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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Clarence Wayne Dixon, Petitioner, vs. David Shinn, et al., Respondents.	No. CV-14-258-PHX-DJH DEATH-PENALTY CASE

State Court Record
Pinal County Superior Court, No. S1100CR202200692
Hearing Exhibits 23–39

CLARENCE W. DIXON, 038977

ARIZONA STATE PRISON, BOX 8200

FLORENCE, AZ 85132

IN PROPRIA PERSONA

IN THE SUPREME COURT OF THE UNITED STATES

CLARENCE WAYNE DIXON,	)	NO. _____
PETITIONER.	)	PETITION FOR WRIT OF
V.	)	CERTIORARI TO THE
STATE OF ARIZONA, ET AL,	)	ARIZONA SUPREME COURT
RESPONDENT.	)	(DEATH SENTENCE CASE)

CAPITAL CASE

QUESTION PRESENTED

SINCE 1991, WHEN PETITIONER DIXON (DIXON) DISCOVERED THAT ARIZONA'S UNIVERSITIES CAMPUS POLICE WERE NOT FULLY VESTED WITH LAW ENFORCEMENT POWERS, DIXON HAS SOUGHT RELIEF IN COCONINO COUNTY SUPERIOR COURT; MARICOPA COUNTY SUPERIOR COURT; COURT OF APPEALS, DIVISION 1; AND THE ARIZONA SUPREME COURT. ALL PETITIONS WERE DENIED WITHOUT STATEMENTS OF FACT AND CONCLUSIONS OF LAW SUPPORTING THE DENIALS. FOUR POST-CONVICTION RELIEF PETITIONS AND ONE SPECIAL ACTION HAVE NOT BROUGHT ANY STATE JUDGE OR JUSTICE TO READ OR APPLY THE LAW AS IT STOOD IN JUNE 1985.

IF THE QUESTION PRESENTED BY THIS PETITION FOR WRIT OF CERTIORARI IS THE FOLLOWING: DOES THE SUPREME COURT HAVE JURISDICTION TO ADDRESS JUSTICE WHERE A THREE-TIER COURT SYSTEM DELIBERATELY AND SYSTEMATICALLY DEPRIVES A PRISONER SENTENCED TO DEATH THE RIGHT TO DUE PROCESS

AND EQUAL PROTECTION BY INTENTIONALLY IGNORING THE LAW WHICH CLEARLY

BENEFITED THE PRISONER?

LIST OF PARTIES.

ALL PARTIES APPEAR IN THE CAPTION OF THE CASE ON THE COVER PAGE.

RELATED CASES

STATE OF ARIZONA V. CLARENCE WAYNE DIXON, NO. 11654, SUPERIOR COURT OF COCONINO COUNTY DENYING POST-CONVICTION RELIEF

STATE OF ARIZONA V. CLARENCE WAYNE DIXON, NO. 1 CA-CR 92-0171-PR, ARIZ COURT OF APPEALS, DIVISION ONE, JUDGEMENT ENTERED DECEMBER 3, 1992.

STATE V. DIXON 153 ARIZ. 151, 735 P.2D 761 (1987). AFFIRMING CONVICTIONS AND SENTENCES.

CLARENCE WAYNE DIXON V. DAVID SHINN, NO. HC-21-0007. ARIZONA SUPREME COURT, DENYING ORIGINAL WRIT OF HABEAS CORPUS ON MAY 21, 2021.

¡RELATED CASES¡ CONTINUED

CLARENCE WAYNE DIXON V. DAVID SHINN, NO. HC-21-0007, ARIZONA SUPREME COURT, DENYING MOTION FOR RECONSIDERATION ON JUNE 4, 2021.

STATE OF ARIZONA V. CLARENCE WAYNE DIXON, NO NO. CR-08-0025-AP/AR ARIZONA SUPREME COURT, AFFIRMING CONVICTION AND CAPITAL SENTENCE ON MAY 6, 2011.

STATE OF ARIZONA. V CLARENCE WAYNE DIXON, NO. CR 2002-019566. MARICOPA COUNTY SUPERIOR COURT, DENYING POST-CONVICTION RELIEF ON JULY 3, 2013.

STATE OF ARIZONA V. CLARENCE. WAYNE DIXON, NO. CR-0238-PC. ARIZONA SUPREME COURT, DENYING PETITION FOR REVIEW ON FEBRUARY 11, 20[illegible]

CLARENCE WAYNE DIXON V. CHARLES RYAN, ET AL, NO. 2:14-CV-00258-PJA, UNITED STATES DISTRICT COURT, DISTRICT OF ARIZONA, DENYING PETITION FOR WRIT OF HABEAS CORPUS ON MARCH 16, 2016.

RELATED CASES - CONTINUED

CLARENCE WAYNE DIXON V. CHARLES RYAN, ET AL. NO. 16-99006, 9TH CIRCUIT COURT OF APPEALS, AFFIRMING DENIAL OF PETITION FOR WRIT OF HABEAS CORPUS ON JULY 26, 2019.

CLARENCE WAYNE DIXON, V CHARLES RYAN, ET AL, NO. 16-99006, 9TH CIRCUIT COURT OF APPEALS, DENYING PETITION FOR PANEL AN EN BANC REHEARING ON OCTOBER 18, 2019.

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IN THE SUPREME COURT

OF THE UNITED STATES

PETITION FOR WRIT OF CERTIORARI

PETITIONER PRAYS THAT A WRIT OF CERTIORARI ISSUE TO REVIEW THE JUDGEMENT BELOW.

OPINIONS BELOW

THE OPINION OF THE HIGHEST STAT COURT TO REVIEW THE MERITS APPEARS AT APPENDIX A TO THE PETITION AND IS UNPUBLISHED BECAUSE THE PETITION FOR AN ORIGINAL WRIT OF HABEAS CORPUS WENT DIRECTLY TO THE ARIZONA SUPREME COURT WHICH ACCEPTED ORIGINAL JURISDICTION AND DENIED THE PETITION, THEREFORE NO LOWER COURT OPINION EXIST.

JURISDICTION

THE DATE ON WHICH THE HIGHEST STATE COURT DECIDED MY CASE WAS MAY 21, 2021. A COPY OF THAT DECISION APPEARS AT APPENDIX A. A TIMELY PETITION FOR RECONSIDERATION WAS THEREAFTER DENIED ON THE FOLLOWING DATE: JUNE 14, 2021. A COPY OF THE ORDER DENYING RECONSIDERATION APPEARS AT APPENDIX B.

ON NOVEMBER 16, 2021, THE CLERK OF THE UNITED STATES SUPREME COURT, SCOTT S. HARRIS, BY CLAUDE ADLE GRANTED PETITIONER SIXTY ADDITIONAL DAYS TO REFILE THIS PRO SE PETITION.

THE JURISDICTION OF THIS COURT IS INVOKED UNDER 28 USC SECTION 1257 (A).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

UNITED STATES CONSTITUTION, AMENDMENTS 4, 6, 8, AND 14

STATEMENT OF THE CASE

PETITIONER CLARENCE WAYNE DIXON IS A DEATH ROW PRISONER WHOM THE STATE OF ARIZONA IS ACTIVELY SEEKING AN EXECUTION DATE. THIS PETITION FOR WRIT CERTIORARI IS SUPPORTED BY THE FOURTH, SIXTH, EIGHTH, AND FOURTEENTH AMENDMENTS TO THE UNITED STATES CONSTITUTION. THIS PETITION IS ALSO SUPPORTED BY THE ARIZONA CONSTITUTION, ARIZONA STATUTES AND CASE LETTER LAW.

BEING TOTALLY BLIND, PETITIONER DIXON BEGS THIS COURT'S INDULGENCE.

REASONS FOR GRANTING THE PETITION

ON JANUARY 24, 2008, IN MARICOPA COUNTY SUPERIOR COURT, A JURY FOUND DIXON GUILTY OF THE MURDER OF DEANNA L. BOUDOIN AND SENTENCED HIM TO DEATH. BEFORE TRIAL, DIXON SOUGHT TO HAVE THE DNA AND VICTIM TESTIMONY EXCLUDED AS POISONOUS FRUIT. SAID MOTION WAS DENIED.

IN JUNE 1985 ATS WAS KIDNAPPED AND SEXUALLY ASSAULTED AND DIXON WAS FOUND GUILTY AND SENTENCED TO SEVEN CONSECUTIVE LIFE SENTENCES FOR THE ASSAULT. STATE V. DIXON 153 ARIZ 151 (1987)

IN 1997 A CRIME DETECTING LAB A DNA HIT THAT MATCHED DNA FOUND ON DEANNA L. BOUDOIN'S PANTIES. STATE V. DIXON, 226 ARIZ. 545 (2011).

WITH ATS WAS A NORTHERN ARIZONA UNIVERSITY COED ASSAULTED OFF-

CAMPUS. THE ASSAULT OCCURRED ON JUNE 10, 1985. THE ASSAULT OCCURRED ONE HUNDRED TO ONE HUNDRED-FIFTY YARDS SOUTH OF LONG TREE ROAD AT THE BEND APPROXIMATELY TWO TO THREE HUNDRED YARDS SOUTH OF THE INTERSTATE 40 OVERPASS RUNNING EAST & WEST. THE CRIME SCENE IS OFF-CAMPUS.

THE NAU. SECURITY OFFICERS INVESTIGATED; THEY INTERVIEWED WITNESSES AND THE VICTIM, GATHERED EVIDENCE, OBTAINED TWO SEARCH WARRANTS AND A COURT ORDER. AND TESTIFIED AT TRIAL AS PEACE OFFICERS.

THE NAU. SECURITY OFFICERS WERE WITHOUT JURISDICTION BECAUSE ARIZONA STATUTE ALLOWED FOR ONLY ON-CAMPUS INVESTIGATIONS. ~~AR~~ APPENDIX E. THE STATUTE THAT GIVES POWER AND AUTHORITY TO THE UNIVERSITIES' SECURITY OFFICERS IS STRAIGHT FORWARD: CAMPUS SECURITY OFFICERS WERE LIMITED TO ON-CAMPUS GROUNDS AND ACTIVITIES. SEE

APPENDIX E. THIS LIMITATION IN AUTHORITY AND POWER IS BUTTRESSED BY A.R.S. 1-215(23)(1981) (DEFINITION OF WHO IS A PEACE OFFICER.) SEE APPENDIX E. THAT STATUTE DOES NOT NOW INCLUDE CAMPUS SECURITY OFFICERS IN THE DEFINITION OF WHO IS A PEACE OFFICER.

BLACK LETTER LAW CONTAINED IN CORPUS JURIS SECUNDUM, JURISDICTION PLAINLY STATES THAT ISSUES OF JURISDICTION MAY BE BROUGHT AT ANY TIME. IN 1992 THE ARIZONA SUPREME COURT SAID THAT IT MUST SCRUTINIZE CLOSELY WHERE A DEATH SENTENCE HAS BEEN IMPOSED. STATE V. BREWER, 170 ARIZ. 486 (1992).

THE JUDGE HELD THE PROSECUTOR LIE THAT DENNIS DNA WAS ON THE MURDER WEAPON, HELD THE PROSECUTOR NOT BE ABLE TO PLACE DIXON AT THE CRIME SCENE, WAS NEVER GIVEN REASONS WHY THE

BOYFRIENDS BROTHER AND ANOTHER PERSONS DNA WERE FOUND ON THE BEDSPREAD IN A SOFTBALL SIZE WET SPOT IN CLOSE PROXIMITY TO THE BODY, WAS NOT TOLD THE VICTIM WAS SEXUALLY ACTIVE BEYOND THE BOY-FRIENDS TESTIMONIAL KNOWLEDGE: ALL OF WHICH WAS INSTANTLY NEGATED AS TO REASONABLE DOUBT WHEN AJS TESTIFIED. THE CHALLENGED AJS VICTIM TESTIMONY ADMITTED 2007-08 TRIAL REMOVED ANY REASONABLE DOUBT ARGUMENTS IN FACT WITH ITS FATALLY PREJUDICE AND BIAS WEIGHT. THE ARIZONA SUPREME COURT KNOWINGLY AND WILLINGLY USED AS UNLAWFUL AND UNCONSTITUTIONAL CONVICTION TO AFFECT A STATUTORY EXECUTION MANIFESTING JUSTICE WITHOUT LAW.

FURTHER, A READING OF A.R.S. 8-1627 (1991) OFFERS CLEAR GUIDANCE WHERE UNIVERSITY SECURITY OFFICERS WERE HELD, AND A DELIBERATE MISREADING OF THIS STATUTE BY NOT ONE BUT SO MANY AND

AND ALL JUDGES AND JUSTICES INDICATES PRIMA FACIE BIAS AND PREJUDICE. WHEN A WHOLE BLOCK OF JURISTS MISSTER DELIBERATELY, THEN SUPREME COURT OVERSIGHT IS MANDATED. (WOULD THIS BE CAUSE FOR THE SUPREME COURT TO CREATE NEW LAW?

IN A NON-PERFECT CRIMINAL TRIAL, WHERE THE PERFECT PENALTY OF EXECUTION IS PRESENT. CONSTITUTIONAL GUARANTEES AND THE RULE OF LAW CANNOT BE ABSENT.

DIXON SOUGHT SELF-REPRESENTATION AT TRIAL BECAUSE HIS COURT APPOINTED ATTORNEYS WOULD NOT RAISE THE POLICE JURISDICTION CLAIM/ ISSUE ON. SINCE 1991 DIXON HAS CONFRONTED THIS UNWILLINGNESS BY DEFENSE COUNSEL(S) TO ADVANCE THIS CLAIM/ISSUE. SEE APPENDIX F.

IV CONCLUSION

DIXON REQUEST THIS COURT REMAND THIS CASE BACK TO THE ARIZONA SUPREME COURT WITH INSTRUCTIONS TO ACT IN ACCORDANCE WITH THIS COURTS DECISION.

RESPECTFULLY SUBMITTED 7 DAY OF JANUARY 2022.

Clarence W. Dixon

CLARENCE W. DIXON, 038977

CLARENCE W. DIXON, 038977

ARIZONA STATE PRISON, BOX 8200

FLORENCE, AZ 85132

IN PROPRIA PERSONA

IN THE SUPREME COURT OF THE UNITED STATES

NO. 21-6820

CLARENCE WAYNE DIXON)

PETITIONER) REPLY TO STATE'S RESPONSE

V.)

DAVID SHINN, DIRECTOR,)

DEPT. OF CORRECTIONS, ET AL)

RESPONDENTS.) (DEATH SENTENCE CASE)

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STATEMENT OF THE CASE

IN DECEMBER 2007. AND JANARY 2008, MR. DIXON REPRESENTING HIMSELF WAS FOUND GUILTY OF THE FIRST DEGREE MURDER OF DEANNA LYNN BUREN. STATE V. DIXON, 226 ARIZ. 545, (2011). IT SHOULD BE NOTED THAT MR. DIXON REPRESENTED HIMSELF BECAUSE ATTORNEYS VICKI LILES AND GARRETT SIMPSON WOULD NOT ADVOCATE HIS LACK OF POLICE JURISDICTION AND SUBSEQUENT UNLAWFUL VICTIM TESTIMONY AT TRIAL.

MR. DIXONS UNDERLYING CLAIM IS STRAIGHT FORWARD IN 1995 N.A.U. CAMPUS POLICE THOROUGHLY INVESTIGATED THE SEXUAL ASSAULT OF A.J.S. THE N.A.U. CAMPUS POLICE GATHERED EVIDENCE, INTERVIEWED WITNESSES AND THE VICTIM, OBTAINED TWO

TWO SEARCH WARRANTS AND A COURT ORDER, AND TESTIFIED AT TRIAL AS PEACE OFFICERS. AT THE TIME OF THE ASSAULT AND MR. DIXONS ARREST, ARIZONA REVISED STATUTE 15-1627 AT PARAGRAPHS F AND G LIMITED THE CAMPUS POLICE TO TO ONLY ON-CAMPUS ACTIVITIES AND LAW ENFORCEMENT. THE ASSAULT OF ANIS. OCCURRED MORE THAN A MILE SOUTH OF THE CAMPUS. A.R.S. 1-215(25), DEFINITION OF WHO IS A PEACE OFFICER AT THE TIME OF THE ASSAULT AND MR. DIXONS ARREST DID NOT INCLUDE THE UNIVERSITIES' CAMPUS SECURITY OFFICERS IN TS DEFINITION OF WHO IS A PEACE OFFICER:

. SINCE 1991 MR. DIXON HAS BROUGHT THIS STRAIGHT FORWARD CLAIM TO ARIZONA'S JUDICIARY IN FOUR POST-CONVICTION RELIEF PETITIONS AND ONE SPECIAL ACTION. ALL

3

THE MANY ARIZONA JUDGES AND JURISTS WHO HAD THE OPPORTUNITY AND DUTY TOO FOLLOW AND APPLY THE LAW JUDICIALLY RECOGNIZING THE APPLICABILITY OF A.R.S. 15-1627(1981) AND A.R.S. 1-215(23)(1981) DELIBERATELY AND SYSTEMATICALLY DEPRIVED MR. DIXON OF OF CONSTITUTIONAL RIGHTS FOUND IN ARIZONA'S AND IN THE UNITED STATES CONSTITUTIONS.

IN THE STATE'S RESPONSE, ITS USE OF THE WORD 'ADEQUATE' AS A MEASURE OF THE QUANTITY AND QUALITY OF THE JURISPRUDENCE AFFORDED A PRISONER SENTENCED TO DEATH IS WOEFULLY WANTING.

II. ARGUES

MR. DIXON HEREIN REPLIES TO SPECIFIC ARGUMENTS RAISED BY THE STATE RESPONSE OF FEBRUARY 4, 2022. THE PRO SE PETITION FOR WRIT OF HABEAS CORPUS FILED ON APRIL 15, 2021, NEVER LEFT THE ARIZONA SUPREME COURT ORIGINAL JURISDICTION IN ART. II, SECT. 18 OF THE STATE CONSTITUTION. AS SUCH, THE STATE USE OF STATE CRIMINAL RULE 32 ET SEQ. IS NOT APPLICABLE. THE SCOPE AND PURPOSE OF THE WRIT OF HABEAS CORPUS APPLIES ONLY.

ADDITIONALLY: BECAUSE THE STATE SUPREME COURT WAS PRESENTED WITH THE LACK OF N.A.U. POLICE JURISDICTION COUPLED TO THE UNLAWFUL TESTIMONY OF THE 1985 SEXUAL ASSAULT VICTIM AT DAVIS' 2007-2008 TRIAL, THIS

PRESENTS THE HIGH STATE COURT WITH AN ISSUE OF JURIS-
DICTION WHICH MAY BE RAISED AT ANY TIME. THE STATE DID NOT
ADDRESSS THIS ISSUE IN ITS RESPONSE.

AFTER HIS CONVICTION AND SENTENCE OF DEATH IN JANUARY
2008, MR. DIXON WAS REPRESENTED ON DIRECT APPEAL BY
CONSTANCE ORMANIAN, KERRIE DROBAN, SARAH STONE, AND KAREN
WILKENSON. ALL THESE ATTORNEYS WERE CONTACTED BY MR.
DIXON VIA MAIL AND TOLD OF THE CLAIM THA THE N.A.U.
POLICE LACKED JURISDICTION IN 1985 AND THAT THE VICTIMS
TESTIMONY IN HIS 2007-2008 FIRST DEGREE MURDER TRIAL
WAS UNLAWFUL. ALL FOUR ATTORNEYS REFUSED TO INCLUDE
THIS CLAIM IN THEIR APPEAL IN STATE AND FEDERAL STATE
PROCEEDINGS. SEE APPENDIX F.

IT IS WORTH NOTING THAT ISSUES OF JURISDICTION MAY BE BROUGHT AT ANY TIME. CORPUS JURIS SECUNDUM, 'JURISDICTION.

THE STATE ASSERTS IN ITS RESPONSE THAT MR. DIXON DID NOT PRESENT A FEDERAL QUESTION. BUT THAT ARGUMENT IGNORES THE REASONS ADVANCED BY MR. DIXON FOR GRANTING CERTIORARI ON PAGES 3 THROUGH 10 OF MR. DIXONS PETITION FOR CERTIORARI. THOSE REASONS ARISE UNDER THE UNITED STATES CONSTITUTION. SPECIFICALLY THE FOURTH, SIXTH, EIGHTH AND FOURTEENTH AMENDMENTS. ID.

III. CONCLUSION.

THE PRINCIPLE DUTY AND OBLIGATION OF THE STATE ATTORNEY GENERAL IS THE PROPER ADMINISTRATION OF JUSTICE. BY ALLOWING PROSECUTORS AND THE JUDICIARY TO IGNORE STATE

STATUTES AND UPHOLD UNLAWFUL AND UNCONSTITUTIONAL CONVICTIONS, MR. DIXON ASSERTS THAT THERE IS A NON-COMPLIANCE WITH AND A REDEFINING OF THE MEANING OF DUTY AND OBLIGATION ERRONEOUSLY AND SUBJECTIVELY TILTING THE SCALES OF JUSTICE TOWARDS GUILT AND CONVICTION.

MR. DIXON REQUEST THAT THE COURT REMAND THIS CASE FOR RETRIAL OR REVERSAL OF THE CONVICTION CONSISTENT WITH THIS COURT'S LAST RESORT ADMINISTRATION OF JUSTICE.

DATED THIS 16TH DAY OF FEBRUARY 2022.

Clarence W. Dixon

CLARENCE W. DIXON 58977

CONFIDENTIAL
Arizona Commission on Judicial Conduct
1501 W. Washington Street, Suite 229
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

HOW TO FILE A COMPLAINT AGAINST A JUDGE

To file a complaint against a judge, complete this form and send it to the Commission on Judicial Conduct at the address above. The information you provide will be used to evaluate and investigate your allegations.

To learn more about the purpose and jurisdiction of the commission and the types of allegations it can investigate, read the enclosed brochure or visit our website at **www.azcourts.gov/azcjc**. A copy of the commission's rules and the Code of Judicial Conduct can be printed from the website.

Under the rules approved by the Arizona Supreme Court, complaints may be made public at the conclusion of their review by the commission or upon the filing of a formal complaint against a judge. If a complaint is dismissed, all personal information will be redacted from what is made public.

Please provide the following information

1. Name: CLARENCE W. DIXON #038977
2. Mailing Address: P.O. BOX 8200
   City: Florence State: AZ Zip Code: 85132
3. Landline phone: _____ Cell phone _____
4. Judge's name: AZ SCT JUSTICES Location: PHOENIX
5. Court: ◯ municipal ◯ justice ◯ superior ◯ court of appeals ☒ supreme court
6. Did you have a case before this judge? ☒ Yes ◯ No. If yes, is the case still pending? ◯ Yes ◯ No
   a. Case name and number: STATE V. DIXON; DIXON V. STINN
   b. List any attorneys who appeared in the case:

   IN PROPER PERSON

   c. List names and phone numbers of any witnesses who observed the judge's conduct:

   N/A

7. I understand the commission **cannot** reverse court orders or assign a new judge to a case: ☒ Yes ◯ No
8. Please read the following statement and sign on the line below:

I affirm, under penalty of perjury, that the foregoing information and the allegations contained in the attached complaint are true.

Clarence W. Dixon — **Signature**

APR. 6 2022 — **Date**

CONFIDENTIAL
Arizona Commission on Judicial Conduct
1501 W. Washington Street, Suite 229
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

COMPLAINT AGAINST A JUDGE

Name: CLARENCE DIXON **Judge's Name:** AZ SCT. JUSTICES

Instructions: Use this form or plain paper of the same size to file a complaint. Describe in your own words what you believe the judge did that constitutes judicial misconduct. Be specific and list all of the names, dates, times, and places that will help the commission understand your concerns. Additional pages may be attached along with copies (not originals) of relevant court documents. Please complete one side of the paper only, and keep a copy of the complaint for your records.

(See Attached)

COMPLAINT AGAINST A JUDGE

CLARENCE WAYNE DIXON, COMPLAINTANT

ANDREW GOULD, JUSTICE, ARIZONA SUPREME COURT

I AM FILING A COMPLAINT AGAINST JUSTICE GOULD FOR HIS FAILURE TO CORRECTLY APPLY RELEVANT STATUTES AND FAILING TO FOLLOW REQUIRED JUDICIAL PROCESS WHILE ALLOWING BLATANTLY INCORRECT INCORRECT LOWER COURT DECISIONS TO STAND IN MY PROSE PETITION FOR WRIT OF HABEAS CORPUS

JUSTICE GOULD REFUSED TO ACKNOWLEDGE AND APPLY THROUGH CLOSE SCRUTINY A.R.S. 1-215(23)(1981) AND A.R.S. 15-1627 (1981) BUT FULLY ACKNOWLEDGES THE APPLICATION OF ARIZONA'S DEATH SENTENCE STATUTES. EQUAL PROTECTION, DUE PROCESS AND FAIRNESS CANNOT BE FOUND IN JUSTICE GOULD'S DECISION TO DENY

MY PETITION FOR WRIT OF HABEAS CORPUS IN THE SUREME COURT.

