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## THE PRESENTENCE DIAGNOSTIC PROGRAM IN NORTH CAROLINA: PROCESS AND PROBLEMS\*

NEVELLE O. JONES\*\*

### I. INTRODUCTION

It is a pleasure to have the presentence diagnostic study procedure in North Carolina as the topic of discussion today, and we certainly appreciate the gracious hospitality of Dean Groves and the faculty and staff of the Law School at North Carolina Central University. I will confine my remarks this morning to the presentence diagnostic service provided by the Division of Prisons. My colleagues from the Division of Adult Probation and Parole will comment on the presentence investigation process this afternoon.

As Mr. Bounds has just indicated, the North Carolina Department of Correction provides two (2) presentence evaluative services to the courts of our state. It provides these services through its two (2) major divisions: the Division of Adult Probation and Parole and the Division of Prisons. State probation/parole officers provide the courts with Presentence Investigation Reports which are based on criminal, social, and situational studies of the defendant; and staff members within the diagnostic centers of the Division of Prisons provide the courts with Presentence Diagnostic Studies which are based on a comprehensive, multidisciplinary study approach. The latter adds to the criminal, social, and situational study procedures of the presentence investigation a series of individual assessments: medical, psychological/psychiatric, moral, economic, and behavioral. Presentence investigations are completed while the offender is yet within the community, either at liberty under the supervision of the court or perhaps in the confinement of the local jail. Presentence diagnostic studies, on the other hand, occur while the offender remains confined within one of the state prison units, without liberty, for the duration of the study process. Both study procedures represent different levels of comprehensiveness; they represent

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somewhat different approaches of study; and they are completed within different settings. We think that both procedures should be used whenever they can be of assistance.

Many criminal justice systems operate such presentence evaluative procedures.<sup>1</sup> The Federal System, Massachusetts, Kansas, California, Oregon, Maryland, Delaware, West Virginia, and other states, in addition to North Carolina, provide presentence evaluative services.<sup>2</sup> In most cases, all of them have the same purpose: to provide additional information to the courts, to facilitate individualized treatment, and to effect a closer coordination of the elements making up the Criminal Justice System.<sup>3</sup> The original presentence diagnostic procedure in North Carolina was based largely on the federal system's process;<sup>4</sup> and although some modification has been made,<sup>5</sup> the basic procedure still provides for the coordination of each multidisciplinary presentence diagnostic study by one key professional, a correctional case analyst. Collateral information is collected from the offender's family, friends, employers, and acquaintances; and records are gathered from both private and public agencies with which the offender might have come into contact. The actual study process provides for not one, but as described before, a series of individualized evaluations; and after examination of each separate report, and after careful formulation of a detailed and comprehensive clinical summary, the clinical team prepares the official report. This report is then forwarded to the court and to defense and prosecuting attorneys as dictated by the governing statute. The defendant, at that point, is returned to the custody of the committing county for sentencing and final disposition. We trust that our minor procedural changes over the years have only been improving refinements to an excellent concept.

We have, over the years, been able to utilize additional facility and staff resources, and the Presentence Diagnostic Program is now operational in all eleven (11) Divisional Diagnostic Centers. But, despite the fact that there are eleven (11) diagnostic centers within the Division of Prisons, the Presentence Diagnostic Program is yet quite small. By comparison, no estimate is available for the number of presentence investigation studies completed annually by the Division of Adult Probation and Parole, but the actual number must be very large, well in the

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1. C.E. Smith, *A Review of the Presentence Diagnostic Study Procedure in North Carolina*, 8 N. C. CENT. L. J. 1, 17-34 (1976).

2. Personal communication from Mr. Robert G. Crosswhite, former Diagnostic and Classification Branch Director, N.C. Department of Correction.

3. *Supra* note 1, at 33.

4. C. E. Smith, *Observation and Study of Defendants Prior to Sentencing*, 26 FED. PROBATION 6 (1962).

5. N. C. DIVISION OF PRISONS, PRESENTENCE DIAGNOSTIC GUIDE BOOK (1974).

tens of thousands. Furthermore, admissions to prisons are also high, over 13,000 last year,<sup>6</sup> and the diagnostic centers within the Division of Prisons made initial intake studies on almost all of these. Therefore, and by comparison, the relative figures presented this morning are very small. For example, the peak case processing year for the Presentence Diagnostic Program was last year, with 238 cases. The Program, then, is small by comparison to other operations.

The Program, even though it is comparatively small, is seen as having at least three utilities. The first is for the courts of North Carolina: additional information, which might otherwise be unavailable, can be provided to the courts for use in sentencing deliberations. This detailed and individualized information can be used by the court in initiating a program of intervention for the offender. The second utility is for the Department, itself: the Division of Prisons uses the presentence diagnostic model as its idealized classification model. Diagnostic centers complete an evaluation for each offender committed to the division's custody with at least social, medical, and psychological factors being considered. The findings of these studies are then used by classification authorities in considering individualized placement and intervention programs for the incarcerated offender. The opportunity for staff training is an additional advantage, for the comprehensive nature of the process allows a very good opportunity for our staffs to improve their professional skills. The process, to some extent, also permits the suggestion for diversionary programming for a few, highly selective offenders. Of course, dealing with 200 cases each year, only a small portion could actually be diverted. The third major utility is for the defendant. Some will question this as a utility; but, nonetheless, the study process does provide the offender with an opportunity to look closely at himself. It affords him the opportunity to define any particular problems, to identify methods or techniques essential to their resolution, and to locate the resources providing these essential services. With these utilities, we trust that the Program will continue and improve. We would like to expand if at all possible; but again, we must live within our resources and our facilities.

