

A. PROTOTYPE FACT SHEET DESIGNED FOR THE DEVELOPMENT
OF A FORENSIC COMPUTERIZED INFORMATION SYSTEM
AT VALKENBERG AND LENTEGEUR HOSPITALS.

DESIREE SHAUN HANSSON

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- TITLE -

A PROTOTYPE FACT SHEET DESIGNED FOR THE DEVELOPMENT OF A FORENSIC
COMPUTERIZED INFORMATION SYSTEM AT VALKENBERG AND LENTEGEUR HOSPITALS.

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Master of Arts in Clinical Psychology.

Cape Town

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- DECLARATION -

I declare that this dissertation, except where otherwise indicated in the text and acknowledgments, is my original work.

The conclusions reached and the opinions expressed in this text are those of the author and not necessarily those of the Human Sciences Research Council who assisted me financially.

Note that with the exception of quotes and references, standard American spelling has been used throughout this paper.

DESIREE SHAUN HANSSON

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DESIREE

- TABLE OF CONTENTS -

TITLE PAGE

DECLARATION

ACKNOWLEDGMENTS

ABSTRACT

INTRODUCTION

- 1 -

1.1.	Introductory Notes	- 1-
1.2.	The General Aim	- 1-
1.3.	The Overall Framework	- 2-
1.4.	A Brief Overview of Forensic Psychiatry	- 5-
1.5.	The Law Pertaining to Forensic Psychiatry in South Africa	- 6-
	1.5.1. Assessment	- 6-
	1.5.2. Post-Assessment	- 7-
1.6.	The Forensic Units at Valkenberg and Lentegeur Hospitals	- 8-

- TABLE OF CONTENTS -

**RATIONALE FOR THE PILOT
& LONGER TERM PROJECTS**

- 2-

2.1.	Introductory Framework	- 9-
2.2.	Rationale for the Forensic Information System	-11-
2.2.1.	A limited empirical knowledge-base in a rapidly growing field	-11-
2.2.2.	The negative consequences of the limited empirical knowledge-base	-12-
2.3.	The Advantages of a Computerized Information System	-17-
2.4.	Rationale for a New System	-21-
2.4.1.	Brief historical note	-21-
2.4.2.	Disadvantages of existing systems	-22-

- TABLE OF CONTENTS -

THE CHOICE OF A DATA
COLLECTION DEVICE

- 3-

3.1.	Central Issues	-32-
3.2.	The Degree of Restructuring	-33-
3.2.1.	Introductory comments	-33-
3.2.2.	The advantages of restructuring case material	-33-
3.2.3.	The disadvantages of restructuring case material	-35-
3.2.4.	The final decision	-36-
3.3.	Methods of Data Transference	-37-

**METHODOLOGY FOR THE DEVELOPMENT
OF THE PROTOTYPE FACT SHEET**

- 4 -

4.1.	Introductory Note	-39-
4.2.	The Background Population	-39-
4.3.	The Test Sample	-40-
4.4.	The Literature Surveys	-41-
4.5.	Discussions and Feedback	-42-
4.6.	The Preliminary Fact Sheet	-42-
4.7.	The Pilot Sample	-43-
4.8.	The Prototype Fact Sheet	-43-

- TABLE OF CONTENTS -

DISCUSSION OF THE PROTOTYPE

FACT SHEET DESIGN

- 5-

5.1.	Introductory Comments	-44-
5.2.	Aspects for Maintaining Confidentiality	-45-
5.3.	Aspects for Promoting Ease of Use	-46-
5.4.	Aspects for Maintaining Data Integrity	-50-
5.5.	Aspects for Maintaining Reliability	-55-
5.6.	Methods for Estimating Reliability	-58-
5.7.	General Criteria for Fact Sheet	
	Data Selection	-60-

**DISCUSSION OF THE PROTOTYPE
FACT SHEET DESIGN**

- 5-

5.8.	A More Detailed Rationale for the Contents	-63-
5.8.1.	Introductory comments	-63-
5.8.2.	The Maudsley framework	-64-
5.8.3.	Modifications to the Maudsley framework	-65-
5.8.4.	The focus on criminal behavior	-71-
5.8.5.	Information on psycholegal issues	-73-
5.8.6.	Information on psychometric and EEG findings	-74-

- TABLE OF CONTENTS -

DISCUSSION OF THE PROTOTYPE
FACT SHEET DESIGN

- 5-

5.8. CONTINUED.....

- | | | |
|---------|---|------|
| 5.8.7. | Information on
dangerousness | -75- |
| 5.8.8. | Information for
service evaluation
and planning | -76- |
| 5.8.9. | Information for cross
cultural comparisons | -77- |
| 5.8.10. | Information for
genetic studies | -78- |
| 5.8.11. | Information for
identification
and follow-up | -79- |
| 5.8.12. | Information for
future management | -80- |
-