.THIS VIOLATION CAN BE FOUND IN THE CODE OF JUDICIAL CONDUCT CANON TWO IMPARTIALITY AND FAIRNESS.

I HAVE PROVIDED THE COMMISSION ON JUDICIAL CONDUCT A COPY OF THE LAW AND ARGUMENTS PORTION OF MY PETITION FOR WRIT OF HABEAS CORPUS AND COPIES OF THE TWO POINTED RELEVANT AZ STATUTES, ARS 1-215(23) AND ARS 15-1627 AT APPENDA A.

I STRONGLY REQUEST THAT JUSTICE ANDREW GOULD BE DISBARRED. . HIS DENIAL OF MY CLAIM WAS COMPLETELY LACKING IN PROFESSIONAL WORKMANSHIP AND HIS ADHERENCE TO HIS OATH TO OFFICE. .HIS CONDUCT OR LACK THEREOF WILL ALLOW THE STATE TO INFLICT A CONSTITUTIONALLY INFIRM IF NOT ILLEGAL AND IMMORAL HOMICIDE UPON MY PERSON AND BODY.

THIS COMPLAINT IS SUBMITTED ON THIS 11th DAY OF APRIL

2022.

Clarence W. Dixon

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4. Judge's name: AZ SCT JUSTICES Location: PHOENIX
5. Court: ◯ municipal ◯ justice ◯ superior ◯ court of appeals ☒ supreme court
6. Did you have a case before this judge? ☒ Yes ◯ No. If yes, is the case still pending? ◯ Yes ◯ No
   a. Case name and number: STATE V. DIXON; DIXON V. SHINN
   b. List any attorneys who appeared in the case:

   EN PROPIA PERSONA

   c. List names and phone numbers of any witnesses who observed the judge's conduct:

   N/A

7. I understand the commission **cannot** reverse court orders or assign a new judge to a case: ☒ Yes ◯ No
8. Please read the following statement and sign on the line below:

I affirm, under penalty of perjury, that the foregoing information and the allegations contained in the attached complaint are true.

Clarence W. Dixon — **Signature**

APR. 9 2022 — **Date**

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COMPLAINT AGAINST A JUDGE

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(See Attached)

COMPLAINT AGAINST A JUDGE

CLARENCE WAYNE DIXON, COMPLAINTANT

ANN SCOTT TIMMER, SUPREME COURT JUSTICE

I AM FILING A COMPLAINT AGAINST JUSTICE TIMMER FOR FAILING TO APPLY RELEVANT STATUTES AND JUDICIAL PROCESS WHILE ALLOWING BLATANTLY ERROR-FILLED LOWER COURT DECISIONS TO STAND IN MY PRO SE PETITION FOR WRIT OF HABEAS CORPUS

JUSTICE TIMMER REFUSED TO ACKNOWLEDGE AND APPLY THRU CLOSE SCRUTINY A.R.S. 1-215(23)(1981) AND A.R.S. 15-1627(1981) FULLY ACKNOWLEDGES AND IS ALLOWING THE APPLICATION AND IMPLEMENTATION OF ARIZONA'S DEATH SENTENCE STATUTES.

EQUAL PROTECTION DUE PROCESS AND FAIRNESS CANNOT BE FOUND IN JUSTICE TIMMERS DENIAL OF MY PRO SE PETITION. THIS

IS A VIOLATION OF CANON TWO, CODE OF JUDICIAL CONDUCT, IMPARTIALITY AND FAIRNESS.

I HAVE PROVIDED THE COMMISSION WITH A COPY OF THE LAW AND ARGUMENTS PORTION OF MY PETITION FOR WRIT OF HABEAS CORPUS AND THE CODES OF THE 1981 STATUTES, 1-215(23) AND 15-1607, AT APPENDIX A.

I STRONGLY REQUEST THAT JUSTICE TIMMERS ACTION OR INACTION IN CONSIDERING MY PETITION FOR WRIT OF HABEAS CORPUS BE GROUNDS FOR DISBARMENT. THIS LACK OF APPROPRIATE AND PROFESSIONAL CONDUCT ALLOWS FOR THE UNCONSTITUTIONALLY INFIRM, ILLEGAL AND IMMORAL GRUESOME INFLICTION OF A HOMICIDE UPON MY PERSON AND BODY. (THE ARIZONA CONSTITUTION EMPOWERS EACH SUPREME COURT JUSTICE HIS OR HER INDIVIDUAL CHOICE TO TO GRANT WRITS OF

(HAB AS CORPUS.)

SUBMITTED THIS 11th DAY OF APRIL 2022.

Clarence W. Dixon

CONFIDENTIAL
Arizona Commission on Judicial Conduct
1501 W. Washington Street, Suite 229
Phoenix, Arizona 85007

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   b. List any attorneys who appeared in the case:

   IN PROPER PERSON

   c. List names and phone numbers of any witnesses who observed the judge's conduct:

   N/A

7. I understand the commission **cannot** reverse court orders or assign a new judge to a case: ☒ Yes ◯ No
8. Please read the following statement and sign on the line below:

I affirm, under penalty of perjury, that the foregoing information and the allegations contained in the attached complaint are true.

Clarence W. Dixon — **Signature**

APR. 9, 2022 — **Date**

CONFIDENTIAL
Arizona Commission on Judicial Conduct
1501 W. Washington Street, Suite 229
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

COMPLAINT AGAINST A JUDGE

Name: CLARENCE DIXON **Judge's Name:** AZ SCT. JUSTICES

Instructions: Use this form or plain paper of the same size to file a complaint. Describe in your own words what you believe the judge did that constitutes judicial misconduct. Be specific and list all of the names, dates, times, and places that will help the commission understand your concerns. Additional pages may be attached along with copies (not originals) of relevant court documents. Please complete one side of the paper only, and keep a copy of the complaint for your records.

(See Attached)

COMPLAINT AGAINST A JUDGE

CLARENCE WAYNE DIXON, COMPLAINTANT

KATHRYN KING, SUPREME COURT JUSTICE

I AM FILING A COMPLAINT AGAINST JUSTICE KING FOR FAILING TO APPLY RELEVANT STATUTES AND APPROPRIATE JUDICIAL PROCESS, WHILE ALLOWING BLATANT ERRONEOUS LOWER STATE COURT DECISIONS TO STAND. IN MY PRO SE PETITION FOR WRIT OF HABEAS CORPUS, JUSTICE KING REFUSED TO ACKNOWLEDGE AND APPLY THROUGH CLOSE SCRUTINY A.R.S. 1-215(28)(1991) AND A.R.S. 13-703(K) BUT FULLY ACKNOWLEDGES AND IS ALLOWING IMPLEMENTATION OF ARIZONAS DEATH SENTENCE STATUTES. EQUAL PROTECTION, DUE PROCESS AND FAIRNESS CANNOT BE FOUND IN JUSTICE KINGS DENIAL OF MY PETITION FOR WRIT OF HABEAS CORPUS.

JUSTICE KING BIAS AND PREJUDICE IN MY CASE IS A VIOLATION OF

CANON TWO, CODE OF JUDICIAL CONDUCT, IMPARTIALITY AND FAIRNESS.

I HAVE PROVIDED THE COMMISSION WITH THE LAW AND ARGUMENTS PORTION OF MY PRO SE PETITION FOR WRIT OF HABEAS CORPUS AND STATUTES A.R.S. 1-213 (1991) AND A.R.S. 15-107 (1991) IN THE ATTACHED APPENDIX A.

I STRONGLY REQUEST THAT THE COMMISSION ON JUDICIAL CONDUCT FIND JUSTICE KING'S DENIAL OF MY PETITION FOR WRIT OF HABEAS CORPUS TO BE COMPLETELY LACKING IN PROFESSIONAL WORKMANSHIP AND AVOIDANCE OF HER OATH OF OFFICE. JUSTICE KING SHOULD THEREFORE BE DISBARRED. HER LACK OF IMPARTIALITY AND FAIRNESS WILL HAVE CAUSE TO INFLICT A CONSTITUTIONALLY INFIRM IF NOT ILLEGAL IF NOT IMMORAL HOMICIDE UPON MY PERSON AND BODY.

THE ARIZONA CONSTITUTION GIVES EACH JUSTICE INDIVIDUALLY THE POWER

TO GRANT WRITS OF HABEAS CORPUS.

I AM 95% BLIND AND BEG THE COMMISSION'S INDULGENCE.

SUBMITTED THIS 11th DAY OF APRIL 2022.

/Chuma Wilson

CONFIDENTIAL
Arizona Commission on Judicial Conduct
1501 W. Washington Street, Suite 229
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

HOW TO FILE A COMPLAINT AGAINST A JUDGE

To file a complaint against a judge, complete this form and send it to the Commission on Judicial Conduct at the address above. The information you provide will be used to evaluate and investigate your allegations.

To learn more about the purpose and jurisdiction of the commission and the types of allegations it can investigate, read the enclosed brochure or visit our website at **www.azcourts.gov/azcjc**. A copy of the commission's rules and the Code of Judicial Conduct can be printed from the website.

Under the rules approved by the Arizona Supreme Court, complaints may be made public at the conclusion of their review by the commission or upon the filing of a formal complaint against a judge. If a complaint is dismissed, all personal information will be redacted from what is made public.

Please provide the following information

1. Name: CLARENCE W. DIXON #038977
2. Mailing Address: P.O. BOX 8200
   City: Florence State: AZ Zip Code: 85132
3. Landline phone: _____ Cell phone _____
4. Judge's name: AZ SCT JUSTICES Location: PHOENIX
5. Court: ◯ municipal ◯ justice ◯ superior ◯ court of appeals ☒ supreme court
6. Did you have a case before this judge? ☒ Yes ◯ No. If yes, is the case still pending? ◯ Yes ◯ No
   a. Case name and number: STATE V. DIXON; DIXON V. SKINN
   b. List any attorneys who appeared in the case:

   IN PROPER PERSON

   c. List names and phone numbers of any witnesses who observed the judge's conduct:

   N/A

7. I understand the commission **cannot** reverse court orders or assign a new judge to a case: ☒ Yes ◯ No
8. Please read the following statement and sign on the line below:

I affirm, under penalty of perjury, that the foregoing information and the allegations contained in the attached complaint are true.

Clarence W. Dixon — **Signature**

APR. 9, 2022 — **Date**

CONFIDENTIAL
Arizona Commission on Judicial Conduct
1501 W. Washington Street, Suite 229
Phoenix, Arizona 85007

FOR OFFICE USE ONLY

COMPLAINT AGAINST A JUDGE

Name: CLARENCE DIXON Judge's Name: AZ SCT. JUSTICES

Instructions: Use this form or plain paper of the same size to file a complaint. Describe in your own words what you believe the judge did that constitutes judicial misconduct. Be specific and list all of the names, dates, times, and places that will help the commission understand your concerns. Additional pages may be attached along with copies (not originals) of relevant court documents. Please complete one side of the paper only, and keep a copy of the complaint for your records.

(See Attached)

COMPLAINT AGAINST A JUDGE

CLARENCE WAYNE DIXON, COMPLAINTANT

WILLIAM MONTGOMERY, JUSTICE, ARIZONA SUPREME COURT

I AM FILING A COMPLANT AGAINST JUSTICE MONTGOMERY FOR HIS FAILURE TO CORRECTLY APPLY RELEVANT STATUTES AND FOLLOW JUDICIAL PROCESS. WHILE ALLOWING ERROR-FILLED LOWER STATE COURT DECISION TO STAND.. IN MY PRO SE PETITION FOR WRIT OF HABEAS CORPUS.

JUSTICE REFUSED TO APPLY AND ACKNOWLEDGE .. THROUGH CLOSE SCRUTINY. A.R.S. 1-216(23)(1981) AND A.R.S. 15-1627(1981).

WHILE IGNORING THESE RELEVANT STATUTES CONTAINED WITHIN MY CLAIM. JUSTICE MONTGOMERY READILY RECOGNIZES AND ALLOWS THE IMPLEMENTATION OF ARIZONA'S DEATH SENTENCE STATUTES.

EQUAL PROTECTION, DUE PROCESS AND FAIRNESS CANNOT BE FOUND

FOUND IN JUSTICE MONTGOMERY'S DENIAL OF MY PETITION FOR WRIT OF HABEAS CORPUS.

JUSTICE MOTGOMERY'S BIAS AND PREJUDICE IN MY CASE IS A VIOLATION OF CANON TWO, CODE OF JUDICIAL CONDUCT, IMPARTIALITY AND FAIRNESS.

I HAVE PROVIDED THE COMMISSION ON JUDICIAL CONDUCT WITH THE LAW AND ARGUMENT PORTION OF MY PRO SE PETITION FOR WRIT OF HABEAS CORPUS AND CODES OF 1981 STATUTES 1-2163 AND 15-1627 IN THE ATACHED APPENDIX A.

I STRONGLY REQUEST THE COMMISSION ON JUDICIAL CONDUCT FIND JUSTICE MONTGOMERY'S DENIAL OF MY PETITION TO BE SEVERELY LACKING IN PROFESSIONAL WORKMANSHIP AND A VIOLATION OF HIS OATH OF OFFICE IN ADDITION TO A CODE VIOLATION.

JUSTICE MONTGOMERY'S CONDUCT ALLOWS THE STATE BY WAY OF THE DEPARTMENT OF CORRECTIONS TO GHOULISHLY INFLICT A CONSTITUTIONAL INFIRM, ILLEGAL AND IMORAL HOMICIDE UPON MY PERSON AND BODY. (THE ARIZONA CONSTITUTION EMPOWERS EACH SUPREME COURT JUSTICE WITH THE GRANTING OF A WRIT OF HABEAS CORPUS.)

SUBMITTED THIS 11th DAY OF APRIL 2022.

Clarence W. Dixon

1

APRIL 16 2022

DEAR COMMISSION CHAIRPERSON,

QUITE RECENTLY, I SUBMITTED COMPLAINTS REGARDING ARIZONA SUPREME COURT JUSTICES AND MY REQUEST THAT THESE SUPREME COURT JUSTICES BE DISBARRED. IT IS MY UNDERSTANDING THAT SIX OF THE TWELVE MEMBERS OF THE COMMISSION WERE APPOINTED BY THE ARIZONA SUPREME COURT, AND I STRONGLY BELIEVE THESE SIX MEMBERS SHOULD SERIOUSLY CONSIDER RECUSING THEMSELVES REGARDING MY COMPLAINT AGAINST THE ARIZONA SUPREME COURT MEMBERS.

I ALSO WANT TO REITERATE THAT I AM REQUESTING DISBARMENT ONLY, SO THERE IS NO CONFUSION REGARDING OTHER AVENUES OF REPROMENT.

IF THIS COMMISSION CANNOT, WILL NOT, OR IS UNABLE

TO DISBAR THESE SUPREME COURT MEMBERS, I REQUEST IMMEDIATE NOTIFICATION SO THAT I MAY TAKE MY COMPLAINT TO THE ARIZONA BAR ASSOCIATION.

I FIND IT UNCONSCIONABLE THAT THESSE ARIZONA SUPREME COURT MEMBERS WOULD LACK PROFESSIONAL INTEGRITY INVOLVING A CAPITAL CASE. THEIR LACK OF IMPARTIALITY AND FAIRNESS LEAD DIRECTLY TO AN EXTRA-JUDICIAL KILLING, AN ILLEGAL AND IMMORAL HOMICIDE CREATED IN THE NAME OF AND FOR THE GOOD PEOPLE OF ARIZONA.

THANK YOU FOR CONSIDERING THIS LETTER. I AM SINCERELY..

Clarence W. Dixon, 038977

Carlos J. Vega

CURRICULUM VITAE

FOREIGN LANGUAGES

Spanish (fluent)

EDUCATION

Sept. '78 -- Dec. '81 -- Nova Southeastern University, Ft. Lauderdale, FL.— Degree Awarded July 1982, Doctor of Psychology from The School of Professional Psychology.

Sept. '77-July '78 -- Nova Southeastern University, Ft. Lauderdale, FL. Degree awarded: Master of Science in Psychology (Counseling and Guidance) from the Behavioral Science Program.

Sept. '75 -- May '77 -- University of Miami, Coral Gables, FL. Degree awarded: Bachelor of Arts, Major in Psychology and Minor in French.

LICENSES AND PROFESSIONAL AFFILIATIONS

State of Arizona licensed (Clinical) psychologist since May 1983 (license #1020).

Arizona Board of Psychologist Oral Examiner (1997)

Past Chair for East Valley Behavior Health Assoc Quality Assurance Committee.

WORK EXPERIENCE

Mar. '87 -- present --Full time private practice.

Aug. '82 -- April '87 --Clinical Director and Clinical Psychologist at the Behavioral Health Agency of Central Arizona. (Jan. '87) Part-time private practice in Phoenix, St. Luke's Medical Building #406.

Sept. '81 --July '82 --Staff Clinical Psychologist at the Miami Mental Health Center, located in Miami FL.

Sept. '80 -- Sept. '81 --Clinical Psychologist Internship at Miami Mental Health Center.

RESEARCH/PROJECTS/PRESENTATIONS

Presented recently on the effects of psychological trauma at CIBHS, a state wide behavioral health agency. several DSM III-R seminars and an interviewing technique seminar to local professionals, a DSM IV seminar to case managers, and two seminars on Psych. Testing to social service providers. Conducted study subsidized by DES of MMPI (personality testing) findings on maltreating mothers in Pinal and Gila Counties. Presented study of human figure drawings of sexually abused girls at NCCMHS. Have also made formal presentations in Spanish such as one on EMG biofeedback in San Juan, Puerto Rico to Puerto Rican graduate students.

MAJOR EDUCATIONAL SEMINARS ATTENDED

(A few of the recent ones)

Training MH Experts in Legal Competency and Restoration. Current Trends in Psychopharmacology. Conducting Effective Mental Status and Risk Assessment.Two of the Annual US Psychiatric and Mental Health Congresses. Recent MMPI-2 & MMPI-A symposia by Dr. Butcher. Dr. Amen's The Healing Brain. Innovations in Addiction Treatment & Behavioral Health Care.

CARLOS J. VEGA, PSY. D.
PSYCHOLOGIST
1298 E. AVENIDA GRANDE
CASA GRANDE, AZ 85122
(520) 836-1835
(520) 876-4653 FAX
drcjvega@gmail.com

PSYCHOLOGICAL EVALUATION
CONFIDENTIAL
FOR PROFESSIONAL USE ONLY

NAME: Clarence W Dixon
DATE OF BIRTH:
AGE: 66 years old
DATE OF EVALUATION: April 23, 2022
EVALUATOR: Carlos J. Vega, Psy.D.
CASE NUMBER: CR2002-019595

REFERAL STATEMENT
Clarence is a 66-year-old Native American male who was court ordered for a psychological evaluation involving a competency matter that exceeds the usual issues covered by a general Rule 11 Exam. With guidance from the Attorney General's Office this evaluation needs to address the following questions:

1. Is Clarence Dixon's mental state so distorted, or his concept of reality so impaired, that he lacks a rational understanding of the State's rationale for his execution?
2. Is Clarence Dixon, due to a mental disease or defect, presently unaware that he is to be punished for the crime of murder or unaware that the impending punishment for that crime is death?
3.

This report addresses Clarence's general psychological functioning, and the referral concerns are summarily addressed in the final section of this report.

ASSSESSMENT PROCEDURES
Clinical Interview *Mental Status Examination *Competency Inquiry *Review of Reports Available

RESULTS OF ASSESSMENT PROCEDURES
Documents reviewed include the "Motion to Determine Mental Competency to be Executed" dated April 8, 2022. The motion indicates that "…Clarence Dixon is a 66-year-old legally blind man of Native American ancestry, who has long suffered from a psychotic disorder—paranoid schizophrenia. Previously, an Arizona court determined that he was mentally incompetent and legally insane. Mr. Dixon has a documented history of delusions, auditory and visual hallucinations, and paranoid ideation. On April 5, 2022, the Arizona Supreme Court issued a warrant of execution scheduling Mr. Dixon's execution date for May 11, 2022…Mr. Dixon's execution by the State of Arizona will violate A.R.S. § 13-4021, which prohibits the State from executing an individual who is mentally incompetent to be executed. Mr. Dixon's execution will also violate the Eighth Amendment to the United States Constitution…which "prohibit[s] a State from carrying out a sentence of death upon a prisoner who is insane." As set forth below, Mr. Dixon's mental illness renders him incompetent to be executed by depriving him of the ability to rationally

comprehend the meaning and purpose of the punishment the State of Arizona seeks to exact by his execution—that is, Mr. Dixon's mental illness thwarts his ability to form a rational understanding of the State's reasons for his execution… Mr. Dixon has a long and well-documented history of severe mental illness, including prior findings of incompetency, a legal finding of not guilty by reason of insanity (NGRI), and multiple diagnoses of paranoid schizophrenia… in September 1977, Mr. Dixon was found incompetent by two different court-appointed psychiatrists… He was released from ASH approximately two months later, after a third psychiatrist found he regained competency to stand trial. At trial for the 1977 assault, Mr. Dixon was found NGRI and released…recognizing Mr. Dixon's serious mental illness…the trial judge also ordered the State to commence civil commitment proceedings. The murder, for which Mr. Dixon is sentenced to death in these current proceedings, occurred on January 7, 1978, less than 48 hours after the trial judge had ordered the State to institute civil commitment proceedings… Subsequently, in 1981, a psychological evaluation of Mr. Dixon administered by the Arizona Department of Corrections described symptoms consistent with his paranoid schizophrenic psychotic disorder…and that he experiences "grossly disturbed perceptual and thought patterns, clear paranoid ideation, feelings of frustration, and moderate agitation…producing inefficiency of intellectual functioning…"

Documents reviewed reveal that in May 2001 Tempe Police Department matched DNA evidence to Clarence W Dixon, of the 1978 murder of 21-year-old Arizona State University Student Deana Bowdoin. Dixon was serving life sentences in prison for a 1986 sexual assault. Dixon, at one point had been released on parole in March 1985, and on April 2, he grabbed a woman in the parking lot at Northern Arizona University, holding a knife to her throat. On June 10, he grabbed a female jogger on the road near NAU. While holding her at knife point, he walked her to the woods where he tied her hands and sexually assaulted the woman. Dixon was arrested, convicted, and sentenced to seven consecutive life terms. A prior psychiatric evaluation indicated that "Mr. Dixon reported no involvement with the Juvenile Justice System…", however there are documents that indicate that as a child he was cruel to animals and may have molested his sister. "…He said he was first convicted of "DUI's" when he was eighteen and nineteen in Gallup, NM. He also stated that he was charged with soliciting prostitution in 1978. He said that he spent five days in jail…" In 1977 he assaulted a young girl whom he thought was his ex-wife or (she looked like his ex-wife)…" In 2005, Clarence was charged with the 1978 sexual assault and murder of a university student. In 1985 Clarence had been convicted in Coconino County of seven counts arising from the sexual assault of a student on the campus at NAU. He was on parole at the time of these offenses and therefore he received seven consecutive life sentences in that case.

Aside, and at times related to Clarence history of antisociality is his admitted history of psychoactive substance abuse. Documents reviewed indicated that Clarence was around 16 years old when he began to use alcohol. He stated that eventually his drinking increased to daily use of etoh. He reported that this went on from 1977 until September 1978 and that it included usually drinking beer but at times he would drink an entire bottle of vodka. He acknowledged to having had frequent blackouts "about once every two or three weeks" from the vodka.

I met with Clarence on April 22 via Google Meet video set up. Clarence is being housed at the Browning Unit at the DOC in Florence. I introduced myself and went over the reason for my visit. Clarence was immediately amenable and cooperative. He stated that he had been in "the DOC for 36 years "and added that he was "on death row" and he was going to be executed "in 11 days."

Even though his psychosocial history is well documented, to help establish a good rapport I obtained a summary of his background information. Clarence reported that he was from Fort Defiance in Arizona. He stated that this was approximately 100 miles from the four corners area. He reported that he has two sisters

and three brothers and acknowledged that he wasn't close to any of them and had lost contact. It's been documented in prior evaluations that Clarence never really felt connected to anyone. He went on to describe himself as a loner. He reiterated that which has been documented in terms of not having any friends. He did mention having had a friend in the sixth grade and that the relationship lasted several years, but admits that this relationship also ended decades ago. With regards to his education, he said that he was an average student in high school and that he was "one semester away from a bachelor's degree in fine arts".

With regards to employment, he stated that he worked approximately a total of "four or five years" and that he was an auto mechanic. He added that he worked two years in the reservation and "two years off [the reservation]". He stated that he enjoyed working.

He was married at one time and was with his wife for about two years and denied having children. Documents indicate that he had a very troublesome marriage and she divorced him when incarcerated.