The statutes authorizing the presentence diagnostic process within our state provide an advantage toward coordinated improvement that other procedures do not always include. The North Carolina statute does not specifically address the offender selection process, but it indicates that the court *may* refer convicted offenders for study to the Department of Correction. Specifically, it states, "Within the limits of its capacity, and in accordance with standards established by the Depart-

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6. N. C. DIVISION OF PRISONS, STATE CORRECTION STATISTICAL ABSTRACT FOR JANUARY THROUGH DECEMBER, 1976.

ment, a diagnostic center may at the request of any sentencing court, make a presentence diagnostic study of any person who has been convicted, is before the court for sentence, and is subject to commitment to the Department."<sup>7</sup> This is an advantage because it allows a careful concentration for, and perhaps a more efficient use of, this scarce diagnostic resource. Such flexibility is essential. At best, neither accurate and detailed assessments nor rehabilitation and offender change are simple processes. Answers to such complex areas are not found without much effort, and the procedure in North Carolina endeavors to utilize the scientific method within a multidisciplinary context. Each case is studied from several perspectives. This multidisciplinary approach, that is to say, evaluations by a number of different professionals rather than the single perspective of any one professional, is used because with such an approach one can consider a wider variety of case factors. These outcomes are examined and practical suggestions are made whenever possible. Periodically, the program itself is examined, especially from the view of final case outcome, to determine what refinements are needed. With the freedom for change and development allowed by the authorizing statute, the Department of Correction, in consultation with the other elements of the criminal justice system in North Carolina, can therefore initiate improvements in the presentence diagnostic process.

That is just what today's discussion can do: it can precipitate improvement in the presentence diagnostic process in North Carolina. The North Carolina process has been under development for almost ten (10) years, and your continued suggestions for improvement are welcomed. We hope that solutions to many of the problems inherent in such an evaluative process are developed as the problems are presented during our discussions today.

For the next few minutes this morning, I'd like to mention a few operational details about the Presentence Diagnostic Program. My remarks will be divided and limited to two (2) basic areas. The first, the process itself—how the Program actually operates and a brief description of what happens at each point; the second, specific comments about this process, how it sometimes seems to work, and how it sometimes seems not to work. Hopefully, these issues can be clarified and resolved through our discussions this afternoon.

## II. THE PROGRAM PROCESS

The basic steps in the presentence diagnostic study procedure are as follows: first, the court makes a referral and our staff schedules an ap-

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7. N. C. GEN. STAT. §§ 148-12, 148-49.3 (1974).

pointment; the offender then arrives at the designated Divisional Diagnostic Center; collateral information is collected from a wide variety of informational sources; a number of individual examinations are conducted; the collected information is carefully reviewed and interpreted by the clinical study team; the report to the Court is formulated and distributed; and finally, a dispositional review closes the case file.

#### *A. Referral*

The process is begun with the referral and the appointment. The court notifies the staff of the Diagnostic Services Branch that a study is requested and the diagnostic center best equipped to conduct the requested study is designated by that staff. The decision as to which center is best equipped to conduct the study is made with security, resource, and geographical considerations. Generally, but not always, the designated center will be the one nearest to the referring court. To allow ready access to the necessary and appropriate staff and other resources at the time of the offender's admission for study, it is important that the staff at the receiving center be as informed as possible about the case at hand. Specific information about the offender is essential at the point of referral. We request that the person scheduling the appointment have at hand: the name of the offender, his age, the offense and offense type, the maximum possible penalty, whether conviction was based on a plea or on a verdict, and any other information pertinent to the referral and study process. We especially need to know the referral reason. We can sometimes infer the court's reason for requesting a study, but it is much more informative if the court is specific and lists the questions or areas of concern to which the study team is expected to respond. Additional information is typically helpful in cases of offenders who are thought to be aggressive or violent or mentally or emotionally disordered. In that the details of such conditions are generally provided by the assigned state probation/parole officer, it is necessary to the study process for the name of this officer to be available when the referral is first made. His report is an integral part of the informational base for a presentence diagnostic study, and it is suggested that it be available at the outset. With this information, little difficulty is encountered in designating an appropriate diagnostic center or in providing a convenient appointment date.

#### *B. Arrival*

The offender is delivered to the designated diagnostic center by deputies of the committing county; the commitment order is reviewed; and the offender is accepted into the custody of the Division of Prisons. Immediate orientation to the rules and regulations of the prison system

is provided, and casework and counseling services are available to help resolve any immediate problems encountered by the offender. During this orientation, the attempt is made to inform the offender what he will experience during his study process. The arrival, then, is at a prison; and the offender is thereby admitted to a prison. This is an important reality that we might remember! From time-to-time, severe emotional and hostile panic reactions have resulted when the offender finds himself within the stark confines of a prison unit when he was expecting the more hospitable atmosphere of a hospital. Prison units, of course, are markedly different from most hospitals with which we are familiar. The offender should be informed by the court that the study is conducted within a prison setting, not a hospital setting!

### *C. Data Collection and Individual Examination*

Throughout the rather lengthy study and observation process, and as the offender proceeds from one individual examination to another, the chief coordinating element of the study process is the assigned correctional case analyst. The case analyst might be considered an offender advocate, and in a sense he is; but the approach used is also one of reality and practicality. The goal is not only to gain information, but also to assist the offender in achieving an understanding of his situation and in formulating an effective plan of acceptable development. In formulating these strategies of intervention, attempts are made to consider needs for both community safety and offender development. Through interviewing, counseling, and casework services provided by the case analyst, the effort continues in its attempt to identify problems, techniques for solving them, and resources essential to their resolution. In addition to responding to the specific concerns of the court, the attempt is made to identify crime-related problems and strategies for their resolution.

Collateral information is collected from a variety of sources. Background and situation information is gathered from the offender's family, friends, and employers. A family questionnaire is forwarded to the family. Frequently, members of the family are personally contacted by members of the study team, generally during their visits to the prison unit, but on occasion and when necessary through field visits to the family's home. Friends and employers are similarly contacted in efforts to gain relevant information. The criminal history is obtained and verified through the records of the Federal Bureau of Investigation, and local law enforcement officials are contacted for specific details as necessary.

The Presentence Investigation Report provided by the assigned state probation/parole officer is the foundation for such community infor-

mation; for with the officer's intimate knowledge of the community he is able to describe the offender's circumstance within the community—his actual home and work situation—and can present the official, detailed version of the actual offense. The circumstances of the offender's situation before the court, including prior, present, and pending actions, are made clear through the presentence investigation. The officer's ability to provide such information and to convey the community mood is crucial to the study team in their efforts to respond to the needs of the offender and to the concerns of the court.

