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A Forensic Mental Health Care Delivery System for the State of North Carolina

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A Forensic
Mental Health Care Delivery System
For The State of North Carolina


by Richard Raymond Earl


A sixth year terminal project submitted to the faculty of Clemson University, College of Architecture as partial fulfillment of the requirements for the degree of:


MASTER OF ARCHITECTURE
May 12, 1978

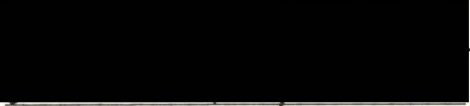
Faculty Committee:



George C. Means
Committee Chairman


Dr. Don K. Freeman
Director of Mental Health
and Lecturer


James E. Dalton
Assistant to Dean


Gayland B. Witherspoon
Head, Department of
Architectural Studies


Vernon Hodges
Professor


Harlan E. McClure
Dean
College of Architecture

ABSTRACT

The existing Criminal Justice System in the United States is undergoing great change. It is an awesome responsibility for our citizens and judiciary branch of government to uphold justice and to protect the citizens of our communities.

One particular area in dire need of more research and development, is the delivery of forensic mental health care. Currently, forensic mental health may be defined as a system which supports a program of psychiatric services provided to the state courts for assessing a defendant's competency to stand trial.

Within the state of North Carolina, the issue of forensic mental health became the primary focal point for this study. Under current practices, the majority of admissions are to the Forensic Unit of Dorothea Dix State Hospital in Raleigh. The Forensic Unit, the only facility in North Carolina to conduct competency evaluations, receives approximately 800 defendants per year from throughout the state, generating great state expenditures in terms of transportation costs and staff time. The unit also has programs for persons found incompetent to stand trial and for management problem patients from other hospital units.

The total systems planning approach was utilized in taking the broadest possible view of the evaluation process, from initiation of the competency evaluation through resolution of the pending charges. Through this methodology, implications for eventual facility design or renovation and space utilization could be determined and more efficient and effective alternatives may be identified and implemented.

This project therefore, focused on the procedures involved in determining competency to stand trial and the impact of these procedures on the resulting architectural responses. Gathering data for this project proved to be difficult for little information was found to be in circulation. Data was collected for defendants previously evaluated for competency; including data

from mental health evaluations, court outcome; and from legal and mental health professionals with previous experience with the competency issue.

Following an analysis of these data, the following changes were proposed:

- The development of a decentralized system giving the local communities primary responsibility for evaluating competency, with staff of the Dorothea Dix Forensic Unit playing a leadership role in coordination training, and evaluation of local efforts;
- the establishment of screening panels at the community level, comprised of legal and mental health professionals. The screening panels will be responsible for all initial competency evaluations;
- limited use of residential evaluations;
- the introduction of evaluation and treatment procedures whereby questionably competent defendants are evaluated and/or treated centrally located in the state within an appropriate setting, independent from the legal and mental health systems.
- implementation of changes in the present legal procedures and statutes, particularly with respect to the use of local evaluations, and the commitment of incompetent defendants.

Architectural recommendations related to the various system level changes are outlined, involving the utilization of community mental health centers for local evaluations, and potential new construction of a new building type, a Statewide Forensic Mental Health Center.

The following chapters are representative of the latest research and planning efforts necessary to define the most appropriate delivery system of forensic mental health care to the state of North Carolina. Although much meaningful information was provided, it is misleading to imply that a comprehensive program can evolve within the time allotted to this study. The details of this program are possibly less important than the concepts on which it is based and the process through which it evolved. The following system and architectural recommendations emerged as a direct result of an intensive total systems planning approach.

DEDICATION

To my loving wife, Tricia and
daughter, Elizabeth, for their
support, through tears and laughter,
of my accomplishments and defeats.

ACKNOWLEDGEMENTS

A project of this scope could not have been successfully completed without the commitment and cooperation of many individuals:

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To the members of the Health Care Facilities Planning and Design Studio, especially Louis P. Batson III for his accuracy, articulations, and deviations within the sporting days of my education.

To my mother and father for their love, support, and constant faith.

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OVERVIEW

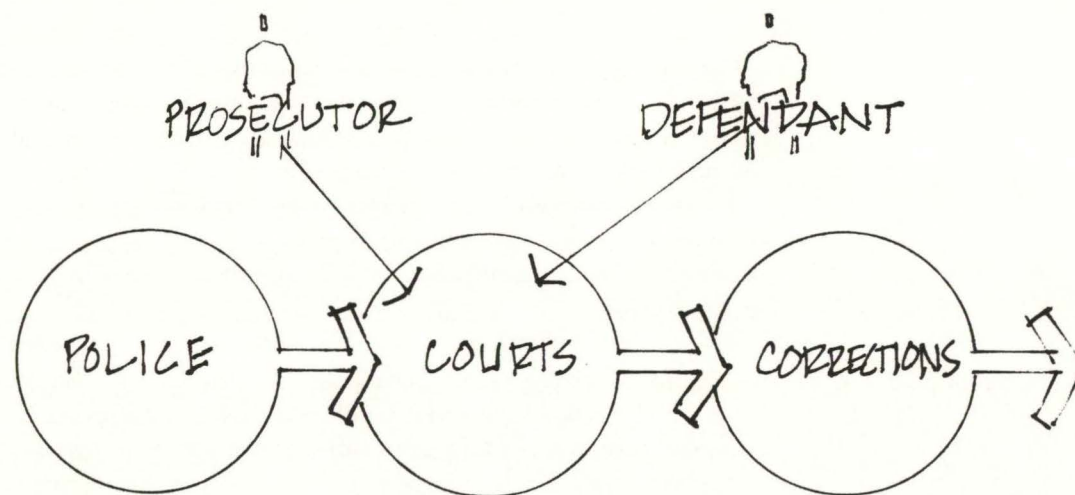


Figure 1-1. The Criminal Justice System

OVERVIEW

INTRODUCTION

History

Corrections is one of the most critical social problems in the United States today. Corrections and larger issues of Crime and Criminal Justice are subject to increasing concern by the public. They have developed into a major area of focus by the U. S. Department of Justice and are of concern at all levels of governmental jurisdictions.

It is generally recognized that previous practices in corrections of punishment by incarceration, repression, and deprivation of basic human needs have been totally ineffective. As stated in the AIA Task Force Report in corrections:

"This nation has arrived at a time when the unsatisfactory conditions which exist in its criminal justice system can no longer be tolerated. The corrections component in particular has been characterized by neglect and too often has contributed to the further development of criminal careers rather than to the attainment of rehabilitative goals."¹

Previous correctional operations have been characterized by ineffective rehabilitation programs and an over-abundance of high security institutions constituting human warehouses. While successful in the infliction of punishment and the temporary protection of society, the correctional milieu has been wholly counter-productive in terms of the integration of the offender into society as a self-sufficient and productive participant.

Trends

Prison environments have almost never been designed as positive elements of an overall program directed toward the eventual return of the social offender to his community. Slowly, over a good many years, the idea of prison environments to make them fully implementable, are beginning to be provided at both the state and federal levels.

The new approach to prison treatment focuses on individualized programs of medical and psychological; psychiatric treatment where needed, this new approach sets the individual on the path of self-responsibility as the first step to his return to the social context of the community. This is no longer a new philosophy of penology, but its implementation is new. Even newer, is the recognition that a large part of the program's effectiveness is in the character of the physical environment within which the program takes place.

This idea was realized when the dehumanized environment of the old-fashioned kind of prison simply did not lend itself to the methods of the new program, and that if the new program were to succeed, the participants — both inmates and counsellors — needed the physical facility which would give reality to the principles of privacy and human dignity on which the programs are premised.

Criminal Justice System

The Criminal Justice System consists basically of three components. They are: police, courts and corrections. Prosecutor and defender activities are most closely associated with functions of the courts but are organizationally independent. Each component has a special function to play in dealing with deviant behavior which, if not controlled, tends to disrupt the balance of social order.

The Criminal Justice System as the illustration implies (Figure 1-1), consists of progression of events.

"This process seeks to enforce the standards of conduct necessary to protect individuals and the community. It operates by

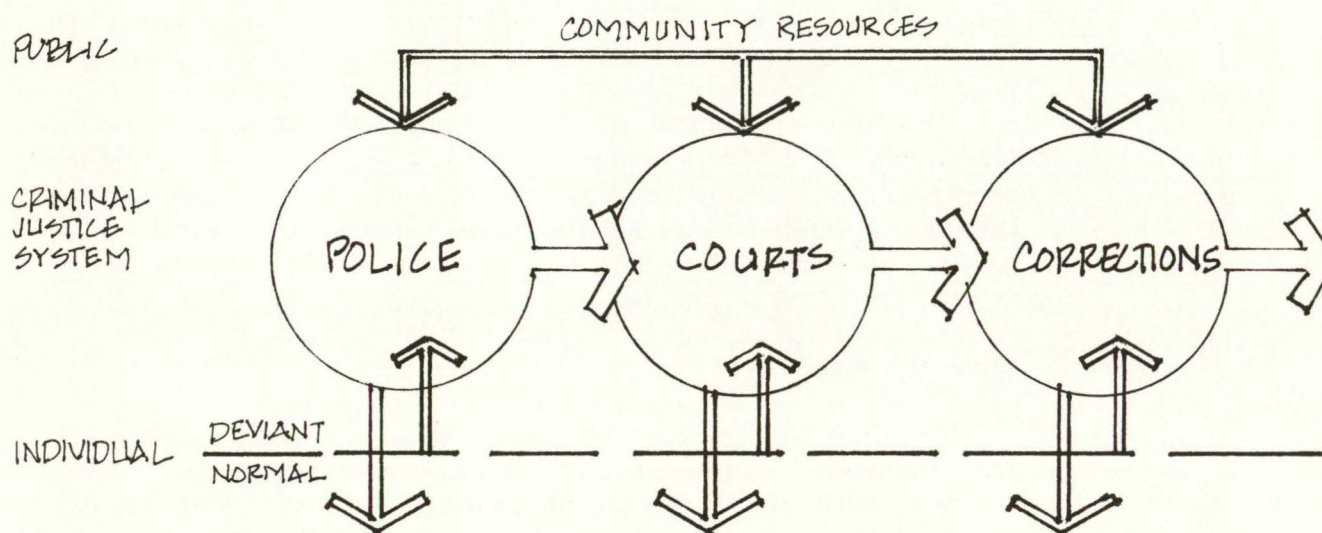


Figure 1-2. Elements of the Criminal Justice System as related to the deviant individuals in society.

apprehending, prosecuting, convicting and sentencing those members of the community who violate the basic rules of group existence as determined by duly sanctioned constitutional and statutory processes. Action taken against law breaking is designed to service three purposes beyond the immediately punitive one: remove dangerous people from the community, deter others from criminal behavior, and give society an opportunity to attempt to transform law breakers into law-abiding citizens."²

Although the components are distinguishable as independent entities, in fact, each of the operations is highly interrelated with the others. This autonomy and interdependence makes improvement to the system most difficult.

As illustrated by the diagram (Figure 1-2), the Criminal Justice System exists to serve the special needs of society generated by those individuals who deviate from normal and acceptable standards of behavior. The level of effectiveness of this system in meeting those needs is dependent upon the degree of support and participation provided by individuals and organizations to assist such persons in rehabilitation opportunities.

Corrections, as one element of the Criminal Justice System, functions largely in social and political isolation. The ability to affect actual long range improvements in corrections will require a major concentration of efforts and resources in the years ahead. There is a need for the establishment of well-defined objectives, standards and delivery techniques. Ideas and theories conceived must be implemented and evaluated. The means for coordination of a complex but integrated system of delivery must be developed. At the operational level the practitioner must adjust to the rejection of the traditional but outmoded methods and be willing to adapt to new practices. Planners and designers of delivery systems must respond to a new need for environments which encourage effective programs rather than restrict them.

Because of the complexities of corrections and of the society which must deal with it, no simple singular solutions will suffice. In the development of the total correctional environment, attention must be directed to the full range of social and physical requirements.

OUTLINE OF STUDY

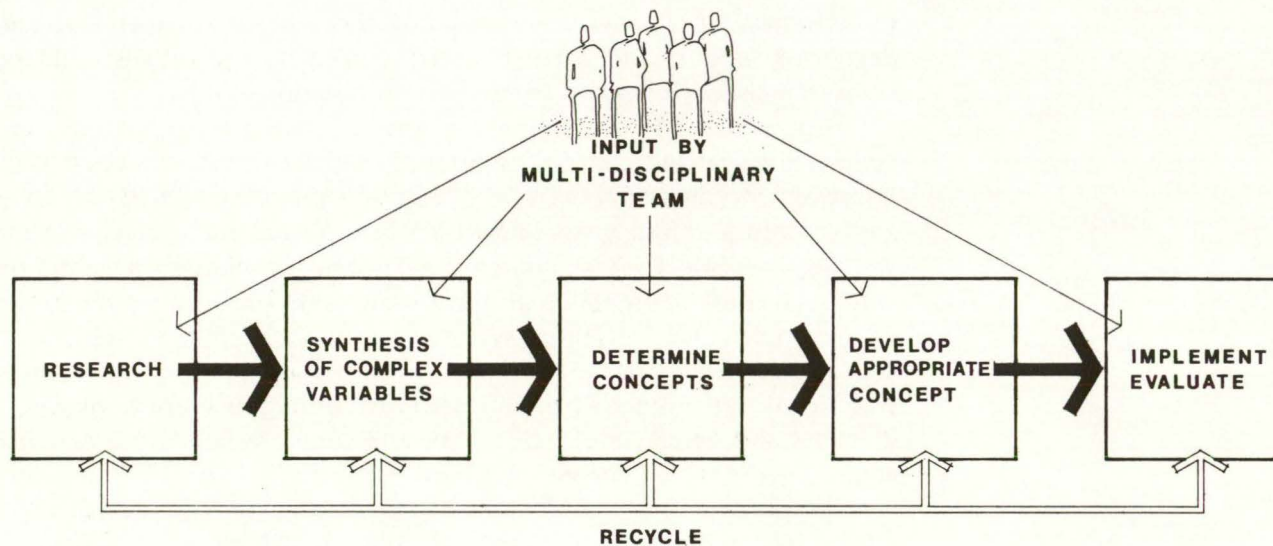
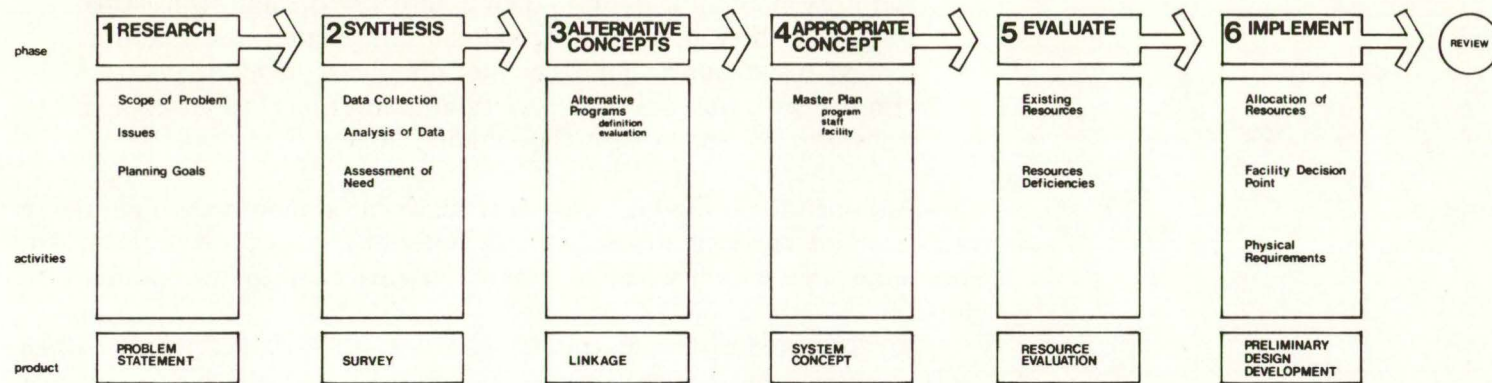


Figure 1-3. Planning Process Diagram

METHODOLOGY

System Planning

The total systems planning process is an approach used by many persons across this nation as well as others abroad. Many vary in detail, but most consist of the major conceptual components. Most share the same art and skill of seeking out well defined problems, setting goals, and achieving them through the efficient systematic use of scarce resources. The following conceptual components are identified as: research, synthesis, determining concepts, adopting appropriate concept, implementation and evaluation. This process does not try to convey that this is a rigid step by step process, it is constantly recycling and revising previously stated data and information. The intent of this process is to establish a system by which to synthesize pertinent information into design criteria which will insure human input into developing the most effective solutions. In utilizing this process as a prerequisite to construction decisions, the commitment for any response to these scarce resources are justifiable through comprehensive analysis. These clearly state possible options and their impact on existing programs. Furthermore, since the decision "to build or not to build" is made at the conclusion of the planning process, the form that any facility takes (if indeed any is recommended) can then benefit from the data and information produced. Significant planning determinants such as size and characteristics of the population and the specific function of the facility, will have been clearly delineated. The net result is the explication of the appropriate design concept (Figure 1-3).

DEFINITIONS

Community Corrections

As recent developments have confirmed, changes in the correctional field are taking place. These changes are far ranging, including large scale planning, non-institutional treatment program development, and innovative facility design concepts.

A major thrust of current efforts in corrections revolves around the concept of "Community-Based Corrections." This concept, a philosophy of correctional reform, includes programs and alternatives to incarceration as well as a more effective use of facility resources. This multi-faceted effort includes the full range of correctional methods of: diversion from confinement, pre- and post-adjudicative referral, intake screening and diagnostic services, work and study release, and offender-public-interaction through various community programs.

The premises for community corrections were based upon the following:

1. Inasmuch as 19 out of every 20 men who enter prison return to society, correctional efforts must emphasize the process of reintegration into the community as the best way of protecting it.
2. It is fiscally advantageous to place corrections within the community because its resources can better be utilized in the total rehabilitative effort.
3. It avoids the isolating effort of traditional institutionalization, and thereby permits the building and rebuilding of sound social ties between the offender, his family and his community.⁴

Delivery System Network

Within the community-based corrections concept is the idea of an integrated delivery system which combines necessary resources together into an operational mechanism that is both responsive to correctional needs and flexible to change. In this system the emphasis is not solely on institutions and physical facilities, but also on the appropriate organizational structure and operational programs necessary to support correctional needs. A whole range of facility resources will be necessary to support such programs. Existing facilities for the most part are inadequate and inappropriate as are new facilities which only duplicate the characteristics of those that are replaced.