Clarence reported not having had any dealings with behavioral health services growing up. However, documents indicate that he reportedly suffered considerable depression as a youngster. In addition, he describes himself as being avoidant, very shy and reticent in his interpersonal dealings. There's also reports of Clarence having been cruel to animals and having molested his sister. The latter is something he subsequently denied. At any rate, he recalls that he first dealt with behavioral health professionals in 1977 when he was referred to "two psychiatrists" for competency evaluation. The latter was in connection to having " attacked a girl with a pipe". Client stated that he did not know his diagnosis but knew that the mental health professionals stated that he had "deep psychological problems". He does not recall ever having been offered medication and he reports that he never took psychotropic medication. There is a psychological report dated 1981 suggesting that Clarence could benefit from medication, a strong tranquilizer like Haldol. Clarence stated that back then he was "passive, stupid and weak" and that he knew "something was wrong [with him]".

Medically, documents indicate that he's had a number of maladies in the past, including cardiac difficulties when he was much younger. However, Clarence basically identified the issue of his vision and a persistent cough as salient. He expressed a lot of frustration with the DOC because he has requested cough drops and they have not listened to his concern about his persistent cough that requires frequent use of cough drops as treatment. He expressed resentment at the DOC staff for thinking they know better than he does about the coughing. He also complained of the fact that he is now legally blind after undergoing "four useless operations". He angrily remarked "I can't get shit out of the health unit".

FINDINGS

Clarence was alert and oriented across all spheres. He was capable of providing all of his personal identifying information without hesitation. This includes his height at 5'8" tall and his weight of 145 pounds. He stated that lately he's been losing weight. He attributes this to the normal processing of aging. Clarence presents as an older looking and somewhat frail Native American male [Navajo]. He did not appear to be in any physical distress and offered no complaints of a medical nature other than the persistent cough that requires he be given cough drops. He never coughed during our 70-minute session. He is legally blind, and he ambulates with a cane. I observed how he came in the room and folded the cane as he sat in the chair maintaining very good posture. Hygiene and grooming appeared to be within normal limits. He then described the seriousness of his visual difficulties. He advised me that he wasn't able to really detail what I looked like. He stated that with short distances, say a couple of feet, he could make out his hands, fingers and colors but that is difficult for him to watch TV.

Clarence was very easy to engage. He was immediately cordial and personable. It's evident that his cognitive and memory functioning are intact. He's capable of expressing himself very well. He's likely to be above average intellect. His affect was mildly blunted but generally appropriate. He described his mood as "depressed". He then added "wouldn't you be depressed (if you were being put to death in a few days)"? He describes having a reactive depression, an adjustment disorder with depressed mood.

With regards to his sleep, he stated that he was "sleeping a lot". He describes hypersomnia. In addition, he stated that he doesn't have much of an appetite. He also has no interest sexually. Clarence denied suicidal ideation. With regards to homicidal ideation or wanting to hurt others, he stated that the only person he would want to hurt badly would be "Donald Trump". Clarence mentioned to this writer that he does follow politics. It's interesting to note that when I asked him about President Biden, he initially blurted out "incompetent". He then modified his response and stated that with regards to President Biden, he would describe him as "a lackluster leader". When I asked about auditory hallucinations, Clarence stated that there are times when he hears his name being called. He described how he heard his name emanating from the side of his head or behind him. He went on to report that he understood that this auditory hallucination was "in [his] head". With regards to visual hallucinations, he stated that sometimes he sees "white squares" and it's annoying because they get in the way of the little vision that he does have when he's watching television. He then revealed that the most frustrating visual hallucination he has pertains to seeing "a little white boy dancing with red and white striped shirt on." He added that this really "pisses [him] off". He explained that he doesn't understand why it has to be a "white boy" that he sees. He would prefer seeing "an Indian boy since I am a Navajo". The hallucinatory experiences he describes appear to be more neurologically than psychiatrically relevant. He responds to the hallucinations with annoyance rather than incorporate them into any kind of a delusional system. He denies ever having had command hallucinations or mood related hallucinations. Interestingly, Clarence himself commented that his hallucinatory experiences may be due to him having "a tumor".

With regards to psychoactive substances, Clarence acknowledges that there was a time back in the late 70's that he had frequent blackouts "about once every two or three weeks" from vodka. He describes having an alcohol dependence. After his incarceration, he learned how to make "hooch" and, years ago, one of the inmates told him that making hooch could be very dangerous and since then he hasn't had any issues regarding the use of psychoactive substances. Notwithstanding, when discussing the issue of the murder conviction Clarence essentially describes having been in an alcoholic blackout because he could not remember what had happened that night.

When it comes to social support system, Clarence reported that he did have a couple of female pen pals. However, he stated that he can't find his address book and he has not been able to keep in touch with these individuals. In addition, he stated that he does have a "spiritual leader" who has been visiting with him since 1986. He stated that his name was Len Foster. It's interesting to know that Clarence initially became rather accusatory of the DOC staff regarding his address book. He began to rant about the fact that the staff had taken his address book and was ascribing malevolent intentions. This went on for a couple of minutes and then Clarence switched gears and stated that perhaps he had misplaced his address book. He remarked needing to do a more thorough search for his address book. This disclosure about the address book is quite revealing when it comes to a Clarence. It shows his tendency to externalize blame to the point that it borders on paranoia but then he recovers. If Clarence's proclivity was to become delusional when suspecting he's been harmed, then one would have expected Clarence to develop and hold on to a position that staff were actively persecuting and tormenting him. He would have contended how this was further evidence of DOC staff targeting him and colluding against him. However, that was not the case at all. Had

he been prone to delusions (as a supposed paranoid schizophrenic) he would've never shifted gears and acknowledge the possibility that perhaps he misplaced the address book.

COMPETENCY INQUIRY

With regards to the incident in 1977 where Clarence "… attacked a girl with a pipe…", Clarence described how he was walking down that side walk and hit her. Asked if the girl reminded him of anyone and he said "no" but he did intimate that there were things going on with him when he assaulted her. I asked him, why did you hit her and essentially he responded that he hit her "because she was there" Asked what he did after he hit her and if he felt bad about hitting her and he said that after he hit her he ran and that he did feel bad about hitting her " … but mostly, I did not want to get caught".

Regarding the DNA and the murder conviction, legally Clarence reiterated that which has been well documented. He assured me it was an illegal conviction and that his DNA was collected by the NAU police and they did not have jurisdiction etc. I focused my inquiry on assessing what transpired and whether he was involved. Clarence initially stated he didn't know the victim but eventually acknowledged that he must have been with her on that fateful night. He stated that he did " not know anything about what went on…I have an idea where it happened…but [only know] what I read in the police report". Were you drunk? "Probably, I was a big drinker at the time…" At that point I tactfully confronted him and suggested that if he had had a blackout as he intimated, that he could have killed her and not remember. Clarence immediately remarked "No, no no [regarding murder], I know I had sex with her ". Later he denied having said that he knew he had sex with her. He explained that he didn't remember having sex with her but stated knowing he had sex with her because " my DNA was there" and "…I'm not denying the evidence" In other words, he'll readily accept that he had sex with her even though he does not remember but he does not believe he killed her. Parenthetically, Clarence also made mention that police had DNA from another individual in that case that was ignored and proceeded to engage in the proverbial blaming of the victim as he detailed how the victim was someone who was known to have numerous sexual partners implying others may have had motive. He felt that focusing on him alone was not fair. Despite his lengthy description of the victim's sexual partners, Clarence insisted that he didn't "remember that girl". He went on to explain that had he killed her on purpose then maybe he deserved the death penalty, adding "… but if I was in another state, they wouldn't be killing me…" He then reported being unfortunate because he is here in Arizona and everyone "says we gotta kill him". He indicated knowing " whether [he] did it or not [it] isn't going to change a damn thing. [He] can't bring that girl back… If [he] could [he] would.". Lastly, when Clarence was asked, hypothetically, how he would feel if he were to suddenly have a memory of having killed her and he replied that if he were to recall having murdered that girl, he would have a sense of relief on his way to his execution.

CONCLUSION & RECOMMENDATIONS

After reviewing all the documentation and considering the results of this evaluation, it is evident to this writer that Clarence is primarily suffering from an antisocial personality disorder with salient paranoid and narcissistic personality characteristics. There are a number of references made to Clarence suffering from schizophrenia. However, throughout his imprisonment that spans over 3 decades, he was never treated for a psychotic disorder. At one time when he was younger, he is described as having suffered severe depression. In the past he may have at times experienced episodes of psychosis. However, there is no evidence that Clarence is experiencing active symptoms of schizophrenia at this time. He reports hallucinations that appear to be more neurologically, than psychiatrically relevant. The notion that he is delusional, because of his insistence on errantly applying inapplicable case law to have his murder conviction overturned, is unfounded. There is no doubt that he is deluding himself legally, but this is likely the function of the kind of cognitive distortions that are part and parcel of personality disordered

individual. Clarence wrote numerous motions attempting to suppress the DNA evidence that linked him to the 1978 murder on the basis that the NAU police were not a legal entity when he was arrested in 1985. Clarence, according to documents reviewed misconstrued "the holding in Goode…[that] does not depend on the 1985 amendments. Instead, Goode holds that the board has implicit authority under ARS 15–1626 [A] [2]." Clarence unsuccessfully re-litigated the issue all the way through the Arizona judicial system. The issue however was not deemed "viable" and the Supreme Court denied review. Clarence narcissistically continues to be convinced that his argument is valid and the Courts are mistaken. This is not delusional thinking. The definition of delusional implies an outrageous false belief. In this type of case, a delusional legal defense would sound something like this. *" John Doe maintaining that Intergalactic Law and Statutes supersede and takes precedence over State, National and International law with Jesus Christ as the ultimate judge"*. As a result, there is no evidence that Clarence's mental state is so distorted, or his concept of reality so impaired, that he lacks a rational understanding of the State's rationale for his execution. As can be seen in the Competency Inquiry section above, Clarence is so well aware of the State's rationale for his execution that he wishes he resided in a different State, one that did not have the death penalty. He made it clear that he does not want to die and believes that there is nothing to be gained by his execution. He even goes as far as to say that if he could bring the victim back to life, he would. He made it clear that he was "going to fight [his execution] until the end". He has deluded himself into believing that he found case law, that supports his position. He admits that he has worked feverishly for years to write numerous motions and describes his motions as having been sufficiently tenable to have been litigated through Arizona's entire judicial system and turned away at the doorstep of the Supreme Court. Furthermore, Clarence insists that he has no memory of the murder, and this additionally motivates him to fight against being put to death. The notion that he has no memory of the incident surrounding the death of the victim appears to be true since Clarence revealed to this writer that if he were to suddenly remember having killed the victim, he would have a sense of relief at his execution.

Furthermore, Clarence is not suffering from any mental disease or defect, that results in making him unaware that he is to be punished for the crime of murder or unaware that the impending punishment for that crime is death. He is suffering from personality disorder, and this is responsible for his deluded notion that the government has refused to agree with his legal argument, not because his argument is not sound but rather the government is afraid of the consequences of admitting they are wrong. Clarence is well aware of his impending punishment and reported that this is responsible for his current level of depression. He has a moderate adjustment disorder with depressed mood, a reactive depression. He insists that aside from what he considers the illegality of his execution, he finds it is immoral. He wishes he were in another State [sans the death penalty]. He claims that if someone murders another individual in the State of Arizona, that individual can be put to death yet when the US government launches a drone bomb strike to kill a terrorist and ends up killing innocent women and children as well, somehow that's not considered immoral or punishable by law.

Thank you very much for allowing me to consult with you in this matter. If I can be of any further assistance to you in the future, please don't hesitate to contact me.

Respectfully submitted,

_____
Carlos J. Vega, Psy.D.
Psychologist

1

APRIL 30, 2022

CASE NO. 22-135, 22-136, 22-137, 22-138, 22-139

DEAR EXECUTIVE DIRECTOR ELLIOTT:

YOUR APRIL 26 LETTER ARRIVED YESTERDAY.

IN ALL FIVE CASES YOU REMARK THAT THE COMMISSION ON JUDICIAL CONDUCT CANNOT REVIEW THE EVIDENCE IN A CASE OR DETERMINE IF A JUDICIAL OFFICER RULED PROPERLY.

THIS IS CONTRARY TO THE COMMISSION'S EXISTENCE.

HOW DOES THE COMMISSION ON JUDICIAL CONDUCT DETERMINE IF A JUDICIAL OFFICER HAS MADE A FAIR AND IMPARTIAL JUDGMENT IN A CASE AS DESCRIBED IN CANON TWO?

WHO DETERMINES OR HOW MANY MEMBERS DETERMINE IN A CASE WHAT IS FAIR AND IMPARTIAL? WHY IS IMPARTIAL.

AND FAIR' AKIN TO CODIFIED N CANON TWO? HOW DOES 'RULED PROPERLY' INTERACT JUDICIOUSLY WITH 'IMPARTIAL AND FAIR'?

ALTHOUGH MY AND MS LEGAL TEAM'S EFFORTS TO STOP MY EXECUTION MAY BE IN VAIN THE DELIBERATE MIS APPLICATION AND IGNORING OF ARIZONA STATUTES AND THE LAW, SPECIFICALLY A.R.S. 13-1627 (F.6)(FIST), WILL RESULT IN AN EXTRA-JUDICIAL KILLING THAT WOULD MERIT DISBARMENT ON THOSE WHO ARE UNCONCERNED WITH THEIR UNPROFESSIONAL REASON FOR BEING EVER AFTER THE TWELFTH HOUR.

BY THE WAY, I WILL NOT PAY THE FERRYMAN UNTIL I AM ACROSS THE OTHER SIDE.

SINCERELY,

Clarence W. Dixon, 037977

DECLARATION

I, Erin Morrissey, declare:

1. I am the duly authorized custodian of medical records at Arizona Department of Corrections Rehabilitation & Reentry, and have authority to certify the authenticity of these records.

2. I have caused a diligent search to be conducted under my supervision, and the attached 56 pages are true copies of the Arizona Department of Corrections Rehabilitation & Reentry Medical Records described in the request for the records of Dixon, Clarence, ADCRR #38977, for the time period of 04/22/2022 to 04/25/2022.

3. Based upon my best information and belief, the attached medical records were compiled by the personnel of the Arizona Department of Corrections Rehabilitation & Reentry Health Unit, medical staff, nurses, physicians, or persons acting under their control, in the ordinary course of Health Unit business at or near the time of the events described in the records.

4. In the event any records contained within the attached documents were generated by entities other than the Arizona Department of Corrections Rehabilitation & Reentry, the above-noted custodian of records cannot avow to the accuracy or completeness of records.

5. I declare under penalty of perjury that the foregoing is true and correct.

Dated: 04/25/2022

Erin Morrissey
Medical Records Monitor

CHSS001 - Patient Record Synopsis

Name: DIXON, CLARENCE W. ADC#: 038977

Patient Description

ADC#:	038977	Inmate Name:	DIXON, CLARENCE W.	SSN:			
Race/Sex:	NA Indian Male	DOB:	08/26/1955	Age:	66	Status:	Active
Location:	ASPC-E BROWNING D/RW	Bed:	WG3G 019B	Custody:	Close		
Medical Grade:	4						
Admission Date:	01/08/1986	Job Assignment:	Unassigned	Earliest Release:			

Current Health Problem/Conditions (1 - 21 of 21)

ID#	Category	Type	National HIE Code(s)	Diagnosis Code	Reaction	Severity	Onset Date	Last Encounter Date
032	Other Diagnosis	Other Diagnosis	SNOMED: 25064002 - Headache (finding)	Headache [R51]			04/12/2022	04/12/2022
031	Other Diagnosis	Other Diagnosis	SNOMED: 60826002 - Coccidioidomycosis (disorder)	Coccidioidomycosis, unspecified [B38.9]			07/22/2021	07/22/2021
030	Mental Health	Mental Health	SNOMED: 48694002 - Anxiety (finding)	Anxiety disorder, unspecified [F41.9]			07/21/2021	07/21/2021
029	Chronic Conditions	Heart Murmur, Rheumatic, etc	SNOMED: 414786004 - Murmur (finding)	Cardiac murmur, unspecified [R01.1]			10/08/2020	02/10/2022
028	Other Diagnosis	Other Diagnosis	SNOMED: 399029005 - Tinea cruris (disorder)	Tinea cruris [B35.6]			04/25/2020	04/25/2020
027	Other Diagnosis	Other Diagnosis	SNOMED: 309529002 - Lung mass (finding)	Other nonspecific abnormal finding of lung field [R91.8]			03/31/2020	03/31/2020
026	Other Diagnosis	Other Diagnosis	SNOMED: 235595009 - Gastroesophageal reflux disease (disorder)	Gastro-esophageal reflux disease without esophagitis [K21.9]			03/17/2020	03/17/2020
025	Other Diagnosis	Pt. Specific Chronic Condition	SNOMED: 61582004 - Allergic rhinitis (disorder)	Other seasonal allergic rhinitis [J30.2]			03/17/2020	03/17/2020
023	Other Diagnosis	Other Diagnosis	SNOMED: 23986001 - Glaucoma (disorder)	Chronic angle-closure glaucoma, bilateral, severe stage [H40.2233]			06/22/2018	06/22/2018
022	Other Diagnosis	Other Diagnosis	SNOMED: 92070006 - 92070006	Benign neoplasm of unspecified cornea [D31.10]			03/09/2017	03/09/2017
021	Other Diagnosis	Other Diagnosis	SNOMED: 69397000 - Angular blepharoconjunctivitis (disorder)	Angular blepharoconjunctivitis, unspecified eye [H10.529]			12/31/2015	12/31/2015
018	Other Diagnosis	Other Diagnosis		Enlarged prostate without lower urinary tract symptoms [N40.0]			10/01/2015	02/10/2015
014	Functional Limitations	Legally Blind		Legal blindness-usa def [369.4]			02/17/2015	02/17/2015
013	Other Diagnosis	Other Diagnosis		Dermatitis NEC [692.89]			02/17/2015	02/17/2015
012	Other Diagnosis	Other Diagnosis		BPH loc w/o ur obs/LUTS [600.20]			02/10/2015	02/10/2015
010	Allergies - Medication	NKDA (No Known Drug Allergies)					12/03/2014	12/03/2014
008	Other Diagnosis	Other Diagnosis		Heart valve replac NEC [V43.3]			12/03/2014	12/03/2014
007	Other Diagnosis	Other Diagnosis		Glaucoma NOS [365.9]			12/03/2014	12/03/2014
005	Other Diagnosis	Other Diagnosis		Prostatitis NOS [601.9]			12/03/2014	12/03/2014
004	Other Diagnosis	Other Diagnosis		Bladder neoplasm NOS [239.4]			12/03/2014	12/03/2014
001	Chronic Conditions	Heart Murmur, Rheumatic, etc					08/15/2014	08/15/2014

ICD-9/ICD-10 (1 - 57 of 57)

Date	Encounter Type	Staff	ICD	Diagnosis
04/12/2022	Provider - Review	Olmstead, Pamela	R51	Headache
07/22/2021	Provider - Review	Fullmer, Samantha	B38.9	Coccidioidomycosis, unspecified
10/08/2020	Provider - Chronic Care	Kary, Sharon	R01.1	Cardiac murmur, unspecified
04/25/2020	Provider - Chronic Care	Weigel, Natalya	B35.6	Tinea cruris
03/31/2020	Provider - Follow Up Care	Hahn, Betty	R91.8	Other nonspecific abnormal finding of lung field
03/17/2020	Provider - Sick Call - Scheduled	Hahn, Betty	J30.2	Other seasonal allergic rhinitis
03/17/2020	Provider - Sick Call - Scheduled	Hahn, Betty	K21.9	Gastro-esophageal reflux disease without esophagitis
10/30/2019	Provider - Sick Call - Scheduled	Powell, Marianne	R05	Cough
06/22/2018	Provider - Follow Up Care	Penn, Mark	H40.2233	Chronic angle-closure glaucoma, bilateral, severe stage
03/13/2017	Provider - Review	Gay, Maureen	H40.9	Unspecified glaucoma
03/09/2017	Provider - Sick Call - Scheduled	Gay, Maureen	D31.10	Benign neoplasm of unspecified cornea
03/16/2016	Provider - Medication Renewal	Bainbridge, Julie	365.9	Glaucoma NOS
03/16/2016	Provider - Medication Renewal	Bainbridge, Julie	H40.9	Unspecified glaucoma
12/31/2015	Provider - Review	Salyer, Nick C	H10.529	Angular blepharoconjunctivitis, unspecified eye
12/11/2015	Provider - Chronic Care	Wilkinson, Xuong	L03.211	Cellulitis of face
09/25/2015	Provider - Medication Renewal	Ruehrup, Jens	365.9	Glaucoma NOS
09/25/2015	Provider - Medication Renewal	Ruehrup, Jens	H40.9	Unspecified glaucoma

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Date	Encounter Type	Staff	ICD	Diagnosis
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	239.4	Bladder neoplasm NOS
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	365.9	Glaucoma NOS
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	369.60	Blindness, one eye
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	595.89	Cystitis NEC
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	599.72	Microscopic hematuria
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	601.9	Prostatitis NOS
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	H40.9	Unspecified glaucoma
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	N41.9	Inflammatory disease of prostate, unspecified
08/17/2015	Provider - Medication Renewal	Salyer, Nick C	V43.3	Heart valve replac NEC
06/01/2015	Provider - Medication Renewal	Jeffrey, Julie R	365.9	Glaucoma NOS
06/01/2015	Provider - Medication Renewal	Jeffrey, Julie R	H40.9	Unspecified glaucoma
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	239.4	Bladder neoplasm NOS
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	365.9	Glaucoma NOS
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	369.60	Blindness, one eye
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	595.89	Cystitis NEC
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	599.72	Microscopic hematuria
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	601.9	Prostatitis NOS
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	H40.9	Unspecified glaucoma
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	N41.9	Inflammatory disease of prostate, unspecified
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	V43.3	Heart valve replac NEC
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	365.9	Glaucoma NOS
05/06/2015	Provider - Medication Renewal	Salyer, Nick C	H40.9	Unspecified glaucoma
02/17/2015	Provider - Sick Call - Unscheduled	Salyer, Nick C	369.4	Legal blindness-usa def
02/17/2015	Provider - Sick Call - Unscheduled	Salyer, Nick C	692.89	Dermatitis NEC
02/17/2015	Provider - Sick Call - Unscheduled	Salyer, Nick C	L25.8	Unspecified contact dermatitis due to other agents
02/10/2015	Provider - Review	Salyer, Nick C	222.2	Benign neoplasm prostate
02/10/2015	Provider - Review	Salyer, Nick C	600.20	BPH loc w/o ur obs/LUTS
02/10/2015	Provider - Review	Salyer, Nick C	D29.1	Benign neoplasm of prostate
02/10/2015	Provider - Review	Salyer, Nick C	N40.0	Enlarged prostate without lower urinary tract symptoms
12/23/2014	Provider - Review	Salyer, Nick C	365.9	Glaucoma NOS
12/23/2014	Provider - Review	Salyer, Nick C	H40.9	Unspecified glaucoma
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	239.4	Bladder neoplasm NOS
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	365.9	Glaucoma NOS
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	369.60	Blindness, one eye
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	595.89	Cystitis NEC
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	599.72	Microscopic hematuria
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	601.9	Prostatitis NOS
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	H40.9	Unspecified glaucoma
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	N41.9	Inflammatory disease of prostate, unspecified
12/03/2014	Provider - Sick Call - Scheduled	Salyer, Nick C	V43.3	Heart valve replac NEC

DSM-IV/DSM-V/ ICD-9/ICD-10 (1 - 1 of 1)

Date	Encounter Type	Staff	Axis	Diagnosis
07/21/2021	MH - Initial Psychiatric Evaluation	Joseph, Adlene, NP		Anxiety disorder, unspecified [F41.9]

Current Drug Prescriptions (1 - 17 of 17)

Issued	Drug Classification	Dosage	Frequency	Status	Expiration Date
04/12/2022	Acetaminophen Tab (Tylenol)/325MG	2 TABS	BID	Received from Pharmacy	06/10/2022
04/07/2022	Aspirin Chw (Bayer Childrens Aspirin)/81MG	1 tab	QD	Received from Pharmacy	07/06/2022
04/06/2022	Atropine Sul Sol (Isopto Atropine)/1% OP	1gtt	BID	Received from Pharmacy	10/02/2022
04/06/2022	Prednisolone Acetate Suso (Pred Forte)/1% OP	1gtt	TID	Received from Pharmacy	06/04/2022
04/06/2022	Cosopt Pf U/D Sol (Dorzolamide Hcl/Timolol Mal)	1 gtt	BID	Received from Pharmacy	07/04/2022
04/06/2022	Latanoprost Sol (Xalatan)/0.005%	1gtt	QHS	Received from Pharmacy	10/02/2022
04/06/2022	Terazosin Hcl Cap (Hytrin)/2MG	1 CAP	QPM	Received from Pharmacy	10/02/2022
04/06/2022	Acetazolamide Tab (Diamox)/250MG	2 TABS	BID	Received from Pharmacy	07/04/2022
04/07/2022	Aspir-Low Tab (Bayer Low Strength)/81MG EC	1 tab	QD	Discontinued - Other	08/04/2022
03/18/2022	Acetazolamide Tab (Diamox)/250MG	2	BID	Discontinued - Other	05/16/2022
03/07/2022	Terazosin Hcl Cap (Hytrin)/2MG	1	QPM	Discontinued - Other	09/02/2022
03/07/2022	Latanoprost Sol (Xalatan)/0.005%	1gtt	QHS	Discontinued - Other	09/02/2022
02/22/2022	Cosopt Pf U/D Sol (Dorzolamide Hcl/Timolol Mal)	1 gtt	BID	Discontinued - Other	05/22/2022
02/21/2022	Prednisolone Acetate Suso (Pred Forte)/1% OP	1gtt	UAD	Discontinued - Other	04/25/2022
01/17/2022	Fluconazole Tab (Diflucan)/200MG	2 tabs	QD	Discontinued - Other	07/15/2022
12/27/2021	Atropine Sul Sol (Isopto Atropine)/1% OP	1gtt	BID	Discontinued - Other	06/24/2022
12/27/2021	Acetazolamide Tab (Diamox)/125MG	1	QID	Discontinued - Other	06/24/2022

Current OTC Medications

Type	Begin Date	End Date	Specify Comments
No Rows Found			

Provider Caseload

Assigned	Staff	Job Title
No Rows Found		

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Latest Encounters (1 - 4 of 4)

Category	Date	Type	Staff	Location
Medical Provider	04/13/2022	Provider - Follow Up Care	Olmstead, Pamela	ASPC-E BROWNING D/RW [A27]
Dental	04/06/2022	Dental - Chart Review	Jeffers, Emilee	ASPC-E BROWNING D/RW [A27]
Mental Health	04/24/2022	MH - Segregation Visit	THOMAS, FELICIA	ASPC-E BROWNING D/RW [A27]
Nursing	04/12/2022	Nurse - Sick Call - Scheduled	Wischhusen, Daphnie	ASPC-E BROWNING D/RW [A27]

Current Alerts

Generated Date	Type	Due Date	Generated By
No Rows Found			

Last Vital Signs

Order Date: 04/12/2022 Temperature: 97.6 Pulse: 77 Respiration: 18

BP: 120 / 78 Weight: 125 lb. Height: 5 ft. 8 in.