Although information is gathered from both the offender and the collateral sources within the community, the core of the actual study process is the number and variety of individual examinations that are conducted. The physical examination attempts to identify any existing medical difficulties; and, in addition, more specific procedures may be completed as indicated. These additional tests can range from technical work-ups—additional blood analysis, electrocardiograms, electroencephalograms—to examinations by particular medical specialists—consulting psychiatrists, neurologists, cardiovascular specialists and other medical experts. The psychological evaluation typically includes an assessment of intellectual, achievement, and personality functioning areas, and psychiatric examinations are conducted as necessary. Attempts are made to review the offender's value system and to compare it with those prevailing within the local neighborhood and general community. Vocational assessment includes examination of the offender's work history, his job skills, abilities, and interests, and a review of his particular economic assets and liabilities. The social history that is taken is compared and integrated with the other data gathered. Each of these individual examinations focus on crime-related problems and their solution; any other problems, not particularly related to the offender's criminal behavior, are only noted, unless of course they represent obstacles to the implementation or effectiveness of the intervention strategies that are developed.

#### *D. Data Analysis*

Data analysis is an integral part of each step of the presentence diagnostic study process, but the final and perhaps most complete analysis occurs during the meeting of the Presentence Diagnostic Committee. The membership of the group generally numbers five (5), and typically includes among its members the assigned case analyst, a diagnostic center director, the examining psychologist, and a staff member from the Diagnostic Services Branch. Other professionals in attendance are often chaplains, psychologists, psychiatrists, probation/parole officers, vocational rehabilitation officials, nurses, or correctional officers. As



many of the individual examiners are included as possible; but the exact membership and composition of the Committee may vary from meeting to meeting.

The Committee first reviews all documents related to the case and then reviews the case presentation made by the assigned case analyst, who synthesizes the information available and concludes with particular suggestions for control and intervention. Each individual examiner present provides a review of his findings and conclusions, and the ensuing discussion is moderated by the Committee Chairman. Tentative identification of pertinent case factors is followed by an interview with the offender which attempts to resolve any questions yet unanswered and to assess the offender's understanding of himself, of his situation, and of the strategies being considered for resolution of the identified, crime-related problems. Once the Committee reaches its conclusions and adjourns, the offender is informed of the specific conclusions and suggestions formulated by the Committee and is briefed on his pending return to the county of conviction for the court's final disposition hearing. Discussions during the meeting of the Presentence Diagnostic Committee are rather lively in most instances; but, during each discussion, at least three (3) primary areas of concern are considered: the status and developmental needs of the offender; the safety needs of the community relative to the offender's characteristics and potentials; and, perhaps most critical, the techniques and resources essential to corrective intervention. The attempt is to retain the elements of effectiveness and practicality.

#### *E. Report to the Court*

The results of the presentence diagnostic study process are summarized and presented to the court in the Report to the Court. The contents of this report, of course, contain the interpretations, conclusions, and suggestions that were developed and formulated by the Committee during its review of the information available. This report addresses the needs of the offender relative to the community's need for protection and attempts to describe the techniques and resources essential for successful problem resolution. It does not presume to address the Court's prerogatives of deterrence or punishment unless germane to the case. That is the province of the courts, not the presentence diagnostic study team.

The report, itself, contains several general sections. The first identifies the offender and the referring court, presents the composition of the Committee, and summarizes the referral information. A brief background description of the offender's developmental years is then presented with a summary of his circumstances at the time of the of-

fense of referral. The findings of the presentence diagnostic study are described, along with the predisposing and precipitating factors related to the criminal behavior. Following this discussion, the report continues with its response to any specific concerns raised by the Court in the initial referral and concludes with a suggested step by step program of intervention. As the specifics of each case studied dictate the particular content and style for each report, some variation will be seen from report to report, but these general topical areas will be found in most Reports of the Presentence Diagnostic Committee.

These reports are forwarded to the committing court by mail, and copies are provided for both the defense and prosecuting attorneys. Attached to the report is also a letter of transmittal addressed to the court which contains primarily administrative information about the case, identifying numbers, admission and release dates, total time in custody during the study process, etc., and on occasion, it may also contain further comment or explanation. Another letter is prepared to the probation/parole officer who prepared the presentence investigation report which summarizes the case study and describes any special factors that might be of particular interest and use to him. Usually such letters involve cases requiring special supervision or particular referrals, and the information is provided to facilitate the officer's efforts at placement and supervision. Specific clinical reports are most often forwarded to the agent or agency delivering the actual intervention program implemented. In every case, the intention is to facilitate continuity of evaluation and treatment.

#### *F. Follow-up*

The procedures for each presentence diagnostic study are completed through two (2) additional steps. The first involves the court's final disposition. In the letter of transmittal to the court, a request is made that our office be informed of the court's final disposition. Each case is reviewed at sixty day intervals, and dispositional information is included in the case file. In the event that the disposition includes incarceration, the admitting diagnostic center uses the total case record in attempting to implement the appropriate intervention program. The second and final step involves outcome assessment. Recommendations of the Committee are reviewed and compared with the actual dispositions of the court, and periodic recidivism studies are conducted as another indicator of program outcome and impact. Completion of these two (2) steps closes the active case file, but the case files are retained in order to permit their use in future research projects.

## III. POTENTIAL PROBLEMS

*A. Referral Rates and Resources for Evaluation*

The first referral to the Presentence Diagnostic Program was made in August, 1967, and this referral to Women's Prison was shortly followed by referrals to Central Prison and Polk Youth Center, in Raleigh, and to Harnett Youth Center, in Lillington. There were eight (8) referrals during the remainder of that first year, and the referral rate increased rapidly thereafter. (See Table 1).

Table 1  
Annual Frequency of Referrals  
By Court of Origin  
for the Period 1967 - 1976

Court	Year									
	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
District	1 (12%)*	5 (7%)	101 (49%)	67 (39%)	91 (50%)	77 (46%)	89 (53%)	70 (40%)	96 (46%)	119 (50%)
Superior	7 (88%)	69 (93%)	104 (51%)	103 (61%)	90 (50%)	92 (54%)	79 (47%)	105 (60%)	114 (54%)	119 (50%)
Annual Totals	8 (100%)	74 (100%)	205 (100%)	170 (100%)	181 (100%)	169 (100%)	168 (100%)	175 (100%)	210 (100%)	238 (100%)

\* Column Percentages Rounded to Nearest Whole Number.