- TABLE OF CONTENTS -

A BRIEF CRITIQUE

- 6-

6.1. The Idiographic-Nomothetic

Data Controversy

-81-

6.2. Summary Feedback from the

Pilot Study

-83-

SUMMARY CONCLUSION

- 7-

7. Summary Conclusion

-84-

- TABLE OF CONTENTS -

BIBLIOGRAPHY

APPENDIX I

The Computerized Systems for
Psychiatric Case Material that
were Considered for this Project

ADDENDUM I

The FOCIS Prototype Fact Sheet

ADDENDUM II

Glossary : Explanation of the Prototype
Fact Sheet Questions and Answer-Option Codes.

- ABSTRACT -

The discussion in this paper centers around the development of a paper-and-pencil fact sheet for collecting and systematizing forensic case material. This paper-and-pencil device is the prototype fact sheet that will be used to collect the data to form a computerized, forensic information system. The system known as FOCIS, the Forensic Computerized Information System, will serve the largest Forensic Unit in the Western Cape, at Valkenberg Hospital, and the new unit that is being developed at Lentegeur Hospital.

FOCIS will comprise case material from all forensic referrals to these two hospitals, under the present law : Sections 77, 78 and 79 of the Criminal Procedure Act 51 of the 1st of July 1977. Additionally, FOCIS will develop dynamically, continuing to incorporate case material as referrals are made to these hospitals. The estimated 7500 cases that will constitute FOCIS by the time this project is completed, include all of the officially classified population groups of South Africa, ie. the so-called 'black', 'coloured' and 'white' groups [POPULATION REGISTRATION ACT, 1982].

- ABSTRACT -

The prototype fact sheet has a schematic layout and uses a mixed-format for data collection, ie. checklists, multiple choice answer-options and semi-structured narrative text. The preliminary fact sheet design was developed from :

- 1] The guidelines arising out of the 20 years of overseas experience in computerized psychiatric systems.
- 2] Surveys of the current empirical findings in the fields of psychiatry, forensic psychiatry, psychology and criminology.
- 3] Discussions with computer personnel, researchers and forensic staff.
- 4] The author's working experience of the needs of the Forensic Units.
- 5] A list of information generated from a test sample of 30, randomly selected forensic cases.
- 6] The application of the preliminary fact sheet to a separate, pilot sample of 60, randomly selected forensic cases.

The information generated from all of these sources was combined to construct the improved prototype fact sheet presented in this paper. Since this paper is brief, the findings from each phase are not presented separately, but have instead been integrated into the discussion and prototype fact sheet.

The need for a forensic information system arises out of the inadequacy of the empirical knowledge-base of forensic psychiatry in South Africa. This inadequacy is highlighted against the background of rapidly expanding referral rates, to the Valkenberg Forensic Unit in particular, and also nationwide.

FOCIS aims to provide a large sample of empirical, South African, forensic data to begin redressing the inadequacy of the knowledge-base. Furthermore, it is hoped that FOCIS will motivate research in the presently barren forensic field.

1. INTRODUCTION

1.1. The Section Layout

This section begins with the aim of the pilot project which is the focus of the paper. This pilot work is then placed in the context of a longer term project in the field of South African forensic psychiatry. The section concludes with a description of the specific forensic units in which both projects are based.

1.2. The General Aim

The general aim of the project discussed in this paper is to develop a prototype, paper-and-pencil fact sheet to collect and systematize forensic, psychiatric case material at Valkenberg and Lentegeur Hospitals, in the Western Cape.

This dissertation comprises three separately bound parts : The first is this paper, which aims to explain the development of, and the rationale for the prototype fact sheet, including its role in the longer term project presented in Section 1.3 below. Addendum I is the prototype fact sheet. Addendum II is the section of the instruction manual which explains the fact sheet questions and answer-option codes.

1.3. The Overall Framework

This project constitutes the pilot study of a longer term project involving the development and implementation of a computerized forensic information system, for the Forensic Units at Valkenberg and Lentegeur Hospitals. This longer term project is a joint endeavour that is to be conducted under the auspices of the Institute of Criminology, and the Department of Psychiatry at the University of Cape Town. Since the focus of this paper is the pilot study, only a summary of the longer term project has been included to provide the reader with the context in which the pilot study was conducted. More detailed information about the longer term project is available from the author.