Corrected Vision: Right: 0 Left: 0 Both: 0

Current Treatment Orders

Category	Type	Approximate Begin Date	Approximate End Date	Status
No Rows Found				

Key Lab Test Results

Order Date	Specimen Date	Results Date	Type	Result	Value
No Rows Found					

Current Special Waivers/Diets (1 - 6 of 6)

Started	Type	Expires
04/12/2022	WASTING SYNDROME	04/12/2023
04/06/2022	RUBBER TIPPED CANE	06/30/2022
04/06/2022	LOWER BUNK	06/30/2022
04/06/2022	LOWER TIER	06/30/2022
03/07/2022	Diet - Non-Formulary	03/06/2023
01/14/2022	WASTING SYNDROME	01/14/2023

Pending Lab Tests

Ordered	Category	Type	Priority
No Rows Found			

Pending Appointments (1 - 5 of 5)

Scheduled	Type	Location	Staff
08/30/2022	Health Services	ASPC-F-CENTRAL D/RW	Generic, Practitioner
07/25/2022	Health Services	ASPC-F-CENTRAL D/RW	Generic, Practitioner
05/02/2022	Health Services	ASPC-E BROWNING D/RW	Generic, Practitioner
04/25/2022	Health Services	ASPC-E BROWNING D/RW	Generic, Clinic Nurse
02/01/2022	Health Services	ASPC-F-CENTRAL D/RW	Generic, Clinic Nurse

Current Transfer Holds (1 - 6 of 6)

Placed	Type	Expires
12/01/2021	Medical Hold	05/31/2022
11/23/2021	Medical Hold	02/22/2022
01/24/2020	Medical Hold	01/31/2022
09/21/2017	Medical Hold	09/21/2018
01/11/2016	Medical Hold	07/31/2016
08/02/2010	Medical Hold	10/02/2010

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CHSS041A - Health Problems/Conditions

Name: DIXON, CLARENCE W. ADC#: 038977

Show Active Problems/Conditions Only: ☐

Health Problems/Conditions (1 - 21 of 21)

ID Number	Category	Type	Diagnosis Code	National HIE Code(s)	Status	Status Date
001	Chronic Conditions	Heart Murmur, Rheumatic, etc			Assessed	08/15/2014
004	Other Diagnosis	Other Diagnosis	Bladder neoplasm NOS [239.4]		Assessed	12/03/2014
005	Other Diagnosis	Other Diagnosis	Prostatitis NOS [601.9]		Converted to ICD10	09/30/2015
007	Other Diagnosis	Other Diagnosis	Glaucoma NOS [365.9]		Converted to ICD10	09/30/2015
008	Other Diagnosis	Other Diagnosis	Heart valve replac NEC [V43.3]		Assessed	12/03/2014
010	Allergies - Medication	NKDA (No Known Drug Allergies)			Assessed	12/03/2014
012	Other Diagnosis	Other Diagnosis	BPH loc w/o ur obs/LUTS [600.20]		Converted to ICD10	09/30/2015
013	Other Diagnosis	Other Diagnosis	Dermatitis NEC [692.89]		Converted to ICD10	09/30/2015
014	Functional Limitations	Legally Blind	Legal blindness-usa def [369.4]		Assessed	02/17/2015
018	Other Diagnosis	Other Diagnosis	Enlarged prostate without lower urinary tract symptoms [N40.0]		Assessed	10/01/2015
021	Other Diagnosis	Other Diagnosis	Angular blepharoconjunctivitis, unspecified eye [H10.529]	SNOMED: 69397000 - Angular blepharoconjunctivitis (disorder)	Assessed	12/31/2015
022	Other Diagnosis	Other Diagnosis	Benign neoplasm of unspecified cornea [D31.10]	SNOMED: 92070006 - 92070006	Assessed	03/09/2017
023	Other Diagnosis	Other Diagnosis	Chronic angle-closure glaucoma, bilateral, severe stage [H40.2233]	SNOMED: 23986001 - Glaucoma (disorder)	Assessed	06/22/2018
025	Other Diagnosis	Pt. Specific Chronic Condition	Other seasonal allergic rhinitis [J30.2]	SNOMED: 61582004 - Allergic rhinitis (disorder)	Assessed	03/17/2020
026	Other Diagnosis	Other Diagnosis	Gastro-esophageal reflux disease without esophagitis [K21.9]	SNOMED: 235595009 - Gastroesophageal reflux disease (disorder)	Assessed	03/17/2020
027	Other Diagnosis	Other Diagnosis	Other nonspecific abnormal finding of lung field [R91.8]	SNOMED: 309529002 - Lung mass (finding)	Assessed	03/31/2020
028	Other Diagnosis	Other Diagnosis	Tinea cruris [B35.6]	SNOMED: 399029005 - Tinea cruris (disorder)	Assessed	04/25/2020
029	Chronic Conditions	Heart Murmur, Rheumatic, etc	Cardiac murmur, unspecified [R01.1]	SNOMED: 414786004 - Murmur (finding)	Assessed	10/08/2020
030	Mental Health	Mental Health	Anxiety disorder, unspecified [F41.9]	SNOMED: 48694002 - Anxiety (finding)	Assessed	07/21/2021
031	Other Diagnosis	Other Diagnosis	Coccidioidomycosis, unspecified [B38.9]	SNOMED: 60826002 - Coccidioidomycosis (disorder)	Assessed	07/22/2021
032	Other Diagnosis	Other Diagnosis	Headache [R51]	SNOMED: 25064002 - Headache (finding)	Assessed	04/12/2022

ARIZONA STATE HOSPITAL
PSYCHOLOGICAL REPORT

NAME			HOSP. NO.
DIXON, Clarence E.	K-2	Moderate Sec.	02-13-10

PSYCHOLOGIST
David L. White, Ed.D.

DATE
October 6, 1977

REASON FOR REFERRAL
Diagnostic Interview

TESTS ADMINISTERED

RESULTS

Clarence was interviewed on October 6, 1977. He demonstrates a generally neurotic adjustment with moderate depression being present. He has inflicted injury upon himself only one time in the past, this being when he held a lighted cigarette to the palm of his hand. He reports no suicidal gestures, denies suicidal ideation, but states that he thinks of various ways in which he might be accidentally killed.

On the day he assaulted the girl, he had a fight with his wife and was involved in three different shoving matches with three different men. Marital discord is long-standing. After the assault occurred, Clarence went and sat in his car to wait for the arrival of the police.

Much of this man's poor emotional condition is apparently due to a poor marital situation which he has perceived as being without solution. His guilt and depression are sufficient to cause fantasies about dying, but he does not appear to be the kind of person who will ever die directly by his own hand. He could manage to die "accidentally" or be killed by someone else if his problems are not significantly reduced.

It appears that his depression may have been of psychotic or near-psychotic proportions when he was examined by Dr. Tuchler and Dr. Bendheim in August of 1977.

Diagnosis: Depressive neurosis (300.4)

Recommendations: 1. Individual and marital counseling
2. Anti-depressant medication at a later date if needed

David L. White - Ed.D.
DAVID L. WHITE, Ed.D.

000645

DLW:lc
10/7/77

LOC GRID: 4A14 | BEAT #: | DAY OF WEEK OFFENSE OCCURRED: SUNDAY | 3 HOUR OF DAY OFFENSE OCCURRED (24 HOUR TIME): 0040HRS

18 ACTUAL CASH LOSS TO VICTIM — CURRENCY NOTES ETC $ ____ (TO NEAREST DOLLAR)
JEWELRY & PRECIOUS METALS $ ____
FURS $ ____
CLOTHING $ ____
MISCELLANEOUS $ ____
(ITEMIZE PROPERTY BELOW)

48 NAME OF BANK OR CREDIT CARD | BRANCH OR CITY
49 PAY TO THE ORDER OF | AMOUNT OF CHECK
50 FIRM NAME ON CHECK | CHECK SERIAL #
50A ACCOUNT # | NAME OF MAKER
51 NAME OF PERSON WHO ACCEPTED CK OR DRAFT | CAN THEY IDENTIFY: YES NO
52 NUMBER OF CHECKS | TOTAL AMOUNT $
53 REASON NOT HONORED | DATE WRITTEN
IDENTIFICATION USED

VICTIM
4 LAST FIRST MIDDLE NAME (FIRM NAME IF BUS.): GUERRA, CHRISTY KAY
5 I.R.#: 77-06700
6 ORIGIN | SEX: F | DOB: 6-27-61 | SOC SEC #
7 TYPE OF REPORT: AW D.W.
8 RES (BUS ADD IF FIRM): 1026 E. SPENCE #305, TEMPE | PHONE #: NO PHONE
9 DATE & TIME OF THIS REPORT: 6-5-77 0300HRS
10 EMPLOYER: JACK-N-BOX WEBER & SCOTTSDALE, TEMPE | ADDRESS | PHONE #
23 WHO CAN SIGN COMPLAINT FOR CO | ADDRESS | PHONE #
24 WHO OWNS PROPERTY? | ADDRESS | PHONE #
25 IF DEATH NAME OF NEXT OF KIN | ADDRESS | PHONE #
26 DOCTOR WHO TREATED VICTIM: DR. GARY GROVE 1500 S. MILL, TEMPE | BUS ADDRESS | PHONE #: 968-9411

LOC
11 ADDRESS OF OCCURRENCE: 1026 E. SPENCE, TEMPE
5 I.R.#: 77-06700
12 DATE & TIME OCCURRED: 6-5-77 0040HRS
5 TYPE OF REPORT: AW D.W.

SUSPECT
13 LAST FIRST MIDDLE: DIXON, CLARENCE WAYNE | (SEC INVESTIGATIVE LEADS) | SOC SEC #: 585-84-7186
14 ORIGIN | SEX | DOB (APPROX) | HEIGHT | WEIGHT | HAIR | EYES | COMPLEXION: I | M | 8-26-55 | 5'7½" | 115 | BLK | BRN
15 ADDRESS: 950 S. TERRACE #0-174, TEMPE | ADDRESS | 16 ARREST #: 54215 | BUS PHONE #
17 EMPLOYER: UNEMPLOYED

22 IF VEHICLE INVOLVED: YEAR 64 | MAKE CHEV | BODY TYPE 4 DR | COLOR TAN | LIC # TSG-920 | STATE AZ | IDENTIFYING MARKS
VICTIM'S / SUSPECT'S: [X] | CAR LOCATED: YES [X] NO
45 WITNESS NAME | ADDRESS | PHONE | EMPLOYER | ADDRESS | PHONE

17 WITNESS OR INVESTIGATIVE LEADS. PERSONS WHO MAY HAVE COMMITTED OR HAVE KNOWLEDGE OF OFFENSE
NAME | ADDRESS | PHONE # | EMPLOYER | ADDRESS | PHONE #

M-1 OFFICER D. CLINE #98, TEMPE P.D.
M-2 DR GARY GROVE, TEMPE COMMUNITY HOSPITAL 1500 S. MILL, TEMPE
968-9411

ON 6-5-77 AT 0045 HRS CLARENCE WAYNE DIXON WAS ARRESTED FOR ASSAULT WITH A DEADLY WEAPON AFTER STRIKING CHRISTY KAY GUERRA WITH A 12" x 1" CAST IRON PIPE CAUSING A SEVERE CUT ON TOP OF MISS GUERRA'S HEAD. WHILE AT 1026 E. SPENCE, TEMPE.

DIXON
000893

21 DID VICTIM RECEIVE A VICTIM'S INFORMATION REPORT? YES [X] NO [ ]
22 OFFICER WRITING REPORT'S #: P. Cline #47 | BEAT #: 4A15 | DATE & TIME TYPED: 7/6/77 | DIVN | CLERK'S #
5 I.R. #: 77-06700
MISCELLANEOUS COMPLAINT

	TYPE OF REPORT	LOC-GRID	BEAT #	IR #
	AWOW		HAIH	77-06700

ON 6-5-77 AT 0041HRS I WAS DISPATCHED TO 1026 E. SPENCE REGARDING UNKNOWN TROUBLE. UPON MY ARRIVAL I CONTACTED CHRISTY GUERRA, VICTIM, WHO WAS SITTING IN THE REAR PARKING LOT OF THE APARTMENT COMPLEX, 1026 E SPENCE, WITH A SEVERE CUT ON TOP OF HER HEAD. MISS GUERRA RELATED THE FOLLOWING.

ON 6-5-77 AT 0036HRS SHE WAS WALKING EAST BOUND ON THE NORTH SIDE OF THE STREET AT 1026 E. SPENCE WHEN A MALE INDIAN WITH LONG BLACK HAIR IN A PONY TAIL APPROACHED HER FROM THE APARTMENT COMPLEX. THE SUBJECT LATER IDENTIFIED AS CLARENCE DIXON STATED "NICE EVENING ISN'T IT". THEN STRUCK HER ON TOP OF HER HEAD WITH AN UNKNOWN OBJECT CAUSING HER TO FALL TO THE GROUND. SHE THEN GOT UP SCREAMING WHICH CAUSED THE SUBJECT TO RUN TO THE REAR OF THE APARTMENT COMPLEX. MISS GUERRA FOLLOWED THE SUBJECT TO THE REAR OF THE COMPLEX AT WHICH TIME I ARRIVED.

I THEN WAS CONTACTED BY OFFICER D. CLINE #98 WHO HAD CLARENCE DIXON IN CUSTODY IN THE PARKING LOT AT THE REAR OF 1026 E. SPENCE. I ESCORTED MISS GUERRA TO OFFICER CLINES LOCATION WHERE SHE POSITIVELY IDENTIFIED CLARENCE DIXON AS THE SUBJECT WHO STRUCK HER ON THE HEAD.

CLARENCE DIXON WAS GIVEN HIS RIGHTS PER MIRANDA BY OFFICER CLINE AND TRANSPORTED TO THE TEMPE CITY JAIL. (SEE OFFICER CLINES SUPPLEMENT)

I THEN CONTACTED DR. GARY GROVE AT TEMPE COMMUNITY HOSPITAL AS TO THE CONDITION OF MISS GUERRA. HE STATED SHE SUFFERED A TWO INCH LACERATION TO THE TOP REAR SECTION OF HER SKULL. REQUIRING THREE SUTURES TO CLOSE THE WOUND.

000894

	LOC-GRID	BEAT #	IR #
PRIOR TO LEAVING TO SCENE I OBSERVED		HAIH	77-06700

CITY OF TEMPE, ARIZONA
POLICE DEPARTMENT

CONTINUATION SHEET

Date	Type Occurence	Page	Of	IR Number
6-5-77	AWOW	3	3	77-06700

LYING ON THE FRONT SEAT OF CLARENCE DIXONS VEHICLE WHICH WAS PARKED AT 1026 E. SPENCE, TEMPE, A 12" x 1" CAST IRON PIPE WITH A NUT SCREWED ON ONE END OF IT. THE NUT HAD SEVERAL CUTS CUT INTO IT. I SIZED THE PIPE AS EVIDENCE AND PLACED IT IN EVIDENCE LOCKER #13 TEMPE POLICE STATION. THERE WERE NO SIGNS OF PHYSICAL EVIDENCE ON THE PIPE.

I THEN CONTACTED CLARENCE DIXON AT THE TEMPE CITY JAIL WHERE I ADVISED HIM OF HIS RIGHTS PER MIRANDA AND ASKED HIM IF HE UNDERSTOOD THEM WHICH HE REPLIED YES. I THEN ASKED HIM IF HE WOULD ANSWER MY QUESTIONS AND HE STATED YES.

I ASKED CLARENCE DIXON IF HE WANTED TO TELL ME WHAT HAPPENED AT 1026 E. SPENCE. HE STATED THAT HE WALKED UP TO MISS GUERRA AND SAID SOMETHING TO HER THEN STRUCK HER OVER THE HEAD WITH THE PIPE. HE THEN RAN TO HIS VEHICLE WHICH WAS PARKED AT THE REAR OF 1026 E. SPENCE WHEN MISS GUERRA BEGAN TO SCREAM. AT THIS TIME HE THREW THE PIPE INTO HIS VEHICLE. I SHOWED CLARENCE DIXON THE PIPE I FOUND ON THE FRONT SEAT OF HIS VEHICLE AND ASKED HIM IF HE STRUCK MISS GUERRA WITH IT AND HE REPLIED YES.

CLARENCE DIXON WAS BOOKED INTO TEMPE CITY JAIL FOR ASSAULT WITH A DEADLY WEAPON.

D Crew #47

TPD—Form 2-80

SUPPLEMENTAL REPORT

1. LOC. GRID OF RECOVERY	3. DAY OF WEEK OF RECOVERY	4. HOUR OF DAY OF RECOVERY 0-23	BEAT OF RECOVERY

18. VALUE OF PROPERTY RECOVERED OR ADDITIONAL PROPERTY TAKEN	7. TYPE OF REPORT	9. DATE OF THIS SUPPLEMENT	5. IR #
PROPERTY RECOVERED [ ] ADDIT. PROP. TAKEN [ ]	AWDW	6-5-77	77-06700
	6. VICTIM'S NAME (FIRM NAME IF BUS.) GUERRA, CHRISTY K.	11. LOCATION OF OCCURRENCE 1026 E. SPENCE	

$ _____ CURRENCY, NOTES ETC. $ _____ CLOTHING

$ _____ JEWELRY, PRECIOUS METALS. $ _____ AUTOS

$ _____ FURS $ _____ MISC.

CLEARED BY ARREST OR EXCEPTIONALLY CLEARED [ ] OVER 18 YEAR OLD [ ] UNDER 18 YEAR OLD [ ]

PENDING [ ] UNFOUNDED [ ] PREVIOUS CLEARED BY ARREST OR EXCEPTION [ ]

ADDITIONAL SUSP: LAST, FIRST, MIDDLE | SOC. SEC. # | SEX | DOB (APPROX.) | RESIDENCE

AT 0095 ON 6.5.77 I ADVISED THE SUSPECT OF HIS RIGHTS PER MIRANDA TO WHICH HE STATED HE UNDERSTOOD. HE STATED HE DID NOT WISH TO ANSWER ANY QUESTIONS. THE INTERVIEW WAS TERMINATED.

I THEN TRANSPORTED THE SUSPECT TO TEMPE P.D. JAIL IN MY VEHICLE. ENROUTE HE ASKED "WHAT DO U GET FOR AGGRAVATED ASSAULT" I TOLD HIM I DID NOT KNOW. HE THEN STATED, "IT WAS A STUPID THING TO DO."

THE LISTED CONVERSATION WAS UNSOLICITED, AND AFTER ADVISEMENT OF RIGHTS.

000896

PAGE # 1 CONT'D ON PAGE #	OFFICER WRITING REPORT'S #	DATE & TIME TYPED	DIVN. CLERK	IR #
	CLINE 98			77-06700

CITY OF TEMPE, ARIZONA
POLICE DEPARTMENT

SUPPLEMENTARY

TPD Form 3 Rev. 1973

90

18. VALUE OF PROPERTY RECOVERED OR ADDITIONAL PROPERTY TAKEN	7. TYPE OF REPORT: A. W. D. W.	9. DATE OF THIS SUPPLEMENT: 6-5-77	5. I.R. #: 77-6700
	4. VICTIM'S NAME (FIRM NAME IF BUS.): C. Guerra	11. LOCATION OF OCCURRENCE: 1026 E. Spence	

PROPERTY RECOVERED ☐ ADDIT PROP. TAKEN ☐ OVER 18 YEAR OLD ☒ UNDER 18 YEAR OLD ☐

$______ CURRENCY, NOTES ETC. $______ CLOTHING CLEARED BY ARREST OR EXCEPTIONALLY CLEARED -

$______ JEWELRY, PRECIOUS METALS, $______ AUTOS UNFOUNDED ☐ PREVIOUSLY CLEARED BY ARREST OR EXCEPTION ☒

$______ FURS $______ MISC. PENDING ☐

On this date, I was assigned this case for review and forwarding to the county attorneys office. After reviewing the report I noted that no further follow-up was needed. I checked with the victim and learned that she required several stitches to close her wound.

The suspect, Mr Dixon, was transported to county jail for arraignment.

Records Check

Suspect - none CIS
Victim - none CIS

Pre C/a

000897

PAGE # 1	OFFICER WRITING REPORT: 62 Chapat	DATE & TIME TYPED	DIVN	CLERK	I.R. #: 77-6700

CONT'D ON PAGE #

CITY OF TEMPE, ARIZONA
POLICE DEPARTMENT

SUPPLEMENTARY

NOTE: FILL IN EVERY SPACE UNLESS THE INFORMATION IS NOT AVAILABLE PRINT LEGIBLY IN INK.

TYPE OF PROPERTY (Circle One Only): EVIDENCE (circled) SAFEKEEPING FOUND

Date and Time Property Seized: 6-5-77 0045 HRS.

NAME OF VICTIM OR OWNER (Last, First, Middle): GUERRA, CHRISTY KAY

ADDRESS: 1026 E. SPENCE #305 TEMPE NO PHONE

TELEPHONE

I.R. NUMBER: 77-06700

NAME OF PERSON ARRESTED, OR SUSPECT (Last, First, Middle): DIXON, CLARENCE WAYNE

CHARGES: A.W.D.W.

I.D. NUMBER

NAME OF PERSON ARRESTED, OR SUSPECT (Last, First, Middle):

CHARGES: File Copy

I.D. NUMBER

CITATION #

NAME OF FINDER OR PERSON REPORTING FOUND PROPERTY:

ADDRESS:

TYPE OF OFFENSE IF KNOWN: AWDW

LOCATION OF OCCURRENCE: 1026 E. SPENCE, TEMPE

BRIEF SYNOPSIS OF OCCURRENCE: (Also use this space for additional suspects or victims)

ON 6-5-77 AT 0045 HRS CLARENCE DIXON WAS ARREST FOR AWDW AFTER STRIKING CHRISTY GUERRA ON TOP OF THE HEAD WITH A 12"x1" CAST IRON PIPE IN FRONT OF 1026 E. SPENCE, TEMPE

ITEMIZE AND DESCRIBE PROPERTY— LIST ONLY ONE ITEM PER LINE, NUMBER EACH ITEM ON THE FORM. Where possible, place each item in plastic bag, and attach property tag to outside of bag.