Although additional diagnostic resources were eventually developed and the capacity for processing study cases was expanded to all eleven (11) of the Divisional Diagnostic Centers, the referral rate soon outstripped the program's capacity requiring a restriction on admissions. Every referral for study was accepted during the first two (2) years of operation, but the rapidly increased demand for service limited the number of referrals that could be accepted. An appointment process, initiated in 1970,<sup>8</sup> included consideration of the demand for services and of the program's resources—bed space, capable examiners, administrative staff, etc.—and has allowed a general consistency in both quantity and quality. With the appointment process, the attempt was made to only evaluate those serious offenders requiring such an extensive examination process.

One of the primary intents of the program, from initial conception to actual operation, has been to provide a thorough and complete study

8. Administrative memorandum from V. L. Bounds, Commissioner of Correction, to Sentencing Court Judges, Subject: Presentence Diagnostic Studies (April 16, 1970).

process for the examination of "serious" offenders.<sup>9</sup> Defining the serious offender as the felon offender or the offender otherwise referred from Superior Court, this intent was only accomplished during the first year of the program's history. By 1969, the rates of completed studies for misdemeanor and felon offenders were nearly equal; and although some fluctuation has occurred during the ensuing years, little significant change has been seen in the respective rates. Some control was effected as to which offender received priority consideration as candidates for study with the implementation of the appointment procedure because misdemeanor referral rates declined and remained lower than the felon referral rates until 1971. There were only minor variations in referral rates from 1971 through 1973, and much of these can be accounted for by the changes in staff allocations during the same period. A reorganization of divisional facilities—from a decentralized system to one primary, centralized facility—equalized the space available for misdemeanants and felons.

Changes in the referral rates were, however, more significant after 1973. The reduction in the misdemeanor referral rate in 1974, actually beginning in 1973, seems largely accounted for by the development of Self Improvement Centers within the Division of Adult Probation and Parole. These centers were designed to provide psychological and vocational assessment and received referrals from both the active probation caseload as well as directly from the courts. These centers, then, provided evaluative services for clients before sentencing and after placement under probationary supervision. Another evaluative service which most likely had an impact on the referral rates for presentence diagnostic study also began operation at this same point in time. Supported by grant funds, the Department of Human Resources developed a program to serve the courts and persons experiencing significant domestic conflict. Until that point, intense family conflict cases were referred to local law enforcement officials and then on to the courts. The development of this referral service provided another alternative. In total, there were at least four (4) alternative services through which the courts could request evaluations in 1974: the local Self Improvement Centers, presentence investigations by state probation/parole officers, presentence diagnostic studies within the Division of Prisons, and evaluative services from the Department of Human Resources.

All of these evaluative services, however, did not continue. The State assumed the financial burden of the Self Improvement Centers for a time; but, along with other legislative cutbacks in 1976, their financial support was lost and they were closed. Although the needs for service

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9. Letter from Robert G. Crosswhite, Diagnostic and Classification Branch Director, to All Superior and District Court Judges (October 5, 1970).

continued—and one court even placed a probation officer under court order to provide the non-existent services—funding support was not available. The status of the program under Human Resources is unclear. Referral rates to the Presentence Diagnostic Program jumped, both the District Court and Superior Court rates. The increase in referrals from District Court seems largely influenced by the closing of the Self Improvement Centers, and the increase in referrals from Superior Court seems influenced by both this and the general increase in felon commitments to the prison system. Last year, 1976, was the record year for presentence diagnostic studies, well over 200; and the projections for 1977 indicate that total studies may number as many as 250 to 300. Referral rates of this magnitude are very taxing when considered in light of the resources which are available.

Ideally, programs and services should be available to the courts consistent with their level of need; but, with the limited resources that are available, use of existing programs must be based on some priority system. Local resources are available within the community for defendants who are obviously in need of physical or mental health services, and local physicians and mental health professionals, as well as, local hospitals and clinics should be used in such cases. For the others, the presentence investigation and presentence diagnostic study procedures are available, but we would suggest that the presentence diagnostic study procedures be reserved for the more serious offender, not for the offender whose crime can only result in incarceration for less than a year or two. Even in cases in which the penalty is more severe, it might be advantageous to obtain a presentence investigation report before considering a referral for presentence diagnostic study. Some of the questions and concerns may well be sufficiently answered by such investigations, thereby allowing the scarce resources allocated to the presentence diagnostic procedures to be used more advantageously for other, more serious offenders.

Commenting further, and as pointed out earlier, one of the very useful sources of information to presentence diagnostic study teams is the probation/parole officer's presentence investigation report. This report contains a wealth of background and current situational information. Our experience has suggested that the presentence investigation is all too often requested only *after* the referral for presentence diagnostic study, not before. This order seems backward! Presentence investigation reports very often provide a direct response to the concerns expressed in referrals for presentence diagnostic study, and some thought has been given to requiring a presentence investigation *before* a referral for diagnostic study can be accepted. Because such a requirement might unnecessarily delay the needed information, and be-

cause such a requirement could easily produce hardships for other components of the criminal justice system, the decision to implement this requirement is only under consideration and has not yet been made. The courts should make the decision of whether to refer or not and not the presentence diagnostic program staff. That decision would be seemingly much more effective if it were made on the basis of the information provided by a presentence investigation study. We would, therefore, strongly encourage users of the presentence diagnostic study procedures to obtain a presentence investigation report *prior* to making a referral for presentence diagnostic study.

