; the role of substance use/intoxication in the instant offense; the role of psychosocial factors (e.g., unemployment, marital/relational strife, abuse history, outpatient/CONREP failures, etc.); and the role of non-compliance with treatment.* Summarize any treatment received shortly after the instant offense (e.g., medicated in jail) and response.
   3. *Provide analysis of contributing factors to the instant offense including:*
      1. *Psychiatric symptoms present before, during, and after instant offense;*
      2. *The role substance use/intoxication played in the instant offense;*
      3. *The role psychosocial factors played;*
      4. *Triggers and precursors related to symptoms leading to offense;*
      5. *The role medication non-adherence and treatment non-adherence played.*

1. *Psychosocial history (If relevant):*
   1. *Childhood and Development:*
   2. *Educational and Employment History:*
   3. *Relationship History:*
   4. *Trauma and Abuse History:*
   5. *Military History:*
   6. *Other Relevant History;*

Clinical Factors

1. *Hospital Course*:

*Summarize current pertinent hospital course, including medication response and involvement in psychosocial treatment. Highlight any violent acts during the course of hospitalization that are especially pertinent to ongoing violence risk (e.g., serious assaults, new criminal charges, WIC 7301 referrals). Give pertinent negatives, if applicable.*

1. *Current Psychiatric Symptoms Status. Describe current mental status. Describe current status of psychiatric symptoms including current emotional stability. Please specifically address the status of symptoms that were present around the time of the instant offense including pertinent negative;*

*Appearance and Behavior, Speech, Mood and Affect, Thought Process, Thought Content, Perception, Cognition and Executive Functions, Insight and Judgment, Impulse Control, Sleep and Appetite.*

*Report any aggressive acts during the past year, including verbal aggression, physical aggression, and property damage and recent seclusion/restraints*

*Discuss current medical problems which are pertinent to mental status.*

*Describe recent treatment and response to treatment including medication trials* *(such as Clozapine), PRNs and psychotherapy.*

*Address the individual’s compliance with (or, adherence to) medications, unit rules/regulations, treatment groups, and/or individual therapy.*

*Describe status of addiction recovery (precontemplative, contemplative, action, maintenance phases)*

1. *Current understanding of instant offense:*

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* 1. *Discuss the patient’s current understanding of the instant offense (patient’s recognition of factors that contributed to exacerbation or recurrence of symptoms leading to the crime) and other past offending, as applicable, and his/her attitude related to past rule violations (i.e. wheeling and dealing, minor rule infractions, etc.).*
  2. *Current Understanding of the Role of Mental Disorder(s) and Substance Abuse, if applicable, in the Instant Offense and Other Past Violence*

1. *Insight into Mental Illness and Treatment*
   1. *Address the patient’s insight into the need for treatment and insight into his/her mental illness: acceptance, knowledge of diagnosis, and recognition of personal symptoms. State whether the patient understands his/her need for treatment and the reason why continued treatment is necessary.*
   2. *Discuss current medication adherence, specifically addressing whether adherence is being obtained through an involuntary medication order or whether the patient is on voluntary medication status. Describe group attendance and participation in treatment. Address past medication and psychiatric follow-up compliance (or non-compliance), and whether the patient has learned from personal history.*

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Risk Management

1. *Discuss Mr./Ms. X’s relapse prevention plan(s) for mental illness and/or substance abuse issues. Discuss Mr. X’s reported plan to address potential destabilizers such as: treatment non-adherence, substance use, negative social influences, and social support including; the individual’s social support system, financial resources, and familial conflict.*
2. *. For COT revocation cases, include a concise summary of information regarding prior PC 1026 inpatient treatment and prior outpatient treatment on COT including a detailed description of events resulting in the current COT revocation. Identify past supervised outpatient supervision failures including CONREP failures;*
3. *Insert brief summary of most recent CONREP report here.* 
   1. CONREP Evaluation: Report Determination (i.e. Not COT Ready, COT Ready in 6-12 months, COT Ready) and rationale from HLV.