Item	DESCRIPTION	SERIAL NO.	DISPO.	DATE
1	12"x1" CAST IRON PIPE			

Placed in property Locker # 13 Date 6-5-77 Time 0300

OFFICER: D. Cave SERIAL: 47 PAGE OF

DISPOSITION OF PROPERTY: PROPERTY ITEMS WERE: 1. Returned to owner 2. Destroyed 3. Sold at auction 4. T.O.T. City 5. Left at Court 6. Unable to locate

FOR CUSTODIAN USE ONLY: REMARKS

Received By	Date	Time	Location
Weil	6-6-77	0745	(1) D-3-3

000898

CITY OF TEMPE POLICE DEPARTMENT PROPERTY INVOICE AND RECEIPT

18. VALUE OF PROPERTY RECOVERED OR ADDITIONAL PROPERTY TAKEN	7. TYPE OF REPORT: AWDW	8. DATE OF THIS SUPPLEMENT: 6-6-77	9. I.R. #: 77-6200
PROPERTY RECOVERED ☐ ADDIT PROP. TAKEN ☐	6. VICTIM'S NAME (FIRM NAME IF DUE.): CHRISTY K. GUERRA	10. LOCATION OF OCCURRENCE: 1026 E. SPENCE	
$ _____ CURRENCY, NOTES ETC. $ _____ CLOTHING	CLEARED BY ARREST OR EXCEPTIONALLY CLEARED -	OVER 18 YEAR OLD ☐	UNDER 18 YEAR OLD ☐
$ _____ JEWELRY, PRECIOUS METALS, $ _____ AUTOS			
$ _____ FURS $ _____ MISC.	PENDING ☐ UNFOUNDED ☐	PREVIOUS CLEARED BY ARREST OR EXCEPTION ☐	

On 6-6-77 at 1400 hours, A/O signed complaint number 61,691 in front of Justice of the Peace MULLENEAUX of the Tempe Justice Court, charging CLARENCE WAYNE DIXON with ASSAULT WITH A DEADLY WEAPON.

	Warrant Issued
	Summons Issued
X	In Custody

PHOTO

000899

PAGE # 1 CONT'D ON PAGE #	21 OFFICER WRITING REPORT Sgt Clancy	SB	DATE & TIME TYPED	DIVN	CLERK	9 I.R. # 77-6700

CITY OF TEMPE, ARIZONA
POLICE DEPARTMENT

SUPPLEMENTARY

1. DOC. RPT. OF RECOVERY	2. DAY OF WEEK OF RECOVERY	3. HOUR OF DAY OF RECOVERY 0-23	BEAT OF RECOVERY

SUPPLEMENTAL REPORT

18. VALUE OF PROPERTY RECOVERED OR ADDITIONAL PROPERTY TAKEN	7. TYPE OF REPORT: A.W.O.W.	9. DATE OF THIS SUPPLEMENT: 6-22-77	5. IR #: 77-06700
PROPERTY RECOVERED ☐ ADDIT. PROP TAKEN ☐	4. VICTIM'S NAME (FIRM NAME IF BUS.): GUERRA, CHRISTY	11. LOCATION OF OCCURRENCE: 1026 E. SPENCE	

$ _____ CURRENCY, NOTES ETC. $ _____ CLOTHING

$ _____ JEWELRY, PRECIOUS METALS. $ _____ AUTOS

$ _____ FURS $ _____ MISC.

CLEARED BY ARREST OR EXCEPTIONALLY CLEARED ☐ OVER 18 YEAR OLD ☐ UNDER 18 YEAR OLD ☐

PENDING ☐ UNFOUNDED ☐ PREVIOUS CLEARED BY ARREST OR EXCEPTION ☐

ADDITIONAL SUSP. (LAST, FIRST, MIDDLE) | SOC. SEC. # | SEX | DOB (APPROX.) | RESIDENCE

ON 6-22-77 AT 0900 HRS I ATTENDED A HEARING FOR CLARENCE WAYNE TYSON ON CHARGES OF A.W.O.W. SUBJECT WAS BOUND OVER TO SUPERIOR COURT

000900

PAGE # / CONT'D ON PAGE #	OFFICER WRITING REPORT'S #	DATE & TIME TYPED	DIVN. CLERK	IR #
	P. Cicero #47	6-22-77		77-06700

TPD Form 3 Rev. 1973 CITY OF TEMPE, ARIZONA POLICE DEPARTMENT SUPPLEMENTARY

Last Name	First	Middle	Personal Property Impounded at Property Room	Arrest Number
DIXON	CLARENCE	WAYNE	☐ YES ☒ NO	36363

Residence	Occupation	Telephone No.	Alias, nicks & scars	I.R. Number
950 S. TERRACE D 179, TEMPE	SERVICE STATION ATT.	968-8855	NONE	77-06700

Sex	Height	Weight	Hair	Eyes	Origin	Birthdate	Age	Birthplace	Soc. Sec. No.	FBI
M	5'7½"	115	BLK	BRN	I	8-26-55	21	AZ	585-84-9185	

Location of Arrest	Grid	Day	Date & Military Time	B.A. Reading	B.A. Operator #	CIS
1026 E. SPENCE	4A14	1	6-5-77 0045	—	—	

Vehicle: Color	Year	Make and Model	License No.	State	Arresting Officers & Serial #
TAN	64	CHEV 4DR	TSG-920	AZ.	P. CICERO 47 / D. CLINE 98

Disposition of Vehicle	Driver's License No.	State	Officer's Court Dates & Time	Recon Officer's Serial #'s only
SECURED 1026 E. SPENCE				98

Charge	Code #	Complaint #	Warrant #	Written Description of Charge
1	13-249			AWDW.
2				
3				
4				

DC99 | Time Booked 6130 | Jailer E7

All "YES" answers require an explanation in the details of arrest.

1. Did the suspect attempt to avoid or resist arrest? ☐ Yes ☒ No
2. Was the suspect armed at the time of arrest? ☐ Yes ☒ No
3. Was the evidence of this offense found in the suspect's possession? ☐ Yes ☒ No
4. Did the suspect admit involvement in the offense? ☒ Yes ☒ No
5. Did the suspect make any threats in connection with the offense? ☐ Yes ☒ No
6. Is there any indication that the suspect is an alcoholic, addict, mentally or physically disturbed? ☐ Yes ☒ No
7. Is there information to indicate the suspect may flee if released on bail? ☐ Yes ☒ No
8. Evidence impounded? ☒ Yes ☐ No

Personal Property: 4/1 | Drawer No. -6- | Signature: Clarence W. Dixon | Signature (Jailer): MC

WALLET + CONTENTS — RING
KEYS — BELT
GLASSES — AIR GAGE
WATCH

Searched by CLINE # 98

DETAILS OF ARREST

SEE IR 77-06700

NCIC-NEG
X3
CRIM

DATE 5?-1 968 8855 OBT Emp

CITY OF TEMPE, ARIZONA
Police Department
54215

ARREST RECORD

000901
ORIGINAL

Last Name	First	Middle	Personal Property Impounded at Property Room: YES / NO (X)	Arrest Number
DIXON	CLARENCE	WAYNE		36363

Residence	Occupation	Telephone No.	Alias, mrks & scars	I.D. Number
738 W 5 ST 13 TEMPE	GAS STAT. ATTEND	9677011	SCAR UPPER LEFT ARM	

Sex	Height	Weight	Hair	Eyes	Origin	Birthdate	Age	Birthplace	Soc. Sec. No.	FBI
M	58	115	BLK	BRN	I	8-2-55	23	AZ	585849186	579653T9

Location of Arrest	Grid	Day	Date & Military Time	B.A. Reading	B.A. Operator #	CIS
WILLIAMS FIELD RD 7351 W	—	MON	9-18-78 2202 HRS			495546-3

Vehicle Color	Year	Make and Model	License No.	State	Arresting Officers & Serial
BEIGE	64	CHEV 4DR IMPALA	TGS 920	AZ	1. DET ROGERS 56 2. A. CANNING 46

Disposition of Vehicle	Driver's License No.	State	Officer's Court Dates & Time	Wagon Officer's Serial #'s only
SECURED AT SCENE	FE8727C	AZ	1. 2.	1. 56 2. 46

Charge	Code #	Complaint #	Warrant #	Written Description of Charge
1	13-849			A.W.D.W
2	13-371		96110	D.P.
3	13-322			BURGLARY 1st
4				

I.D. Unit		Time Booked	Jailor
DCP	All "YES" answers require an explanation in the details of arrest.	2302	DCB

1. Did the suspect attempt to avoid or resist arrest? ☐ Yes ☒ No
2. Was the suspect armed at the time of arrest? ☒ Yes ☐ No
3. Was the evidence of this offense found in the suspect's possession? ☐ Yes ☒ No
4. Did the suspect admit involvement in the offense? ☒ Yes ☐ No
5. Did the suspect make any threats in connection with the offense? ☒ Yes ☒ No
6. Is there any indication that the suspect is an alcoholic, addict, mentally or physically disturbed? ☒ Yes ☐ No
7. Is there information to indicate the suspect may flee if released on bail? ☐ Yes ☒ No
8. Evidence impounded? ☒ Yes ☐ No

Personal Property:	Drawer No:	Signature in:	Signature out:
$5.01	2	Clarence W. Dixon	Dep. K. [illegible] 7-26-75

WALLET + CONTENTS — 2 NUTS + WASHERS
1 - BELT — GLASSES
1 - AZ DRIVERS LIC. — CARD CASE W/CONTENTS
1 - PEN

Searched by: CANNING #46

DETAILS OF ARREST: SEE I.R.'S 78-11825 + ~~78-11824~~ 78-11924

Rec - neg.
2V
Cards
1K [illegible]

763-[illegible]

ARREST RECORD

Rev. 10-73

[illegible] 000902

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

Key Features That Define the Psychotic Disorders

Delusions

Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, grandiose). *Persecutory delusions* (i.e., belief that one is going to be harmed, harassed, and so forth by an individual, organization, or other group) are most common. *Referential delusions* (i.e., belief that certain gestures, comments, environmental cues, and so forth are directed at oneself) are also common. *Grandiose delusions* (i.e., when an individual believes that he or she has exceptional abilities, wealth, or fame) and *erotomanic delusions* (i.e., when an individual believes falsely that another person is in love with him or her) are also seen. *Nihilistic delusions* involve the conviction that a major catastrophe will occur, and *somatic delusions* focus on preoccupations regarding health and organ function.

Delusions are deemed *bizarre* if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences. An example of a bizarre delusion is the belief that an outside force has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars. An example of a nonbizarre delusion is the belief that one is under surveillance by the police, despite a lack of convincing evidence. Delusions that express a loss of control over mind or body are generally considered to be bizarre; these include the belief that one's thoughts have been "removed" by some outside force (*thought withdrawal*), that alien thoughts have been put into one's mind (*thought insertion*), or that one's body or actions are being acted on or manipulated by some outside force (*delusions of control*). The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.

Hallucinations

Hallucinations are perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control. They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the individual's own thoughts. The hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (*hypnagogic*) or waking up

(*hypnopompic*) are considered to be within the range of normal experience. Hallucinations may be a normal part of religious experience in certain cultural contexts.

Disorganized Thinking (Speech)

Disorganized thinking (*formal thought disorder*) is typically inferred from the individual's speech. The individual may switch from one topic to another (*derailment or loose associations*). Answers to questions may be obliquely related or completely unrelated (*tangentiality*). Rarely, speech may be so severely disorganized that it is nearly incomprehensible and resembles receptive aphasia in its linguistic disorganization (*incoherence* or "word salad"). Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication. The severity of the impairment may be difficult to evaluate if the person making the diagnosis comes from a different linguistic background than that of the person being examined. Less severe disorganized thinking or speech may occur during the prodromal and residual periods of schizophrenia.

Grossly Disorganized or Abnormai Motor Behavior (Inciuding Catatonia)

Grossly disorganized or abnormal motor behavior may manifest itself in a variety of ways, ranging from childlike "silliness" to unpredictable agitation. Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living.

Catatonic behavior is a marked decrease in reactivity to the environment. This ranges from resistance to instructions (*negativism*); to maintaining a rigid, inappropriate or bizarre posture; to a complete lack of verbal and motor responses (*mutism* and *stupor*). It can also include purposeless and excessive motor activity without obvious cause (*catatonic excitement*). Other features are repeated stereotyped movements, staring, grimacing, mutism, and the echoing of speech. Although catatonia has historically been associated with schizophrenia, catatonic symptoms are nonspecific and may occur in other mental disorders (e.g., bipolar or depressive disorders with catatonia) and in medical conditions (catatonic disorder due to another medical condition).

Negative Symptoms

Negative symptoms account for a substantial portion of the morbidity associated with schizophrenia but are less prominent in other psychotic disorders. Two negative symptoms are particularly prominent in schizophrenia: diminished emotional expression and avolition. *Diminished emotional expression* includes reductions in the expression of emotions in the face, eye contact, intonation of speech (prosody), and movements of the hand, head, and face that normally give an emotional emphasis to speech. *Avolition* is a decrease in motivated self-initiated purposeful activities. The individual may sit for long periods of time and show little interest in participating in work or social activities. Other negative symptoms include alogia, anhedonia, and asociality. *Alogia* is manifested by diminished speech output. *Anhedonia* is the decreased ability to experience pleasure from positive stimuli or a degradation in the recollection of pleasure previously experienced. *Asociality* refers to the apparent lack of interest in social interactions and may be associated with avolition, but it can also be a manifestation of limited opportunities for social interactions.

Disorders in This Chapter

This chapter is organized along a gradient of psychopathology. Clinicians should first consider conditions that do not reach full criteria for a psychotic disorder or are limited to one

domain of psychopathology. Then they should consider time-limited conditions. Finally, the diagnosis of a schizophrenia spectrum disorder requires the exclusion of another condition that may give rise to psychosis.

Schizotypal personality disorder is noted within this chapter as it is considered within the schizophrenia spectrum, although its full description is found in the chapter "Personality Disorders." The diagnosis schizotypal personality disorder captures a pervasive pattern of social and interpersonal deficits, including reduced capacity for close relationships; cognitive or perceptual distortions; and eccentricities of behavior, usually beginning by early adulthood but in some cases first becoming apparent in childhood and adolescence. Abnormalities of beliefs, thinking, and perception are below the threshold for the diagnosis of a psychotic disorder.

Two conditions are defined by abnormalities limited to one domain of psychosis: delusions or catatonia. Delusional disorder is characterized by at least 1 month of delusions but no other psychotic symptoms. Catatonia is described later in the chapter and further in this discussion.

Brief psychotic disorder lasts more than 1 day and remits by 1 month. Schizophreniform disorder is characterized by a symptomatic presentation equivalent to that of schizophrenia except for its duration (less than 6 months) and the absence of a requirement for a decline in functioning.

Schizophrenia lasts for at least 6 months and includes at least 1 month of active-phase symptoms. In schizoaffective disorder, a mood episode and the active-phase symptoms of schizophrenia occur together and were preceded or are followed by at least 2 weeks of delusions or hallucinations without prominent mood symptoms.

Psychotic disorders may be induced by another condition. In substance/medication-induced psychotic disorder, the psychotic symptoms are judged to be a physiological consequence of a drug of abuse, a medication, or toxin exposure and cease after removal of the agent. In psychotic disorder due to another medical condition, the psychotic symptoms are judged to be a direct physiological consequence of another medical condition.

Catatonia can occur in several disorders, including neurodevelopmental, psychotic, bipolar, depressive, and other mental disorders. This chapter also includes the diagnoses catatonia associated with another mental disorder (catatonia specifier), catatonic disorder due to another medical condition, and unspecified catatonia, and the diagnostic criteria for all three conditions are described together.

Other specified and unspecified schizophrenia spectrum and other psychotic disorders are included for classifying psychotic presentations that do not meet the criteria for any of the specific psychotic disorders, or psychotic symptomatology about which there is inadequate or contradictory information.

Clinician-Rated Assessment of Symptoms and Related Clinical Phenomena in Psychosis

Psychotic disorders are heterogeneous, and the severity of symptoms can predict important aspects of the illness, such as the degree of cognitive or neurobiological deficits. To move the field forward, a detailed framework for the assessment of severity is included in Section III "Assessment Measures," which may help with treatment planning, prognostic decision making, and research on pathophysiological mechanisms. Section III "Assessment Measures" also contains dimensional assessments of the primary symptoms of psychosis, including hallucinations, delusions, disorganized speech (except for substance/medication-induced psychotic disorder and psychotic disorder due to another medical condition), abnormal psychomotor behavior, and negative symptoms, as well as dimensional assessments of depression and mania. The severity of mood symptoms in psychosis has prognostic value and guides treatment. There is growing evidence that schizoaffective

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doi:10.1093/schbul/sbp045
Advance Access publication on June 8, 2009

Unmet Need for Mental Health Care in Schizophrenia: An Overview of Literature and New Data From a First-Admission Study

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[2]Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; [3]Department of Psychiatry and Behavioral Sciences, State University of New York, Stony Brook, NY; [4]American Psychiatric Association, Washington, DC

We present an overview of the literature on the patterns of mental health service use and the unmet need for care in individuals with schizophrenia with a focus on studies in the United States. We also present new data on the longitudinal course of treatments from a study of first-admission patients with schizophrenia. In epidemiological surveys, approximately 40% of the respondents with schizophrenia report that they have not received any mental health treatments in the preceding 6–12 months. Clinical epidemiological studies also find that many patients virtually drop out of treatment after their index contact with services and receive little mental health care in subsequent years. Clinical studies of patients in routine treatment settings indicate that the treatment patterns of these patients often fall short of the benchmarks set by evidence-based practice guidelines, while at least half of these patients continue to experience significant symptoms. The divergence from the guidelines is more pronounced with regard to psychosocial than medication treatments and in outpatient than in inpatient settings. The expansion of managed care has led to further reduction in the use of psychosocial treatments and, in some settings, continuity of care. In conclusion, we found a substantial level of unmet need for care among individuals with schizophrenia both at community level and in treatment settings. More than half of the individuals with this often chronic and disabling condition receive either no treatment or suboptimal treatment. Recovery in this patient population cannot be fully achieved without enhancing access to services and improving the quality of available services. The recent expansion of managed care has made this goal more difficult to achieve.

Key words: unmet need for care/treatment patterns/mental health services

Introduction

This article presents an overview of the literature on patterns of mental health service use and, by extension, the unmet need for care in individuals with schizophrenia. In addition, new data on the longitudinal course of treatments in a first-admission sample of patients with schizophrenia are presented. Randomized clinical trials have repeatedly shown the efficacy of pharmacological and psychosocial interventions in the management of schizophrenia.[1,2] Findings from these studies have been synthesized into practice guidelines with the aim of improving the treatment of schizophrenia across various settings.[3–8] However, treatments offered in routine clinical practice often fall short of guideline recommendations, and many patients in the community receive no or little treatment.[9–18] Thus, our knowledge of evidence-based treatment practices does not always translate into better care and outcomes for patients.

In comparison to hundreds of randomized clinical trials of various pharmacological and psychosocial treatments for schizophrenia, there are relatively few studies of the treatment patterns in routine care settings and the extent and the correlates of the unmet treatment needs in this patient population. Furthermore, much of the available data focus on patterns of pharmacotherapy, and less is known about the patterns of use of psychosocial treatments.

From a public health perspective, the issue of unmet need for care can be defined at different levels (eg, the community and the services) or from different perspectives (eg, the patients, their families, or their clinicians). Furthermore, there is currently a debate about the threshold at which care would be essential, and the lack of care would constitute an unmet need.[19] For example, it is not clear whether treatment would be needed for the large number of people in community-based epidemiological studies who meet the full diagnostic criteria for a mood or anxiety disorder but who do not seek treatment.[20–22] Some authors have argued that many of these individuals experience "appropriate homeostatic responses that are neither pathologic nor in need of treatment."[20](p114) These debates are likely less relevant to schizophrenia, in which the duration of illness, the severity of symptoms, and the social and occupational dysfunction that are the defining

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characteristics of the disorder[23] justify treatment in almost all individuals with the diagnosis.

In both community and service settings, unmet needs are often evaluated by examining the patterns of service use and by comparing these patterns with the treatments recommended by evidence-based practice guidelines. An alternative approach would be to directly assess the perceptions of consumers, family members, or clinicians of the extent of met and unmet needs.

At the level of services, unmet needs commonly result from the discontinuities in treatment or provision of substandard treatments due to inadequate resources, prohibitive cost of treatments, inadequate health insurance, changes in insurance coverage, or the lack of satisfaction with the available treatments. These factors often coexist and may act synergistically in interfering with treatment.

In this article, we will present an overview of some of the studies that have evaluated the unmet need for treatment in schizophrenia. We will approach the question of unmet need for treatment according to 3 definitions as (a) the prevalence of cases of disorder that have not received any treatment in community settings or patients who have dropped out of treatment in representative clinical samples, (b) the prevalence of inadequate treatment or treatment of low quality in routine clinical settings, and (c) the prevalence of self-rated unmet need for treatment as perceived by the patients. For assessing the extent of unmet need for treatment based on the first 2 definitions, we will rely on studies of treatment patterns among individuals who meet the criteria for schizophrenia in general population epidemiological surveys or in clinical epidemiological studies that are based on representative clinical samples drawn from delimited geographical regions and clinical sample of patients drawn from routine treatment settings. We will also present data on the longitudinal course of mental health treatments in patients with schizophrenia from the Suffolk County Mental Health Project—a clinical epidemiological study of first-admission psychotic disorders in Long Island, New York. To assess the prevalence of unmet need for treatment as perceived by patients, we will briefly examine the growing literature on patient-perceived needs. Discussing these studies in concert highlights the various limitations and strengths of each approach as well as the complexities of assessing the unmet needs for care in schizophrenia. Our overview focuses on studies from the United States. However, where appropriate or in cases where there are few US studies, we will also discuss studies conducted in other countries.

Treatment Patterns

Treatment Patterns in Population Samples

Much of our current knowledge about treatment patterns in individuals with common mood and anxiety disorders comes from the epidemiological surveys of general populations.[24,25] Fewer epidemiological studies of general populations have investigated the treatment patterns in representative samples of individuals with schizophrenia. In a 1980 review of the literature on the rates of mental health treatment in epidemiological studies, Link and Dohrenwend[18] identified 7 studies from across the world conducted between 1938 and 1973 that specifically examined the lifetime treatment rates for schizophrenia. The median rate of lifetime treatment in these studies was 83.3% (range: 50%–100%) as compared with the general population studies of overall psychopathology (mostly mood, anxiety, and alcohol disorders) in which the median rate of treatment was only 26.7% (range: 7.8%–52.0%). Comparison across these studies, however, is hampered by the sociocultural variations in the samples, variations in case ascertainment methodology, and diagnostic criteria.

The introduction of explicit diagnostic criteria such as the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition) (*DSM-III*) and the incorporation of these diagnostic criteria into structured interview instruments paved the way for a second generation of epidemiological studies, which use standardized assessments and generally have large and representative population-based samples.[26] In the United States, the Epidemiologic Catchment Area (ECA) study is the earliest and the best known of the second-generation studies that specifically focused on *DSM-III* disorders, including schizophrenia.[27] The ECA was conducted in the early 1980s and sampled over 20 000 adults from 5 sampling sites across the United States. One advantage of the ECA over subsequent epidemiological studies was that in addition to the household samples, individuals in institutions were also sampled. The ECA found that about 1.3% of the population met lifetime *DSM-III* criteria for schizophrenia based on the lay-administered Diagnostic Interview Schedule.[27] Another 0.2% met criteria for the schizophreniform disorder. The large majority of these cases were identified in the community as opposed to an institutional setting.[27] The ECA found that among individuals with symptoms in the past 6 months (6-mo schizophrenia), only 57% had received some form of outpatient mental health care in this period: 40% from the specialty mental health sector (psychiatrists, psychologists, social worker, or other mental health professionals) and 17% from the general medical sector or the human services (such as the clergy or nonmental health social work).[27] The ECA study did not report the lifetime history of treatment in this group of patients. However, the 57% rate of 6-month treatment seeking is much smaller than the 83% lifetime treatment from earlier epidemiological studies. It is not clear whether changes in the time and the diagnostic criteria or differences in the time frame (6 mo vs lifetime), in sociocultural characteristics of the samples, or in the

ascertainment methods (structured interview vs clinician evaluation) accounted for this difference.

The second landmark US epidemiological survey, the National Comorbidity Survey (NCS), was conducted a decade later, between 1990 and 1992. The NCS included a nationally representative sample of individuals between the ages 15 and 54 years and administered the University of Michigan revised version of the Composite International Diagnostic Interview (CIDI). This study found a similar lifetime prevalence of the *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition Revised) schizophrenia and schizophreniform disorder to that from the ECA (1.3%).[28] However, the NCS also reported prevalence estimates based on the clinical reinterviews with the NCS respondents who had been assigned a diagnosis of schizophrenia or schizophreniform disorder by the lay-administered structured interview. The concordance between the structured interview and the interviews by the senior clinicians was quite low, with only 10% of the reinterviewed subjects being assigned a diagnosis of schizophrenia or schizophreniform disorder and 37% receiving a broader diagnosis of "nonaffective psychoses." By the clinician diagnosis, the lifetime prevalence rates were 0.2% for schizophrenia or schizophreniform disorders and 0.3% for nonaffective psychoses—much lower than the estimates from the structured interviews. Among the clinician-identified cases of nonaffective psychoses symptomatic in the past 12 months, 57.9% had used some form of mental health services in that time frame: 47.5% had used specialty mental health services, 21.5% general medical services, 16.3% human services, and 22.0% self-help resources.[29]

A further wave of the NCS, the US National Comorbidity Survey-Replication (NCS-R), was conducted a decade later, between 2001 and 2003. The NCS-R sampled adults aged 18 years and older and administered a revised version of the CIDI. It also used a significantly modified ascertainment scheme to minimize false-positive responses[30] as well as the statistical method of multiple imputation,[31] commonly used to estimate missing data, to estimate the predicted prevalence of the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) clinician-diagnosed nonaffective psychoses based on the responses to the structured interviews. The lifetime prevalence of the probable nonaffective psychoses (including schizophrenia, schizophreniform disorder, as well as the other nonaffective psychoses) was 1.5% based on the structured interviews and 0.5% based on the predicted clinician diagnoses.[30] We note that the 0.5% prevalence rate is consistent with the estimates from the other epidemiological studies.[32]

Among the NCS-R cases with a predicted clinician diagnosis of nonaffective psychosis who had active symptoms in the past 12 months, 57.8% reported mental health treatment contacts in the same 12-month period: 49.8% were treated in the mental health specialty sector, 5.0% in the general medical sector, 11.9% in the human services sector, and 13.4% in the complementary-alternative medicine sector.[30]

The differences in the sampling frame, the age ranges, the diagnostic criteria, the interview instruments, and the ascertainment methods make comparisons across these 3 US surveys very difficult.[20] The difficulty is compounded by the inaccuracies inherent in estimating the prevalence of rare conditions in population samples[33] that are likely responsible for the discrepancy in prevalence rates based on the lay-administered interviews and the clinician interviews.