### *B. Issues Related to Referral Reasons and Final Recommendations*

Effective communication between the courts and the department is essential to each study case. Formal dialogue between the program and the courts was begun at the outset, but it took some time before the concerns of the court were clearly communicated to the study teams on a regular basis (See Table 2). Even in 1971, four (4) years after the program began, only 8% of the referrals for study were accompanied by the specific concerns of the referring court. The dialogue did continue—through formal presentations, personal contacts, and topical discussions, such as ours today—and as a result, the questions of the court have increasingly been forwarded to the study teams. From the low of 8% observed during 1971, the frequency of specific court questions accompanying referrals rose steadily until it reached 78% during 1976. Similarly, the increasing frequency of responses by the diagnostic study team to the court is almost identical to the increasing frequency of court questions. In other words, the response percentage rate follows the general pattern of the question of concern percentage rate. As questions have increased, responses have increased. It is es-

Table 2  
Frequency of Referral Questions  
and Program Replies for the Period 1971 - 1976

	Year					
	1971*	1972*	1973*	1974	1975	1976
Referral Questions	4 (8%)**	12 (24%)	13 (26%)	43 (86%)	29 (58%)	39 (78%)
Program Replies	3 (6%)	8 (16%)	9 (18%)	23 (46%)	26 (52%)	33 (66%)

*Note:* Data calculated from 50 randomly selected cases per year.

\* *Supra* note 1, at 24.

\*\* Column percentages rounded to nearest whole number.

sential that this trend continue, for study teams must know the referral reasons if they are to provide pertinent responses to the concerns of the courts. In a like fashion, the courts must also have a specific response if their subsequent dispositional hearings are to include consideration of the original issues which lead to the referral for presentence diagnostic study. Our continuing efforts will be toward increasing the effectiveness of communication so that the court is provided with a relevant response to each area of concern. Effective communication is essential.

A few statistics, from three (3) different studies over the years, might be helpful at this point in posing another potential problem for discussion. A review of the first 100 study cases, completed in 1970,<sup>10</sup> indicates that the recommendations for disposition included 38% for active sentences and 60% for community placement. The courts followed these suggestions in 69% of the cases, implementing a probationary recommendation in 73% of the cases and an active sentence recommendation in 62% of the cases. A similar review was completed in 1972 with similar results.<sup>11</sup> Courts followed the suggested dispositions in 80% of the cases. Community placement had been recommended for 65% of the cases, and incarceration had been recommended in 35% of the cases. Of those cases in which probation was recommended and in which the outcome included probation, only 8% of the cases were subsequently found to have violated the conditions of probation. Yet, of those cases in which an active sentence was recommended and in which the outcome was a probationary disposition, 80% of the cases were found to have violated probation within 6 to 12 months. It should be noted that in 55% of cases where the court did not follow the suggestion for disposition, the recommending group actually presented a divided opinion. Suggestion and outcome distributions similar to those were observed during 1976:<sup>12</sup> recommendations included probation for 41% of the cases, split sentence for 14%, and incarceration for 39% of the cases. In general, these studies indicate that recommendations for community-based programs of intervention were made in 60-70% of the cases studied and that suggestions for disposition were implemented by the courts in 70-80% of the cases. Two (2) areas for discussion have been raised from such data. The first is related to the high percentage of cases in which probation is suggested as the disposition,

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10. R. Rilkopf, *Results of Descriptive Study of 100 Presentence Diagnostic Study Cases of the Central Prison PSD Center for Incorporation into the Essay "Potential for Social Work Involvement in the PSD Case,"* (unpublished manuscript dated February 12, 1970).

11. F. S. Alexander, *Overview and Evaluation of the Presentence Diagnostic Program.* (Unpublished manuscript dated December 15, 1972).

12. E. D. Beshears & N. O. Jones, *Use and Effectiveness of the Presentence Diagnostic Study Process: One State's Experience,* (manuscript in preparation, 1977).

and the second is related to the high percentage of cases in which the courts have implemented the suggestions of the presentence diagnostic study teams.

Although some have suggested that offenders referred for study are probation candidates at the outset, our reviews of offender characteristics do not support this suggestion. Our studies indicate that the offender who is referred for presentence diagnostic study is not like someone who might be placed on probation. He is not necessarily different either. Neither is he like the incarcerated offender, but again he is not markedly different. No consistent similarities or differences among these three (3) offender groups have been found—those in prison, on probation, or confined for presentence diagnostic study.<sup>13</sup> The most remarkable characteristic of offenders referred for presentence diagnostic study seems to be a subjective uniqueness; that is, they are not like most other offenders. The most common factor seems to be that offenders who are referred for presentence diagnostic study are in some way different. Something is unusual about the background, the offense of conviction, the behavior during the offense, the behavior in court during the trial process, etc. The court may well be considering probation at the outset, but no characteristic of the offender which would consistently support this interpretation has been clearly identified.

We do, however, receive younger offenders more often than older offenders.<sup>14</sup> It appears that the courts would rather redirect a younger offender than attempt change with a "habitual" offender (See Table 3). Generally, the age range has been in the late 20's, and for a couple of years, the early 30's. In 1971 the average age was 26, and in 1972 and 1973 the average age was 32.<sup>15</sup> During the years 1974 through 1976, the average ages were 27, 25, and 26, respectively. Perhaps the two (2) highest years, 1972 and 1973, with age averages of 32, are related to some of the factors referred to earlier. It seems that there were quite a few cases referred from domestic, or from convictions that resulted from domestic situations, and one could conclude that the Human Resource evaluation and intervention services had taken a portion of the case load, perhaps those older and in family circumstances, which later lowered the average age. In any event, the courts repeatedly tell us that they are interested in working with the youthful offender if at all possible.

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13. E. D. Beshears & N. O. Jones, *Similarities and Differences Among Convicted Offenders: A Demographical Study of Probated Offenders, Incarcerated Offenders, and those Committed for Presentence Diagnostic Study*, (manuscript in preparation, 1977).

14. See also, J. L. Gallemore, Jr., *Problematic Youthful Offenders*, 5 N. C. J. OF MENTAL HEALTH 5 (1971).

15. *Supra* note 1.



Table 3

Selected Sample Characteristics for Offenders  
Referred for Presentence Diagnostic Study  
during the Period 1971 - 1976

Characteristics	Year					
	1971*	1972*	1973*	1974	1975	1976
Mean Age	26	32	32	27	25	26
Age 21 or Less	20 (40%)	28 (56%)	27 (54%)	18 (36%)	26 (52%)	25 (50%)
Number of Pending Charges	21 (42%)	19 (38%)	24 (48%)	7 (14%)	8 (16%)	7 (14%)
Number of Guilty Pleas	N.A.	22 (44%)	32 (64%)	35 (70%)	48 (96%)	44 (88%)
Number Psychiatric Diagnoses	14 (28%)	13 (26%)	7 (14%)	30 (60%)	22 (44%)	20 (40%)

*Note* Data calculated from 50 randomly selected cases per year and percentages rounded to the nearest whole number.