Figure 1-4. Integrated Networks

New facilities are required which provide for both regionalized and local community correctional needs. In most, if not all instances, a network of facilities will be most appropriate, in conjunction with a network of program alternatives. Such integrated networks of programs and facilities work together to provide a diversity of services necessary to relate to the range of correctional demands.

The integrated network approach can apply to any service area. Within major metropolitan areas a network of dispersed programs, services and facilities can be appropriately developed in a configuration which best relates to the various planning determinants and constraints. In a sparsely populated area where resources and offenders are insufficient to justify separate major programs and facilities, it may be advantageous to consolidate and develop a centralized regional facility and program operation. Examples of various kinds of correctional delivery system networks are illustrated (Figure 1-4).

Facility Concepts

While the emphasis on Community-Based Corrections is upon non-institutional rehabilitation efforts, facility resources will continue to be a necessary element of such correctional systems. Although very little research is available on the positive impact of the physical setting in rehabilitation goals, there is almost universal agreement by correctional experts that inhumane physical environments are harmful. It takes little more research than a short-term exposure to the traditional harsh, noisy, impersonal and perceptually sterile correctional facility to intuitively react negatively to the dehumanizing atmosphere. The impact of this environment affects inmates and staff alike, with definite indications that human interactions and treatment opportunities are adversely affected.

Proceeding in the assumption that the physical environment can, in fact, provide positive support to correctional goals, the National Clearinghouse for Criminal Justice Planning and Architecture (NCCJPA) has identified four key levels of contribution. These include:

1. Provision of space for conduct of program activities.
2. Definition of a physical framework which provides

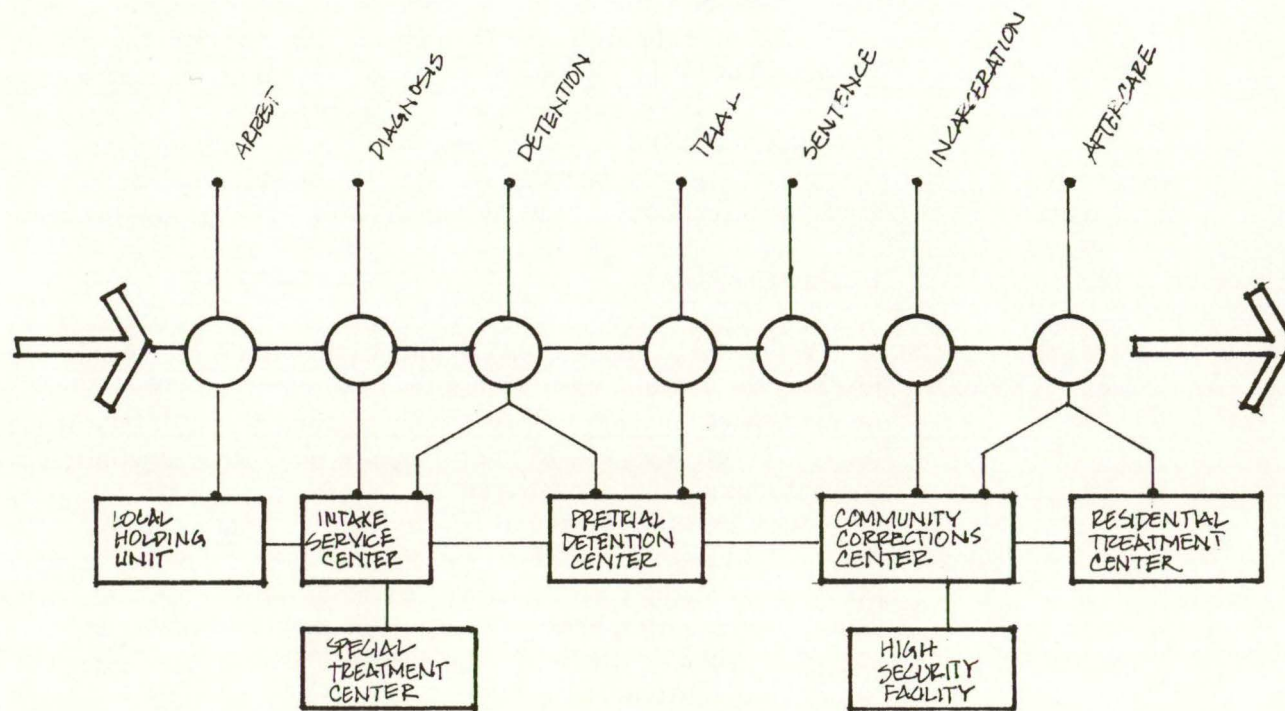


Figure 1-5. Criminal Justice System as it relates to facility concepts

flexibility of use in structuring individualized and varied activity patterns.

3. Development of a physical setting for encouraging relationships between people, both internally within the facility and externally with the community.
4. Establishment of a physical environment which communicates unhostile messages and which reinforces positive behavior patterns.⁵

A variety of facility types which are applicable to any correctional delivery system network have emerged as models appropriate to Community Corrections philosophies. The following diagram and interpretations illustrates and defines the Criminal Justice system as it relates to facility concepts (Figure 1-5).

LHU — Local Holding Unit

Located at a law enforcement facility, the holding unit provides for short-term security custody of persons apprehended and awaiting arrest and booking. Such facilities, while requiring high security capability, should be attractively designed with a de-emphasis upon the security characteristics. Such facilities are intended for temporary detention uses for periods not exceeding 1-2 hours, after which individuals not otherwise released should be transferred to the Intake Service Center (ISC).

ISC — Intake Service Center

This facility type is the source of initial contact in the judicial process after apprehension and booking. Operationally, it encompasses initial activities of screening, diagnosis, and classification of alleged offenders. Diversion into pretrial intervention programs as well as on-going review and evaluation of program effectiveness would also be Intake Service Center functions.

The reintegration of the offender back into society by providing an in-community transitional resource from institutionalization.

STC — Special Treatment Center

These are operations designed to meet the needs of special offenders such as alcoholics, drug addicts, and mentally ill offenders. In most cases, the problems involved are medically related and such operations should be combined with such resources. Various other treatment programs such as counseling and community treatment are also necessary. Security conditions would vary with the type of clientele.

PDC — Pretrial Detention Center

This facility type serves the purposes of temporary detention for persons awaiting trial. This population would consist largely of those who could not qualify for a pretrial release or intervention program of any kind. This would include those charges with non-bailable offenses, those posing a risk of non-appearance if released, and those analyzed to be a danger to society. It is desirable for such an operation to be in direct proximity to courts facilities.

CCC — Community Correctional Center

This operation serves as a primary treatment center for convicted offenders not otherwise eligible for release to other community programs. It would function as a facility with a range of residential security characteristics and living units. Major features of such an operation would be emphasis on residential treatment programs, and an extensive use of community resources of all kinds. The program might serve any or all of the following:

- sentenced misdemeanants
- sentenced felony offenders
- conditioned released program

It would normally function as the correctional coordination center for individualized offender treatment programs through an entire correctional system, including residential and non-residential programs.

RTC — Residential Treatment Center.

Normally referred to as a halfway house, this type of program provides for a partial release operation within a minimum security setting. They offer opportunities for work release, educational release, community adjustment, intensive supervision and conditional release programs.

HSF — High Security Facility

In certain situations it may be necessary to locate high-risk sentenced offenders in separate facilities in order to provide for specialized treatment and adequate protection of the public.

Within this overall system framework one facility type has been selected for conceptual design development. The following sections are representative of programmatic considerations concerning a new building type which can be associated with a special treatment center facility concept.

PROBLEM DEFINITION

PROBLEM DEFINITION

NEED FOR STUDY

Early in 1975, the staff of the Forensic Services Unit of Dorothea Dix Hospital, Raleigh, North Carolina, were informed of legislation to become effective September 1, 1975. This legislation would have a direct impact on the services currently provided to the state courts by the Forensic Unit for assessing a defendant's competency to stand trial. As a result of the legislation, the Forensic Unit would now be required to evaluate, in addition to defendant's accused of felonies, all misdemeanants whose competency was in question.

The Forensic Unit is the only state facility responsible for conducting competency evaluations. Admissions for such evaluations have been constantly increasing during the past several years, with the total number of evaluations approaching 800 in fiscal year 1977.

An increase in caseload has amplified a concern among Forensic Unit staff that the current forensic facility does not meet current space and program needs for the competency evaluations and for the treatment of other patients housed in the Forensic Unit. This situation prompted an evaluation of the current Forensic Unit.

SCOPE OF THE PROBLEM

The Forensic Unit is dependent upon the courts throughout the state for evaluation referrals. While the Forensic Unit treats other patients, as previously indicated, competency evaluations comprise the bulk of the work. Changes in the court referral criteria would obviously have a large impact on the Forensic Unit and, consequently, on the space requirements for a new facility. Thus, this report focuses upon the procedures involved in

COMMITMENT/CASE LOAD							
	1971	1972	1973	1974	1975	1976	1977
Felony Case Filed	17,194	19,394	22,091	25,762	30,762	29,010	29,350
Evaluation at Dorothea Dix	213	286	301	444*	691	758	774
Evaluation/Cases	1/81	1/68	1/73	1/58	1/44	1/37	1/38

*increase due to the discontinued use of Cherry Hospital competency evaluations.

Figure 2-1. Commitment/Case Load

determining competency to stand trial and the impact of these procedures upon the resulting architectural responses. The determination of competency is an especially complex procedure because it involves the interaction of two independent systems, legal and mental health.

NORTH CAROLINA LEGAL SYSTEM

The issue of competency for trial is one which arises in the courts. To protect rights to a fair trial, defendants must be able to understand the proceedings against them, the consequences of conviction for the alleged crime, and must be able to assist in their own defense through cooperation with their attorneys. The court typically requests an evaluation by mental health professionals when a defendant's competency is questioned. These competency evaluations are usually conducted by the staff of the Dorothea Dix Hospital Forensic Unit. Following the evaluation, a report is sent to the court to assist a judge in determining a defendant's competency. In practice, the recommendations and opinions contained in the mental health evaluations reports are almost uniformly accepted by the court. It should be apparent that due to the complexities of the interaction between the legal and mental health systems, accurate communication and understanding of the legal and psychiatric concepts involved in the determination of competency is essential.

The court trend most directly affecting the needs of the Forensic Unit is the rising felony caseload. The number of felony cases brought to trial has been steadily increasing.

Figure 2-1 shows the felony caseload for the years 1971 to 1977. In 1977, 29,350 felony cases were filed, a figure which represents a 79% increase over the 17,194 cases filed in 1971. Consequently, the number of competency evaluation referrals has also increased but at a rate significantly higher than the felony case increase. Figure 2-1 shows in percentage change, that evaluation referrals have risen from 213 referrals in FY-1971 to 774 in FY-1977, an increase of 363 percent. The dramatic increase is largely due to the discontinued use, beginning in early 1974, of Cherry Hospital for competency evaluations.

The rate of competency referrals in relation to the felony caseload has also been increasing. Data included in Figure 2-1 show that 213 competency referrals in 1971 represented one case for every 81 felony cases. By 1977, this rate increased to one referral per 39 felony cases.

NORTH CAROLINA MENTAL HEALTH SYSTEM

The mental health system's participation in the competency procedures is largely through the evaluations conducted by the staff of the Forensic Unit at Dorothea Dix Hospital. The Forensic Unit (Spruill Building) is a medium-to-maximum security facility centrally located on the grounds of Dorothea Dix Hospital in Raleigh, North Carolina. It is the only residential unit in the state to provide treatment and evaluative services for persons for whom the court has ordered evaluation of competency to stand trial and/or assessment of responsibility at the time of the crime. Defendants are committed on a court-ordered observation order (General Statutes of North Carolina, Chapter 15A, Section 1001) to the Forensic Unit, remaining there not more than 60 days, whereupon the defendant must be returned to court for a competency hearing. If a competent determination is made, the defendant will be scheduled for trial; if an incompetent determination is made, commitment proceedings will be initiated. Persons admitted for evaluation of competency comprise the majority of annual admissions to the Forensic Unit.

In addition to defendants committed for evaluation of competency, four other categories of clients are treated in the Unit:

1. persons found incompetent to stand trial and judicially or civilly committed back to the hospital;
2. inmates transferred from the Department of Corrections;
3. persons found not guilty by reason of insanity;
and
4. persons considered management problem cases from other hospitals or wards in Dorothea Dix.

Women from all legal categories are housed in other wards of the hospital.

ISSUES

The following discusses a number of legal, psychiatric and evaluation issues surrounding the use of competency to stand trial procedures.

Constitutional Basis of the Competency Procedures

The assurance that a defendant has the capacity to rationally and effectively participate in the legal process is critical to the American justice system's concept of a fair trial. The present guidelines for competency to stand trial have their basis in English common law: defendants could not be tried, convicted, sentenced, or punished if they did not understand the nature and consequences of the proceedings against them and were not able to participate in their defense. It is believed that the absence of competency may lead to the erroneous conviction of those defendants who might otherwise be able to contribute evidence or assistance to counsel that would lead to acquittal. On an ethical level, it is seen as unfair to try, convict, or punish an individual who is incapable of understanding his circumstances or the justification for his punishment.

The current standard defining the basis for a determination of competency to stand trial was established by the Supreme Court. Most states have adopted the criteria specified in this decision. The relevant part of the decision reads:

"It is not enough for the district judge to find that the defendant is oriented to time and place and has some recollection of events; but that the test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding . . . and whether he has a rational as well as factual understanding of the proceedings against him."⁶

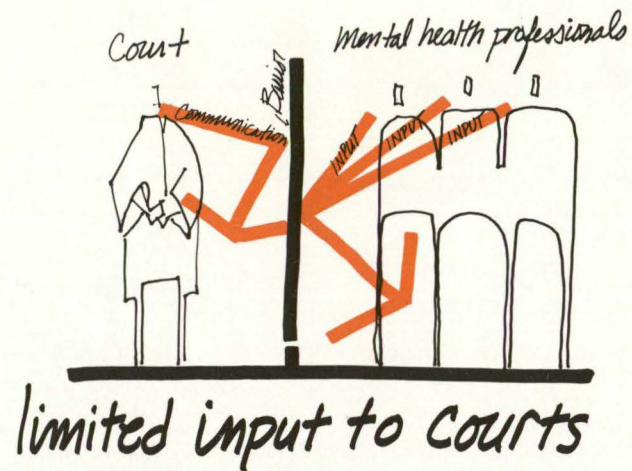


Figure 2-2. Issues of Competency to Stand Trial

While the issue of competency to stand trial is designed to protect the rights of a defendant to a fair trial, it has been argued that the procedures used to determine competency may result in an increased infringement of the rights of the accused. Bail is usually denied during the period of evaluation; the evaluation may take place in an unnecessarily restrictive environment; rights to a speedy trial are jeopardized; the commitment procedures are less stringent than civil commitment procedures; and the defendant is usually held longer than necessary for an evaluation. (See Figure 2-2)

In conclusion, the Supreme Court also holds that:

“A person charged by a state with a criminal offense who is committed solely on his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the state must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant. Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by that progress toward that goal.”⁷

It is interesting to note that although the Supreme Court failed to quantitatively define “a reasonable length of time,” many states limit criminal commitments to durations of 15 months or less.

Competency and Responsibility

Another issue surrounding the use of competency to stand trial procedures is the fact that competency and responsibility (insanity defense) are frequently confused by both the legal and psychiatric communities. The issue of responsibility refers to the defendant's mental state at the time of the alleged crime and is used as a trial defense. The issue of competency refers primarily to the ability of the defendant to assist in the preparation of

his defense. Thus, a defendant can be competent to stand trial (i.e., prepare his defense) but found not responsible for the commission of a crime by reason of insanity. Conversely, a defendant could be found incompetent but still be responsible for the crime. Unfortunately, despite the important legal distinctions between competency and responsibility, both law and psychiatry continue to confuse the two standards.

Regardless of the reasons for the current methods of defining and evaluating competency, it seems clear that the entire process could be improved through an increased interaction between legal and mental health professionals. One method for achieving this interaction would be the participation of the legal community in the evaluation process, a practice which is likely to increase and clarify communication between the two disciplines and lead to a clearer definition of competency.

COMPETENCY RESEARCH

This section will review studies which have attempted to provide statistical information on defendants evaluated for competency.

Admission Rates for Evaluation and/or Treatment

In 1969 a national survey was published of hospitals which treated criminal offenders. As a result, fifty primary hospitals (primary facility within a state for treating offenders) reported that, of 11,209 admissions, competency evaluations accounted for 38 percent of the total offender admissions; defendant committed following a determination of incompetency accounted for an additional 14 percent. Thus, commitments for evaluation and/or treatment accounted for over one-half of the total admissions in the offender category. These 50 hospitals admitted over 5,800 of these defendants in 1969 alone.

A more recent study by the Department of Health, Education, and Welfare indicated that there were 403,924 admissions to state and county mental hospitals throughout the country. The incompetent to stand trial category, which included evaluations for competency and commitment of

incompetent defendants, accounted for a total of 9,261 admissions or 2.3 percent. Only 5 percent of these were female.

A present study shows that admissions for competency evaluations to Dorothea Dix Hospital have also been steadily increasing, partly as a result of the discontinuation, in 1973, of evaluations at Cherry Hospital.

Figure 2-1 shows that in 1971 there were only 213 admissions for evaluation, while in 1977 the total reached almost 800.

In summary, studies of admission rules suggest that the use of competency evaluations has been steadily increasing throughout the country in terms of hospital expenditure and professional time.

Base Rates of Incompetency Determination

No specific base rate can be established. The number of defendants found incompetent will vary from location to location, depending upon admission practices, evaluation procedures, legal guidelines and other numerous factors.

In a study conducted on the Forensic Unit at Dorothea Dix Hospital (Laczko, James and Alltop 1970) all admissions for evaluation between 1958 and 1964 were reviewed. Evaluations of 435 defendants resulted in determinations of incompetency in 104 (23.9 percent) cases.

There appear to be several motivations for requesting a competency evaluation, motivations which are not related to a concern about competency. If indeed defendants in the Laczko, James and Alltop 1970 study were more properly referred, a high rate of incompetency determination would be more likely to result.

Type of Offense

Case studies suggested that defendants charged with more serious crimes are more likely to be referred for competency evaluations. For example, most referrals were for homicide and assault with larceny being the next most frequent charge.

Some interpretations suggested that competency evaluations is frequently a defense or prosecution maneuver and concluded that

"the use of incompetency as a diversion from the criminal justice system greatly depends on no medical, dispositional, and procedural machinations."⁸

The studies reviewed suggest that defendants charged with more serious crimes are more likely to be referred for competency evaluations. This data lend some support to the contention that the evaluations are used for reasons other than questions of competency, especially when the charges and consequences are grave.

This as well as other data supports the contention that competency evaluations are frequently misused.