In the first phase of the longer term project, the prototype fact sheet designed during the pilot study, will be used to collect and systematize the forensic case material pertaining to an estimated 7500 defendants, referred to the Forensic Units at Valkenberg and Lentegeur Hospitals, under Sections 77, 78 and 79 of the Criminal Procedure Act 51 of 1977. The reader is referred to Section 1.5. on pages six and seven for an explanation of these sections of the Act. The sample will include all forensic cases referred from the inception of Act 51 on the 1st of July 1977, to the 31st of December 1989 when the first phase of the project will be completed.

1.3. The Overall Framework - continued

The prototype fact sheet will also function as the specification for a computerized system known as FOCIS, the Forensic Computerized Information System. This system is presently being developed to store and process the systematized case material collected during the first phase. To complete the first phase, the transformed case material will be entered from the paper-and-pencil fact sheets into the computerized system, to form the part of FOCIS known as the retrospective database.

Throughout the first phase, the prototype fact sheet will be critically evaluated regarding its utility for data collection in forensic research and practice, at the Valkenberg and Lentegur Units. The conclusions reached from this process of critical evaluation will be used to improve the prototype fact sheet, for application during the second phase of the longer term project. During the latter part of the first phase, the improved fact sheet will gradually be introduced as the new, routine data collection device for the two Forensic Units.

1.3. The Overall Framework - continued

The second phase will involve the development of the part of FOCIS known as the prospective database. Feedback gained during the introduction of the improved fact sheet in the latter part of the first phase, will be used to modify the fact sheet. From the 1st of January 1990, this form of the improved fact sheet will be used in routine data collection for all defendants referred to the Forensic Units at Valkenberg and Lentegur Hospitals. In future therefore, as defendants are referred for forensic assessment, case material will be entered into FOCIS, so developing a dynamic, prospective database. This prospective database will be functionally integrated with the retrospective database established during the first phase.

1.4. A Brief Overview of Forensic Psychiatry

Traditionally, forensic psychiatry has been the sub-speciality of general psychiatry that has served the criminal justice system, by providing expert psychiatric opinion to inform legal decisions about criminal responsibility [AMERICAN PSYCHIATRIC ASSOCIATION, 1982].

Gradually the role of forensic psychiatry has expanded. The original concept of criminal responsibility has increased in complexity and now includes issues such as, the appreciation of moral wrongfulness and the ability to act in accordance with this appreciation; the major defences of automatism, intoxication, irresistible impulse, provocation and the effect of other extenuating circumstances.

Today, forensic psychiatrists provide opinion on competency to stand trial, factors in mitigation of sentence, dangerousness, curability and deterability [SCHIFFER, 1978]. Forensic psychiatry has also expanded beyond assessment, to the management and rehabilitation of offenders, especially those with chronic conditions such as, psychosis and personality disorder [GUNN, 1983].

1.5. The Law Pertaining to Forensic Psychiatry in South Africa

1.5.1. Assessment

The law regarding the mental health of defendants forms the interface between forensic psychiatry and the criminal justice system. In South Africa, these laws are contained in Sections 77, 78 and 79 of the Criminal Procedure Act 51 of 1977. Generally at the pretrial stage, defendants are referred to a Forensic Unit for observation and assessment under these sections. Section 77 lays down the procedure for establishing a defendant's capacity to understand court proceedings, ie. triability or competency to stand trial. Section 78 deals with the assessment of a defendant's criminal intention or responsibility, ie. the appreciation of wrongfulness and capacity to act in accordance with this appreciation. Section 79 sets out provisions for a panel to enquire and report on Sections 77 and 78, in the case of a capital offence [KRUGER, 1980].

1.5.2. Post-Assessment

Following forensic assessment, defendants who have been found to be unfit to stand trial in terms of Section 77, and those who have been found to lack criminal responsibility under Section 78; are detained as President's Patients, either in hospital or prison. These patients need never be tried, pending the decision of the State President. Generally in the case of minor offences however, Section 6 (a) of the Criminal Procedure Act is invoked. The prosecutor then withdraws the charges and the defendant is detained and treated under a hospital order, until the medical superintendent deems him/her fit to return to the community. Defendants who are found to be triable, non-certifiable and criminally responsible, are returned to the criminal justice system to be tried, and forensic psychiatrists may be called to give expert evidence in court [KRUGER, 1980].