\**Supra* note 1, at 24.

Turning back to the recommendations of the study team and to another question, little information is available which would clearly indicate why the courts consistently follow the recommendations of the study teams. Do the courts consistently follow the suggestions because they are expected, because they are correct, or is there some other reason? The findings and conclusions could be the expected ones, for they could very well confirm the subjective opinions which led to the original referral. In the attempt to explain the behavior and behavioral patterns leading to the offense of conviction, the study teams could also provide an expected rationale; and they could, therefore, explain in more detail the problem areas and the means for problem resolution. In addition, there seems to be a consensus by those involved that the results are accurate; but, again, this too is only verified through the general acceptance of the findings and does not clearly explain the reasons for the high proportion of recommendations that are implemented by the Court. Without more information, we are still only speculating, and continued investigation and discussion would seem in order. One final point will be made regarding the high proportion of suggestions implemented by the court. Assuming that the purpose of the program is both to identify crime-related problems and to identify programs of intervention with the potential for resolving these problems, any final recommendation must include mention of the

needed resources and their location. And where are these resources? They are, of course, for the most part found within the community-at-large. Very few are found within correctional settings. If medical resources are needed, if psychological resources are needed, or if resources facilitating personal interaction are needed, they are more likely to be found within the community than within the prison. Almost any recommendation for correctional intervention is likely influenced by this reality. Only clear and verifiable evidence indicating the presence of imminent threat is likely to contraindicate this trend toward suggestions for community-based correctional intervention. It might also be remembered that the purpose of the presentence diagnostic procedure is that of evaluation, not sentencing. Sentencing responsibility is reserved by the court. The program is primarily responsible for providing additional, detailed information gathered through presentence diagnostic process and is only one source of information available to the court, not the only source of information, and certainly not an authoritative source that mandates a particular action. The court bases its actions and decisions on information from all sources and toward the various ends of justice—rehabilitation, deterrence, incapacitation, retribution, and punishment.

### *C. Factors Restricting Effective Study Procedures*

Some referrals for study present marked difficulties beyond the complexities of the case factors themselves. Cases based on convictions for which the maximum possible penalties are only very short sentences are examples. In these instances, the amount of time remaining on the active sentence after study all too often does not permit intervention activities to begin, much less to continue to their completion. Once the time spent in confinement during the study process, itself, and the time spent in confinement during the trial, conviction, and sentencing processes are subtracted from the penalty imposed by the Court, the offender has served his sentence. He is released without supervision, guidance, or intervention. Of course, if program planning has included consideration of community-based intervention, there are no particular difficulties beyond those of the case study itself; but for those few cases in which the case factors dictate a period of confinement as desirable as an intervention technique or location, the desired program cannot be achieved if the maximum allowed period of incarceration is very short. This is true for almost every case in which the maximum penalty is under twelve (12) months. Perhaps case studies should not be attempted under these circumstances.

Pending charges have also proven to be a problem. It is extremely difficult, if not even impossible, for the clinical study team to arrive at

an effective and meaningful conclusion and to suggest practical alternatives for correctional intervention when there are outstanding charges. Cases with pending charges closely related or similar to the offense of referral almost rule out any detailed inquiry. To talk about the particular behavior which led to the conviction and referral would mandate inquiry into the behaviors related to the charges still pending. It is most difficult to provide the evaluative services effectively when the findings of the study process may well impact on future legal decisions. Although there has been a significant decline in the frequency of referrals having pending charges (See Table 3), some do continue to come in. In 1971 the rate of referrals having such outstanding charges was 42%, in 1972 it was 38%, in 1973 it was 48%, in 1974 it was 14%, in 1975 it was 16%, and in 1976 it was 14%. Communication with the courts through presentations, seminars, institutes, and personal, day-to-day, working dialogue has certainly contributed to the lowered proportion of cases referred with pending charges; but those few cases still referred present an almost impossible task to the study team. Without knowing the outcome of the pending charges, one cannot adequately plan a meaningful program for correctional intervention.

Another salient factor observed early in the program's history was a tendency by some to use the presentence diagnostic study procedure as a stratagem for delaying the court's final disposition or to provide for a brief period of confinement. These uses of the program as a "cooling off period" or as a "taste of prison" all too often surfaced as a possible reason for referral for study. Use of the process as a delaying technique is in error. The program is, and always has been, an evaluative service, not one of custody and control, and should be used to gain insights into the emotional, behavioral, and criminal dynamics presented by a convicted offender. It should not be misused, neither should an offender be so confined without sentencing nor should the scarce resources allocated to the procedure be consumed unnecessarily. Fortunately, the continuing dialogue among the components of the criminal justice system regarding the program and its use have significantly reduced this particular problem. It may occur on occasion yet; but, for the most part, we trust that this problem is only historical.

Problems that for the most part have been resolved are appellate cases and cases in which the primary questions relate to issues of probation violation. We were instructed by our legal staff not to accept cases in which a District Court conviction was subsequently appealed to Superior Court with the referral originating in Superior Court before a finding of guilty was found.<sup>16</sup> Once it is accepted for appeal, the

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16. Administrative memorandum from Martin R. Peterson, Chief of Custody and Security, to Robert G. Crosswhite, Diagnostic and Classification Branch Director, Subject: N. C. GEN.

previous conviction does not stand. We've similarly seen a decrease in questions relating to probation or parole violation issues. Some years ago, the Attorney General's office instructed the program not to accept such referrals for study and the courts were informed accordingly.<sup>17</sup> Only one or two inquiries in this area were received during the past year. The originating statute specifies that presentence studies are conducted before sentencing, and probation judgments apparently constitute sentencing. We are, therefore, to deal only with "new" offenses and not to consider probation violation issues. If there is a new offense and a new conviction, the presentence diagnostic procedure can be used.