The probability of correctly identifying cases of a disorder based on a screen-positive result (positive predictive validity) and of the cases free of the disorder based on a screen-negative result (negative predictive validity) is significantly affected by the true prevalence of the disorder, as well as by the sensitivity and specificity of the screening test. Eaton et al[33] estimated that, eg, in a population survey of 1000 persons with a true prevalence of schizophrenia of 1%, a measure having 90% sensitivity and specificity (far higher than the sensitivity of currently available structured interview instruments) would identify 9 true cases and 99 false-positive cases, generating a prevalence estimate of more than 10% or 10 times higher than the true prevalence of the disorder.

Thus, the majority of the cases of schizophrenia identified using a lay-administered interview would be false-positive cases. Unless true cases of a disorder in a population can be identified with some accuracy, the patterns of treatment for that disorder cannot be accurately determined. Furthermore, the prevalence estimates of rare disorders are particularly sensitive to the selective nonresponse,[25] and there is some evidence that individuals with schizophrenia in the community are less likely than other individuals to respond to surveys or appear in population-based samples if they are living in nursing homes and other quasi-institutional community settings.[34]

Despite these limitations, the similarity in treatment patterns of individuals with schizophrenia across the 3 population surveys is remarkable. About 57%–58% of individuals with active symptoms of schizophrenia in the 6–12 months prior to interview reported receiving some form of mental health treatment in that time frame. In the NCS and the NCS-R, between 47.5% and 49.8% received treatment in the specialty mental health sector. Thus, based on these data, at least 40% of individuals with actively symptomatic schizophrenia-spectrum disorders living in community settings in the United States have no consistent contact with needed services, and more than half have no contact with the specialty mental health treatment sector. These numbers reflect a large degree of potential unmet need for treatment among individuals with schizophrenia living in the various US communities.

Treatment Patterns in Clinical Epidemiological Samples

Whereas general population epidemiological surveys have typically been the gold standard for estimating the burden of the unmet need for treatment in the population,[24] the limitations in ascertaining cases of rare disorders, noted earlier, constrain their usefulness for assessing the degree of unmet need for treatment in schizophrenia. Furthermore, many seriously ill individuals are likely underrepresented in these surveys because they live in the institutional settings or because they are homeless or incarcerated. Finally, epidemiological surveys generally collect limited information about the specific content and course of the treatments, such as history of recent hospitalizations and outpatient visits and the current use of medications. A thorough assessment of the psychiatric treatment history would require more detailed information on the content and course of treatments.

Epidemiological studies of clinical populations have an advantage over general population epidemiological surveys in that they typically collect more detailed information on the content and course of treatments in patients recruited from clinical settings in a well-defined geographical region.[11,35–39] The ascertainment of cases in some of these studies is quite exhaustive, approximating that of general population surveys.[36] When compared with clinical studies, epidemiological studies of clinical samples also provide a less biased picture of the use of clinical services and the extent of unmet need for care. This is especially true of the longitudinal studies involving first-contact or first-admission patients[36,37] in which the frequent and infrequent users of services are equally likely to be included. In contrast, in studies of current patients in routine clinical settings, the probability of being sampled is proportional to the volume of service use, leading to what Cohen and Cohen labeled the "clinician's illusion."[40] Thus, longitudinal studies of first-contact or first-admission patients offer a more balanced view of the patterns of service use and the unmet needs for care than is possible when drawing from cross-sectional clinical samples.

For example, the report of Jablensky et al[36] based on the follow-up data from the World Health Organization (WHO) 10-country study identified subgroups of patients with psychotic disorders who had considerable gaps in their care. Furthermore, the treatment patterns varied significantly across the settings. Only 15.9% of the patients in the developing countries (Colombia, India, and Nigeria) were on antipsychotic medications for more than 75% of the follow-up period, compared with 60.8% in the industrialized countries (Czech Republic, Denmark, Ireland, Japan, Russia, United Kingdom, and United States). Similarly, 55.5% of the patients in the developing countries were never hospitalized during the follow-up period compared with 8.1% in the industrialized countries.[32] These

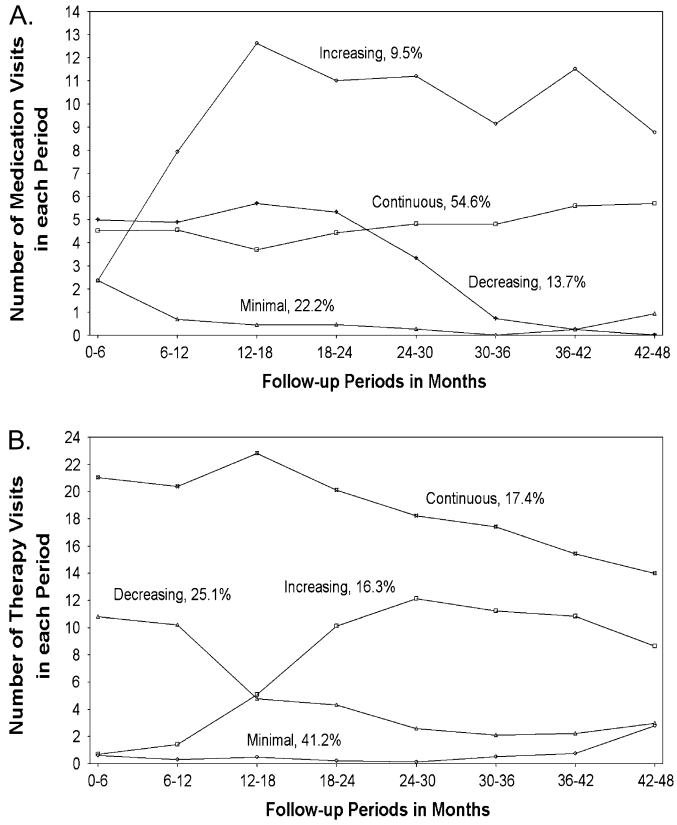

Fig. 1. Trajectories of Medication Visits (A) and Therapy Visits (B) in Patients With a Diagnosis of Schizophrenia in the Suffolk County Mental Health Project.

numbers reflect considerable variation across the industrialized and the developing countries in the patterns of service use and the unmet need for care that would not be identified in studies involving clinical samples as the patients with less use of services in clinical samples would not be equally represented as the frequent users.

As another example, in a clinical epidemiological study of first-admission psychotic disorders from the private and public inpatient facilities in the Suffolk County, NY,[14,37,41] we were able to use the latent growth class methodology[42–44] to identify subgroups of schizophrenia patients according to their use of services in the 4-year period after their first admission.[42,44] Groups were defined based on their longitudinal patterns (or trajectories) of medication and psychotherapy (individual, group, and family therapy combined) visits assessed at 6-month intervals (figure 1A and 1B).

In this study, which took place in a semiurban area of Long Island, only 54.6% of the 172 first-admission patients with a consensus diagnosis of schizophrenia based on 2 years of observation had continuous medication visits in the 4 years following first admission (ie, 3–6 visits per 6 mo throughout the 4-y follow-up) and only 17.4% had continuous psychotherapy visits (ie, 12–24 visits per 6 mo). In contrast, 22.2% had minimal medication

visits in the follow-up (ie, consistently less than 3 visits per 6 mo), and 41.2% had minimal therapy visits (ie, consistently less than 6 visits per 6 mo) (figure 1A and 1B). Overall, 12.8% of the sample fell in both the minimum medication and therapy visits and 16.3% in both the continuous medication and therapy visit classes.

Medication visits were strongly associated with being on psychiatric medications at each time point. For example, at the 6-month follow-up, 85.7% of the participants with continuous medication visits were taking any psychiatric medications compared with 44.4% of those with minimal medication visits ($\chi^2_{df=1}$=21.94, $P < .001$). Similarly, 90.0% of those with continuous medication visits and 39.4% with minimal medication visits were taking any psychiatric medications at the 24-month follow-up ($\chi^2_{df=1}$=34.32, $P < .001$).

The majority of the patients in the minimal medication visits and minimal psychotherapy visits remained in need of treatment through most of the first 4-year period after the index admission. Almost half of these patients were rated as continuously ill on the WHO Course of Illness Scale[36] at the 4-year follow-up and as many were rated as having marked deterioration on the Schedule for Affective Disorders and Schizophrenia[45] (tables 1 and 2). Furthermore, large percentages of patients in minimal medication or psychotherapy visit groups suffered from multiple episodes of illness with incomplete remission between episodes (45.7% in the minimal medications group and 50.0% in the minimal psychotherapy group). Very few of the patients with minimal contact with services remained in full remission after the first episode of illness (tables 1 and 2).

Patients with minimal medication visits were more likely than those with continuous medication visits to have multiple hospitalizations during the first 4 years (34.2% vs 21.3%, $P = .045$). However, they were less likely to remain consistently in treatment between the 4- and 10-year follow-ups or to be on any psychiatric medications at the 10-year follow-up (table 1).

Compared with patients with continuous psychotherapy visits in the first 4 years, those with minimal psychotherapy visits were more likely to be continuously ill during the first 4 years and between the 4- and 10-year follow-ups (47.0% vs 24.1% in the first 4 y and 72.4% vs 51.7% between the 4 and 10 y). However, these differences were only at a statistical trend level and did not reach a statistically significant level. Patients with continuous psychotherapy visits in the first 4 years were significantly more likely to be receiving any psychotherapy at the 10-year follow-up (table 2).

Another example that shows the utility of clinical epidemiological studies is the Australian Study of Low Prevalence Disorders.[11] In that study, Jablensky et al used a 2-phase survey of all the individuals with psychotic disorders who made a contact with the public mental health services in 4 urban or predominantly urban areas in Australia in the late 1990s.[11] In the second phase of the study, relatively detailed interviews were conducted with a stratified random sample of the individuals screened in the first phase of the survey. In addition, the authors surveyed individuals with psychotic disorders who received care from general medical professionals or psychiatrists in private practice; homeless individuals identified at night shelters, hostels, or other "safety net" services in the community; and individuals with a history of contact with services in the past 3 years but no current contact who were identified from the service registries.[46] Among the patients thus identified, only 59.6% had used any outpatient services in the past 12 months and 43.6% had used inpatient services.[47] A total of 21.9% reported that they had used no psychiatric services in this period.

The nonusers of services generally had lower levels of symptomatology and were twice as likely as the current users to have a course of illness characterized by a single episode of psychotic illness followed by recovery and 3 times less likely to have a course of illness characterized by severe deterioration.[11] The nonusers were also less likely to have a comorbid substance use disorder and to have a history of self-harm behavior, arrests, and/or victimization.[11] These variations echo earlier research in other settings[48] indicating that in heterogeneous samples of patients with various psychotic disorders service use and the needs for care vary considerably among different subgroups of patients. However, these results are at variance with those from the homogeneous prospectively followed sample of patients with a diagnosis of schizophrenia from the Suffolk County Mental Health Project, discussed earlier, in which the course of illness in the minimal treatment group was characterized by continuous illness or significant residual symptoms.

In summary, clinical epidemiological studies address some of the deficiencies of the general population epidemiological surveys by using patient samples, thus reducing the false-positive rate, and by incorporating more detailed information on the nature and the volume of service use. Furthermore, studies of first-contact or first-admission patients, such as the Suffolk County Mental Health Project[41] or the WHO 10-country study,[36] and studies using patient registries to identify the previous users of services, such as in the Australian Study of Low Prevalence Disorders,[11] can identify subgroups of patients who use fewer services or drop out of treatment—patients who are not well represented in cross-sectional clinical samples (see below).

Nevertheless, clinical epidemiological studies tend to be labor intensive and expensive. As a result, relatively few recent clinical epidemiological studies of psychotic disorders are available, and much of our knowledge about the patterns and the quality of treatments in schizophrenia patients comes from nonepidemiological, cross-sectional studies of chronically ill, clinical samples.

Table 1. Outcomes at 4 and 10 y According to Medication Visit Trajectories in First-Admission Patients With a Research Diagnosis of Schizophrenia in the Suffolk County Mental Health Project

	Medication Visit Trajectories									
	Continuous (N = 94)		Increasing (N = 16)		Decreasing (N = 24)		Minimal (N = 38)		Comparisons, Test$_{df}$, P	
Variable	N	%	N	%	N	%	N	%	All Groups	Continuous Vs Minimal
Outcomes, 4 y										
SADS rating of functioning[45,a]										
Return to highest premorbid level	13	15.3	0	0.0	3	13.6	3	9.7	χ^2_6 = 9.01, .173	χ^2_2 = 0.81, .668
Any residual impairment	37	43.5	3	20.0	7	31.8	13	41.9		
Marked deterioration	35	41.2	12	80.0	12	54.6	15	48.4		
WHO rating of course of illness[36,b]										
Single psychotic episode + full remission	1	1.1	0	0.0	0	0.0	1	2.9	χ^2_6 = 6.90, .330	χ^2_2 = 3.55, .169
Multiple episodes or incomplete remission	58	65.2	7	46.7	11	47.8	16	45.7		
Continuous illness	30	33.7	8	53.3	12	52.2	17	48.6		
Number of rehospitalizations[c]										
0	33	35.1	5	31.3	13	54.2	17	44.7	χ^2_6 = 11.7, .070	χ^2_2 = 6.18, .045*
1	41	43.6	9	56.3	8	33.3	8	21.1		
2+	20	21.3	2	12.5	3	12.5	13	34.2		
Outcomes, 10 y										
SADS rating of functioning[45,d]										
Return to highest premorbid level	2	2.6	1	7.1	0	0.0	3	10.0	χ^2_6 = 6.00, .424	χ^2_2 = 3.15, .207
Any residual impairment	28	35.9	3	21.4	8	44.4	8	26.7		
Marked deterioration	48	61.5	10	71.4	10	55.6	19	63.3		
WHO rating of course of illness[36,e]										
Single psychotic episode + full remission	0	0.0	0	0.0	0	0.0	0	0.0	χ^2_3 = 1.31, .726	χ^2_2 = 1.19, .275
Multiple episodes or incomplete remission	27	34.2	5	35.7	6	33.3	7	23.3		
Continuous illness	52	65.8	9	64.3	12	66.7	23	76.7		
Number of rehospitalizations[f]										
0	41	54.0	8	57.1	8	47.1	14	51.9	χ^2_6 = 1.70, .945	χ^2_2 = 0.36, .834
1	8	10.5	2	14.3	3	17.7	2	7.4		
2+	27	35.5	4	28.6	6	35.3	11	40.7		
Percent of time in treatment between 4- and 10-y follow-ups[g]										
0	0	0.0	0	0.0	1	5.9	3	12.5	χ^2_9 = 15.87, .070	χ^2_3 = 11.71, .008**
1 to <50	3	4.4	1	8.3	1	5.9	3	12.5		
50 to <100	16	23.2	1	8.3	6	35.3	3	12.5		
100	50	74.5	10	83.3	9	52.9	15	62.5		
Medication use at 10-y follow-up[h]										
Any	68	91.9	14	100	16	88.9	19	76.0	χ^2_3 = 6.84, .077	χ^2_1 = 4.43, .035*
None	6	8.1	0	0.0	2	11.1	6	24.0		

Note: SADS, Schedule for Affective Disorders and Schizophrenia; WHO, World Health Organization.
[a]N = 153.
[b]N = 162.
[c]N = 172.
[d]N = 140.
[e]N = 141.
[f]N = 134.
[g]N = 122.
[h]N = 131.
*P < .05, **P < .01.

Treatment Patterns in Clinical Samples

Over the years, a number of studies have examined patterns of treatment in clinical samples of patients with schizophrenia.[9,10,12,15–17,49–64] Differences in the time period, chronicity of the patient populations, treatment settings, and assessment methods make comparison across these studies difficult. Nevertheless, a common theme that emerges from many of these studies is the inadequate quality of treatments provided in routine treatment settings.

A number of studies have compared the treatment patterns in routine treatment settings against the evidence-based practice guideline benchmarks.[9,12,17,49,53,55,64]

Table 2. Outcomes at 4 and 10 y According to Therapy Visit Trajectories in First-Admission Patients With a Research Diagnosis of Schizophrenia in the Suffolk County Mental Health Project

	Therapy Visit Trajectories									
	Continuous (N = 94)		Increasing (N = 16)		Decreasing (N = 24)		Minimal (N = 38)		Comparisons, Test$_{df}$, P	
Variable	N	%	N	%	N	%	N	%	All Groups	Continuous Vs Minimal
Outcomes, 4 y										
SADS rating of functioning[45,a]										
Return to highest premorbid level	5	18.5	3	12.0	4	10.3	7	11.3	χ^2_6 = 2.81, .832	χ^2_2 = 2.14, .342
Any residual impairment	12	44.4	9	36.0	17	43.6	22	35.5		
Marked deterioration	10	37.0	13	52.0	18	46.2	33	53.2		
WHO rating of course of illness[36,b]										
Single psychotic episode + full remission	0	0.0	0	0.0	1	2.6	1	1.5	χ^2_6 = 6.65, .354	χ^2_2 = 5.36, .069
Multiple episodes or incomplete remission	22	75.9	16	57.1	21	53.9	33	50.0		
Continuous illness	7	24.1	12	42.9	17	43.6	31	47.0		
Number of rehospitalizations[c]										
0	14	46.7	9	32.1	19	44.2	26	36.6	χ^2_6 = 8.14, .228	χ^2_2 = 1.95, .377
1	11	36.7	16	57.1	15	34.9	24	33.8		
2+	5	16.7	3	10.7	9	20.9	21	29.6		
Outcomes, 10 y										
SADS rating of functioning[45,d]										
Return to highest premorbid level	3	10.7	0	0.0	1	2.9	2	3.5	χ^2_6 = 8.09, .232	χ^2_2 = 4.62, .099
Any residual impairment	13	46.4	5	25.0	11	32.4	18	31.0		
Marked deterioration	12	42.9	15	75.0	22	64.7	38	65.5		
WHO rating of course of illness[36,e]										
Single psychotic episode + full remission	0	0.0	0	0.0	0	0.0	0	0.0	χ^2_3 = 4.61, .203	χ^2_2 = 3.66, .056
Multiple episodes or incomplete remission	14	48.3	5	25.0	10	29.4	16	27.6		
Continuous illness	15	51.7	15	75.0	24	70.6	42	72.4		
Number of rehospitalizations[f]										
0	17	58.6	12	60.0	17	53.1	25	47.2	χ^2_6 = 3.79, .705	χ^2_2 = 1.07, .587
1	4	13.8	1	5.0	2	6.3	8	15.1		
2+	8	27.6	7	35.0	13	40.6	20	37.7		
Percent of time in treatment between 4- and 10-y follow-ups[g]										
0	0	0.0	0	0.0	1	3.3	3	6.3	χ^2_9 = 9.41, .400	χ^2_3 = 3.98, .264
1 to <50	0	0.0	1	5.6	4	13.3	3	6.3		
50 to <100	6	23.1	5	27.8	8	26.7	7	14.6		
100	20	76.9	12	66.7	17	56.7	35	72.9		
Psychotherapy visits in the last 6 mo of the 10-y follow-up[h]										
Any visits	22	75.9	12	63.2	18	56.3	25	47.2	χ^2_3 = 6.59, .086	χ^2_1 = 6.31, .012*
None	7	24.1	7	36.8	14	43.8	28	52.8		

Note: SADS, Schedule for Affective Disorders and Schizophrenia; WHO, World Health Organization.
[a]N = 153.
[b]N = 162.
[c]N = 172.
[d]N = 140.
[e]N = 141.
[f]N = 134.
[g]N = 122.
[h]N = 133.
*P < .05.

However, again the diversity of practice guidelines and the differences in operationalization of the benchmarks limit comparison across these studies.[58,65] Nevertheless, some of these studies used the Schizophrenia Patient Outcome Research Team (PORT) benchmarks.[9,12,49,66] The results of 4 such studies are summarized in table 3. The PORT benchmarks set evidence-based quality indicators for pharmacological as well as psychosocial treatments of schizophrenia in inpatient and outpatient settings. The PORT guidelines were first published in 1998[8] and were subsequently revised in 2004.[67] All studies in table 3 used the 1998 PORT guidelines.

Table 3. Percent of Participants With Schizophrenia in Clinical Studies Who Are Receiving Treatments That Are Conformant With the PORT Treatment Recommendations

	Lehman et al[12]		West et al[49]	Dickey et al[9]		Busch et al[66]	
PORT Recommendations	Inpatient (%)	Outpatient (%)	Mixed Inpatient and Outpatient (%)	Inpatient (%)	Outpatient (%)	Outpatient Managed Care (%)	Outpatient Fee for Service[a] (%)
Inpatient antipsychotic treatment	89.2	—[b]	—[c]	86.2–86.7	—[b]	—[b]	—[b]
Appropriate dose of inpatient antipsychotics	62.4	—[b]	—[c]	59.3–69.2	—[b]	—[b]	—[b]
Maintenance antipsychotic treatment	—[b]	92.3	99[c]	—[b]	92.9–95.1	88.3	86.2–87.6
Appropriate dose of maintenance antipsychotics	—[b]	29.1	83[c]	—[b]	34.1–45.0[e]	—[d]	—[d]
Anti-Parkinson treatment	53.9	46.1	51	—[d]	—[d]	4.8	4.9–5.6
Depot medication	50.0	35.0	30	—[d]	—[d]	—[d]	—[d]
Adjunctive depression medications	32.2	45.7	38–100[f]	—[d]	—[d]	—[d]	—[d]
Adjunctive anxiety medications	33.3	41.3	45	—[d]	—[d]	—[d]	—[d]
Adjunctive psychosis medications	22.9	14.4	—[d]	—[d]	—[d]	—[d]	—[d]
Any psychotherapy	96.5	45.0	69	90.0–98.9[g]	79.2–81.2[g]	20.3[h]	36.9–71.6[h]
Family therapy	31.6	9.6	—[d]	30.0–53.2[i]	—[d]	0.05	0.2–0.6
Vocational rehabilitation	30.4	22.5	0	—[d]	20.4–23.2	—[d]	—[d]
Case management	8.6[j]	10.1[j]	38	31.9–38.3	43.4–64.0[k]	—[d]	—[d]

Note: PORT, Patient Outcome Research Team.
[a]Includes patients in carve-out region before transition to the carve-out plan and patients in comparison regions before and after transition.
[b]Not relevant.
[c]The study did not report separate values for inpatients and outpatients.
[d]Not reported.
[e]Mean standardized monthly dose within PORT-recommended range.
[f]All the patients with a diagnosis of major depression received antidepressants, but only 38% of those with "moderate to severe" depressive symptoms did so.
[g]Any psychosocial treatment.
[h]Individual therapy and/or group therapy.
[i]Any family contact.
[j]Assertive community treatment and assertive case management were included.
[k]Case management was reported only in high-risk patients (ie, patients with a history of hospitalization in the past 6 mo).

The PORT group's study is perhaps the best-known research assessing the conformance of the treatment patterns in routine care settings with the evidence-based recommendations.[12] The study examined treatment patterns in a random sample of over 700 individuals with a clinical diagnosis of schizophrenia recruited from routine care settings in a southern and a midwestern state between 1994 and 1997. The patients were sampled from inpatient units and outpatient clinics in private and public institutions, including the Veteran's Administration facilities. The sampling sites included rural as well as urban sites.[12] The data collected by surveying the patients and abstracting the inpatient and outpatient medical records showed a modest level of conformance with nearly all evidence-based recommendations, except for any prescription of antipsychotic medications, for which there was a high conformance (table 3). For most recommendations, fewer than half of the patients received guideline-conformant treatment. Furthermore, conformance was generally poorer for the outpatient treatments than for the inpatient treatments and for psychosocial treatments than for medications.[12]

Similar findings were reported in the 1999 American Psychiatric Association Practice Research Network (PRN) study, which used a nationally representative group of psychiatrists to obtain information about a sample of

their patients and the treatments they received.[49] Of the 151 patients with a clinical diagnosis of schizophrenia identified in this study, 99% received antipsychotic medications. However, 37% of these patients had difficulty adhering to medications, and 64% suffered from moderate to severe psychotic symptoms, likely partly due to poor adherence. Only 42% of the patients received any psychotherapy and 69% any form of psychosocial intervention, including case management.[49] The rates of conformance with the practice guideline recommendations for the psychosocial treatments ranged from 0% to 43% and were especially lower among the patients with public insurance.