1.6. The Forensic Units at Valkenberg and Lentegeur Hospitals

At present Valkenberg houses the largest forensic unit in the Western Cape. This unit also has the second highest forensic referral rate in South Africa [ZABOW, 1987]. The Valkenberg Forensic Unit comprises a 65 bed-capacity, maximum security ward; a 25 bed-capacity, medium security ward; a 50 bed-capacity, closed ward; a 35 bed-capacity, open ward and a rehabilitation facility. This unit is staffed by a multi-disciplinary team comprising a specialist psychiatrist, a registrar, a clinical psychologist, an intern psychologist, an occupational therapist, two social workers, a number of psychiatric nurses and security personnel [ZABOW, 1981].

Lentegeur Hospital, on the Cape Flats, has only recently been opened and its forensic unit is still being planned. In the service of the South African Government's policy of separate development, this unit is to serve the so called 'coloured' population. Until Lentegeur is opened however, all forensic referrals will continue to be admitted to the Valkenberg Forensic Unit. At Valkenberg the officially classified population groups are separated, with 'white' people admitted to the Observatory wards, and 'black' and 'coloured' people to the Pinelands wards of the Hospital [POPULATION REGISTRATION ACT, 1982].

2. RATIONALE FOR THE PILOT AND LONGER TERM PROJECTS

2.1. Introductory Framework

Due to the interrelatedness of the pilot and longer term projects, the relevance of the pilot work, or prototype fact sheet, can be understood only by reference to the rationale that gave rise to both projects. The rationale is presented in Sections 2.2. to 2.5.

In Sections 2.2 to 2.5., the rationale underlying the overall project is explained by answering the following three questions :-

- * Why is a forensic information system necessary in South Africa ?
- Section 2.2.
- * Why has a computerized system been chosen ?
- Section 2.3.
- * Why is a new system being developed ?
- Section 2.4.
- * Why has retrospective case material been included in the system ?
- Section 2.5.

2.1. Introductory Framework - continued

In Sections 3 to 6, the discussion is focused on the prototype fact sheet developed during the pilot study. In these four sections the following questions are addressed :-

- * Why has a paper-and-pencil fact sheet been chosen for data collection ?
- Section 3.
- * How was the prototype fact sheet developed ?
- Section 4.
- * What informed the design of the prototype fact sheet ?
- Section 5.
- * What are the main criticisms of the prototype fact sheet and the associated retrospective database ?
- Section 6.

Details of the prospective database have not been discussed, because the focus of this paper is the prototype fact sheet that will be used to develop the retrospective database. The prospective database will be developed using an improved version of the prototype fact sheet. Since improvements to the prototype fact sheet will be derived from its application, this form of the fact sheet is not yet available.

2.2. Rationale for the Forensic Information System

2.2.1. A limited empirical knowledge-base in a rapidly growing field

In South Africa, the paucity of systematic, psychiatric research is becoming an issue for concern. For forensic psychiatry, this problem is highlighted against the background of a rapidly increasing referral rate. Nationwide, the total number of defendants referred for forensic assessment has increased by 65%, over the nine year period from 1978 to 1986 [ZABOW, 1987].

An estimated 6000 defendants were referred to the Valkenberg Forensic Unit between 1978 and 1986. This constituted 20% of all admissions to Valkenberg hospital. It is noteworthy, that the growth rate in referrals to the Valkenberg Unit exceeded the national rate by 19% [ZABOW, 1987].

The empirical knowledge-base of psychiatry informs practice and should facilitate ongoing evaluation and improvement. It is a matter of serious concern therefore, that the development of the empirical knowledge-base of South African forensic psychiatry has not kept pace with the growth in referrals.

2.2.2. The negative consequences of the limited empirical knowledge-base

The underdeveloped empirical knowledge-base of South African forensic psychiatry has resulted in a number of negative consequences. One such negative consequence is that mental health professionals frequently can give only limited, hypothetical answers to the increasing number of questions raised by the legal profession. From the author's experience of working in the Valkenberg Unit, the questions most frequently answered in this limited manner relate to predictions of dangerousness, curability, deterability, the role of psycho-social factors, and especially the behavioral effects of drug combinations on criminal responsibility.

In forensic practice, it is the specific behavioral effects of psycho-social variables that are more commonly at issue, than the effects of classifiable mental disorder. To illustrate the importance of the role of psycho-social variables in criminal behavior, a conservative estimate showed that these factors were implicated in at least 57% of cases of violent offences, assessed at Valkenberg between 1982 and 1986 [ZABOW, 1987].

2.2.2. The negative consequences - continued

In South Africa, concern about public safety appears to be on the upswing, commensurate with the heightened political strife of the past 10 years. This concern is particularly marked in the Western Cape, where we have one of the highest, violent crime rates in the world [OFFEN ET AL, 1986].