The frequency of offenders referred for presentence diagnostic study whose convictions were based on guilty pleas as opposed to verdicts of guilty, has increased over the last four or five years (See Table 3). The reasons are unclear, but the rate rose from 44% in 1972, to 64% in 1973, to 70% in 1974, and then to 96% in 1975. Although a decrease to 88% was observed during 1976, the rate remains well above the earlier rates. Two (2) explanations have been recently offered. Perhaps the foremost rationale is the general increase in plea bargaining which has developed as an alternative technique for dealing with the court's heavy workload. Another suggestion that deserves discussion is the proposition that the offender referred for presentence diagnostic study is one whose mental competency is lower than that of other offenders. Some have suggested that a guilty plea is negotiated during the trial process and that the considerations also include an agreement to refer the offender for study. Issues of competency should not be referred to presentence diagnostic processes, but rather should remain with the court for resolution. If needed, assistance can be obtained through the mental hospitals or through private experts for this task. This potential area of concern, presented with the intention of stimulating discussion, is one with which the presentence diagnostic procedure is ill-equipped to handle. Questions relating to the mental competency or incompetency of the defendant are not answered through presentence studies.

Another concern to any evaluative procedure is the quality of the relationship between the examiner and the client being examined. The relationship issue between the individual examiner and the offender referred for presentence diagnostic study, as Dr. Smith has already

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STAT. §§ 148-12(b), 148-49.3 (February 9, 1973), based on the opinion by Robert Morgan, Attorney General, and Dale Shepherd, Staff Attorney, Subject: Interpretation of Statutes Concerning Presentence Diagnostic Studies (July 3, 1970) as reviewed (December, 1972—January, 1973).

17. Administrative memorandum from Bert M. Montague to The Superior Court Judges, Subject: Presentence Diagnostic Studies (August 13, 1970).

pointed out,<sup>18</sup> is complex and can present difficulties beyond those normal to the case. Generally, professional relationships are based on a mutual trust that develops between the examiner and the examinee; but, in the circumstances of a presentence diagnostic study and under the framework provided by the examinee's recent conviction and possible incarceration, the examiner faces, either directly or indirectly, an involuntary client. Relationship problems with involuntary clients are well known. Added to the relationship difficulties provided by the coercive circumstance, the issue of confidentiality, or the lack of it, contributes further hindrance to the development of an effective relationship between the examiner and the convicted offender. It is essential that the offender become involved in his or her life during the study process, for without motivation, one can expect little success in the efforts for corrective intervention. The professional relationship must, therefore, be very sound. If it is not, not only will the offender be less motivated to change or to take advantage of the opportunities and resources available, but the study results could also be inadequate or even inaccurate. Although it is difficult to determine what an adequate or effective study might be, the quality of the total presentence diagnostic process, as well as its outcome, must also be examined thoroughly at some point.

One additional problem should be mentioned before closing this portion of discussion: the continuing problem of information disclosure. The final reports, generated by the presentence diagnostic procedures, are public information, as is the other information compiled by the court; but these particular reports contain very private information about people which is filed in very public places. One can easily wonder if we are not doing a disservice to an offender, to his family, and to other persons as well, when we describe in very explicit detail, very personal and individual characteristics, dynamics, and relationships and then proceed to make these descriptive comments available to the general public. All too often, the results of a presentence diagnostic study can be seen or heard in the local media, either accurately or inaccurately paraphrased and/or quoted, but always in graphic detail. We would not propose that access be denied to those requiring access, but we would propose that some means be developed to insure an appropriate level of confidentiality. As of this point, there has been too little discussion, and certainly, no real resolution to this problem.

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18. *Supra* note 1.

*D. Mentally Disturbed Offenders—A Particular Problem*

In their referrals, the courts have consistently asked questions about the offender's mental condition, about the preferred treatment, and about the resources essential to successful intervention. In response to this particular area of concern, presentence diagnostic study cases are referred to the psychological and psychiatric staffs whenever there is any indication or suspicion that mental or emotional disorders might be present. As psychological and psychiatric examinations are an integral part of the multidisciplinary process in these cases, some studies, then, include a formal diagnosis among the results of the evaluative process (See Table 3). During the first year considered in today's review, 1971, the results of these examinations included formal diagnoses in 28% of the cases. There was an all time high of 60% in 1974; and, in 1976, formal diagnoses were observed in 40% of the cases studied. As for these shifts in the rates of formal diagnoses, two (2) points might provide some clarification: the first, a policy decision which for a time resulted in mandatory examination of all offenders; and second, changes that occurred in 1973 in the state statutes governing commitment procedures to the state hospitals.<sup>19</sup>

The decision was made during 1974 to require mandatory psychiatric examinations for all offenders referred by the courts for presentence diagnostic study. At that time, the presentence diagnostic program was being decentralized, that is, operation of the program was beginning at several locations across the state; and the diagnostic services of the Division of Prisons as a whole were being expanded, as opposed to the previous operation of the Presentence Diagnostic Program at only one, centralized location. This decentralization of diagnostic capabilities was initiated in order to provide for a more convenient, more efficient, and larger capacity of service. Psychiatric examinations were conducted for every offender referred for evaluation by the courts as an integral part of the process. Frequency of examination was subsequently reduced, however, due to the time demands on the psychiatric staff caused by the number of disturbed offenders within the division's custody. Nonetheless, referrals are still made for psychiatric examination in every case where serious disorders are suspected or where the opinion of the psychiatric staff is seen as vital to either the understanding of the factors of the case or of the strategies for effective intervention.

The changes in the state statutes governing commitment to the state mental hospitals in 1973 were also significant. These changes made it more difficult to commit offenders to the state mental hospitals. Due

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19. N.C. GEN. STAT. § 122-58.

process procedures were afforded to everyone considered for commitment, but this same procedural benefit for some inhibited the efforts to commit others. Perhaps some cases not so committed were referred for presentence diagnostic study due to the inherent difficulty of the new commitment procedures.