CURRENT PROCEDURES IN NORTH CAROLINA FOR DETERMINING COMPETENCY TO STAND TRIAL

Overview of Procedures

The issue of competency can be raised at any time during the legal proceedings but is usually raised at a defendant's arraignment. The defense attorney, prosecution, or the court may submit a motion questioning a defendant's competency. The court may deny or grant the motion. Normal legal proceedings continue if the motion is denied, but if the motion is granted the court typically orders an evaluation by the Forensic Service Staff at Dorothea Dix Hospital. The court rarely exercises the other two options available:

1. evaluation by medical experts, presumably in a non-institutional setting, or
2. immediate hearing without an evaluation by mental health professionals.

Defendants committed to Dorothea Dix Hospital for an evaluation can be held up to 60 days but are currently returned to the court after approximately 17 days. The typical evaluation procedure includes interviews

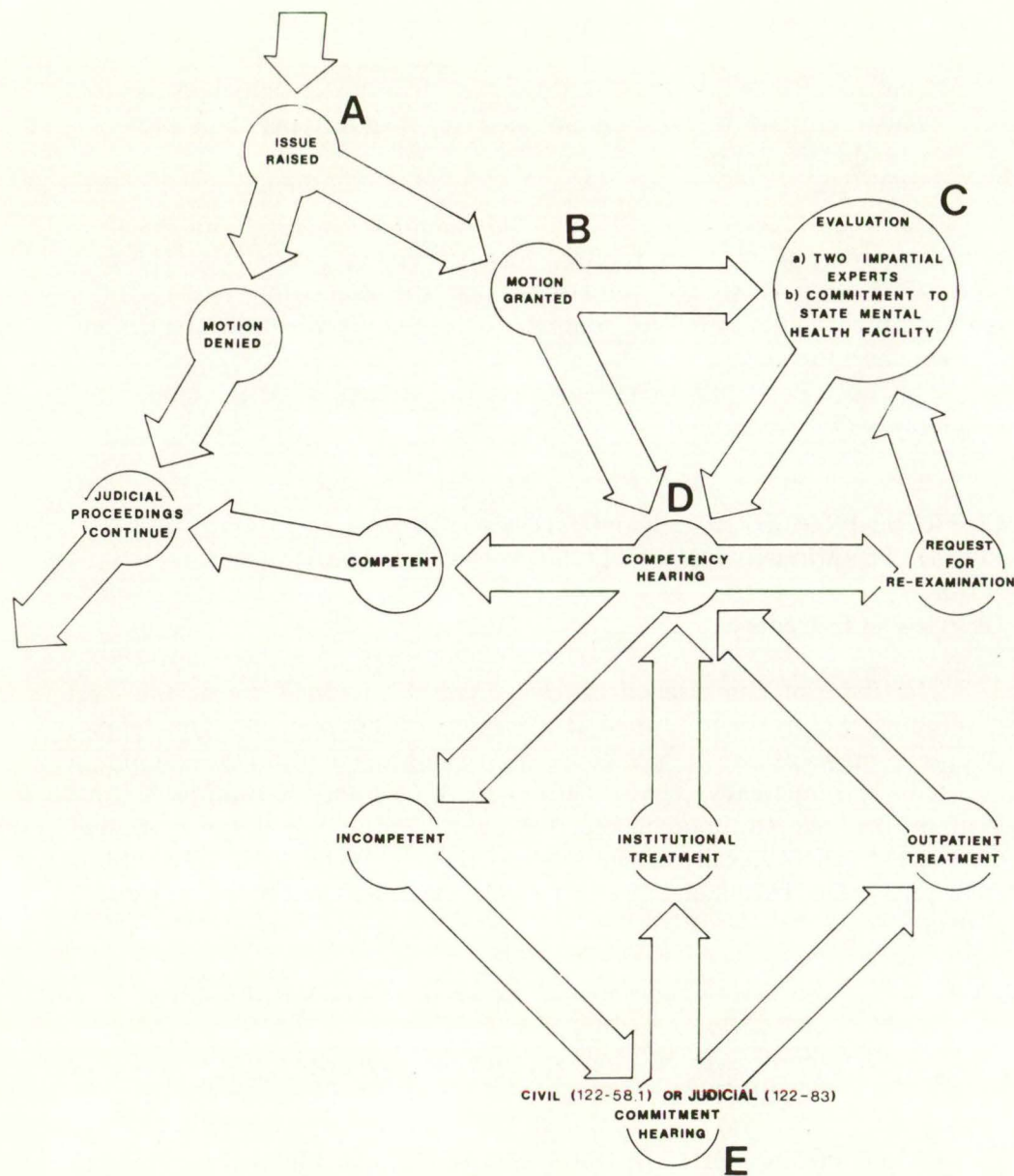


Figure 2-3. A Flow Chart Showing Current Procedures

by psychiatrists and other mental health professionals, and the gathering of psychological test data background information. At the end of the evaluation period, a report to the court is prepared. This report includes a summary of the interview and test data and a recommendation regarding the defendant's competency to stand trial.

Following this evaluation, a court hearing is held to reach a decision about competency. The court does not have to agree with the evaluation recommendations, but, in practice, disagreement rarely occurs. Normal legal proceedings continue if a defendant is determined to be competent; incompetent defendants may be committed to an institution under either civil or criminal commitment statutes. Legal proceedings are suspended until competency is regained or the charge(s) against an incompetent defendant is dismissed.

A flow chart of the current procedures is illustrated to facilitate an understanding of the system of determining competency as it presently functions (Figure 2-3).

Hospital Records

Throughout the evaluation process within the Forensic Unit, typical reports are required to document interviews by psychiatrists, psychological test data, recommendations regarding competency, as well as other background information. The following hospital reports are:

1. Mental Status Exam (MSE) is a report of an initial interview conducted by a psychiatrist. The MSE contains information about the reason for the evaluation referral, the charges against a defendant, psychiatric interview impressions, current medication, psychiatric diagnosis, and initial recommendations regarding competency and treatment in the hospital. This report is usually completed within one week of admission.
2. Diagnostic Conference Report and Discharge Summary. This report (DCDS) is completed after the hospital staff have reached a decision about competency, usually within 60 days of admission.

The DCDS is usually completed for those defendants who are to be immediately returned to court. Until recently, incompetent defendants were not discharged but, rather, were retained in the hospital. Their legal status was changed from observation to treatment for an indefinite period. These defendants have a separate Diagnostic Conference Report and a Discharge Summary (see below). The DCDS is the official hospital report to the court. It typically contains the following information:

- A. Identifying data—demographic information, type of offense, and county of referral.
 - B. Mental status on admission—a summary of the information contained in the MSE report.
 - C. Physical examination results.
 - D. Discharge medication.
 - E. Recommendations—this section states whether the defendant is competent, and, in some of the cases, contains recommendations regarding further treatment after return to court. It may also include legal disposition recommendations, such as dismissal of charges.
- 3. Diagnostic Conference Report. The DCR is completed only for incompetent defendants who are not discharged within the 60 day limit. The DCR contains information similar to the DCDS, except for post-hospital recommendations.
 - 4. Discharge Summary. The DS is completed when an incompetent defendant is ready to be returned to the court (as competent) or after the charges have been dismissed and an incompetent defendant is to be released. The DS contains a summary of the defendant's behavior in the hospital since admission and the psychiatric opinions, diagnosis, and recommendations discussed above.

SURVEY

SURVEY

A recent study of competency procedures in North Carolina conducted by Dorothea Dix was designed to examine the legal and mental health aspects of present procedures.

The purpose of the study was to determine the nature of differences that distinguished defendants who were found competent from those found incompetent. Identification of such differences could lead to improvements of the evaluation procedure. In order to evaluate differences, a control group of 140 competent defendants, matched with 130 incompetent defendants, was randomly selected from a list of competency evaluation admissions for the fiscal years 1965 to 1977.

The following is representative of their findings:

DEMOGRAPHIC DATA

There were 140 defendants in the competent group, 10 of whom were female; the incompetent sample totalled 130, 8 of whom were female. Approximately 41% of the total sample was black, a figure which is consistent with the North Carolina arrest rate for blacks. A slightly higher percentage of blacks were found incompetent, but the difference between groups was not significant. Only about 27% of the total sample were married when referred for a competency evaluation. The incompetent group was significantly older, with a mean age of 36 as compared with 29 years for the competent group. The incompetent sample also had significantly fewer years of education, although only about 19% of the total sample had completed high school. Differences between the incompetent groups with regard to race and marital status were not significant.

PSYCHIATRIC TREATMENT HISTORY

The incompetent sample was significantly more likely to have previous psychiatric admissions to Dorothea Dix Hospital; they were also significantly more likely to have a history of admissions to other psychiatric facilities. Following discharge, incompetent defendants continued to have more involvement with Dorothea Dix Hospital. Fifty-six of the 130 incompetent defendants were readmitted to Dix, compared with only 14 of the 140 competent defendants. Twenty-five incompetent defendants had more than one subsequent admission, compared with only five competent defendants.

PSYCHIATRIC DIAGNOSIS

A Comparison of the Initial and Final Psychiatric Diagnosis

Many defendants did not receive an initial diagnosis; but it was clear that when an initial diagnosis was given, the incompetents receive a psychotic level (schizophrenia, other diagnoses of psychosis, organic brain syndrome), while the competent defendants received a label of without psychosis. Mental retardation accounted for almost all of the remaining psychiatric diagnoses of incompetent defendants. The difference in initial diagnosis between the two groups was significant. The different use of labels is even clearer for the final diagnosis. If the 23 incompetents as mentally retarded are added to the psychosis diagnosis cases, the two labels account for 87% of the diagnoses for the incompetent sample. On the other hand, the competent sample rarely received a psychosis label. In fact, 101 competents (72%) received a diagnosis of without psychosis, and only nine were considered to be mentally retarded. The differential use of final diagnostic labels of psychosis or mental retardation for the two groups was significant.

LENGTH OF HOSPITALIZATION

Defendants found incompetent at the end of the evaluation period (in

the past, the evaluation took approximately 43 days, compared with the current average length of stay of 17 days) were almost uniformly retained in the hospital until competent. Thus, a longer length of hospitalization would be expected for the incompetent sample. Competent defendants remained in the hospital for an average of 43 days, while incompetent defendants remained an average of almost three years.

Incompetent defendants discharged in 1971 were held for an average of almost two years. The length of hospitalization increased dramatically in 1973 and 1974. It appears that this is due to the release of several defendants held for many years. Incompetent defendants are generally held for two to three years.

One hypothesis regarding length of hospitalization is that incompetent defendants charged with violent crimes will be held in the hospital longer than those defendants charged with less serious offenses. The rather lengthy hospitalization period for incompetent defendants (the mean length, regardless of type of offense, is 945 days) seems unjustifiable. If a defendant cannot be restored to competency by an active treatment program within a reasonable period of time, he should not continue to be deprived of his liberty by prolonged incarceration, unless he is imminently dangerous to himself or others and hence civilly committable.

TYPE OF OFFENSE

Incompetent defendants were significantly more likely to be charged with violent crimes, particularly murder and assault, while competent defendants had a higher proportion of property crimes and other non-violent offenses. The frequency of murder charges was high in both groups, accounting for 27% of the offenses in the competent sample, and 38% in the incompetent group. The majority of the defendants were charged with violent offenses (murder, assault, rape, and other violent offenses). Violent offenses accounted for 67% of the offenses in the competent group, compared with 77% in the incompetent group. The remainder were charged with property crimes or other non-violent offenses.

PSYCHIATRIC MEDICATION

Psychiatric medication, especially tranquilizers, was used extensively for incompetent defendants. During the last four months of hospitalization, 97 of 130 (75%) incompetent defendants were taking anti-depression medication. Only 22 competents (16%) were taking medications during the last few months of hospitalization. Again, tranquilizers were most frequently used. Many defendants were taking more than one drug. In fact, 42 defendants were taking two or more tranquilizers simultaneously, and 10 defendants were taking an anti-depressant and a tranquilizer at the same time.

Forty-eight incompetent defendants (37%) were instructed to continue taking medication at discharge. Again, most defendants were taking tranquilizers. Thirty-four defendants were also taking a second medication. Only 15 competent defendants (11%) were to continue taking medication.

Use of medication during the hospital stay can be more easily regulated since nursing personnel are available to ensure that the medication is being taken. The medication is undoubtedly of some value in restoring the competence of some individuals. However, the use of medication following discharge poses some difficult problems. A defendant on tranquilizers, for example, may be able to stand trial only if he continues to take the medication. Upon discharge from the hospital, there is typically a delay before trial begins, or before some other disposition is reached. During this time, the defendant may be in jail, with no trained personnel available to see that he takes the medication. If he does not take the medication, the defendant may not be competent when the trial begins. Psychiatrist cannot rely upon jailers to ensure that medication is being taken. If medication is necessary, arrangements should be made with local mental health centers to supervise the in-jail or outpatient medication maintenance.

SYSTEM RECOMMENDATIONS

SYSTEM RECOMMENDATIONS

The review and analysis of the present procedures for determining competency to stand trial and the analysis of the information collected formed the basis of the recommendations for changes within the current operation and function of the existing system. These changes will dictate significant planning determinants, such as size and characteristics of the population and a specific function for a new Forensic Mental Health Center in Raleigh, North Carolina.

The following system recommendations are:

- The creation of a decentralized system whereby local communities will assume responsibility for evaluating competency and whereby the Dorothea Dix Forensic services will play a creative and directive role in the coordination, training and evaluation of the efforts of the local communities.
- The establishment of screening panels, composed of legal and mental health professionals, at the community level. The screening panel will be responsible for all initial competency evaluations.
- The screening panels will be trained and coordinated by Forensic Service Staff. Forensic service staff will also be responsible for carrying out the recommendations for community-based evaluations.
- A limited use of residential evaluation.
- The introduction of evaluation and treatment procedures whereby questionably competent defendants are evaluated and/or treated centrally located in the state within an appropriate setting, independent from the legal and mental health systems.
- The implementation of changes in the legal procedures necessary to create a fair and constitutionally defensible system.

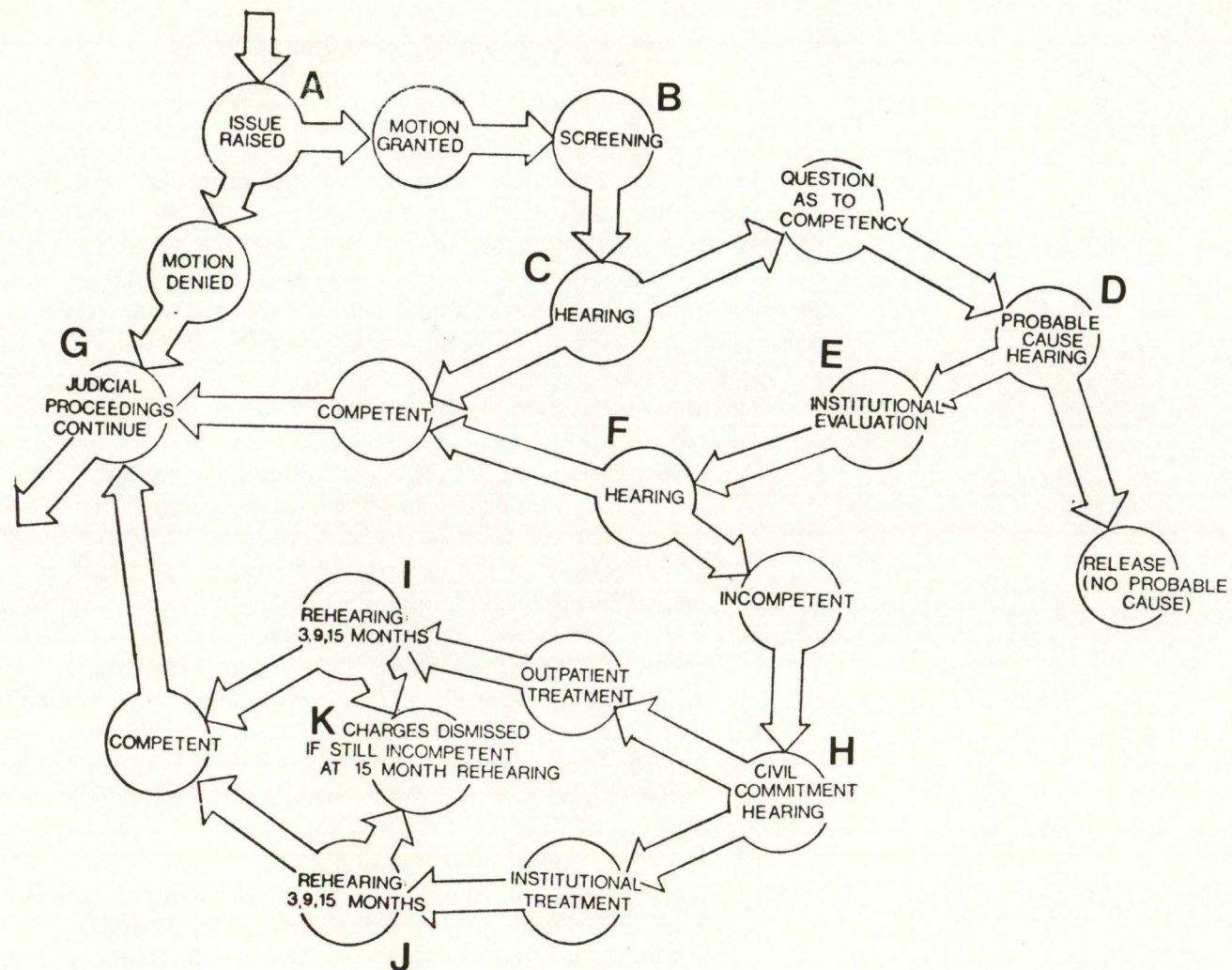


Figure 4-1. A Flow Chart Showing Proposed Procedures

The remainder of this section will discuss the alternative proposal for a new system for determining competency to stand trial. This involves the use of the Forensic Unit services to evaluate defendants who, as a result of the screening process, are questionably competent.

ALTERNATIVE PROCEDURE

Figure 4-1 displays in flow chart format the process of determining competency based on the recommendations set forth below.