Consider that 55% of the forensic cases referred to Valkenberg between 1982 and 1986, involved violent offences, and that approximately 50 new President's Patients are admitted here annually. The majority of these people may well be dangerous, since they have been charged with violent crimes [ZABOW, 1987]. The lack of systematic evaluation of the predictive accuracy of psychiatric opinion on dangerousness and deterability, have bred uncertainty that often leads to protracted admissions for President's Patients, and sometimes even to entire lifetimes of hospitalization [OFFEN, 1986 [b]].

2.2.2. The negative consequences - continued

In the interests of both public safety and patient welfare, it is stating the obvious to point out the grave responsibility borne by forensic professionals, for ensuring that accurate predictions are made and that all referrals, dangerous and harmless, are appropriately assessed and managed.

Historically, there has been a tenuous positive relationship between mental health and legal professionals, not only here, but worldwide [BRODSKY, 1973]. Understandably, the paucity of 'hard data' in South African forensic psychiatry seems to have made our experts reticent when giving evidence in court. One result has been that psychiatric extenuation is infrequently led. This raises the question of whether due justice is being done [ZABOW, 1983].

2.2.2. The negative consequences - continued

One way in which our forensic psychiatrists appear to have dealt with the inadequate empirical knowledge-base, is by relying on overseas research. This is problematic, because it has functioned as a 'stopgap' that obscures the paucity of South African research. Consequently, there has been a relative neglect of systematic investigation into issues that are peculiar to this country. One example of a neglected area, is the question of the behavioral effects of the methaqualone-cannabis drug combination, that is particular to the gang subculture of the Western Cape.

Valkenberg is one of the largest psychiatric teaching hospitals in South Africa and the Forensic Unit has been operating for 10 years under the present law. It is disturbing to note therefore, that with this experience we still have not developed a text book for forensic psychiatry.

2.2.2. The negative consequences - continued

A fundamental ethical principle of both psychiatry and psychology, is the provision of the best possible assessment and management. Without systematic, empirical evaluation of our forensic services, we cannot claim to be practising according to this principle [HAYES-ROTH ET AL, 1972]. This leaves one with the disturbing question of how can we improve when we don't even know what we have done ?

After considering these negative consequences of the inadequate empirical knowledge-base, it seems that the time is ripe to begin redressing this problem. To this end, a forensic information system is being developed for the storage and processing of case material. It will comprise a wide range of accessible, empirical data relevant to South African forensic psychiatry. This system will be the first step to expanding the empirical knowledge-base directly, and will hopefully also motivate research in the longer term. Given the author's location in the Western Cape and the importance of the Valkenberg and Lentegeur Forensic Units in this region, these units have been chosen as the focus of this endeavour.

2.3. The Advantages of a Computerized Information System

A computerized system and a microfiche method were the two options available for the safe and economical storage of a large volume of forensic case material. Microfiche was rejected, because it does not have the required, built-in applications for automatic data extraction, sampling, statistical analysis and report generation. Due to its many advantages, a computerized information system was selected.

Advanced electronic technology now facilitates the safe, long term storage of voluminous quantities of data in very limited space. Even a desktop microcomputer can store the contents of approximately 7000 hospital folders, that presently fill a large room [WEIZENBAUM, 1984]. Since data collection methods must be standardized for computer purposes, storage and processing resources are not wasted on repetitive, contradictory and irrelevant data [SPACE, 1981].

2.3. The Advantages of a Computerized Information System - continued

To fully appreciate the advantages of computerization, it is necessary to contrast the planned computerized system with the existing manual filing system. At present, the forensic case material is stored in a paper-and-pencil form, in the archives at Valkenberg and Lenteguur. It would be unfair to comment on the Lenteguur manual system, as this is still in a developmental stage. In conducting the pilot project, the author found the filing system at Valkenberg in disarray. Hospital folders were literally decaying and often could not be located. Much of the case material was illegibly handwritten and the data for certain variables was present only inconsistently. It took two months to locate the pilot sample of 60 cases and five were not found at all. It is not surprising therefore, that the wealth of over 40 years of forensic experience embodied in the case material, is rarely used in research.

Contrast this situation, with the exciting prospect of accessing a multi-stratified sample and data across numerous variables for a 1000 cases, at the push of a computer button. Rapid and easy access to large samples is the central advantage of computerized systems [KLINE, 1981].

2.3. The Advantages of a Computerized Information System - continued

Forensic decision-making is enhanced by the rapid accessing of legible, systematically organized information about defendant's previous admissions, and in difficult cases, information about similarities with previous cases [PETRILA & HEDLUND, 1983; KAHN ET AL, 1981]. Better decision-making is essential to improved forensic assessment and management [MEZZICH ET AL, 1981 [a]; SPACE, 1981].