The variation across the studies in table 3 can be attributable to a number of factors including differences in the composition of samples, method of assessing conformance, and differences in the definitions used. For example, the study by Lehman et al[12] examined conformance with PORT guidelines in patients in public mental health facilities in 2 states using chart reviews, whereas the study by West et al[49] used a sample of patients from practices of psychiatrists who volunteered to participate in the American Psychiatric Association PRN study, and the data provided by these psychiatrists were not independently verified. As another example, Dickey et al[9] categorized any family contact as family therapy, whereas in Busch et al[66] study family therapy was more stringently defined based on coded claims data. These differences make direct comparison of estimates in table 3 difficult. Furthermore, the definitions of psychotherapy and vocational rehabilitation in these and other studies of quality of treatments in routine clinical settings are often very broad and overinclusive. Thus, these studies likely overestimate the rates of conformance with evidence-based guidelines with regard to these treatments. Nevertheless, it is noteworthy that even with the broad and overinclusive definitions the rates of conformance in these studies are consistently low (table 3).

A few studies have investigated the impact of contextual and service-level characteristics on treatment patterns.[9,17,51] For example, Young et al[17] examined the treatment patterns of 224 outpatients with schizophrenia recruited from 2 publicly funded clinics: an outpatient Veterans Administration (VA) clinic and a Community Mental Health Center (CMHC) clinic. The authors found significant differences in the treatment patterns between the 2 settings. More patients in the VA clinic compared with the CMHC clinic received poor quality medication management of their symptoms and side effects (44% vs 31%). Even after excluding patients who had characteristics that contributed to poor treatment quality (such as poor adherence or substance use disorders), the difference between the settings persisted. However, the schizophrenia patients with severe disability in the CMHC clinic were somewhat more likely to receive poor quality case management than those in the VA clinic.[17]

A reanalysis of the PORT study data by Rosenheck et al[51] mainly confirmed the results of the Young et al[17] study by finding greater conformance with the PORT guidelines in the non-VA settings compared with the VA settings of the PORT study. Patients in the non-VA outpatient settings were more likely than their VA counterparts to be taking at least one antipsychotic medication, to be on a depot medication if they had trouble with compliance, or to be receiving work therapy or job training and were less likely to be receiving a dose greater than 600 mg equivalent of chlorpromazine. Patients in the non-VA inpatient settings were also more likely to be offered individual or group therapy or assertive community treatment. However, these patients were more likely than their VA counterparts to be on a dose smaller than 300 mg chlorpromazine equivalent.[51]

In summary, studies comparing treatment patterns in routine treatment settings have mostly found that conformance is poorer for psychosocial treatments than for medications treatments, for outpatient settings than for inpatient settings, and in the VA than in the non-VA facilities. When contrasted with the relatively high-conformance rates with medication treatment benchmarks, the modest conformance rates for vocational rehabilitation and family therapy suggest that the main focus of treatments in many services is on management of symptoms rather than on rehabilitation and improvement of social and occupational functioning.

Correlates of Treatment Patterns

A large number of clinical studies have specifically examined the impact of clinical and sociodemographic characteristics on treatment patterns in general and on adherence with medication treatments in particular.[68,69] Lack of insight, cognitive problems, comorbid substance use disorders, minority racial status, and younger age have all been associated with poorer adherence with treatment.[16,68–71] Whereas the use of depot medications[68] and various psychosocial interventions[2,72] have been shown to improve adherence with medication treatments, the use of both remains limited (table 1). Lack of efficacy and bothersome side effects remain the major reasons for medication nonadherence in most cases.[1]

The Impact of Managed Care

The majority of studies reviewed above were based on data from the 1990s. However, since then, there have been significant changes in the structure and the content of services for patients with severe mental disorders in the United States, most importantly due to expansion of managed care plans. Findings with regard to patterns of treatment under managed care payment arrangements have been mixed.[37,65,66,73,74] One study of 420 Medicaid beneficiaries in Massachusetts found no differences between patients enrolled in a capitated managed care plan and those in

a fee-for-service program with regard to patterns of medication use or the use of psychosocial treatments.[9]

In another study of Medicaid enrollees, the introduction of a carve-out arrangement led to a reduction in the proportion of patients with schizophrenia who received any form of psychosocial treatment, including individual or group psychotherapy or psychosocial rehabilitation. No changes were observed in the area of medication management (eg, likelihood of receiving any antipsychotic medication, receiving second-generation antipsychotics, management of side effects). The authors attributed these changes in the receipt of psychosocial treatments to the fact that managed care carve outs were at financial risk for providing these treatments but not for providing medications.[66]

Similar findings were reported in other settings. For example, results from a Medicaid program in 2 counties in Florida between 1994 and 2000 revealed no meaningful changes in the percentage of patients with schizophrenia who had used antipsychotic medications: 86.2% in 1994–1995 vs 89.8% in 1999–2000.[73] In contrast, in the same time span, the use of individual and/or group therapy decreased from 52.4% to 30.4%, and the rate of psychosocial rehabilitation decreased from 47.6% to 39.7. Less than 1% of the patients received family therapy across the years.[73] A later study based on a sample of patients in the Florida Medicaid program found that the care of patients in a prepaid mental health program and a Health Maintenance Organization was much less likely to conform to the American Psychiatric Association's practice guidelines, mainly due to the low conformance with psychotherapy guidelines.[75]

Another study found a significant increase in the discontinuity of antipsychotic medications after transition to the mental health carve-out arrangement in the Tennessee Medicaid program.[74] The study used administrative data on over 8000 patients in 2 cohorts enrolled in the Medicaid program, one cohort preceded the introduction of the carve-out plan and the other immediately followed it. Among patients for whom continuity of treatment was deemed "essential" based on their history, 29% in the posttransition cohort compared with 20% in the pretransition cohort experienced discontinuity of over 60 days in medication treatment.[74] This study did not examine changes in the use of psychosocial treatments.

Finally, a study examining the prior authorization regulation for the use of atypical antipsychotic medications implemented in the Maine Medicaid program in 2003 also found increased psychiatric medication discontinuity and switching of medications.[76] The Maine program was discontinued in 2004, but as the authors note, many other Medicaid managed care programs across the United States require preauthorization for the costlier antipsychotic medications.[76]

The introduction of the new Medicare Part D insurance may have created new complexities in the care of patients with schizophrenia as this insurance plan includes a cap on spending. There is some evidence that patients with severe mental disorders are at increased risk of discontinuities in medication treatment when faced with gaps in medication insurance coverage such as those imposed by spending caps.[77] The effects of the Part D insurance in this patient population have yet to be fully appreciated.

In summary, managed care arrangements have had variable effects across different settings but are typically associated with reduced use of psychosocial treatments.[71,73,75,78] Furthermore, in some, but not all settings, managed care arrangements appear to be associated with increased discontinuity in treatment.[37,74,78,79]

Unmet Need for Other Services

Patients with schizophrenia often face unmet needs for many other services beyond the traditional mental health services. There has been a renewed interest in the medical care of these patients, including receipt of the needed preventive and treatment services for chronic medical conditions and dental care.[80,81] There is also a growing body of literature pointing to the lower quality of the medical services in patients with schizophrenia and other severe mental disorders,[82–84] as well as a widening mortality gap between these patients and the general population.[85]

The widespread use of the atypical or second-generation antipsychotic medications has further contributed to the medical problems of patients with schizophrenia as some of these medications are associated with significant weight gain and an increased risk of hyperglycemia and hyperlipidemia.[1] Nevertheless, the need for proper monitoring of these metabolic parameters and interventions to reduce the risk of future comorbidities often remains unmet. In one study of Medicaid patients who were started on an atypical antipsychotic medication, only 19% received baseline glucose testing and 6% received baseline lipid testing.[86] The rates increased modestly between 1998 and 2003.[86] In another study of patients in 3 VA clinics between 2002 and 2004, 46.2% had a weight problem.[87] In almost none was the weight problem appropriately managed. As another example, a recent study of smokers with type 2 diabetes found that individuals with schizophrenia in this sample were significantly less likely than their counterparts without a serious mental illness to receive preventive treatments such as regular blood pressure examinations, lipid profiles, or treatment with angiotensin converting enzyme inhibitors or statins.[88]

The high prevalence of medical problems in patients with schizophrenia also calls for integration or better coordination of mental health and general medical services.[89] However, coordination between various services for this patient group and other patients with severe mental disorders is often inadequate.[90] For example, in a study of the Massachusetts Medicaid beneficiaries, contact between the mental health and the outpatient primary care providers was noted in only 43%–50% of

the inpatients and 22.1%–24.2% of the outpatients with schizophrenia.[9]

Another mostly unmet service need in this patient population that also calls for integration of services or coordination across services is the need for substance abuse treatment.[90] Drug and alcohol disorders are commonly comorbid with schizophrenia. For example, in the National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness, about 60% of schizophrenia patients were found to use substances and 37% met criteria for a current substance use disorder.[91] Furthermore, these disorders have significant implications for the management and the social and clinical outcomes of schizophrenia.[91–94] Nevertheless, in many of these patients, substance disorders go untreated. In one study, only about half of the schizophrenia patients with a need for substance abuse treatment received such care.[9] The traditional separation between mental health and substance abuse services further contributes to the problem of unmet need for substance abuse treatment in this patient population. The recognition that substance comorbidity in this population is the norm rather than an exception and that addressing one problem without the other is inefficient has led to a number of recent attempts at implementation of integrated programs.[95,96] Dual diagnosis programs are also now available in many substance disorder treatment facilities, although the range of services needed by dual diagnosis patients is not available in all these programs.[97]

Many schizophrenia patients smoke.[98–100] A meta-analysis of over 40 studies from across the world found both a greater risk of current smoking (odds ratio [OR] = 5.3, 95% confidence interval [CI] = 4.9–5.7) and a lower likelihood of smoking cessation (OR = 0.46, 95% CI = 0.23–0.69) in patients with schizophrenia.[98] The estimated prevalence of smoking in schizophrenia patients in this meta-analysis was 62%,[98] attesting to the unmet need for management of smoking in this patient population.

Meeting the patients' multiple needs for medical care and substance abuse treatment is especially difficult for practitioners working in solo practices or in small, single specialty group practices. For these practitioners, the solution to this problem calls for establishing more meaningful links and better coordination with other providers or agencies. The growing use of information technology can potentially facilitate such coordination.[101,102] However, psychiatry has been slow in adopting information technology.[103]

Better integration of individuals with schizophrenia in the community would ultimately depend on their ability to attain meaningful social roles, including useful employment that can provide a sense of mastery and self-worth. Due to the disabling nature of the illness, many individuals with schizophrenia would need extra support and guidance beyond traditional vocational counseling to find and maintain useful employment. There is a growing body of literature indicating that supported employment produces better results than conventional vocational training or other interventions in this patient population.[104–107] Dissemination of these practices in the VA system has produced modest but promising results.[108–110]

Finally, many patients with schizophrenia are at increased risk of homelessness and associated adverse social and health outcomes, such as victimization and sexually transmitted diseases.[91,111–116] These patients often need the help of a case manager to negotiate the elaborate maze of social service organizations and to obtain housing and other needed social services.[117] However, as data reviewed earlier suggest (table 3), only a minority of patients in need of case management receive such service.

Patients' Perceived Unmet Need for Care

The studies reviewed above underscore the deficiencies in the treatment of schizophrenia by examining the patterns of service use in routine treatment settings and, in some cases, by comparing these patterns with the evidence-based practice guideline recommendations for the treatment of schizophrenia. Another perspective on the problem of unmet need for care in this patient population is the patients' perceptions of the nature and extent of their met and unmet needs.[118–124] This direct approach to assessing needs is in keeping with current trends toward shared decision making in the care of patients with severe mental disorders and reflects the diversity of the needs in this patient population.[125–127]

Over the years, a number of instruments have been developed to assess the patients' perceptions of their needs.[122–124] Perhaps, the most widely used of these measures is the Camberwell Assessment of Needs (CAN) instrument that asks questions regarding the perceived met and unmet needs of the patients in areas ranging from the management of psychotic symptoms to the need for food, child-care, and transportation. Studies comparing patient and staff reports of met and unmet needs in these areas have identified some consistencies.[119,123] However, the studies have also identified differences between the patient and staff views, especially with regard to unmet needs. For example, in a Nordic study of schizophrenia patients, the most prevalent patient-identified unmet needs were in the domains of company, intimate relationships, and psychological distress; whereas, psychotic symptoms and daytime activities were among the top-rated areas of unmet need by the staff.[119] Furthermore, the small number of patient-reported unmet needs in these studies is surprising given the wide gaps in the quality of treatment in routine treatment settings. For example, out of the 22 possible unmet needs on the CAN instrument, the patients and caregivers in the Nordic study identified on average about 2 unmet needs.[119] The differences in the patient and staff views, as well as between the unmet needs identified in the epidemiological and

the clinical studies on the one hand and the patients' perceptions of unmet needs on the other hand, highlight the complexities inherent in defining needs and, by extension, in defining the unmet needs in this patient population.[122]

A number of factors likely contribute to the differences in results of need assessment using these different approaches and perspectives. Many patients with schizophrenia may not fully appreciate the extent of their mental health problems and their mental healthcare needs.[128,129] Furthermore, individuals vary in their needs and responses to treatments, whereas evidence-based standards provide universal benchmarks based on the needs and treatment responses of a typical patient. Finally, perceptions of need naturally differ between different stakeholders, and no one perspective can be said to be necessarily more accurate or true than another. Rather, these differences in the patient and provider perspectives may present opportunities to involve patients and families as well as other stakeholders in the treatment planning process.[130,131]

Conclusion

The preceding overview of the literature on patterns of treatment in schizophrenia and the extent of the unmet need for care reveals considerable gaps in our current knowledge. First, there is a paucity of reliable data from population-based epidemiological studies in the United States on which to base the population estimates of treatment and the potential unmet need for treatment. As noted earlier, difficulties inherent in the assessment of rare disorders severely limit our ability to accurately identify individuals with schizophrenia in ongoing epidemiological surveys of general populations using lay-administered interview instruments.[33] Without accurate identification of the cases, establishing treatment patterns and the extent of the unmet need for care in these surveys is not feasible. Multistage survey methods[132] or clinician-augmented surveys[30] improve upon such classification, but they typically incur considerable additional costs and are not always implemented. Furthermore, these methods cannot resolve the problem of selective nonresponse and undersampling of individuals who are homeless, incarcerated, or living in quasi-institutional community settings.[30]

Nevertheless, the available data from the major US population surveys suggest that approximately 40% of individuals in the community with schizophrenia remain out of care either consistently or at least for long periods of time while experiencing significant symptoms. Clinical epidemiological studies address some of the limitations of general population surveys by reducing the false-positive rate and by using more detailed assessments.[11,36,41] These studies also indicate that a significant percentage of patients remain consistently out of treatment after their initial contact with services. In the Suffolk County Mental Health Project, eg, 20% of patients with a diagnosis of schizophrenia remained consistently out of medication treatment and about 40% remained consistently out of therapy.

As the large majority of these individuals continue to experience significant symptoms and disability, making services available to them remains a priority. The stigma associated with mental illness and its treatment is a major barrier to treatment seeking among these individuals. Much attention has focused on reducing this stigma using media and educational campaigns. The World Psychiatric Association's program to fight stigma and discrimination against schizophrenia, implemented in over 20 countries, has been one of the most extensive of such efforts.[133] With regard to more common disorders, such public campaigns have resulted in modest improvements in attitudes and treatment seeking.[134,135] There is also evidence from Australia and Germany that public attitudes toward mental health treatment seeking for schizophrenia became more favorable between the early 1990s and the early 2000s.[136,137] However, due to the relative rarity of schizophrenia, the impact of changes in public attitudes on treatment seeking for this disorder may be more difficult to assess than the impact on treatment seeking for the more common mood and anxiety disorders.

Another significant problem affecting the continuity of treatment of schizophrenia in routine care settings is the problem of nonadherence with treatments.[14–16,72] Up to half of schizophrenia patients, experience extended gaps in their treatment in a 1-year period leading to increased hospitalizations and other adverse outcomes.[14,138,139] There have been a number of focused attempts to reduce the frequency of these gaps and to improve the patients' adherence using psychosocial interventions based on motivational interviewing methods, other cognitive-behavioral approaches, psychoeducation, medication self-management, and, more recently, environmental support.[72,140,141] However, the evidence with regard to the efficacy of some of these interventions has been mixed.[142–144] Furthermore, the mental health services have been slow in adopting these interventions.

The problem of unmet need for care in individuals who never initiate treatment or in patients who disengage from treatment is compounded by the unmet needs of a large proportion of patients who are in treatment but who continue to experience significant symptoms and disability. At least half of all patients with schizophrenia treated in routine care settings continue to have significant psychotic or other psychiatric symptoms that are potentially amenable to pharmacological treatments.[49,87] Comparisons of the treatment patterns in routine treatment settings with evidence-based standards show that the overwhelming majority of individuals in treatment receive antipsychotic medications. Furthermore, at least in inpatient settings, the dose of prescribed antipsychotic medications is usually in the therapeutic range. However, there are gaps between current practices

and evidence-based recommendations with regard to the appropriate pharmacological management of nonpsychotic symptoms and side effects, use of psychosocial treatments, and use of medical, dental, and substance disorder services and social services and with regard to coordination among the different services.

There is growing evidence that guideline-conformant treatments could potentially improve patient outcomes and reduce the avertable social and health burden of psychiatric illness[75,145] at minimal additional costs.[75,146] However, services have been slow in adopting care practices that are consistent with the evidence-based guidelines. The individual practice styles and institutional barriers such as lack of resources all likely contribute to the slow adoption of the guideline-consistent practices.[147,148]

Setting performance measures appears to be a straightforward approach to improving conformance with practice guidelines. In the VA health-care system, creating system-wide evidence-based performance measures has had some degree of success in improving conformance with the guidelines.[149–151] For example, one performance measure requiring that all veterans have a primary care provider has led to significant improvement in medical care and receipt of preventive services in patients with severe mental disorders. However, changing clinician's practice styles is not easy.[152] Although introducing incentives, eg, in the form of pay-for-performance arrangements, appears to be an attractive approach to changing clinician's behaviors, when applied in general medical settings, these initiatives have had mixed results, sometimes with unintended adverse consequences.[153–157]

The expansion of managed care in more recent years may have further widened the gap between usual practice and evidence-based standards, at least with regard to the use of psychosocial treatments[66,73,75] and, perhaps, continuity of treatments.[37,74] As Mechanic[65] notes, the trend toward restricting the intensity of services under managed care plans may have led to more homogeneous service patterns and less variation among the different patient populations with different levels of need.

The consistent finding of a reduced use of psychosocial treatments under managed care is disconcerting as psychosocial treatments are often complementary to medications and can potentially address problem areas that are less responsive to medication treatments, such as poor social skills and negative symptoms.[2,158,159] Furthermore, psychosocial treatments are likely more beneficial in the later stages of illness when the acute symptoms have subsided.[2] The long-term impact of managed care on the clinical and social outcomes of the patients with schizophrenia remains to be fully appreciated.[65,75]

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disorder, it is usually secondary to repeated interpersonal failures due to angry outbursts and frequent mood shifts, rather than a result of a persistent lack of social contacts and desire for intimacy. Furthermore, individuals with schizotypal personality disorder do not usually demonstrate the impulsive or manipulative behaviors of the individual with borderline personality disorder. However, there is a high rate of co-occurrence between the two disorders, so that making such distinctions is not always feasible. Schizotypal features during adolescence may be reflective of transient emotional turmoil, rather than an enduring personality disorder.

Cluster B Personality Disorders

Antisocial Personality Disorder

Diagnostic Criteria 301.7 (F60.2)

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
   1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
   2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
   3. Impulsivity or failure to plan ahead.
   4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
   5. Reckless disregard for safety of self or others.
   6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
   7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Diagnostic Features

The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern has also been referred to as *psychopathy, sociopathy,* or *dyssocial personality disorder.* Because deceit and manipulation are central features of antisocial personality disorder, it may be especially helpful to integrate information acquired from systematic clinical assessment with information collected from collateral sources.

For this diagnosis to be given, the individual must be at least age 18 years (Criterion B) and must have had a history of some symptoms of conduct disorder before age 15 years (Criterion C). Conduct disorder involves a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The specific behaviors characteristic of conduct disorder fall into one of four categories: aggression to people and animals, destruction of property, deceitfulness or theft, or serious violation of rules.

The pattern of antisocial behavior continues into adulthood. Individuals with antisocial personality disorder fail to conform to social norms with respect to lawful behavior (Criterion A1). They may repeatedly perform acts that are grounds for arrest (whether they are arrested or not), such as destroying property, harassing others, stealing, or pursuing illegal occupations. Persons with this disorder disregard the wishes, rights, or feelings of others. They are frequently deceitful and manipulative in order to gain personal profit or pleasure (e.g., to obtain money, sex, or power) (Criterion A2). They may repeatedly lie, use an alias, con others, or malinger. A pattern of impulsivity may be manifested by a failure to plan ahead (Criterion A3). Decisions are made on the spur of the moment, without forethought and without consideration for the consequences to self or others; this may lead to sudden changes of jobs, residences, or relationships. Individuals with antisocial personality disorder tend to be irritable and aggressive and may repeatedly get into physical fights or commit acts of physical assault (including spouse beating or child beating) (Criterion A4). (Aggressive acts that are required to defend oneself or someone else are not considered to be evidence for this item.) These individuals also display a reckless disregard for the safety of themselves or others (Criterion A5). This may be evidenced in their driving behavior (i.e., recurrent speeding, driving while intoxicated, multiple accidents). They may engage in sexual behavior or substance use that has a high risk for harmful consequences. They may neglect or fail to care for a child in a way that puts the child in danger.

Individuals with antisocial personality disorder also tend to be consistently and extremely irresponsible (Criterion A6). Irresponsible work behavior may be indicated by significant periods of unemployment despite available job opportunities, or by abandonment of several jobs without a realistic plan for getting another job. There may also be a pattern of repeated absences from work that are not explained by illness either in themselves or in their family. Financial irresponsibility is indicated by acts such as defaulting on debts, failing to provide child support, or failing to support other dependents on a regular basis. Individuals with antisocial personality disorder show little remorse for the consequences of their acts (Criterion A7). They may be indifferent to, or provide a superficial rationalization for, having hurt, mistreated, or stolen from someone (e.g., "life's unfair," "losers deserve to lose"). These individuals may blame the victims for being foolish, helpless, or deserving their fate (e.g., "he had it coming anyway"); they may minimize the harmful consequences of their actions; or they may simply indicate complete indifference. They generally fail to compensate or make amends for their behavior. They may believe that everyone is out to "help number one" and that one should stop at nothing to avoid being pushed around.

The antisocial behavior must not occur exclusively during the course of schizophrenia or bipolar disorder (Criterion D).

Associated Features Supporting Diagnosis

Individuals with antisocial personality disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal (e.g., feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile (e.g., using technical terms or jargon that might impress someone who is unfamiliar with the topic). Lack of empathy, inflated self-appraisal, and superficial charm are features that have been commonly included in traditional conceptions of psychopathy that may be particularly distinguishing of the disorder and more predictive of recidivism in prison or forensic settings, where criminal, delinquent, or aggressive acts are likely to be nonspecific. These individuals may also be irresponsible and exploitative in their sexual relationships. They may have a history of many

sexual partners and may never have sustained a monogamous relationship. They may be irresponsible as parents, as evidenced by malnutrition of a child, an illness in the child resulting from a lack of minimal hygiene, a child's dependence on neighbors or nonresident relatives for food or shelter, a failure to arrange for a caretaker for a young child when the individual is away from home, or repeated squandering of money required for household necessities. These individuals may receive dishonorable discharges from the armed services, may fail to be self-supporting, may become impoverished or even homeless, or may spend many years in penal institutions. Individuals with antisocial personality disorder are more likely than people in the general population to die prematurely by violent means (e.g., suicide, accidents, homicides).

Individuals with antisocial personality disorder may also experience dysphoria, including complaints of tension, inability to tolerate boredom, and depressed mood. They may have associated anxiety disorders, depressive disorders, substance use disorders, somatic symptom disorder, gambling disorder, and other disorders of impulse control. Individuals with antisocial personality disorder also often have personality features that meet criteria for other personality disorders, particularly borderline, histrionic, and narcissistic personality disorders. The likelihood of developing antisocial personality disorder in adult life is increased if the individual experienced childhood onset of conduct disorder (before age 10 years) and accompanying attention-deficit/hyperactivity disorder. Child abuse or neglect, unstable or erratic parenting, or inconsistent parental discipline may increase the likelihood that conduct disorder will evolve into antisocial personality disorder.