Raising the Issue of Competency

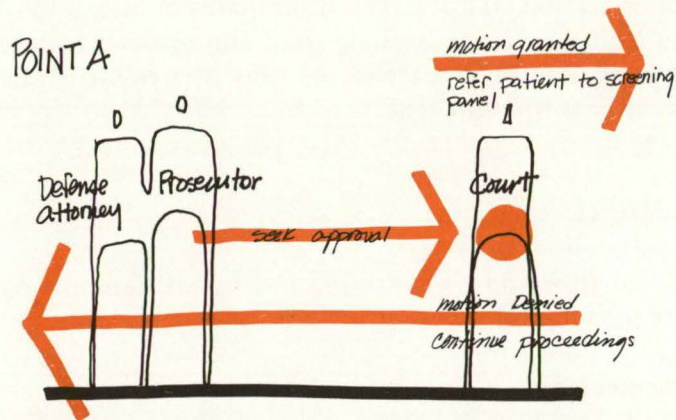
One of the major problems in the current method of raising the issue of competency (Figure 4-1, Point A) is that the motions requesting an evaluation are typically vague. Therefore, it has been recommended that motions be written detailing the following information:

1. What behaviors did the defense attorney (or the prosecution or court) observe that led to requesting the motion?
2. How do these behaviors hinder the preparation of a defense?

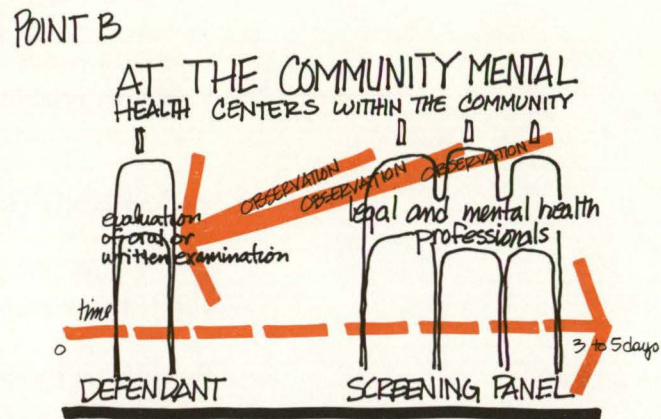
Given that the motion contains the necessary information, the court will grant the motion if there is sufficient reason to believe it is justified. If the court does not believe there is sufficient reason to question a defendant's competency, the motion should be denied and judicial proceedings should continue. When the motion is granted, the court will refer the defendant to a screening panel (Figure 4-1, Point B).

Screening Panel

The screening panel will consist of representatives of the legal and mental health professions and will be responsible for conducting an initial evaluation of all defendants referred by the court. The screening panel will complete the evaluation within three to five days following the referral, and will submit a report to the court within ten days.



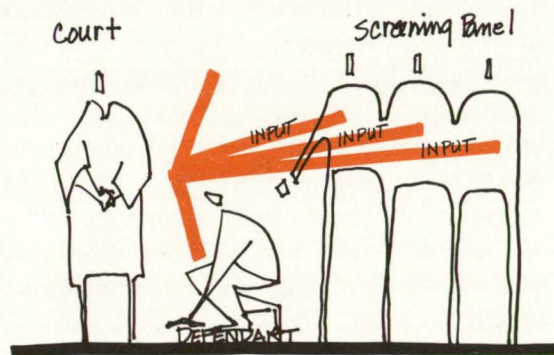
1. Raising the issue of competency



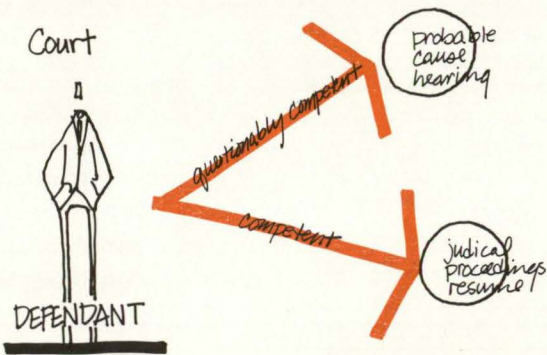
2. Screening Panel

this procedure will screen out 80% of the forensic present population

POINT C



3. Competency Hearing



Competency determination

Figure 4-1, Point A-C. System Components

The screening process will take place in suitable surroundings, such as a community mental health center located with the local community. Based upon the current rate of incompetency determinations, approximately 90% of defendants evaluated would be found by the court to be competent to stand trial. Since this screening procedure is considerably less expensive and involves less delay than sending the defendant to Dorothea Dix for an inpatient evaluation, the state would be saved considerable time and expense, and defendants would not be unnecessarily detained.

Based on an average length of hospitalization of 17 days at Dorothea Dix Hospital and an estimated cost of \$47.27 per day, the cost of one evaluation is approximately \$804. This figure does not include the cost of transportation to and from Dorothea Dix. The cost of an evaluation by a screening panel is estimated to be \$300 to \$400, based on two professionals spending two hours each per evaluation. If the evaluations are conducted by staff from community mental health center, the cost reduction would be even greater.

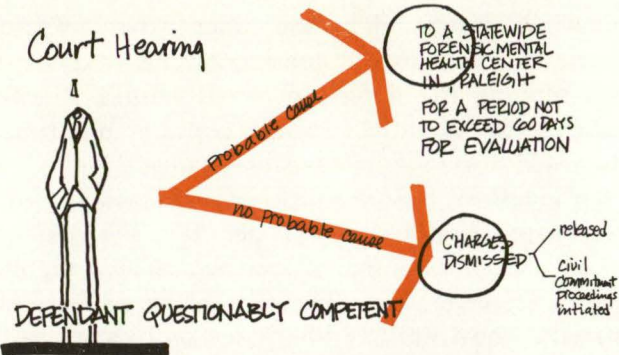
Competency Hearing

After the screening evaluation is completed, a hearing (Figure 4-1 Point C) will be held to review the findings and testimony of the screening panel. The court should weigh these findings and arrive at a determination. The court should operate on the assumption that the defendant is competent unless there is clear and convincing information to the contrary. If the court finds the defendant competent, then judicial proceedings will immediately resume. It is estimated that the majority of defendants will be determined to be competent at this point. The remaining defendants will be considered to be questionably competent so that evaluation beyond the relatively brief screening evaluation is necessary. These defendants will proceed to a probable cause hearing (Figure 4-1, Point D).

Probable Cause Hearing

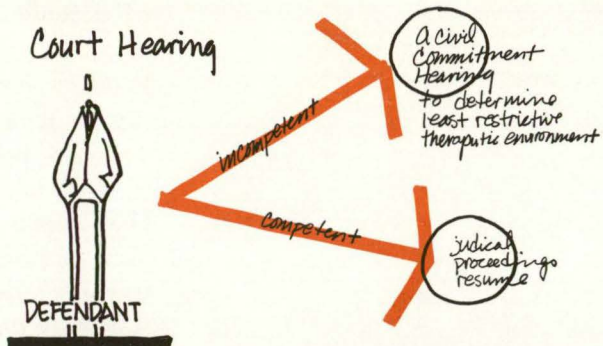
The rationale for this hearing basically provides a safeguard against the unnecessary evaluation (and possible commitment) of incompetent de-

POINT D



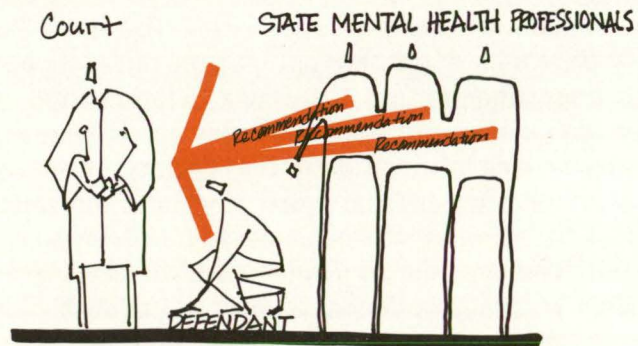
4. Probable Cause Hearing

POINT F



Competency determination

POINT H



5. Civil Commitment Hearing

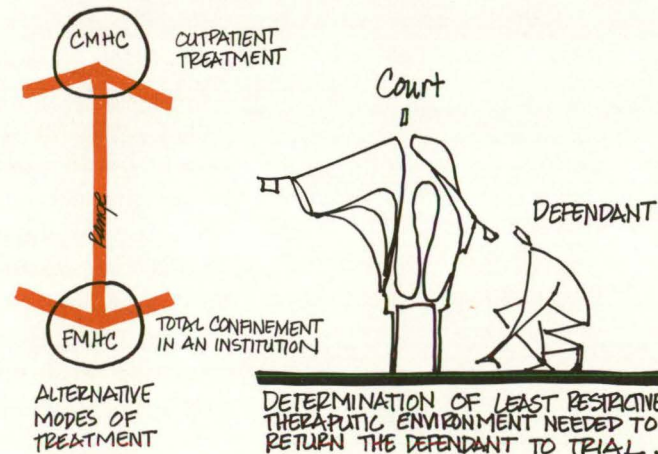


Figure 4-1, Point D-H. System Components

fendants for whom probable cause does not exist. If no probable cause is established, charges against the defendant will be dismissed. Upon dismissal of charges, a defendant would either be released or civil commitment proceedings would be initiated.

However, if probable cause does exist, questionably competent defendants would be admitted to a statewide Forensic Mental Health Center in Raleigh, N. C., (Dorothea Dix Hospital) (Figure 4-1, Point E) for further evaluation for a period not to exceed 60 days. At the end of the evaluation period, these defendants would be returned for a hearing. (Figure 4-1, Point F) If, as a result of the hearing, the defendant is found competent, judicial proceedings would continue. For defendants found incompetent, a civil commitment hearing would be held to determine the least restrictive therapeutic environment needed to return the defendant to trial. These alternatives may range from outpatient treatment to total confinement in a mental institution.

Civil Commitment Hearing

A civil commitment hearing is held for all defendants found incompetent (Figure 4-1, Point H). The purpose of this hearing would be to consider treatment alternatives for the restoration of competency. These alternatives, as indicated before, range from various forms of out-patient treatment to institutional treatment. If a defendant is required to receive outpatient treatment, rehearings would be held at 3, 9 and 15 months. Charges would be dismissed if the defendant was considered incompetent at the 15 months rehearing. If the defendant was determined to be competent during this period, judicial proceedings would continue.

Likewise, defendants committed to an institution would have rehearings at 3, 9 and 15 months. If, at any time, an institutionalized defendant is determined to be competent, judicial proceedings would be reinstated. If a defendant was incompetent at the 15 month rehearing, charges would be dismissed. However, further commitment could be ordered if the defendant was still considered to be dangerous and mentally ill.

The recommendation for dismissal of charges after 15 months, or one-half the maximum sentence, whichever is lesser.

If, at the end of this period, such as the 15 month period recommended for North Carolina, a defendant is still incompetent, it is unlikely that competence will ever be regained. Thus, the fact that charges remain pending can only serve to allow the continued confinement and punishment, of these defendants.

ARCHITECTURAL RECOMMENDATIONS

ARCHITECTURAL RECOMMENDATIONS

This section presents the architectural recommendations for the forensic facility at Dorothea Dix Hospital. Outlined are the basic facility choices:

1. a short-term renovation facility, and
2. a new facility with a capacity of 46 persons.

The recommended capacity of 46 is based upon the implementation of community level evaluations. Under the alternative procedure proposed, it is estimated that the screening panels would find about 80% or more of the referrals to be competent. Thus, only 20% or less would be referred to the forensic facility for further evaluation. At current admission rates, this would indicate approximately 150 to 175 referrals annually. However, the total court referral rate may actually decrease since many of the inappropriate uses of the competency evaluations would be eliminated. Further, the analysis of recent admissions to the Forensic Unit showed that very few defendants were held more than three weeks. The average length of hospitalization was approximately 17 days. Defendants held longer than three weeks probably represent the more difficult decisions. Only 14 of 140 competent defendants were held longer than three weeks. This information suggests that the screening panel would be able to make immediate decisions for all but a very few cases. Thus, a capacity of 46 should sufficiently meet the future evaluation and treatment needs of forensic services.

DOROTHEA DIX HOSPITAL

Through the efforts of Dorothea Lynde Dix, legislative appropriation for a state mental hospital in Raleigh was passed in 1849. Construction of

the Dix Hill State Asylum for the Insane was completed in 1856, accommodating 40 patients at a cost of approximately \$8,000. The hospital retained this name until 1958 when the North Carolina General Assembly passed a resolution to rename the institution Dorothea Dix Hospital.

The hospital today is located atop the same 1,054 acre campus site overlooking downtown Raleigh and within sight of Central Prison. The hospital has grown to a capacity of approximately 1,200 patients served by a staff of approximately 1,450. Dorothea Dix Hospital provides psychiatric treatment services to the South Central Region of the North Carolina mental health system and forensic services to the entire state.

FORENSIC UNIT

Organization and Program Components

Patients in the Forensic Unit fall into one of five legal categories:

1. person admitted by court order for evaluation of competency to stand trial,
2. persons found incompetent to stand trial and judicially or civilly committed back to the hospital,
3. inmates transferred from the Department of Corrections,
4. persons found not guilty by reason of insanity through the course of a jury trial, and
5. persons considered management problem cases from other hospital or wards in Dorothea Dix.

Women, regardless of their legal classification, are housed in closed wards elsewhere on the hospital grounds.

Currently there are four wards in the Spruill Building. The Admissions Wards (#3 and #4) house men currently being evaluated for competency to stand trial who present no particular management-behavior problems. Psychological testing, interviews and physical examinations are conducted. Social services are provided through the help of the Regional Assistants who

act as a liaison between the patient, his or her lawyer, family and other necessary contacts. Treatment and programs provided for these patients include group therapy, recreation and participation in a patient government. Patients are placed in wards #3 and #4 according to the geographic mental health region from which they are admitted. (Ward #3 houses persons from the North Central and Western regions; on Ward #4, defendants are committed from South Central and Eastern regions.) Defendants from both these wards are returned to the county from which they were committed.

The Nursing Care Ward treats persons who, either upon admission or during the course of their stay, have physical problems and require close observation. The Management Ward supervises patients who have behavior problems and are regarded as "management problems" by other wards or hospitals. They are described as hostile patients, agitated, and acting out physically and/or verbally. After these patients become more restrained, they are released to their "home unit" and eventually discharged to family or jail, depending on their legal status. Patients on this ward participate in group therapy, and a point system in which they may obtain various privileges. Patients' cases are reviewed by the treatment team every 30 days.

Patients found not guilty by reason of insanity, transferred from the Department of Corrections, found incompetent to stand trial, and/or those awaiting pending charges are placed under the supervision of the ward best suited to their treatment needs. Depending on the level of security necessary and the ability of patients to participate in programs, vocational rehabilitation programs, group therapy, work therapy (job assignments on the hospital grounds), exercise classes, recreation and other special education classes are provided. The Rehabilitation Pre-Release Program, is designed to facilitate a patient's re-entry into society through re-learning of social skills using behavior modification techniques.

Existing Forensic Facility

The Dorothea Dix Forensic Unit is currently housed in the basement, first and second floors of the Spruill Building. The building was apparently constructed in four stages. The original wing was built in the Depression, and the last addition was constructed during the 1950's. During the 1960's, the

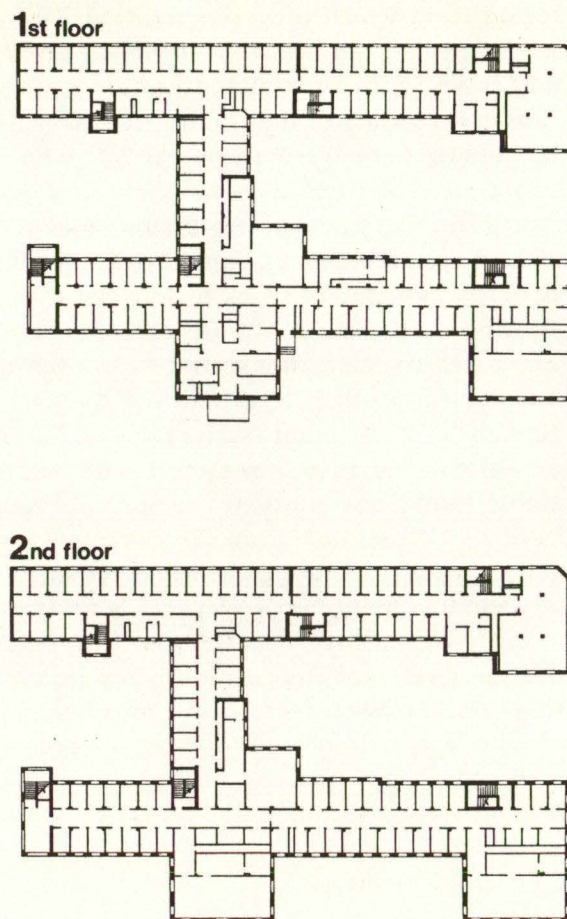


Figure 5-1. Existing Forensic Facility

entire facility was renovated. Currently, the building is structurally sound and well maintained. To the rear of the building is a fence-enclosed recreation yard with guard walks between the inner and outer fences for staff security and observation.

The first floor of Spruill houses the management ward patients and the nursing care ward as well as the main office, staff office space, classroom, conference room, and examination room. The management ward contains 30 single occupancy rooms and 8 seclusion rooms for acting-out patients, no bedrooms in the Forensic Unit contain toilet facilities. Patients are locked in their rooms at night with a container and are not allowed to leave. The nursing care ward on this floor has seven single occupancy rooms for patients.

The second floor houses the two admissions wards (#3 and #4). There are 74 single bedrooms and 8 seclusion cells on the floor. There are two dayrooms and one recreation room. There are four bathrooms, five offices, one conference room and one conference room/mini-lab.

The basement provides spaces for the kitchen and dining area, church, recreation room, occupational therapy room and vocational rehabilitation lab (Figure 5-1).

The Forensic Unit is basically comprised of five components, two operational components:

1. Administration
2. Residential Support
 - A. Kitchen/Dining
 - B. Chapel
 - C. Occupational Therapy

and three categories of residency:

1. Management Ward (aggressive residents)
2. Nursing Care (physically ill)
3. Admission Wards (competency evaluation)

The building poorly serves the needs of the Forensic Unit population and staff. The three most strikingly inappropriate characteristics of the building are:

1. Limited architectural relationship to evaluation and treatment philosophies;

2. Inefficient circulation;
3. Absence of necessary health needs determined by the Joint Commission on Accreditation of Psychiatric Hospitals.

A survey of the building indicates that, while it is feasible to renovate the structure in order to provide more appropriate facilities, such a strategy is inadvisable. Such renovation would be extremely costly, requiring extensive removal of interior partition walls and the installation of a substantial amount of new plumbing. At the conclusion of such renovations, the building would, to a significant extent, retain many of its present faults, particularly with regard to interior pedestrian circulation and the poor physical relationship between staff offices and the residential units. The needs of the current population could be better and more efficiently served by the construction of a new facility of appropriate size and design rather than by extensive renovation of Spruill.