Computerized psychiatric systems have decreased clinicians' administrative workloads by automatically generating routine reports [JOHNSON ET AL, 1981 [b]]. Consider the benefit of this facility to a Valkenberg forensic psychiatrist, who must write up to 50 detailed court reports each month. Since workloads are commonly reported as impediments to psychiatric research, time that is saved could be used for much-needed research [PETRILA & HEDLUND, 1983].

▪ The quality and timeliness of research endeavors often depends on how well the more mundane tasks are handled. When quality research depends upon systematic and precise data handling, with rapid turnaround on analysis.... computers are the only choice ▪

[GREEN & ATKISSON, 1981 : 499].

2.3. The Advantages of a Computerized Information System - continued

To conclude this section, it is argued that the forensic computerized information system will motivate research by improving accessibility to data; by providing ease of sampling and data extraction from a large background population; and by facilitating versatile data processing. Valuable, interdisciplinary work could also be promoted, because Valkenberg and Lentegur are teaching hospitals that serve students from many disciplines including, psychiatry, medicine, clinical psychology, social work and occupational therapy. The mere existence of an up-to-date computerized system may itself raise an awareness of the importance of generating information.

2.4. Rationale for a New System

2.4.1. Brief historical note

Computers are certainly not a new arrival to the psychiatric field. From the 1960's onward mainframe computers were being introduced to psychiatric practice, at first mainly to fulfil administrative and fiscal functions. By 1970 however, computing was well established in North American clinical practice, in both the psychiatric and psychological fields. The trend which characterized the decade from 1960 to 1970, was the development of large scale, shared, mainframe databases at institutions linked to major universities [CASTELLAN, 1981; PAVEL, 1981].

In South Africa of 1987 however, the Forensic Computerized Information System will be a first. In planning this system, there was the advantage of learning from the 20 years of experience in other countries. The major decision therefore, was whether to use an existing system that had been designed for use in overseas institutions, or whether to develop a new system for the South African context.

2.4.2. Disadvantages of existing systems

The reader is referred to Appendix I for a list of the available, psychiatric computer systems that were considered for the purposes of this project. After careful evaluation of these existing systems and their associated data collection devices, it was concluded that no single, available system could adequately fulfil the requirements of the Forensic Units at Valkenberg and Lentegour Hospitals.

The central reasons for this conclusion are as follows :-

- * With the exception of the Forensic Computer Supported Information System, these systems do not cater for information that is particularly pertinent to forensic psychiatry. For example, they do not include information about alleged offences, the legal referral process and forensic decisions.

2.4.2. Disadvantages of existing systems - continued

For the reasons discussed above, it was decided to develop a new computerized system particular to South African forensic psychiatry, and to the needs of the Forensic Units at Valkenberg and Lentegeur Hospitals. In designing the prototype fact sheet however, aspects of the existing systems were incorporated wherever these were both appropriate to our needs, and had proven reliability and validity. These aspects are discussed further in Section 5.6 on page 57.

2.5. Rationale for the Retrospective Data-Base

2.5.1. Introductory note

Given the availability of 10 years of retrospective forensic case material and two years of data that will be routinely collected during the period of this project; a decision had to be made about whether the forensic computerized system should include this material, ie. information from an estimated 7500 cases. The disadvantages and advantages of incorporating this material were carefully considered and are presented in Sections 2.5.2. and 2.5.3. below.

2.5.2. Disadvantages of including the retrospective case material

For sound research, data must be reliable and valid [COUPER AT AL, 1987; COZBY, 1981]. The retrospective case material is of uncertain reliability and validity, because :-

- * The variables for which data was collected were not systematically defined.

- * The data was not consistently collected for a full range of variables.

- * The data collection methods were not standardized.

- * The sources from which data was collected and the credibility of these sources were not consistent across cases. In some instances, data was collected from unsubstantiated self reports and from individual, subjective clinical judgements.

2.5.2. Disadvantages of including the retrospective case material - continued

Additional disadvantages include :-

- * The data is retrospective and it may lack information that is of contemporary interest [SPAULDING ET AL, 1981].

- * Data extraction from case material of this quality and volume is often time consuming and therefore, expensive. [SPAULDING ET AL, 1981].

2.5.3. Advantages of including the retrospective case material

The inclusion of the retrospective case material was discussed with interested researchers, forensic staff and colleagues in the fields of psychology and criminology. The following advantages were put forward :-

- * The systematization of the case material by using the prototype fact sheet and computerization itself, will improve accessibility to this data and will increase its utility. Additionally, in the process of transforming this material, specific information can be collected about reliability, the range of variables covered and areas of omission. This will constitute a clear profile of the type and quality of material comprising the retrospective database, which would seem to be a marked improvement on the present uncertainty of the case material contents.