Other Relevant Information or Considerations (include if relevant) :

*Discuss other relevant sources of clinical concern that may not directly answer each discreet legal criteria. Examples would include situations in which extension of commitment is considered for the purposes of providing intensive treatment, or making adequate/safe placement arrangements: patients at high risk of suicide or severe SIB, medically infirm patients unable to transition into the community without specialized medical care needs, etc.*

**Mr./Ms. XX has serious difficulty in controlling his dangerous behavior by reason of his mental disease, defect, or disorder.**

*Highlight violent/threatening behaviors, or lack thereof, which were clearly related to his/her mental disorder(s), elaborating on how that relationship affects volition. Even ongoing predatory violence associated with APD/psychopathy could add support to difficulty controlling dangerous behavior since those individuals lack empathy and appreciation of consequences, both of which contribute to normal self-control of dangerous behavior. Likewise, impulsivity is a hallmark of APD and other personality disorders.*

*Formulate[[1]](#footnote-1) violent/threatening behaviors, or lack thereof, which were clearly related to his/her mental disorder(s), elaborating on how that relationship affects volition. Even ongoing predatory violence associated with APD/psychopathy could add support to difficulty controlling dangerous behavior since those individuals lack empathy and appreciation of consequences, both of which contribute to normal self-control of dangerous behavior. Likewise, impulsivity is a hallmark of APD and other personality disorders.*

*Describe in detail the types of external controls that have been necessary to manage behavior (e.g. staff intervention, PRN medication, restraint). This may include a description of the secure facility itself.*

*Alternatively give specific examples of how the patient has been able to demonstrate self-control. Describe the degree to which he/she has insight and relapse prevention skills for both mental illness and substance abuse (if applicable), which can be characterized as internal controls on behavior. Relapse of either mental illness or substance abuse impairs ability to self-control violence, whereas sustained remission enhances self-control capacity. Some of the pertinent data may have already been discussed under the prior criterion in which case that data can be specifically referenced.*

Forensic Quality Review Panel

The Forensic Quality Review Panel (FQRP) is an essential component to the discharge process for patients committed under PC 1026 and consists of forensic experts in the fields of Psychology and Psychiatry. These experts complete an in-depth review of a patient’s history and progress in treatment to identify violence risk factors that remain untreated, and they also consult with senior supervising clinicians to develop thorough feedback to convey to a patient’s treatment team. The treatment team is then tasked with gearing treatment interventions towards these feedback items and then refers the patient back to the FQRP when the team determines the patient is ready to be evaluated for community outpatient treatment. This review process serves to identify factors that may be a subtle pattern across his lifespan that may be missed by direct treatment providers and has been shown previously to improve patient outcomes when transitioning into community outpatient treatment. In the case of Mr. XX, these subtle patterns may have been overlooked when he was supervised with parole between prison terms and prior to the instant offense.

The FQRP highlighted the following areas as requiring greater intervention:…. These items remain the focus of his treatment in order to maximize the chances of successful community reintegration.

### RECOMMENDATION AND RATIONALE

*Provide a concise summary explaining the reason for the recommendation.*

**It is the opinion of the undersigned that Mr. XX should be considered for an extension of commitment, pursuant to PC 1026.5(b)(1), as the data above support that by reason of a mental disease, defect, or disorder, he/she represents a substantial danger of physical harm to others and he/she has serious difficulty controlling his/her dangerous behavior.**

Assessment of Mr./Ms. XXX’s readiness for discharge and the degree to which he/she can be safely and effectively treated on an outpatient basis is ongoing and will be reviewed in a separate report when appropriate.

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**The following personnel, who are not currently treating this individual, administratively reviewed this report:**

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| Patricia Tyler, M.D., or her Designee |
| Medical Director |

cc: Health Information Management Department, Unit Chart, Program File, CONREP

1. Insert here your violence risk formulation- this may include your HCR-20 analysis and scenarios, and any other risk assessment tool you have administered or considered. [↑](#footnote-ref-1)