Potential New Construction

Should the state construct a new facility to house the forensic function, its capacity should be limited to 46 residents. The proposed capacity of 46 is contingent upon the implementation of the proposed system recommendations. Under this proposal, the Forensic Unit will receive approximately 150-175 evaluation referrals each year, since the screening panel process will eliminate inappropriate referrals. The staff will receive more difficult cases and will require more time for evaluation and treatment than is presently the case. Thus, if these defendants remain the entire 60 days allowed by court, the new forensic facility would require approximately 30 beds for evaluation referrals. The remaining 16 beds would be used for treatment of those patients found incompetent for 3, 9, and 15 months.

IMPLEMENTATION

IMPLEMENTATION

INTRODUCTION

A Statewide Forensic Mental Health Center (FMHC) is a new building type for which no operating model exists. Therefore, schematic drawings, an integral part of the program description, should be provided in all initial applications. The three-stage submission of drawings and specifications—schematic, preliminary and working drawings, plus the necessary specifications and cost estimates—are rather ordinary requirements for demonstrating the progressive development of design concepts and architectural program into a complete building design. However, the special requirement that schematic drawings be submitted at the very earliest stage of the work emphasizes the importance attached to design within the FMHC concept.

To illustrate how such schematic designs evolve, a design presentation is included later in the chapter. The design process can be a catalyst to refine the architectural, evaluation and treatment programs. The following facility concept emerged as a result of an intensive total systems planning approach.

ROLE AND RELATED FUNCTIONS

The role of a new Forensic Mental Health Center is to support elements of the proposed decentralized system in a state of equilibrium. Its related functions are to evaluate questionably competent defendants for a period not to exceed 60 days, and to treat those defendants found incompetent for 3, 9, and up to 15 months. The related functions support its role and identifies two key programs, evaluation and treatment. These programs, evaluation and treatment, as well as architecture, develop simultaneously. Decisions affecting such issues, as the character of the building and overall design objectives, evolve as these programs progress.

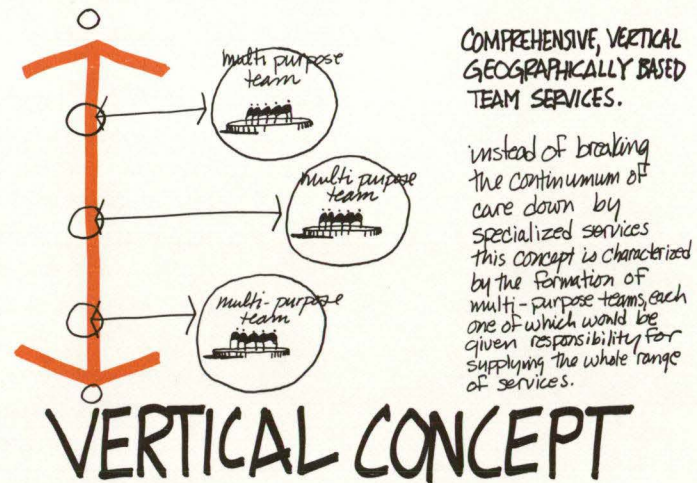
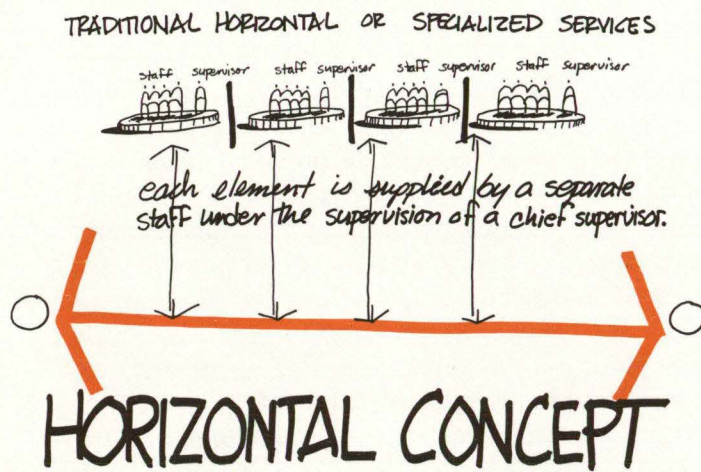


Figure 6-1. Concepts of Administrative Patterns

ADMINISTRATIVE PATTERNS

In formulating an evaluation and treatment program, two basic administrative patterns, or variations of them, needed to be considered. The first, and most common of the two is the Horizontal Pattern or Specialized Services. Whereas each element of service is supplied by a separate staff under the supervision of a chief or supervisor. The second, Vertical Pattern, is characterized by the formulation of multi-purpose teams. Instead of breaking the continuum of care down by individual, specialized services, each team would be given responsibility for supplying the whole range of services (Figure 6-1).

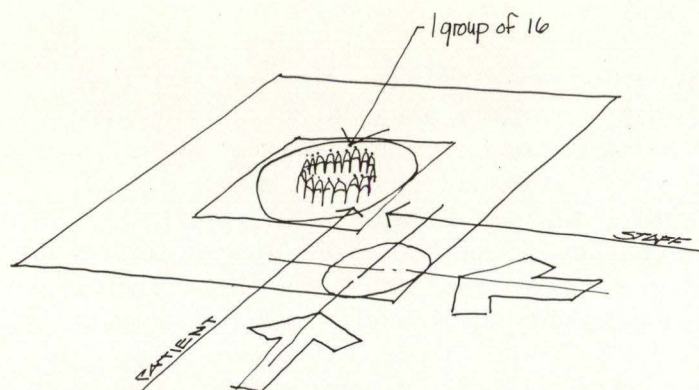
The multi-purpose team approach, (Vertical Pattern), was chosen for its capacity to care for a small and very high risk patient population. It encompasses effective and efficient use of limited professional personnel and observation time. The chief strength of the multi-purpose team arrangement is that it supplies continuity to the patient-therapist relationship. The same team treats the patient regardless of modality of care. Moreover, the team is responsible for the patient's activity on a twenty-four hour basis. Each team occupies its own quarters and is able to change evaluation and treatment methods for each patient, as his needs change, without transferring him to another specialized service. All treatment and evaluation goes on in the same team area, mixing various patients and staff together.

The remainder of this section will discuss elements and issues in team composition and effectiveness, and its overall impact in characterizing the evaluation, treatment, and architectural program.

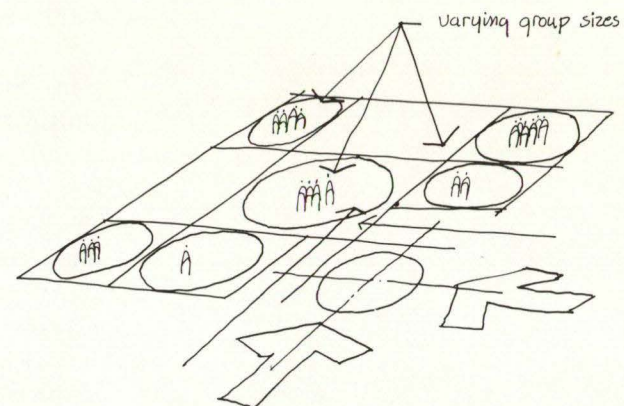
TEAM COMPOSITION AND EFFECTIVENESS

Team effectiveness is partially determined by the attributes that each individual patient and staff member brings to the team. Effective teams tend to have interactive compatible, and responsive members.

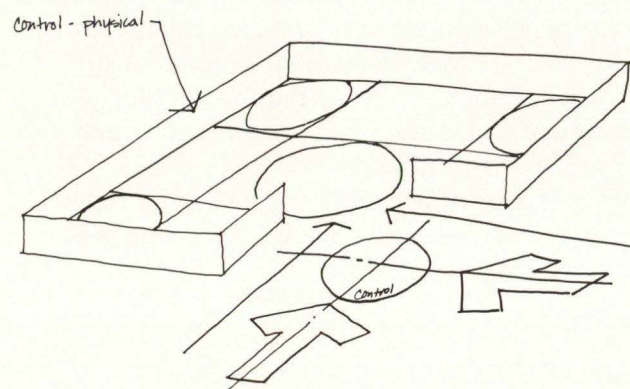
Several compositional factors can reinforce the development of effective teams:



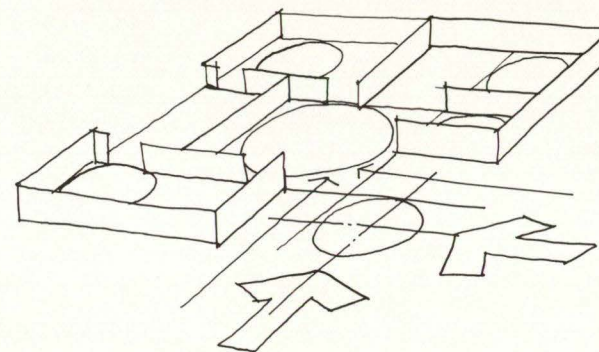
Each team shall have its own multi-purpose work area.



Team areas will provide integrated care as suited for individual needs.



All team areas will be controlled.



Various functions within the team area shall be articulated.

Figure 6-2a. A schematic evolution of the multi-purpose team area and its relationship to the evaluation and treatment program.

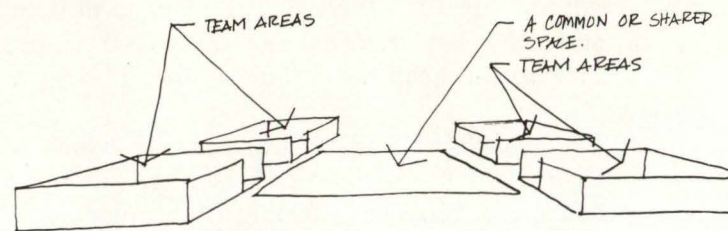
BALANCE—Most effective teams are composed of members who differ with respect to behavioral attributes. An individual may be selected for team membership because of a specific skill or personality trait, appropriate for others in the team to imitate and adopt to their own style of behavior. A person who has developed some talent or interests or who can keep his temper in an argument may be a potential model.

ENVIRONMENT—The situation in which a group of people find themselves has a definite effect on the mood of the group. A small room can provide a feeling of intimacy for one group, a feeling of crowding for another. For some groups, a station wagon can be an exciting, attractive meeting place. Providing an appropriate environment can be a significant contribution to group effectiveness.

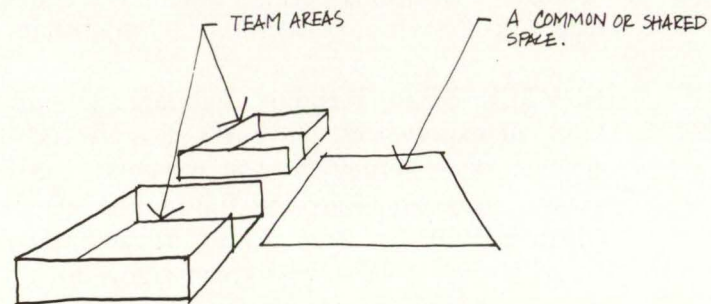
TIME—Some groups need to meet only once to accomplish their objectives effectively; others require a considerable amount of time. Groups are more likely to be effective if the group makes carefully considered decisions pertaining to the frequency, length, and time of meetings. Establishing definite time limits help groups develop quickly.

NUMBER—Small, medium, and large groups offer patients different kinds of experiences. No one size is necessarily more beneficial than another size. Actually, many patients need experience in groups of various sizes. Small groups, four to six members, provide a setting in which patients are forced into greater interaction with one another. Large groups, twelve to sixteen, allow for anonymity. The roles are more formal. There is some opportunity for interaction among patients, particularly within subgroups in the larger group.

No matter how "good" the composition of a team may be, it cannot assure the achievement of treatment goals. Nevertheless, the skillful composition of a team can enhance its effectiveness.



Four general adult multi-purpose team areas are representative of each catchment area within the state.



Special team areas will primarily be used by the elderly, handicapped and adolescents.

Figure 6-2b. Grouping of Multi-Purpose Team Areas

EVALUATION AND TREATMENT PROGRAM

The following considerations characterize the evaluation and treatment program (Figures 6-2a and 6-2b).

- Each team will have its own multiple purpose work area.
- Each team area will be designed and equipped to provide integrated care as suited for individual needs.
- All team treatment areas will be controlled with maximum emphasis upon team therapeutic involvement, patient interdependence, and patient responsibility.
- Teams will be assigned according to the patient's geographic area. This will permit groups large enough for effective milieu modalities, small enough to permit good interaction between patients and staff.
- There will be four general adult multi-purpose teams, each with full treatment and evaluation responsibility for certain patient populations. Adding to the team's personal observation of the patient's mental condition will be a wide range of readily obtainable information concerning his social, educational, vocational, and physical well-being.
- Two other special team areas, adolescents and elderly are to be considered separately, since both of these groups generally require services keyed to their special needs.
- A 24 hour emergency service staffed by a psychiatric assistant or psychiatrist will be offered in the FMHC with admission directly to the team area without immediate holding or observation wards.
- All patients, other than those with medical diagnosis which takes precedence over treatment, will be accepted for treatment evaluation in the FMHC.
- Treatment services will be based in a central facility affiliated with Dorothea Dix State Hospital to maximize staff cooperation, and interchangeability. The FMHC facility and staff will be large enough and flexible enough to modify programs as opportunities arise.

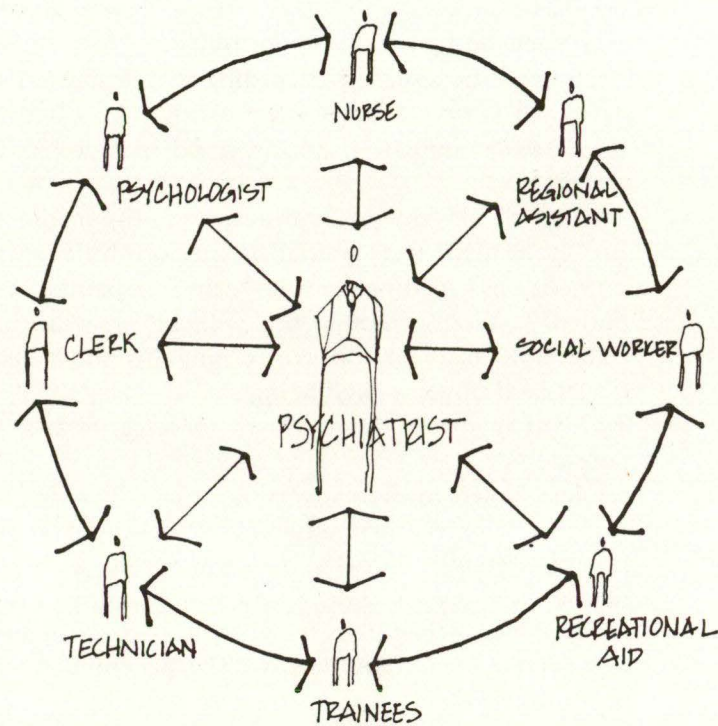


Figure 6-3. Professional and non-professional team members

A psychiatrist will head each of the team areas. Each team will consist of eight full-time professional and non-professional staff members. A clerk will handle all reception work, clerical procedures, special typing and record keeping in the team area.

A social worker will be required to gather environmental data about the patient's life which is thought to be related to the alleged act for which he/she is charged. One head nurse shall be responsible to maintain healthy physical and emotional well-being on a 24 hour basis. One recreational aide, one health care technician, and one regional assistant will complete the staff. A part-time psychologist will be available for necessary diagnostic testing and for supervision of program evaluation projects relating to the team's work. A part-time vocational counselor will also be available to each team (Figure 6-3).

Staff members will wear no distinguishing uniforms. Therapy will concentrate upon groups (patients being seen individually, chiefly to facilitate their ability to progress in group programs). Activities groups, occupational, vocational, and recreational therapy, will be the responsibility of the team staff, thus, emphasizing group cohesiveness.

At its administrative level, the FMHC will be headed by a director or chief of services. This position should be filled by a psychiatrist with a good background in both criminal psychiatry and administration. His assistants will include two other psychiatrists. One will be chief of clinical services, to whom all team leaders will report. The other will be director of training. Also serving the director will be a business administrator with a background in administration. A clerical pool arrangement will handle general typing and centralized record keeping.

ARCHITECTURAL EXPRESSION

The architectural expression of the Forensic Unit is critical to its function, and to its image in the urban like setting. It should express a normative atmosphere and character both externally and internally. Circulation systems and mass-space articulation should provide a clear functional and visual orientation, both to the user and casual observer. Security intake and service functions should be screened or sheltered from public zones. A strong over-powering institutional image should be avoided.

GRAND TOTALS NET BUILDING AREAS

Major Activity	Net Area
I. Main Entrance Level	
A. Reception	2,780
B. Commons Areas	18,000
C. Special Team Areas (2)	4,095
D. Facility Administration	3,760
E. Service Area	5,120
II. Upper Level	
A. General Adult Teams (4)	5,845
Net Subtotal	61,240
III. System Administration (optional)	
A. Administration	400
B. Staff Development	400
C. Patient/Offender Assessment	400
D. Program, Research and Development	600
E. Information and Records	1,400
F. Administrative Support	1,735
Net Subtotal	4,935
TOTAL NET BUILDING AREA	66,175

Figure 6-4. Major activity area sizes

While a secure outer perimeter must be established, a visual manifestation of security character through the use of steel bars, locks, etc., should be avoided. High-strength unbreakable glass is currently available on the market and is recommended for use in security settings such as this facility.

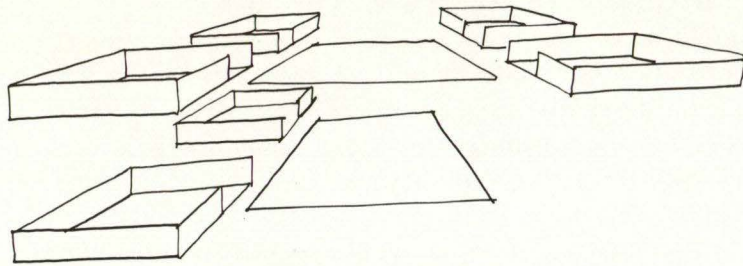
Interior spaces should reflect the nature of the various functions. The office spaces for administration and staff should provide comfortable and efficient work spaces, with flexibility for change as work patterns vary. Residential areas and associated program/service spaces should provide an inviting, comfortable atmosphere with an emphasis on functional and visual variety. Isolation of residents from program and activity space and from custodial staff should be minimized. The use of normative interior amenities such as carpeting, color and standard furniture is encouraged.