2.5.3. Advantages of including the retrospective case material - continued

- * If incorporated, within two years the retrospective case material will constitute a very large sample by research standards, ie. approximately 7500 cases. Providing that the data comprising the sample is meaningful, findings drawn from such a large sample are likely to be more reliable and valid [ERDMAN.ET AL, 1981; JOHNSON ET AL, 1976]; than those generated from the small samples that have generally been used in South African forensic research.

- * The retrospective case material embodies an important part of the history of South African forensic psychiatry. This information would seem to be invaluable given the importance of evaluating past practice, so as to improve future functioning. The long term nature of the material could also facilitate valuable time trend research showing dynamic, historical processes such as, changes in the criteria for establishing criminal responsibility. This type of study is too infrequently conducted, due to the difficulty of collecting retrospective data [PETRILA & HEDLUND, 1983].

2.5.3. Advantages of including the retrospective case material - continued

- * The case material is of added value, because forensic psychiatry is generally the only source of accumulated, detailed information, about criminal behavior that occurs relatively infrequently [SPACE, 1981]; such as, infanticide and mass murder.

- * During this project, the author found a marked paucity and experienced great difficulty, deriving even basic statistics about forensic referrals such as, the ages, sexes and types of criminal offences, admission rates and outcomes. In the 'empirical desert' of South African forensic psychiatry, the few projects that have used the forensic case material, have shown the value of even basic descriptive statistics [OFFEN, 1986 [a]; [b]; ZABOW, 1983].

2.5.4. The final decision

In addition to these important advantages, the prospect of establishing a substantial forensic database within only two years, weighed the decision in favor of including the retrospective case material in the forensic computerized information system. In comparison, it is estimated that it will take at least five years to successfully implement and develop the prospective database to an equivalent sample size. Considering the pressing need to redress the negative consequences of our inadequate empirical knowledge-base, the development of the retrospective database in the shorter term, was believed to be the most appropriate strategy. It is the invaluable feedback and experience that will be gained in developing the retrospective database, that finally tilted the scales in favor of this project. Knowing the past weaknesses and the strengths will improve data collection for the prospective database [MEZZICH ET AL, 1981 [b]].

3. THE CHOICE OF A DATA COLLECTION DEVICE

3.1. Central Issues

The decision to incorporate the retrospective, forensic case material in the computerized system, necessitated the transformation of this material into a form suitable for efficient, computerized storage and processing. To achieve this end, two central questions had to be addressed :-

* To what extent should the case material be restructured ?

- Section 3.2.

* How should the restructured case material be transferred into the computerized system ?

- Section 3.3.

3.2. The Degree of Restructuring

3.2.1. Introductory comments

The available options ranged from completely structured questionnaires with coded answer-options, to completely unstructured narrative text. The degree to which the semi-structured, narrative case material was to be restructured, was influenced by the following advantages and disadvantages :-

3.2.2. The advantages of restructuring case material

* In computerized systems, accessibility and rapid data extraction are improved when data is partitioned into discrete elements [JOHNSON ET AL, 1981 [a]]. For example, having a computer print out 100 complete accounts of alleged offences, so that one can extract information about the relationship between defendants and victims, requires a great deal more time and effort, than instructing a computer to extract this element of information only, from a prestructured field in a 100 cases.

3.2.2. The advantages of restructuring case material - continued

- * Data redundancy and repetition in the narrative case material wastes computer resources. In restructuring the case material contradictory, irrelevant and repetitive information can be omitted. The variability of unstructured narrative material also makes automated data searches, processing and assessments of the reliability, consistency and content of a database unfeasible [ERDMAN ET AL, 1981]. Partitioning and systematizing narrative case material makes for more economical computerized storage and processing [SHERMAN, 1981].

- * Restructuring the case material into discrete elements can provide a profile of the nature and quality of the available information. This is essential for planning research based on this material.

3.2.3. The disadvantages of restructuring the case material

- * Previously, users have found that overly structured data collection devices are complex, time consuming, inflexible and boring [MEZZICH ET AL, 1981 [b]].

- * Data that is partitioned into discrete elements can lose its meaning [STROTZ ET AL, 1969].

- * Valuable, qualitative information is often omitted from computerized systems, because it is difficult to structure [MEZZICH ET AL, 1981 [b]].