Table 4

Frequency of Psychiatric Diagnosis  
by Major Category for the Period 1974 - 1976

Year	Major Category						Annual Totals
	Mental Retardation	Organic Brain Syndron	Psychosis	Neurosis	Personality Disorder	Situational Reaction	
1974	2 (4%)	2 (4%)	0 (0%)	1 (2%)	18 (36%)	4 (8%)	27 (54%)
1975	5 (10%)	2 (4%)	2 (4%)	0 (0%)	10 (20%)	2 (4%)	21 (42%)
1976	1 (2%)	0 (0%)	8 (16%)	3 (6%)	6 (12%)	2 (4%)	20 (40%)

*Note:* Data calculated from 50 randomly selected cases per year and percentages rounded to the nearest whole number.

Over this same time period, the rate of major psychopathology among those referred for presentence diagnostic study has varied (See Table 4). In 1976, eight (8) cases, or 16%, included impressions of a major psychosis; and in 1975, only two (2) cases, or 4%, included diagnostic impressions of such severe disorder. Over the years, most impressions have been in the area of personality disorder or characterological disturbance. Yet, the number of psychopathic or sociopathic diagnostic impressions have been relatively low (See Table 5). There were two (2) in 1974, three (3) in 1975, and none (0) in 1976. This may reflect any number of things: an increasing number of referrals, not characterized by sociopathic tendencies, but rather by mental disorder or deficits, or new members of the psychiatric staff with new orientations toward diagnosis, etc.<sup>20</sup> The most frequent characteristics of personality disorder have included immaturity, passive-aggressiveness, or passive-dependency, as opposed to a strict psychopathic definition of personality psychopathology.

It should be noted, however, that even though the percentage of measured psychosis may not be very high within the presentence diagnostic referral population, those cases which do involve a serious disorder

20. See generally S. L. BRODSKY, *PSYCHOLOGISTS IN THE CRIMINAL JUSTICE SYSTEM*, Ch. 12 (1972).

Table 5  
Frequency of Specific Personality Disorders  
for the Period 1974 - 1976

Year	Specific Personality Disorders						Annual Totals
	Alcoholic	Drug	Inade-quate	Sexual	Psycho-path	Annual Other	
1974	3 (6%)	2 (4%)	6 (12%)	1 (2%)	2 (4%)	5 (10%)	19 (38%)
1975	5 (10%)	0 (0%)	1 (2%)	0 (0%)	3 (6%)	1 (2%)	10 (20%)
1976	3 (6%)	0 (0%)	1 (2%)	0 (0%)	0 (0%)	3 (6%)	7 (14%)

*Note:* Data calculated from 50 randomly selected cases per year and percentages rounded to the nearest whole number.

present a major difficulty. Incarceration within a prison for one who is mentally ill does not seem appropriate unless that particular offender presents a real and imminent threat to the community at large. Certainly, the general public must be secure from such threat; but, at the same time, mentally and emotionally disordered or deficient persons should be afforded every effort toward the necessary and appropriate treatment. Yet, commitment to a state hospital for such persons is almost unattainable in some cases. If the patient is willing to commit himself voluntarily, such a course of action is recommended if appropriate. This is likely even though we have seen several instances where the offender was placed into a hospital, released from the supervision and care of the hospital's professional staff in short order, and then very soon convicted on another charge and again incarcerated. If, on the other hand, the offender is not willing to commit himself voluntarily, and many of the offenders suffering from particular, serious mental disturbances fall into this category, a very real and practical problem is faced by those attempting to provide the essential services needed for the offender. We have been unable to document any behavior that resulted in an involuntary commitment for treatment, and the seriously mentally ill offender remains a particular problem for the presentence diagnostic program. Long-term programming for the seriously mentally ill is very difficult at best.

#### IV. SUMMARY AND CONCLUSION

The Presentence Diagnostic Program as developed and operated within North Carolina is appreciated. It gives the opportunity to serve the various state courts, it allows an effective staff training vehicle, and



it permits a few, selected offenders the chance for more acceptable and successful lives. Certainly, these traits, plus the increased communication among the components of the criminal justice system, warrant a continuation, refinement, and improvement of the presentence diagnostic study process in North Carolina. Today's discussion can produce just such successful progress.

Comments from the courts indicate the presentence diagnostic study procedure is most often used when the court is in doubt, when the court is of the opinion that there are behaviors or behavioral dynamics which are unclear, and when the information provided to the court by the study procedure can provide helpful information for the sentencing procedures. The presentence diagnostic study procedures should be used whenever they are needed and as the resources of the program allow, but they should also be used appropriately. There are some study cases for which the thorough background and status examination inherent to the presentence investigation process will suffice, but there are still others that perhaps require the evaluative process inherent to the presentence diagnostic study procedures. We have found that, for the most part, the courts differentiate and identify candidates for presentence diagnostic study very well.<sup>21</sup> Most of the referrals surveyed have been ones that were considered appropriate; that is, they appeared as cases warranting a complete study, and to warrant a study within a secure environment. The courts are invited to refer cases for investigation and study as needed. Our staffs will do their best to respond appropriately to these referrals and to provide the additional information that is requested.

There are, of course, many problems in the study process, both theoretical and operational. There are those related to the referral rates and the actual capacity of the Program as allowed by allocated resources; there are those related to the best type of offender for referral and study, whether minor or major, and admittedly both can have serious problems; and there are those related to the actual study process, itself, whether it is accomplished through presentence investigation, presentence diagnostic, or some other service provided by an agency external to the Department of Correction. The primary complicating factors for the presentence diagnostic study process are: pending charges, confidentiality of information, professional relationships, referral as a delaying tactic, and possibly guilty pleas. The mentally or emotionally disordered or deficient offender is noted as presenting a very serious difficulty. These, and others as well, should be discussed at length this afternoon.

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21. E. D. Beshears & N. O. Jones, *The Appropriateness of Presentence Diagnostic Study Referrals* (manuscript in preparation, 1977).

In conclusion, I trust that our discussions this afternoon will be sufficient to touch on at least some of the problems and issues, develop alternative strategies which can be explored toward their certain definition and resolution and, thereby, continue the development and improvement of the presentence diagnostic study process in North Carolina.<sup>22</sup>

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22. The legislation authorizing the presentence diagnostic study process has recently been revised. *See generally* N.C. GEN. STAT. §§ 15A-1331-1335 (1978).