ARCHITECTURAL PROGRAM

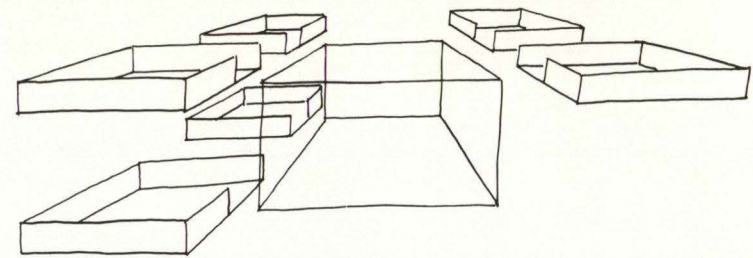
The first basic document for communication in the building field is the architectural program. It will be the prime source of information for administrator, treatment personnel, public officials, the architect and his staff, consulting engineers, and many others. The complete program evolves gradually and is not readily discerned at the beginning of work. It must represent the function and the character of the facility; therefore, dialogue, observation and questions from parties involved is necessary. This demands a commitment to understanding on the part of the architect and planner together with the pledge that in determining program requirements, it will be possible to do three things:

- establish true needs
- shape and order them, as environment and space
- and achieve this within the real limitations imposed by the project determinate and objectives.

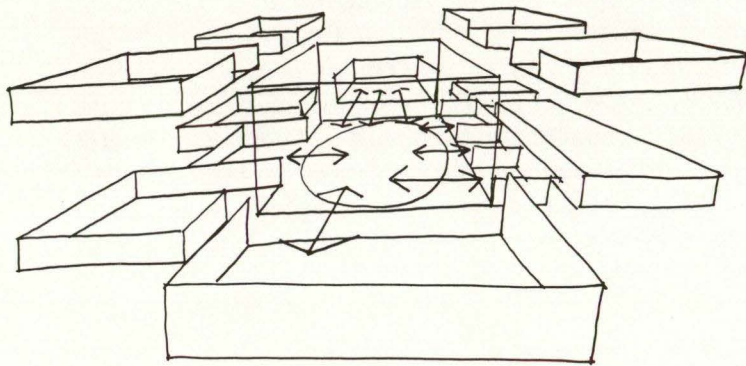
All too frequently, the architect is handed a predetermined program—a skeletal and lifeless outline listing the minute particulars of various spaces. The list of spaces approach is common and often seems very impressive, with



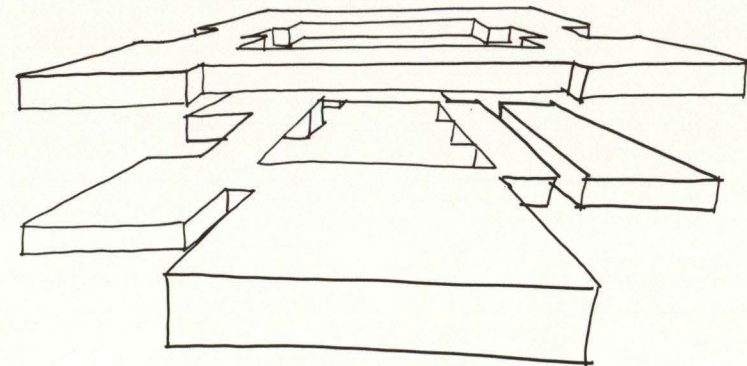
By stacking the team group areas, levels of interactions can be regulated.



The Central court arrangement is an appropriate method of relating the individual teams to each other.



The courtyard should be an active place, where varying levels of interaction may occur.



The relationships of teams to one another became a key element to a facility concept.

Figure 6-5a. Interrelationship between and within major activity areas

its detailed observations on requirements. Restricting program information to these details represents a serious misunderstanding of the part to be played by programming and by the architect himself.

An integral part of the program description is schematic drawings. Schematic drawings and diagrams make clear the interrelations between spaces, activities, and personnel. In this study the schematic drawings are either abstract diagrams indicating program relationships or more detailed but still schematic plan elevation and perspective drawings showing all the required interior and exterior activity settings related to the site and to each other.

Major activity areas, detailed room designations and sizes are listed in Appendix and refer specifically to the schematic design solution included within this study.

A list of major activity area sizes shown in Fig. 6-4 underwent continuous revision during the design process. The functional components and their interrelationships are a direct consequence of the evaluation and treatment program.

Relative Relationships

The focus on the treatment team and the relationships of teams to one another, is a key to the proposed facility concept. This conceptual approach to the team problem places four evaluation and treatment teams on one level, symmetrically arranged about a central court (Figure 6-5a and 6-5b).

The central court arrangement is appropriate method of relating the individual teams to each other while preserving a sense of identity and privacy on each of the four corners of the plan. It is a carefully ordered plan, directly expressed by a consistent structural bay system throughout its parts.

The preliminary design presentation is not, and this should be emphasized, fully-developed architectural proposals. For instance, the nurses station control area, therapy areas, and possible arrangements of the large multi-use group space in the team area require further design development, as do other specific detail elements of the plan. The concrete column, beam and slab structural system lack detailed design development, and a sophisticated development of materials, furnishings, and similar details are beyond the intended scope of the project.

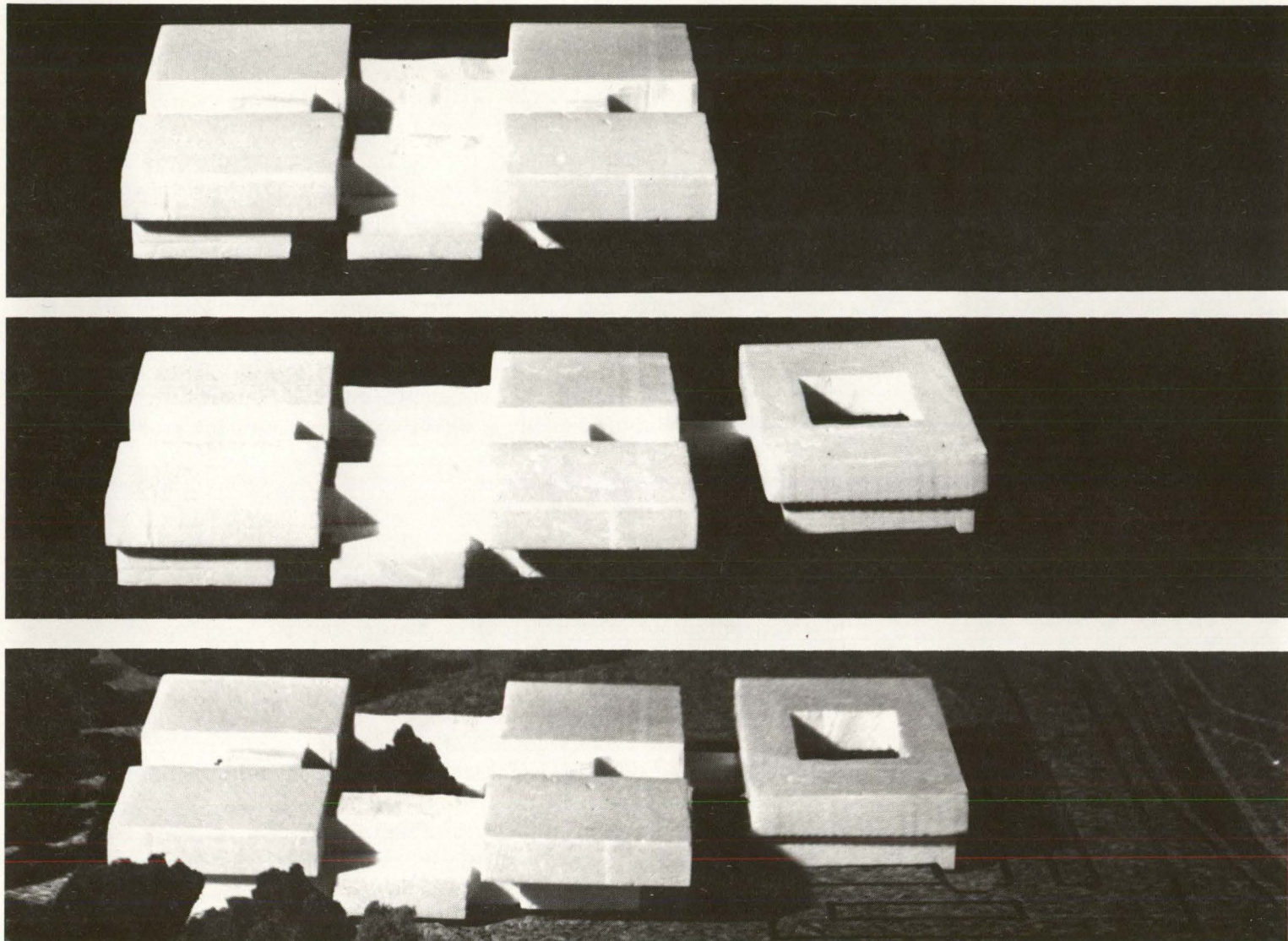
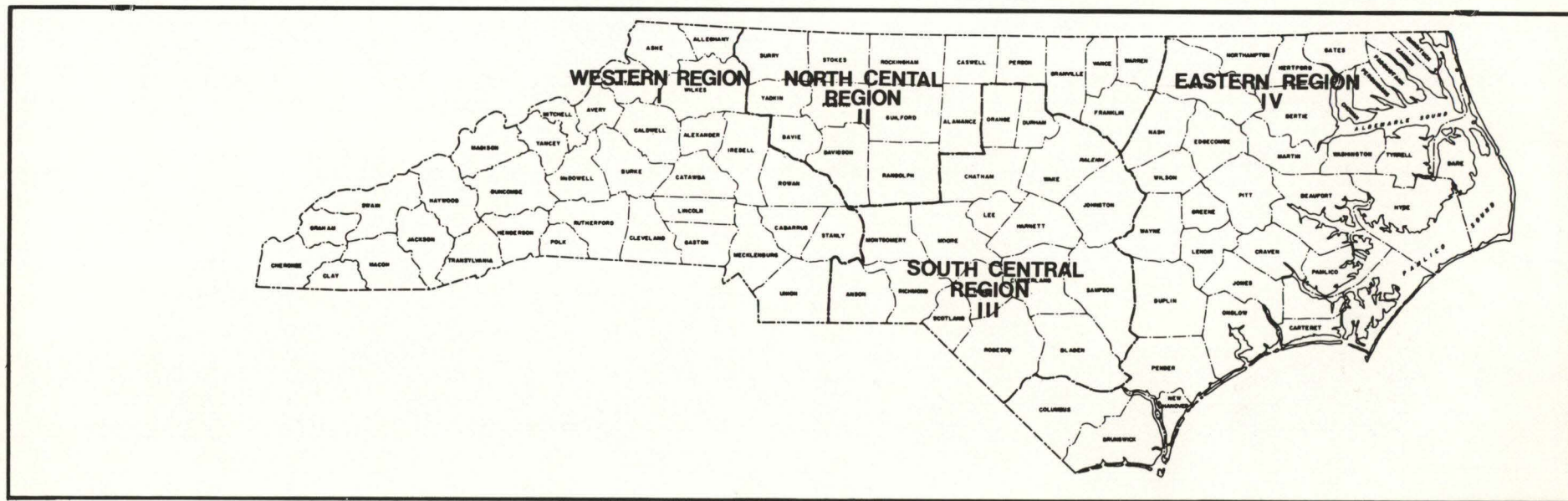
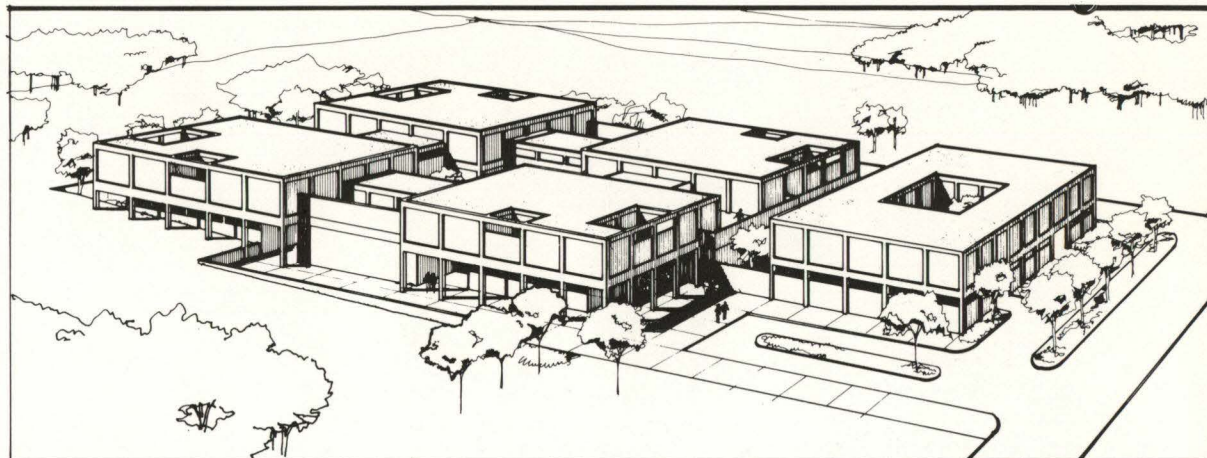
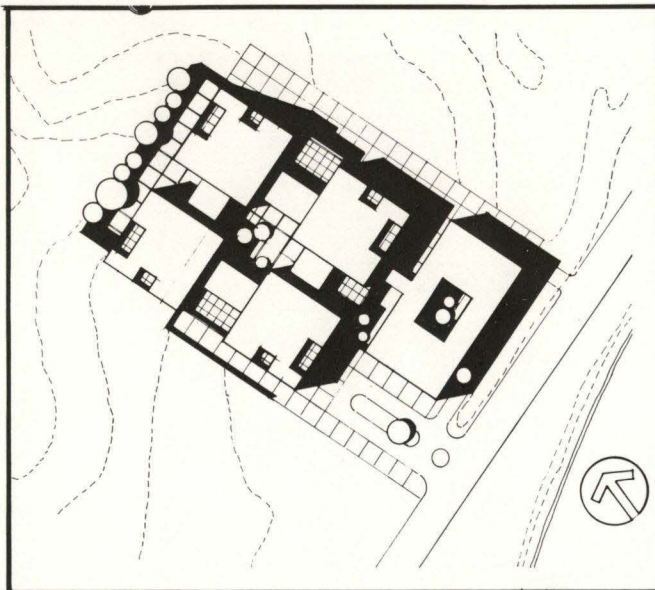
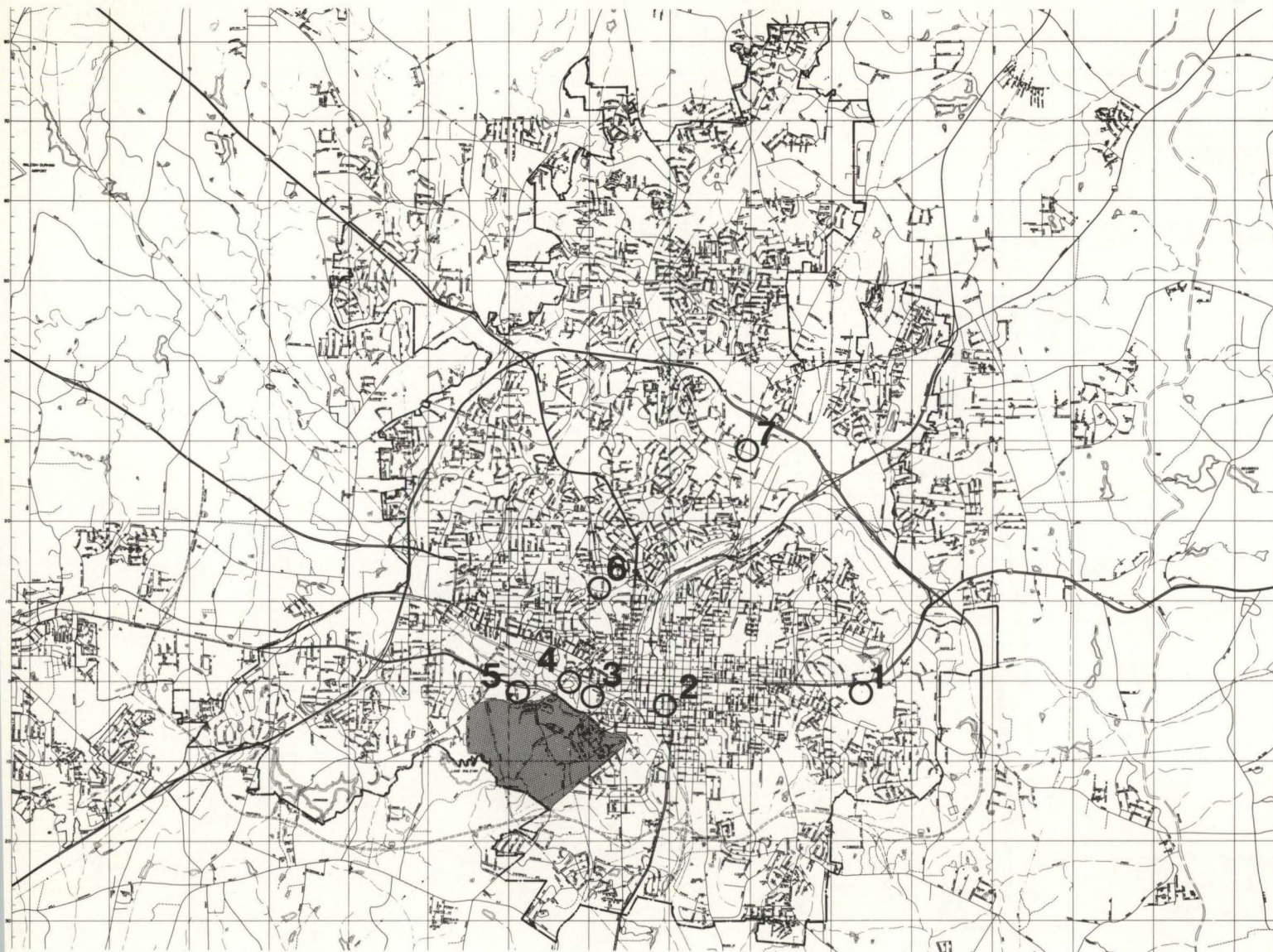