Prevalence

Twelve-month prevalence rates of antisocial personality disorder, using criteria from previous DSMs, are between 0.2% and 3.3%. The highest prevalence of antisocial personality disorder (greater than 70%) is among most severe samples of males with alcohol use disorder and from substance abuse clinics, prisons, or other forensic settings. Prevalence is higher in samples affected by adverse socioeconomic (i.e., poverty) or sociocultural (i.e., migration) factors.

Development and Course

Antisocial personality disorder has a chronic course but may become less evident or remit as the individual grows older, particularly by the fourth decade of life. Although this remission tends to be particularly evident with respect to engaging in criminal behavior, there is likely to be a decrease in the full spectrum of antisocial behaviors and substance use. By definition, antisocial personality cannot be diagnosed before age 18 years.

Risk and Prognostic Factors

Genetic and physiological. Antisocial personality disorder is more common among the first-degree biological relatives of those with the disorder than in the general population. The risk to biological relatives of females with the disorder tends to be higher than the risk to biological relatives of males with the disorder. Biological relatives of individuals with this disorder are also at increased risk for somatic symptom disorder and substance use disorders. Within a family that has a member with antisocial personality disorder, males more often have antisocial personality disorder and substance use disorders, whereas females more often have somatic symptom disorder. However, in such families, there is an increase in prevalence of all of these disorders in both males and females compared with the general population. Adoption studies indicate that both genetic and environmental factors contribute to the risk of developing antisocial personality disorder. Both adopted and biological children of parents with antisocial personality disorder have an increased

risk of developing antisocial personality disorder, somatic symptom disorder, and substance use disorders. Adopted-away children resemble their biological parents more than their adoptive parents, but the adoptive family environment influences the risk of developing a personality disorder and related psychopathology.

Culture-Related Diagnostic Issues

Antisocial personality disorder appears to be associated with low socioeconomic status and urban settings. Concerns have been raised that the diagnosis may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy. In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur.

Gender-Related Diagnostic Issues

Antisocial personality disorder is much more common in males than in females. There has been some concern that antisocial personality disorder may be underdiagnosed in females, particularly because of the emphasis on aggressive items in the definition of conduct disorder.

Differential Diagnosis

The diagnosis of antisocial personality disorder is not given to individuals younger than 18 years and is given only if there is a history of some symptoms of conduct disorder before age 15 years. For individuals older than 18 years, a diagnosis of conduct disorder is given only if the criteria for antisocial personality disorder are not met.

Substance use disorders. When antisocial behavior in an adult is associated with a substance use disorder, the diagnosis of antisocial personality disorder is not made unless the signs of antisocial personality disorder were also present in childhood and have continued into adulthood. When substance use and antisocial behavior both began in childhood and continued into adulthood, both a substance use disorder and antisocial personality disorder should be diagnosed if the criteria for both are met, even though some antisocial acts may be a consequence of the substance use disorder (e.g., illegal selling of drugs, thefts to obtain money for drugs).

Schizophrenia and bipolar disorders. Antisocial behavior that occurs exclusively during the course of schizophrenia or a bipolar disorder should not be diagnosed as antisocial personality disorder.

Other personality disorders. Other personality disorders may be confused with antisocial personality disorder because they have certain features in common. It is therefore important to distinguish among these disorders based on differences in their characteristic features. However, if an individual has personality features that meet criteria for one or more personality disorders in addition to antisocial personality disorder, all can be diagnosed. Individuals with antisocial personality disorder and narcissistic personality disorder share a tendency to be tough-minded, glib, superficial, exploitative, and lack empathy. However, narcissistic personality disorder does not include characteristics of impulsivity, aggression, and deceit. In addition, individuals with antisocial personality disorder may not be as needy of the admiration and envy of others, and persons with narcissistic personality disorder usually lack the history of conduct disorder in childhood or criminal behavior in adulthood. Individuals with antisocial personality disorder and histrionic personality disorder share a tendency to be impulsive, superficial, excitement seeking, reckless, seductive, and manipulative, but persons with histrionic personality disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviors. Individuals with histrionic and borderline personality disorders are

manipulative to gain nurturance, whereas those with antisocial personality disorder are manipulative to gain profit, power, or some other material gratification. Individuals with antisocial personality disorder tend to be less emotionally unstable and more aggressive than those with borderline personality disorder. Although antisocial behavior may be present in some individuals with paranoid personality disorder, it is not usually motivated by a desire for personal gain or to exploit others as in antisocial personality disorder, but rather is more often attributable to a desire for revenge.

Criminal behavior not associated with a personality disorder. Antisocial personality disorder must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic of this disorder. Only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impairment or subjective distress do they constitute antisocial personality disorder.

Borderline Personality Disorder

Diagnostic Criteria **301.83 (F60.3)**

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Diagnostic Features

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician's announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this "abandonment" implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic

Evaluating Competency for Execution after *Madison v. Alabama*

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This article summarizes the evolution of the U.S. Supreme Court's standard for assessing defendants' competency for execution. In *Ford v. Wainwright* (1986), the Court categorically exempted insane defendants from execution but failed to agree on how to define insanity. In *Panetti v. Quarterman* (2007), the Court ruled that defendants may be executed only if they rationally understand why they are being punished. In its most recent decision, the Supreme Court ruled in *Madison v. Alabama* (2019) that defendants who cannot remember committing the original crime may be executed, but dementia may prevent defendants from rationally understanding why they are being punished. The Court remanded the case to Alabama's trial court with instructions to redetermine Mr. Madison's competency. This article concludes by recommending best practices for those who evaluate defendants for competency to be executed.

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In 1986, the U.S. Supreme Court ruled that the Eighth Amendment prohibits executing insane defendants.[1] Years later, in 2007, the Court clarified that the Eighth Amendment forbids executing those who cannot rationally understand why they are to be executed and noted that psychotic disorders may preclude such an understanding.[2] Most recently, in 2019, the Court ruled that a finding of incompetency to be executed is not associated with any particular diagnosis but rather with a specific consequence, i.e., the defendant's inability to rationally understand the reasons for the imposition of the death sentence. This article reviews Supreme Court cases on competency for execution and concludes by recommending best practices for those who evaluate defendants in this capacity.

Ford v. Wainwright

Ford v. Wainwright (1986)[1] marked the first time that the U.S. Supreme Court addressed the question of whether the Eighth Amendment's prohibition against cruel and unusual punishment forbids executing "the insane" (Ref. 1, p 401). Although Alvin Ford appeared competent throughout his trial, he exhibited signs of delusions during his subsequent imprisonment. Unlike many cases, the Court in *Ford* did not achieve a traditional majority opinion. Instead, Justice Powell concurred in part with four other Justices to hold that "the Eighth Amendment prohibits a State from carrying out a sentence of death upon a prisoner who is insane" (Ref. 1, pp 409–10). The Court reasoned that "[i]t is no less abhorrent today than it has been for centuries to exact in penance the life of one whose mental illness prevents him from comprehending the reasons for the penalty or its implications" (Ref. 1, p 417).

Four of the five Justices who formed the plurality believed that defendants should have the right to cross-examine state experts, among other procedural protections.[1] Justice Powell, however, expressed the view that "ordinary adversarial procedures—complete with live testimony, cross-examination, and oral argument by counsel—are not necessarily the best means of arriving at sound, consistent judgments as to a defendant's sanity" (Ref. 1, p 426). The only procedural right that Justice Powell explicitly endorsed was the defendant's right to present "expert psychiatric evidence that may differ from the State's own psychiatric examination" (Ref. 1, p 427).

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The Court plurality declared that "we leave to the State the task of developing appropriate ways to enforce the constitutional restriction upon its execution of sentences" (Ref. 1, pp 416–17). In other words, the plurality did not articulate a specific standard for assessing competency for execution. Justice Powell, however, noted that, at a minimum, states' statutes agreed that defendants must "know the fact[s] of their impending execution and the reason for it" (Ref. 1, p 422). Justice Powell wrote, "I would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it" (Ref. 1, p 422). Thus, Justice Powell considered a defendant able to understand why they are being executed "[i]f the defendant perceives the connection between his crime and his punishment" (Ref. 1, p 422).

When applying this standard to Mr. Ford, Justice Powell concluded, "According to petitioner's proffered psychiatric examination, petitioner does not know that he is to be executed, but rather believes that the death penalty has been invalidated. If this assessment is correct, petitioner cannot connect his execution to the crime for which he was convicted" (Ref. 1, pp 422–23).

Panetti v. Quarterman (2007)

The Court next addressed competency for execution in *Panetti v. Quarterman* (2007),[2] where Scott Panetti displayed "a fragmented personality, delusions, and hallucinations" (Ref. 2, p 936). After the trial court found Mr. Panetti competent for execution, Mr. Panetti's counsel filed a writ of *habeas corpus*. The district court[3] held that "[b]ecause the Court finds that Panetti knows he committed two murders, he knows he is to be executed, and he knows the reason the State has given for his execution is his commission of those murders, he is competent to be executed" (Ref. 3, p 712). Mr. Panetti subsequently appealed to the U.S. Court of Appeals for the Fifth Circuit,[4] claiming that:

> the Eighth Amendment forbids the execution of a prisoner who lacks a rational understanding of the State's reason for the execution . . . [and] this understanding is lacking in his case because he believes that, although the State's purposed reason for the execution is his past crimes, the State's real motivation is to punish him for preaching the Gospel (Ref. 4, pp 817–18).

The Fifth Circuit found Mr. Panetti competent for execution because "'awareness,' as that term is used in *Ford*, is not necessarily synonymous with 'rational understanding,' as argued by Panetti" (Ref. 4, p 821). The Supreme Court subsequently granted *certiorari*.[5]

The Court identified the question before it as "whether [Mr. Panetti's] delusions can be said to render him incompetent" for execution (Ref. 2, p 956). According to the Court, the Fifth Circuit found Mr. Panetti competent because "[f]irst, petitioner is aware that he committed the murders; second, he is aware that he will be executed; and, third, he is aware that the reason the State has given for the execution is his commission of the crimes in question" (Ref. 2, p 956).

Nevertheless, the Court held that "the Court of Appeals' standard is too restrictive to afford a prisoner the protections granted by the Eighth Amendment" (Ref. 2, pp 956-57). In its decision, the Court criticized the Fifth Circuit for concluding "that its standard foreclosed petitioner from establishing incompetency by . . . showing that his mental illness obstructs a rational understanding of the State's reason for his execution" (Ref. 2, p 957). As the Court noted, a "prisoner's awareness of the State's rationale for an execution is not the same as a rational understanding of it. *Ford* does not foreclose inquiry into the latter" (Ref. 2, p 959). Furthermore, although *Ford* "did not set forth a precise standard for competency" (Ref. 2, p 957), the Court explained that "[t]he beginning of doubt about competence in a case like petitioner's . . . is a psychotic disorder" (Ref. 2, p 960).

The Court elaborated, writing that "[g]ross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose" (Ref. 2, p 960). If these delusions influence "the prisoner's concept of reality [so] that he cannot reach a rational understanding of the reason for the execution," then they preclude execution (Ref. 2, p 958). As a result, states cannot use "a strict test for competency that treats delusional beliefs as irrelevant once the prisoner is aware the State has identified the link between his crime and the punishment to be inflicted" (Ref. 2, p 960).

In its opinion, the Court cautioned that "[a]lthough we reject the standard followed by the Court of Appeals, we do not attempt to set down a rule governing all competency determinations" (Ref. 2, pp 960–

61). Nevertheless, the Court observed that "[t]he conclusions of physicians, psychiatrists, and other experts in the field will bear upon the proper analysis. Expert evidence may clarify the extent to which severe delusions may render a subject's perception of reality so distorted that he should be deemed incompetent" (Ref. 2, p 962).

Madison v. Alabama (2019)

First convicted of capital murder of a police officer in 1985, Vernon Madison spent so much time on death row that he "suffered [several] strokes resulting in significant cognitive and physical decline" (Ref. 6, p 1177). During Mr. Madison's competency for execution hearing in the trial court, a defense expert testified that:

> his strokes caused major vascular disorder (also known as vascular dementia) and related memory impairments and that, as a result, he has no memory of committing the murder—the very act that is the reason for his execution. To the contrary, Mr. Madison does not believe he ever killed anyone (Ref. 6, p 1177).

As a result, pursuant to *Ford* and *Panetti*, Mr. Madison's defense claimed that he was incompetent to be executed because he lacked "a rational understanding of why the state [was] seeking to execute him" (Ref. 6, p 1177).

In contrast, Alabama's expert testified that Mr. Madison "was able to accurately discuss his legal appeals and legal theories with his attorneys," and therefore must rationally understand why he was being executed (Ref. 6, p 1177). The trial court overseeing Mr. Madison's competency hearing agreed with the State of Alabama, finding Mr. Madison competent for execution. Alabama argued that Mr. Madison was competent for execution because he understood his legal situation and did not display any sign of psychosis or delusions, which the Court had focused on in *Panetti*. In response, Mr. Madison's writ of *habeas corpus* to the relevant federal district court was denied; thereafter, he appealed to the U.S. Court of Appeals for the Eleventh Circuit.

The Eleventh Circuit observed that Mr. Madison qualified as legally blind and had experienced a minimum of two strokes recently (Ref. 6, p 1179). In the aftermath of the first stroke, Mr. Madison regularly requested that someone tell his mother about the stroke, even though she had died several years prior to the incident. After the second stroke, Mr. Madison "reported frequently urinating on himself because 'no one will let me out to use the bathroom,' although he ha[d] a toilet in his cell" (Ref. 6, p 1179). Perhaps most telling, Mr. Madison informed his attorney "that he planned to move to Florida after his release from prison" (Ref. 6, p 1179). On the basis of this evidence, the Eleventh Circuit held that Mr. Madison's dementia prevented him from "rationally understand[ing] the connection between his crime and his execution" (Ref. 6, p 1186), ruling that "the state court's decision that Mr. Madison is competent to be executed rested on an unreasonable determination of the facts" (Ref. 6, p 1178) because the state's expert "never testified that Mr. Madison understands that his execution is connected to the murder he committed" (Ref. 6, p 1187).

In addition, the Eleventh Circuit noted that "the State suggests that only a prisoner suffering from gross delusions can show incompetency under *Panetti*" (Ref. 6, p 1188). Rejecting this argument, the court said that neither *Ford* nor *Panetti* required that "a prisoner must suffer from delusions to be deemed incompetent" (Ref. 6, p 1188). The Eleventh Circuit held that "[a] finding that a man with no memory of what he did wrong has a rational understanding of why he is being put to death is patently unreasonable" (Ref. 6, p 1189). Finally, the Eleventh Circuit determined that, "due to his dementia and related memory impairments, Mr. Madison lacks a rational understanding of the link between his crime and execution" (Ref. 6, p 1190). The state of Alabama appealed this decision to the U.S. Supreme Court.

Pursuant to the Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA), the Supreme Court held in *Dunn v. Madison* (2017)[7] that "[n]either *Panetti* nor *Ford* 'clearly established' that a prisoner is incompetent to be executed because of a failure to remember his commission of the crime" (Ref. 7, pp 11–12). Thus, the question of whether an individual recalls committing a crime is "distinct from a failure to rationally comprehend the concepts of crime and punishment as applied in his case" (Ref. 7, p 12). Mr. Madison, therefore, displayed competency to be executed despite severe memory loss because "he recognizes that he will be put to death as punishment for the murder he was found to have committed" (Ref. 7, p 12). The Court ruled that Mr. Madison's "claim to federal *habeas* relief must fail" because the appeal was pursuant to the highly deferential standards of the AEDPA. The Court further clarified that "[w]e express no

view on the merits of the underlying question" in any context other than *habeas corpus* proceedings (Ref. 7, p 12). As a result, the Court reversed the Eleventh Circuit's decision.

Following the Court's *Dunn v. Madison* opinion, Mr. Madison's attorney once again alleged on remand that he was incompetent for execution, but Alabama's Circuit Court for Mobile County disagreed, scheduling an execution date. The Supreme Court issued a stay of execution on January 25, 2018,[8] and granted *certiorari* on January 26, 2018.[9] On February 27, 2019, the Court decided *Madison v. Alabama*,[10] addressing two separate questions: "does the Eighth Amendment forbid execution whenever a prisoner shows that a mental disorder has left him without any memory of committing a crime?"; and "does the Eighth Amendment apply similarly to a prisoner suffering from dementia as to one experiencing psychotic delusions?" (Ref. 10, p 722). In a 5–3 decision written by Justice Kagan, in which Justice Kavanaugh did not participate, the Court held that "a person lacking memory of his crime may yet rationally understand why the State seeks to execute him; if so, the Eighth Amendment poses no bar to his execution" (Ref. 10, p 726). Thus, "[a]ssuming . . . no other cognitive impairment, loss of memory of a crime does not prevent rational understanding of the State's reasons for resorting to punishment" (Ref. 10, p 727). If memory loss "interacts with other mental shortfalls," however, and the defendant cannot rationally understand the reason for the punishment, then the defendant is incompetent to be executed (Ref. 10, 727–8). This standard applies to all defendants who have "difficulty preserving any memories, so that even newly gained knowledge (about, say, the crime and punishment) will be quickly forgotten" (Ref. 10, p 728). The same standard also applies "when cognitive deficits prevent the acquisition of such knowledge at all, so that memory gaps go forever uncompensated" (Ref. 10, p 728).

The Court further held that "a person suffering from dementia may be unable to rationally understand the reasons for his sentence; if so, the Eighth Amendment does not allow his execution" (Ref. 10, pp 726–7). According to the Court, the proper standard for determining incompetency for execution is whether "a particular *effect*" exists, specifically, "an inability to rationally understand why the State is seeking execution" (Ref. 10, p 728, italics in original). The "precise *cause*" of that effect is irrelevant (Ref. 10, p 728, italics in original). It is not the diagnosis of mental illness, but the consequence of it that governs competency for execution. For this reason, the Court cautioned states against emphasizing a given diagnosis (or its lack) over the "downstream consequence" of that diagnosis (Ref. 10, p 729).

The Court provided additional clarity, writing that "[p]sychosis or dementia, delusions or overall cognitive decline are all the same under *Panetti*, so long as they produce the requisite lack of comprehension" (Ref. 10, p 728). Consistent with this reasoning, "if and when that failure of understanding is present, the rationales kick in—irrespective of whether one disease or another (say, psychotic delusions or dementia) is to blame" (Ref. 10, p 729). As the Court recognized, although many delusions inhibit "the understanding that the Eighth Amendment requires," some delusions do not (Ref. 10, p 729). Similarly, dementia

> can cause such disorientation and cognitive decline as to prevent a person from sustaining a rational understanding of why the State wants to execute him . . . . But dementia also has milder forms, which allow a person to preserve that understanding. Hence the need—for dementia as for delusions as for any other mental disorder—to attend to the particular circumstances of a case . . . (Ref. 10, p 729)

In both scenarios, "[w]hat matters is whether a person has the 'rational understanding' *Panetti* requires—not whether he has any particular memory or any particular mental illness" (Ref. 10, p 727). This "kind of comprehension is the *Panetti* standard's singular focus" (Ref. 10, p 727), thus "the sole inquiry for [reviewing] court[s] remains whether the prisoner can rationally understand the reasons for his death sentence" (Ref. 10, p 728). The Court concluded by remanding the case to Alabama's trial court "for renewed consideration of Madison's competency (assuming Alabama sets a new execution date)" (Ref. 10, p 731).

Justice Alito wrote the dissent and was joined by Justices Gorsuch and Thomas. According to the dissent, Mr. Madison's attorney requested *certiorari* to address the issue of whether states can execute defendants who do not remember committing the crime for which they are to be executed. Following the Court's grant of *certiorari*, however, the dissent alleged that Mr. Madison's attorney changed tactics by then arguing that Mr. Madison's dementia prevented him from rationally understanding why he was to be executed. In Justice Alito's view, the Majority erred by ruling on a question that the Court did not agree to address.

Best Practices for Evaluators

When discussing whether the American Academy of Psychiatry and the Law (AAPL) should oppose executions as a professional organization, Halpern and colleagues called upon AAPL to "tak[e] a stand on vital social issues that are clearly in the public interest" (Ref. 11, p 182). This same principle holds true when it comes to establishing the minimum requirements that professionals should meet in conducting evaluations of defendants' competency for execution.[12] Absent instruction from professional organizations like AAPL, we recommend that, at a minimum, qualified evaluators must be licensed psychologists, psychiatrists, or physicians in good standing in their profession with extensive experience assessing mental health disorders prior to being considered for appointment as an expert evaluator. This standard mirrors the minimum requirements that legal scholars have proposed for professionals who assess capital defendants for intellectual disability.[13]

Evaluators should meet with the defendant in person[14] for an appropriate length of time[15,16] when conducting a competency evaluation. What constitutes an appropriate period of time will necessarily vary based on the evaluee's mental state. In situations where the evaluee is too impaired to meaningfully participate in the interview process, interviews may be brief. Other interviews, however, could last several hours. Because the required threshold for establishing competence for execution is relatively low, a single meeting may be sufficient to evaluate defendants who are cognitively intact and not actively displaying symptoms of mental illness. In other, more complex situations involving defendants exhibiting cognitive decline and active symptoms of mental illness, it may be necessary to meet with the defendant on multiple occasions.[12] The evaluations themselves should take place in "a private, distraction-free area," which may require temporarily moving the defendant off of death row (Ref. 12, p 209), where noise pollution is prevalent.[17]

Because competence for execution evaluations require "a strong commitment to . . . the most thorough and detailed evaluation" possible, Radelet and Barnard recommended videotaping all evaluations (Ref. 18, p 46). AAPL, however, has previously declined to endorse "a blanket rule of requiring videotaping in all forensic interviews" (Ref. 19, p 357). Evaluators, therefore, should educate themselves about the specific videotaping requirements of their associated jurisdictions. If the jurisdiction does not require videotaping, evaluators should rely on their own judgment and personal preferences when deciding whether to videotape evaluations.

In addition to face-to-face interviews, a forensic psychologist recommended that evaluators obtain information from as many of the following sources as possible:

> (1) prison medical records; (2) prison psychiatric records; (3) psychiatric records prior to incarceration; (4) academic records, including prior intellectual testing with raw data; (5) records of past psychological evaluations; (6) any and all videotapes made of the inmate; (7) military or veterans affairs records; (8) records and transcripts of testimony of the inmate; (9) writings or letters of the inmate [within] the prior year; (10) videotapes of the inmate demonstrating bizarre behavior; and (11) art work of the inmate (Ref. 16, p 49).

While this list serves as a useful overview of materials that evaluators may wish to explore, it need not be followed rigidly. Reviewing videotapes featuring the evaluee is generally good practice, for example, but some videos are likely to prove more relevant than others. Evaluators, therefore, should focus the majority of their attention on recent video footage because this speaks more directly to the evaluee's competence to be executed. Similarly, routine surveillance footage may have limited value for ascertaining the evaluee's competency for execution. Academic records, including tests conducted, are sometimes a useful piece of information, but they may be less relevant if they are several decades old. Evaluees' artwork is also unlikely to be relevant except in a few rare instances.

In light of the Court's *Madison* ruling, evaluators should pay careful attention to any medical diagnoses or conditions that may render defendants' ability to formulate a rational understanding of why they are to be executed exceptionally difficult. Per *Madison*, diagnoses themselves are ultimately immaterial, but they may still serve to highlight cases that require closer examination. This topic was raised by the *Panetti* Court, in which it instructed that the presence of psychosis indicated the need to thoroughly evaluate defendants for incompetency. According to the Court, neither medical nor psychological diagnoses automatically qualify defendants as incompetent to be executed. Nevertheless, these labels may reasonably be construed as a crude screening tool signaling "[t]he beginning of doubt about competence" (Ref.

2, p 960). The same is true for major medical events like strokes, such as Mr. Madison experienced. The broader significance of *Madison*, therefore, is that the Court recognized that defendants' medical histories may directly influence their ability to rationally understand why they are to be executed, although specific diagnoses themselves are insufficient to establish incompetency. As a result, evaluators should be sure to review relevant medical records and construct a detailed medical history whenever possible.

Finally, evaluators should engage in serious self-reflection before participating in the treatment or reevaluation of incompetent capital defendants given that successful treatment exposes the evaluee to death via execution.[18,20] Evans[21] argued that these behaviors constitute "the fringe of what the profession has defined as ethical conduct" (Ref. 21, p 264), although this sentiment is not shared universally.[22] Radelet and Barnard[23] recommended that states protect evaluators from "the ethical dilemma created by the demand to treat prisoners so that they can be executed" by passing legislation permanently commuting incompetent defendants' death sentences to life imprisonment without possibility of parole (Ref. 23, p 306).

In conclusion, while the *Madison* Court preserved a broad interpretation of the category of persons who may qualify as incompetent for execution, the Court declined to address a number of related concerns surrounding competency evaluations. In the absence of guidance from the Court, professional organizations such as AAPL may wish to take the advice of Halpern and colleagues[11] and play a more prominent role by engaging in the debate. As a first step, we recommend that AAPL create a minimum set of standards that individuals must meet before they qualify to conduct evaluations of competency to be executed.

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