Figure 6-5b. Function, Form and Site Relationships

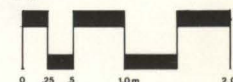


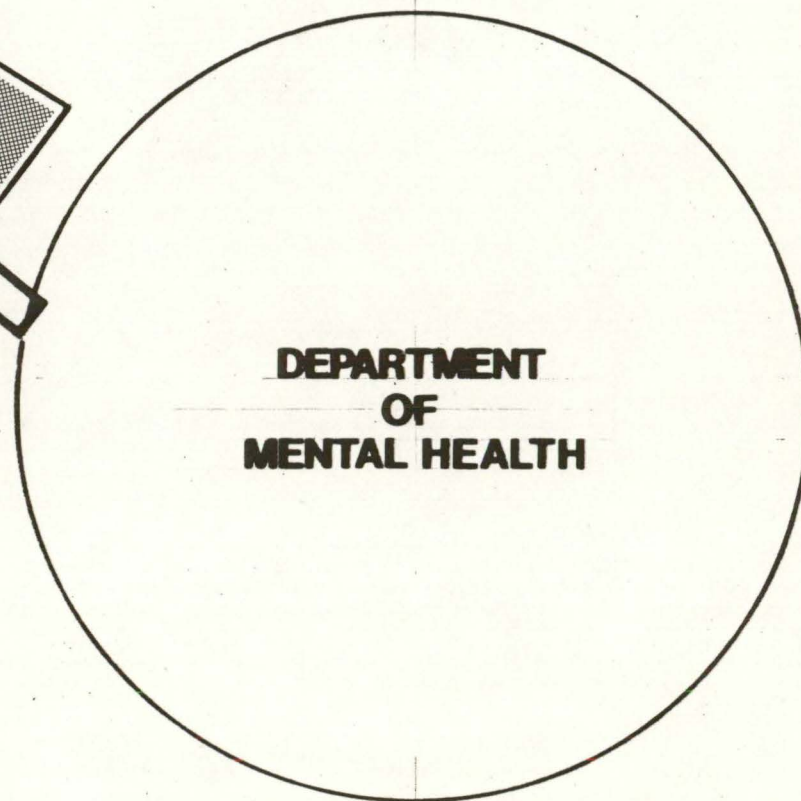
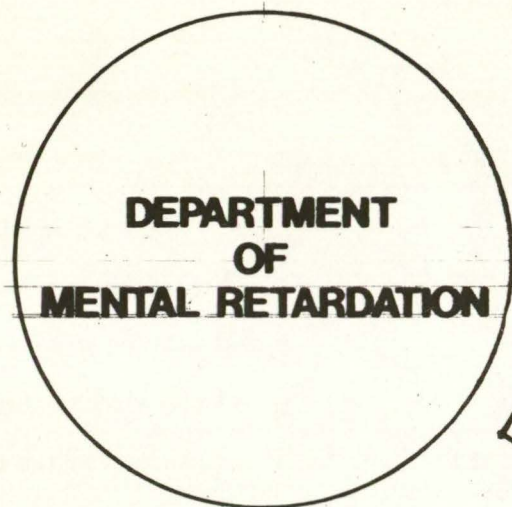


LEGEND:

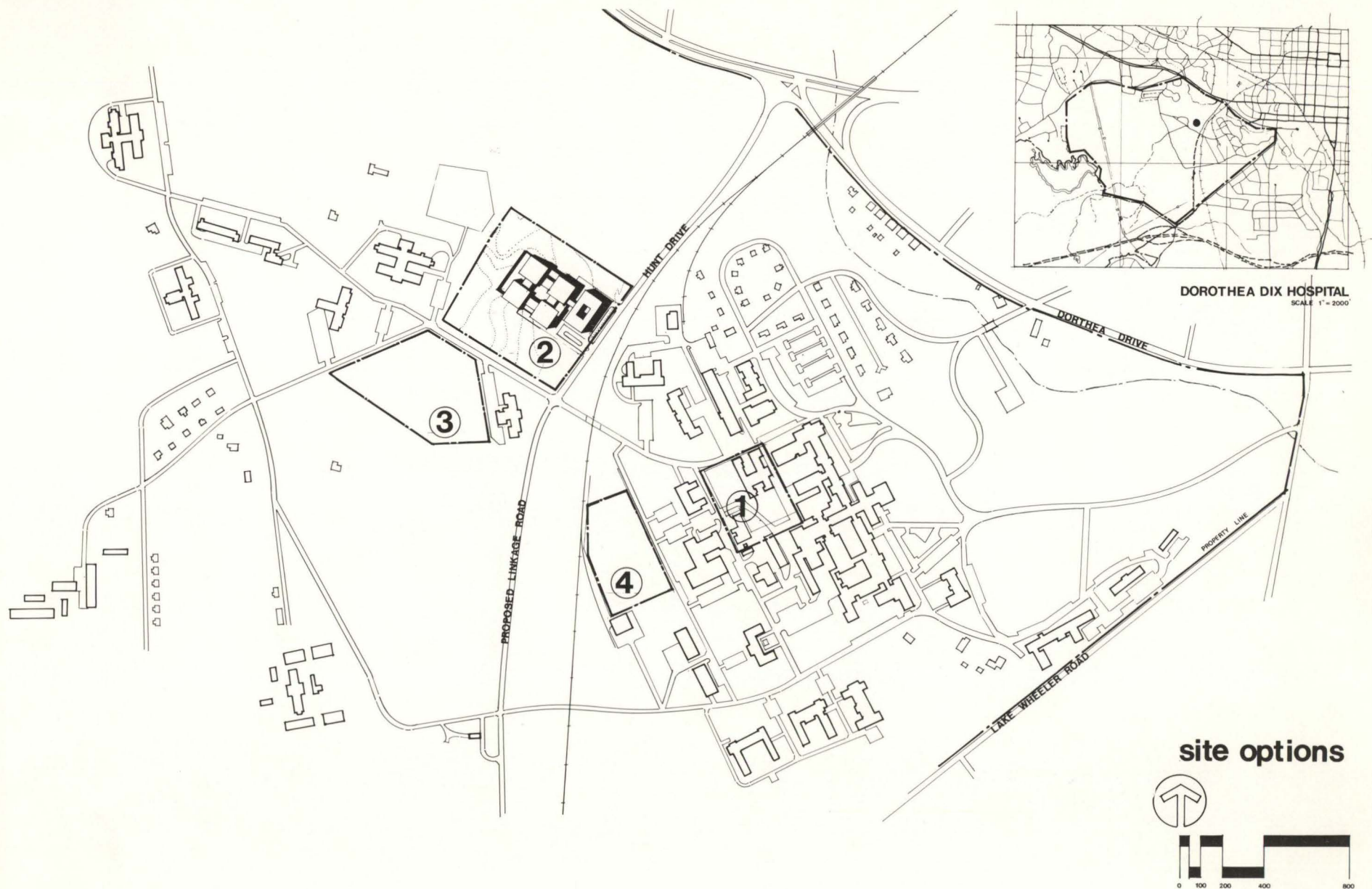
- 1** WAKE MEMORIAL HOSPITAL
- 2** WAKE COUNTY COURTHOUSE
- 3** CENTRAL CORRECTIONS INST.
- 4** SCHOOL FOR THE BLIND
- 5** CATHOLIC ORPHANAGE
- 6** REX HOSPITAL
- 7** MARY ELIZABETH HOSPITAL

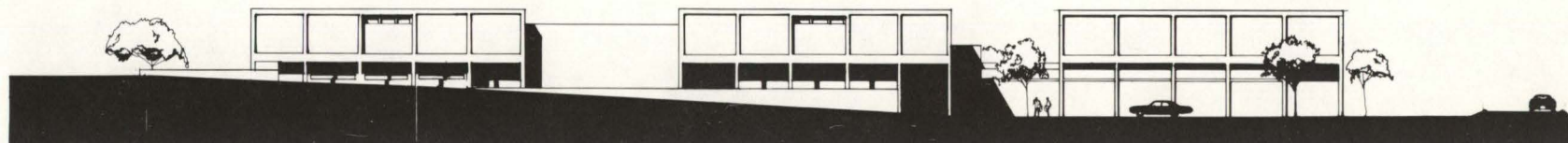
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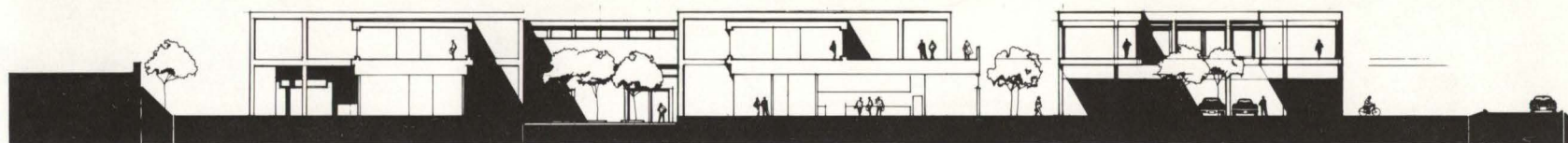


**VEHICULAR ACCESS TO
DOROTHEA DIX FROM
PROPOSED BY - PASS**

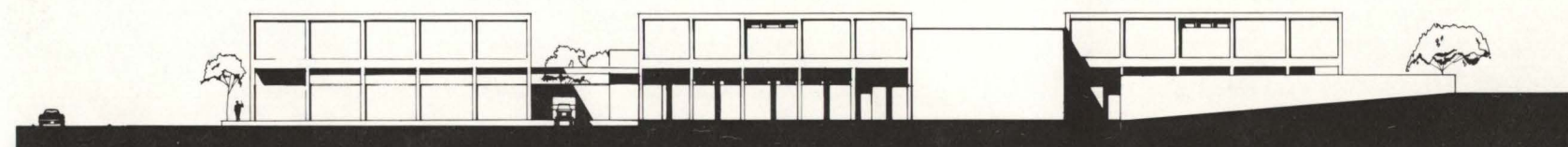




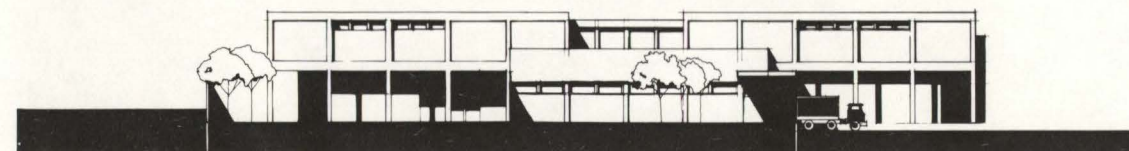
elevation
SCALE 1" = 20'



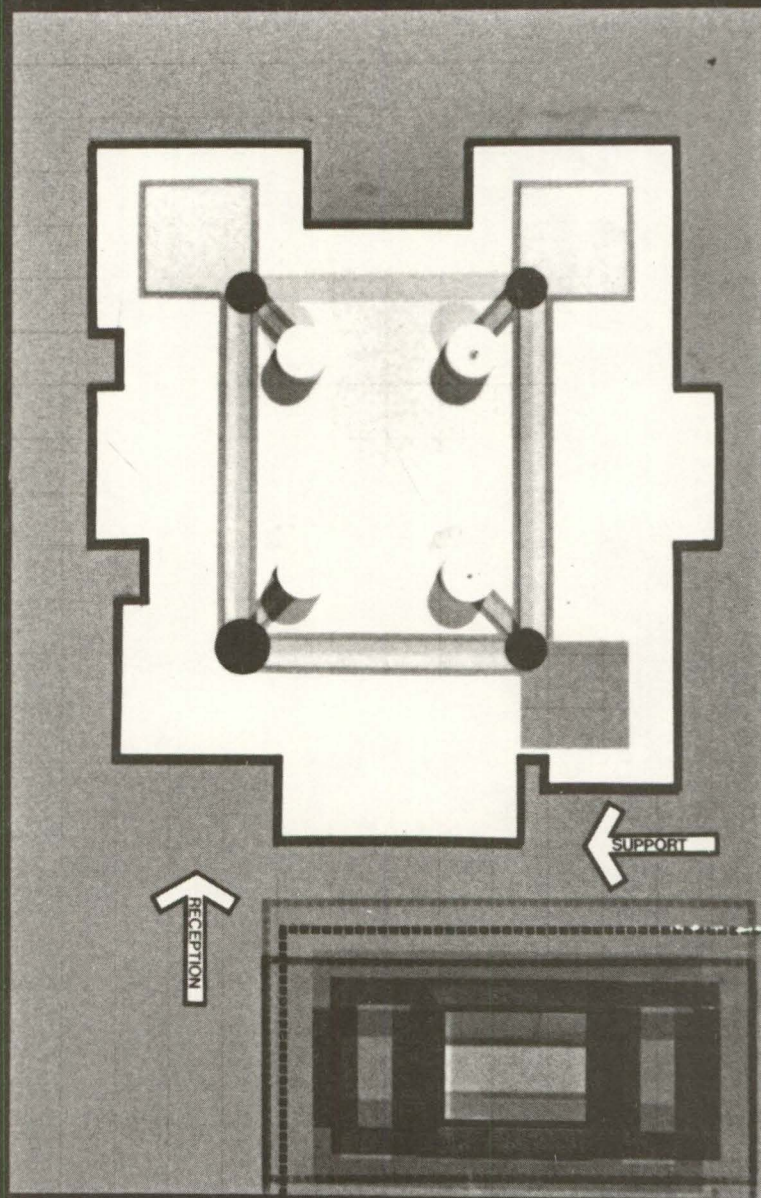
section a-a
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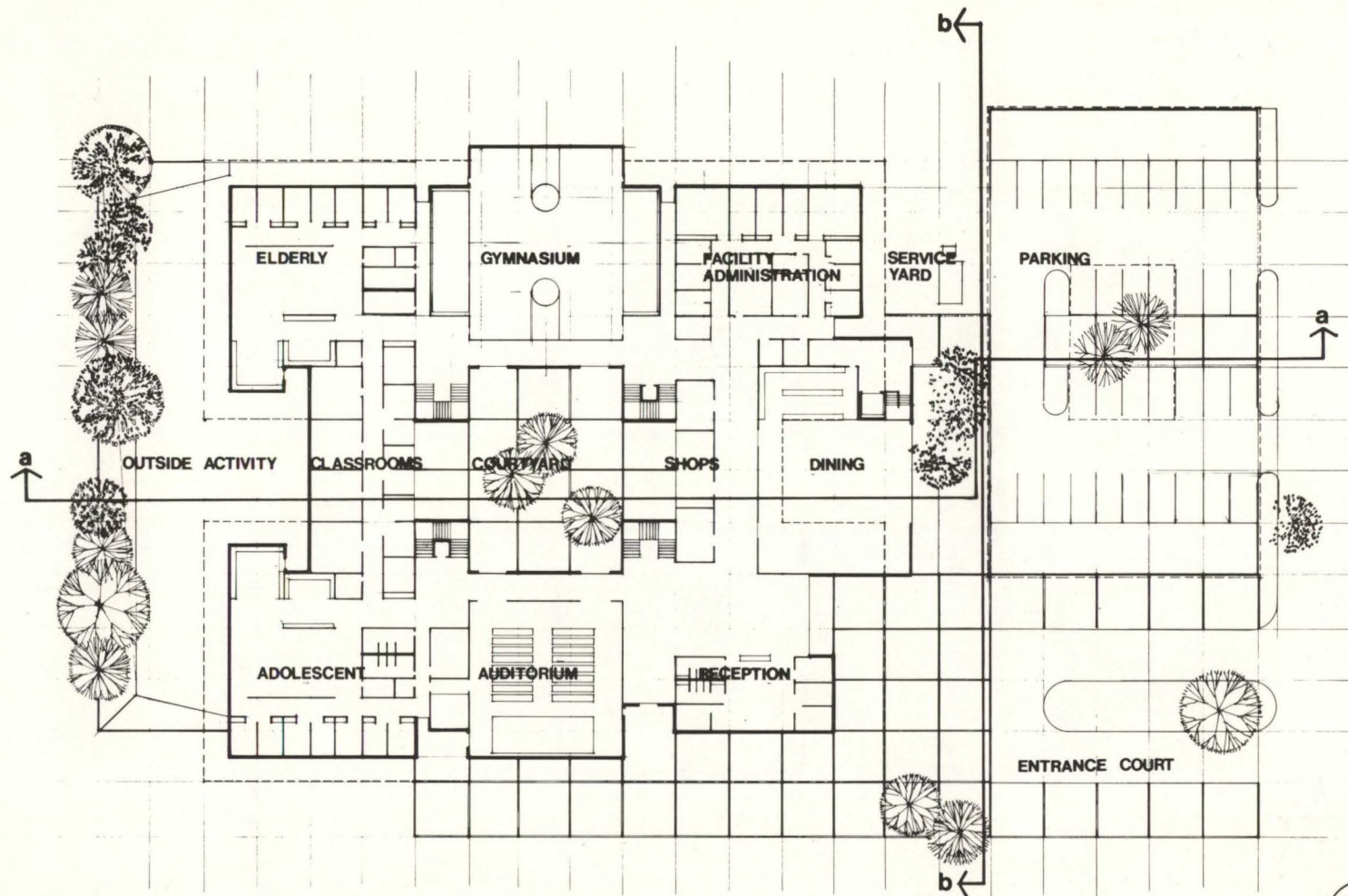


elevation
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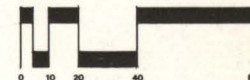


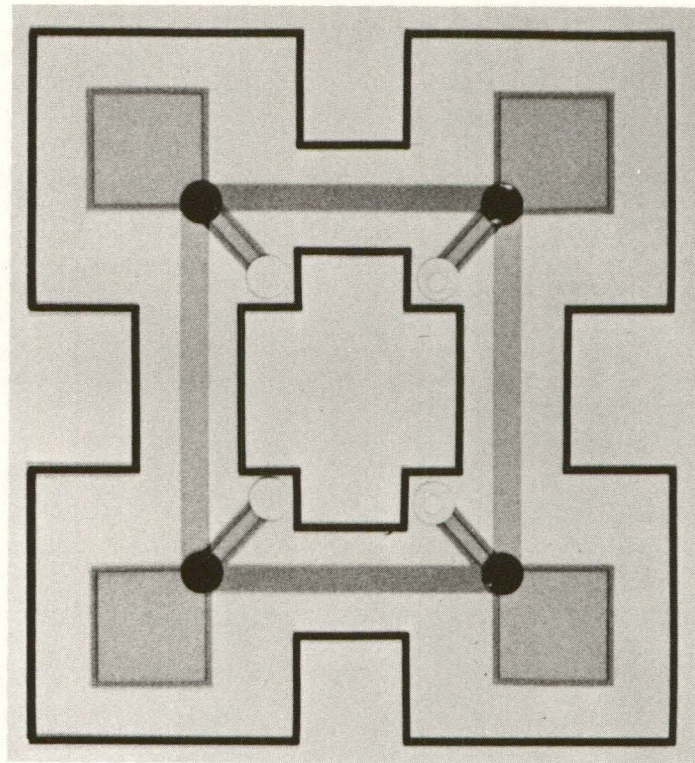
section b-b
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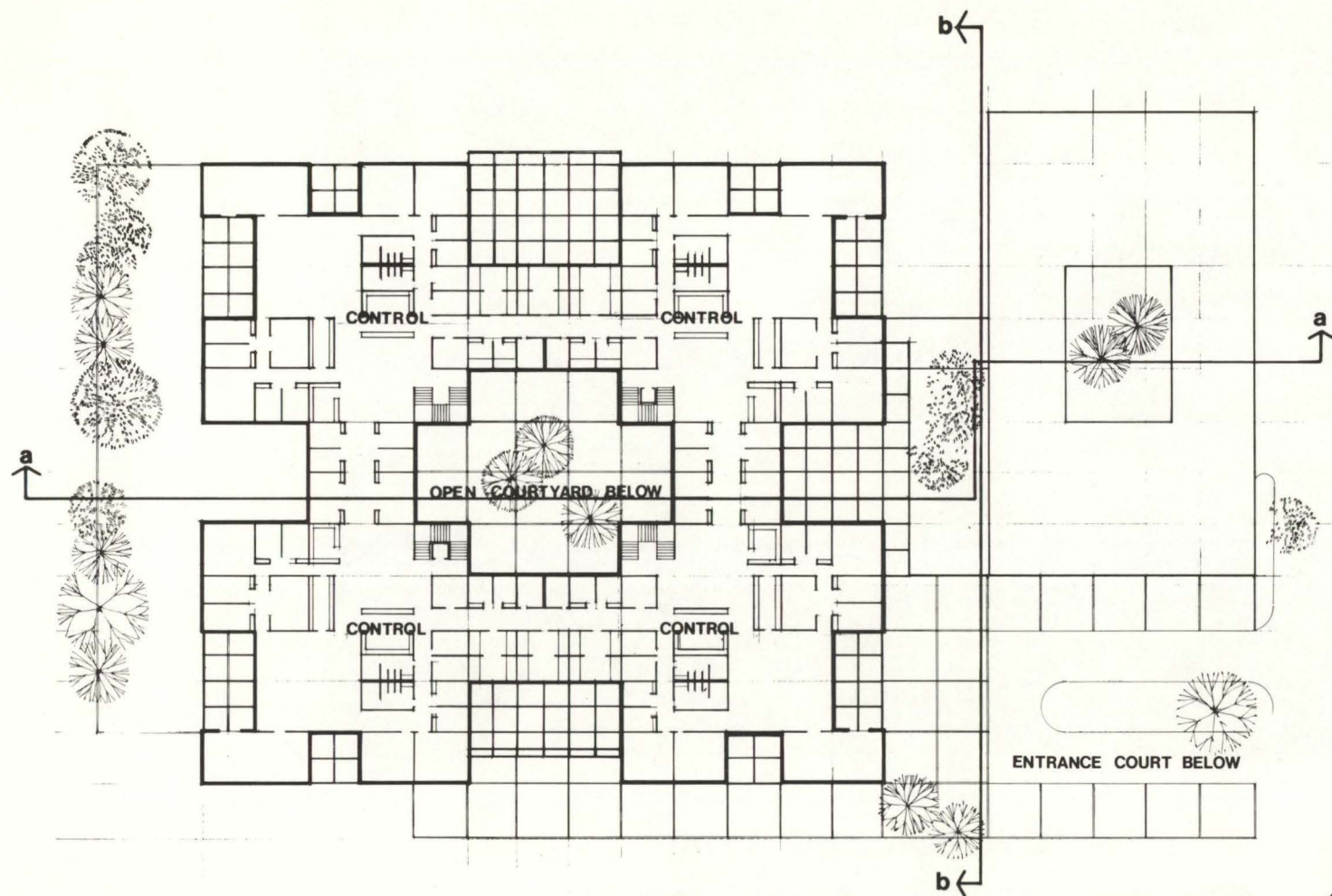




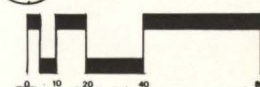
lower level

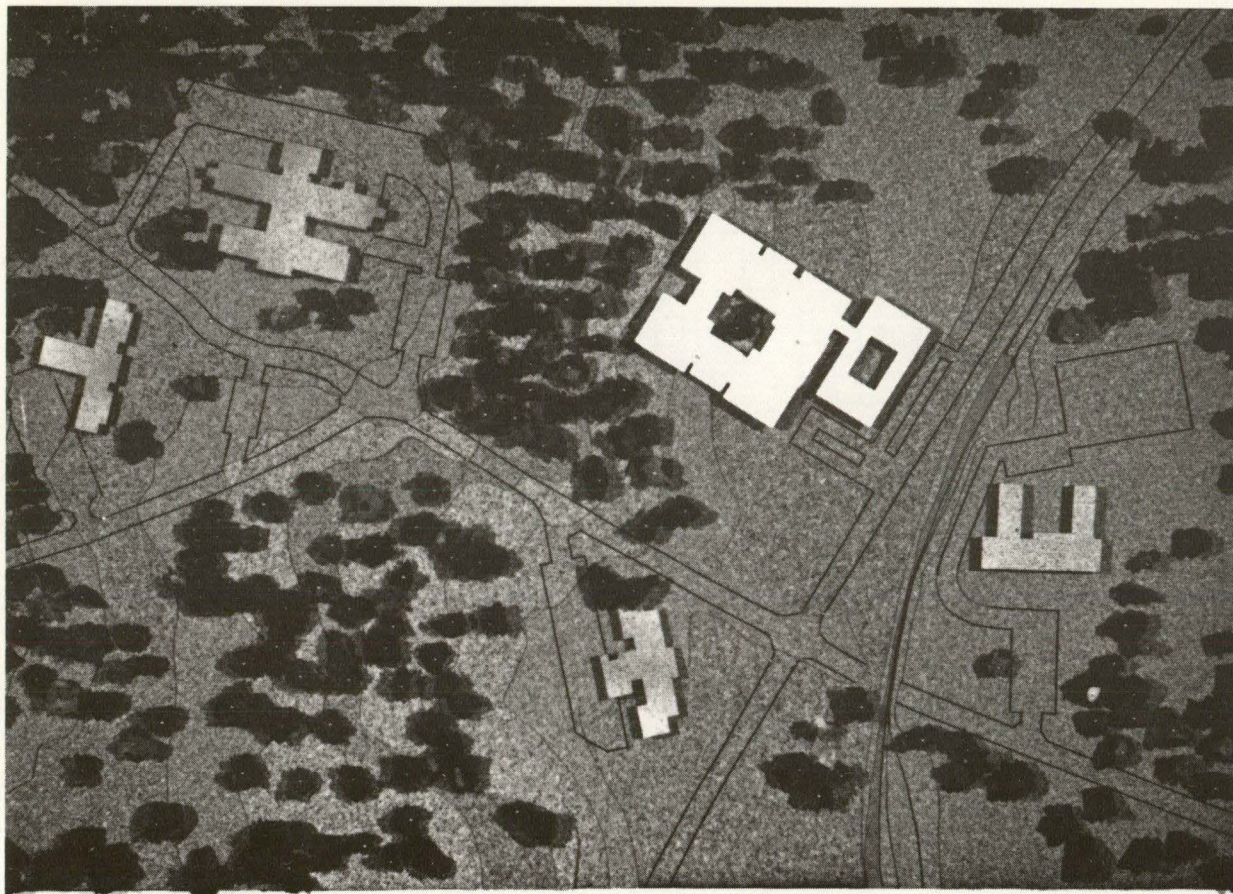






upper level



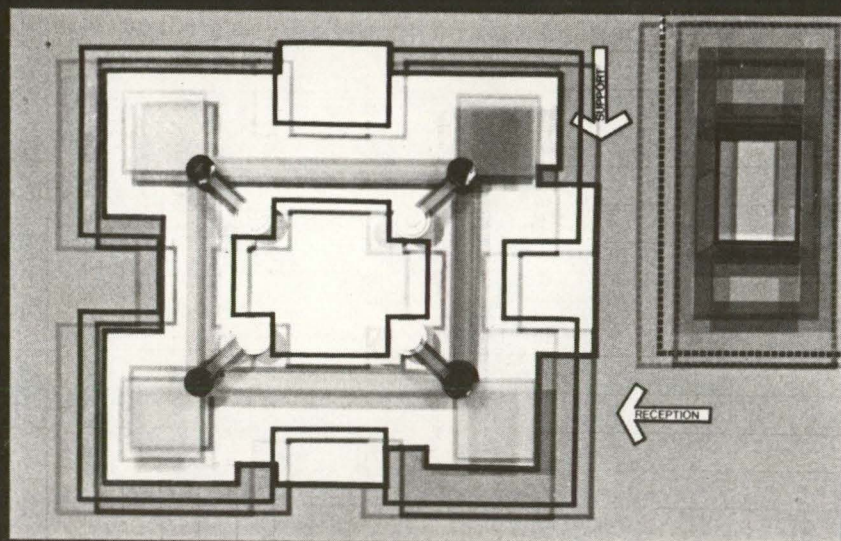


**A NEW BUILDING TYPE
FORENSIC MENTAL HEALTH FACILITY**

MASS MODEL

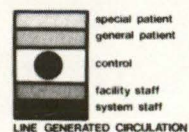






A NEW BUILDING TYPE FORENSIC MENTAL HEALTH FACILITY

MOVEMENT SYSTEM



LINE GENERATED CIRCULATION



special team
area



general adult
team area



facility
administration

POINT GENERATED CIRCULATION



A Critical Review

Admissions are very direct and identifiable from the entrance. The courtyard arrangement actually hinders direct access to an individual team area, for it is difficult for a patient to know which stair to use. In fact, the symmetry of the plan makes it difficult for anyone, patient or staff member, to know where he is, since all sides look alike.

The treatment team offices wrapping around two sides of the larger group areas, are well located. The special team areas need more treatment and architectural programming information. The major circulation path of two adult teams is located by the special team area's entrance. These are considered to be improperly placed.

The courtyard is an attractive space, but it does not encourage active use and may even portray an inappropriately formal characteristic to the building.

The team terrace spaces are attractive and offer a guide to the proper location and character of one type of exterior space within a FMHC complex. Directly accessible from team areas, these terraces vary in size and location. They offer different types of privacy and group activities.

Facility administration is removed from public traffic, but it is too distant from the team areas. Service requirements are, as yet, undefined.

The regular bay system provides a modular, flexible layout, but the fixed and finite symmetrical arrangement limits expansion.

CONCLUSION

SUMMARY

Design is a process that involves trial, error and analysis. However, too often, a design is presented as finite and unchangeable. This may be the case when the process of programming does not involve review and evolution; but when the programming process is, in itself, dynamic and involves many participants, then it is inevitable that the design will develop in a like manner.

A great deal more remains to be accomplished in the design and planning of forensic mental health programs and facilities. This project is only one of the ways in which needed guidance can be given.

In making use of the diverse experiences of many professionals and non-professionals, this project illustrates the working alliances that each of the two independent systems, legal and mental health, must incorporate if they are to creatively meet forensic mental health needs on state and local levels.

Those who will make use of forensic mental health programs and facilities, must participate in the planning, programming and design. This approach, which involves many people throughout the entire process, is neither easy nor expedient. Through such a process, an architectural response can evolve that has meaning to the casual observer as well as the active users.

By including this work, imperfect and incomplete in many areas, it is hoped that all who participate in the planning of the delivery of forensic services will better understand the role they can play, as individuals and as team members, in evolving a design which truly carries out the spirit and purpose of the delivery of forensic mental health care in the state of North Carolina.

APPENDIX A

APPENDIX A

TOTAL NET BUILDING AREA

The following is a listing of major activity areas, detailed room designation and sizes which has resulted into the schematic design solution included within this study.

Components and Service	Areas in Sq. Ft.
I. Main Entrance Level	
A. Reception	
1. Reception and waiting	1,500
2. Toilets—Men	200
—Women	200
3. Examination Rooms—3 @ 120	360
4. Nurses' Station	250
5. Storage	150
6. Holding Room	120
	<hr/> 2,780
B. Common Areas (Staff, Patient, Public)	
1. Common dining	3,250
2. Kitchen	800
3. Serving	350
4. Pharmacy	300
5. Canteen	600
6. Library	300
7. Active Therapy (multi-purpose recreation)	6,000
8. Passive Therapy (Assembly)	3,600
9. Meeting rooms—2 @ 300	600
10. Educational Therapy	
4 Classrooms @ 400	1,600
6 Offices @ 100	600
	<hr/> 18,000

C.	Special Team Areas (2)	
1.	Reception and waiting	325
2.	Nurses' Station	90
3.	Clerks	120
4.	Records	115
5.	Toilets—2 @ 167.5	335
	Dressing and lockers—2 @ 95	190
	Showers—2 @ 107.5	215
6.	Storage	200
7.	Offices—2 @ 175	350
8.	Sleeping	1,500
9.	Quiet rooms—2 @ 150	300
10.	Toilet	35
11.	Staff lounge	310
		<hr/>
		4,095
D.	Facility Administration	
1.	Reception	320
2.	Conference	350
3.	Toilets—2 — 95	190
4.	Records	220
5.	Clerks	600
6.	Offices	
	1 @ 265	265
	1 @ 240	240
	1 @ 225	225
	3 @ 175	525
	5 @ 165	825
		<hr/>
		3,760
E.	Service Area	
1.	Receiving	575
2.	Housekeeper	180
3.	Team linens and pantry storage	
	1 @ 265	265
	1 @ 160	160

4.	General Storage	
	1 @ 235	235
	1 @ 790	790
5.	Team Laundry—1 @ 210	210
6.	Staff toilets, lockers	
	Men	225
	Women	225
7.	Mechanical equipment room	<u>1,680</u>
		5,120
II.	Upper Level	
A.	General Adult Teams (4)	
1.	Reception and waiting	575
2.	Nursing station	90
3.	Records	115
4.	Pantry	160
5.	Utility	100
6.	Toilets—2 @ 167.5	325
	Dressing and lockers—2 @ 95	190
	Showers—2 @ 107.5	215
7.	Offices, Conference or Group	
	2 @ 175	350
	8 @ 150	1,200
8.	Sleeping, multipurpose	2,025
9.	Quiet rooms—2 @ 150	300
10.	Toilet	35
11.	Staff lounge	<u>310</u>
		5,845
III.	System Administration (optional)	
A.	Administration	
1.	Offices—2 @ 120	240
2.	Work areas	<u>160</u>
		400
B.	Staff Development	
1.	Offices—2 @ 120	240
2.	Work areas	<u>160</u>
		400

C.	Patient/Offender Assessment		
1.	Offices—2 @ 120	240	
2.	Work areas	<u>160</u>	
			400
D.	Program Research and Development		
1.	Offices—4 @ 120	480	
2.	Work areas	<u>120</u>	
			600
E.	Information and Records		
1.	Work area	1,400	
F.	Administrative Support		
1.	Library	320	
2.	Conference	160	
3.	Reproduction	90	
4.	Supply	140	
5.	Toilets		
	Men	225	
	Women	225	
6.	Lobby/Lounge	<u>575</u>	
			1,735

APPENDIX B

APPENDIX B

PROJECTED ADMISSION RATES FOR EACH COUNTY/REGION

Admissions		Male/Female	
Region I		Dr. Royal	Gay
		Mean 1974-1976	Projected 1977
1.	Cherokee	2/1	—
2.	Clay	0/1	—
3.	Graham	2/0	—
4.	Swain	0	—
5.	Macon	0	—
6.	Jackson	2/0	—
7.	Haywood	4/1	—
8.	Transylvania	0	—
9.	Madison	1/0	—
10.	Buncombe	19/2	11
11.	Henderson	7/0	6
12.	Yancey	—	—
13.	McDowell	1/0	6
14.	Polk	1/0	—
15.	Rutherford	4/0	17
16.	Cleveland	5/0	17
17.	Buke	1/1	6
18.	Mitchell	1/0	—
19.	Avery	2/0	6
20.	Gaston	18/0	—
21.	Lincoln	2/0	—
22.	Catawba	8/3	22
23.	Caldwell	6/0	—

Region I (Cont)		Dr. Royal	Gay
		Mean 1974-1976	Projected 1977
24.	Watauga	5/1	—
25.	Ashe	3/1	6
26.	Wikes	2/0	27
27.	Alleghany	1/0	—
28.	Alexander	1/0	—
29.	Iredell	10/0	6
30.	Rowa	3/0	6
31.	Cabarras	5/0	22
32.	Mecklenburg	36/3	50
33.	Union	8/2	—
34.	Stanley	5/1	—
TOTAL		165/17	208

Region II		Dr. Royal	Amy
		Male/Female	
		Mean 1974-1976	Projected 1977
1.	Surry	4/0	6
2.	Yadkin	—	—
3.	Davie	2/0	—
4.	Davidson	10/1	17
5.	Rockingham	14/0	27
6.	Stokes	—	—
7.	Caswell	—	—
8.	Person	3/1	—
9.	Granville	2/0	6
10.	Vance	7/0	11
11.	Warren	—	—
12.	Franklin	3/0	11
13.	Randolph	5/1	6
14.	Forsyth	24/3	27
15.	Guilford	43/3	33
16.	Alamance	13/4	38
TOTAL		130/14	182

Region III

Dr. Rollins

Male/Female

		Mean 1974-1976	Projected 1977
1.	Orange	9/0	27
2.	Durham	15/0	27
3.	Chatham	4/0	6
4.	Wake	48/3	66
5.	Lee	8/2	—
6.	Harnett	12/1	6
7.	Johnston	16/2	27
8.	Montgomery	4/0	6
9.	Moore	9/0	6
10.	Hope	2/1	—
11.	Cumberland	19/1	—
12.	Sampson	5/0	11
13.	Ansor	2/0	—
14.	Richmond	5/0	6
15.	Scotland	3/0	11
16.	Robeson	9/1	6
17.	Bladen	2/0	—
	TOTAL	142/11	205

Region IV

Dr. Rollins

Male/Female

	County	Mean 1974-1976	Projected 1977
1.	Halifax	11/3	—
2.	Northampton	1/0	11
3.	Hertford	7/0	6
4.	Gates	—	—
5.	Camden	—	—
6.	Currituck	—	—
7.	Pasquatank	1/0	—
8.	Perquimans	2/0	—
9.	Chowan	2/0	6
10.	Bertie	2/0	6
11.	Nash	7/0	6
12.	Edgecombe	1/0	17
13.	Martin	5/0	—
14.	Washington	2/0	—
15.	Tyrrell	1/0	—
16.	Dare	2/0	6
17.	Wilson	6/0	6
18.	Pitt	25/2	17
19.	Greene	1/0	—
20.	Beaufort	5/0	6
21.	Hyde	—	—
22.	Wayne	17/0	17
23.	Lenoir	10/1	17
24.	Craven	8/1	—
25.	Pamlico	—	—
26.	Duplin	10/0	6
27.	Jones	2/0	—
28.	Carteret	4/3	11

Region IV (Cont)

Dr. Rollins

		Mean 1974-1976	Projected 1977
29.	Onslow	5/0	11
30.	Pender	4/0	—
31.	Columbus	3/0	17
32.	Brunswick	8/0	11
33.	New Hanover	20/1	38
TOTAL		172/11	215

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