3.2.4. The final decision

Experience has shown that information should be restructured only if its validity can be maintained [JOHNSON ET AL, 1981 [a]]. Considering the advantages and disadvantages of prestructured computerized information; it is not surprising that combinations of partially and completely prestructured information have proved to be of the greatest value, in the computerization of psychiatric case material [GOUPY ET AL, 1976; KAHN ET AL, 1981; MEZZICH ET AL, 1981 [b]; STROTZ ET AL, 1969]. This experience influenced the final decision to use a data collection device of a mixed-format comprising checklists, multiple choice-type answer-options, semi-structured narrative text and verbatim quotes.

3.3. Methods of Data Transference

In choosing a method for transferring data into the computerized system, the two available options were the paper-and-pencil fact sheet and the on-line, interactive methods. In essence, the research assistants collecting the case material could use a 'computerized questionnaire' to enter this material directly into the computerized system. Alternatively, they could use a paper-and-pencil fact sheet or questionnaire, to collect and systematize the material; and this information could then be transferred into the computerized system.

The following factors influenced the decision to use a paper-and-pencil fact sheet :-

- * A paper-and-pencil device is efficient, because it takes less time for assistants to reach an acceptable level of reliability in their use of a new paper-and-pencil device, than in the use of an unfamiliar on-line facility [PETRILA & HEDLUND, 1983].

- * Using a paper and pencil device provides an intermediate stage for checking and correcting errors, before information becomes part of a computerized database.

3.3. Methods of Data Transference - continued

- * Data stored on paper functions as a backup set of information in the unfortunate event of a computer 'crash'.

- * One of the biggest disadvantages of paper-and-pencil devices, has been the increased time and effort necessary to transfer data from these devices into computer systems. The new optical scanning, fax machine is able to 'read' data from paper-and-pencil fact sheets into computer memory. Therefore, manual data transference need not be a disadvantage of using paper-and-pencil devices for database development [ROSCH, 1987].

- * Paper-and-pencil devices are less costly to modify and can therefore, facilitate the dynamic development of a computerized system.

4. METHODOLOGY FOR THE DEVELOPMENT OF THE PROTOTYPE FACT SHEET

4.1. Introductory Note

Note that due to the brevity of this paper, the detailed findings from each phase of the pilot project have not been presented. Instead, these findings have been incorporated in the fact sheet design and the discussion thereof.

4.2. The Background Population

The background population from which the samples were selected comprised all of the Valkenberg and Lentegour Hospital case files pertaining to admissions under Sections 77, 78 and 79 of the Criminal Procedure Act 51 of 1977; from the inception of this Act on the 1st of July 1977 to the 31st of June 1987, when this pilot study was completed.

4.3. The Test Sample

A stratified test sample of 30 forensic cases was randomly selected. Six cases including, one 'black' female, one 'white' female, one 'coloured' female, one 'black' male, one 'white' male and one 'coloured' male; were chosen from each of the years 1978, 1980, 1982, 1984 and 1986. The test sample was stratified according to ethnic groups, because this is an important factor under the present apartheid system in South Africa. These terms derive from the official classificatory system used in South Africa [POPULATION REGISTRATION ACT, 1982].

The author read the material for each of the test sample cases. The order in which the cases were read was randomized. A list was generated from this process, of the types of information comprising the case material. This list was one of the factors that informed the selection of variables for the prototype fact sheet.

4.4. The Literature Surveys

The major, comprehensive works in the fields of forensic psychiatry, psychiatry, clinical psychology and criminology were surveyed to highlight the most relevant variables in forensic psychiatry. For example, some of the works consulted were :- the text on child and adolescent psychiatry by RUTTER & HERSOV, [1985]; the text on child development by GARMEZY & RUTTER, [1983]; the texts on adult psychiatry by GELDER ET AL, [1983]; the American Psychiatric Association's DSM III, [1980]; and the South African text by GILLIS, [1986]; and the forensic works of SLOVENKO, [1973], SCHIFFER, [1978] and GRISSD, [1986].

A computerized literature search was conducted to indicate already existing computerized systems designed for psychiatric case material.

4.5. Discussions and Feedback

Discussions were held with experienced computer analysts and programmers to gain information about the costs, constraints and advantages of available computer software and hardware.

Discussions were also held with key forensic staff to gain a thorough understanding of the needs and functioning of the Valkenberg and Lentegeur Forensic Units.

4.6. The Preliminary Fact Sheet

The author designed a preliminary fact sheet using the information collected to this point.

4.7. The Pilot Sample

A new, stratified pilot sample of 60 forensic cases was randomly selected. Six cases including, one 'black' female, one 'white' female, one 'coloured' female, one 'black' male, one 'white' male and one 'coloured' male; were chosen from each of the years between the 1st of July 1977 and the 31st of June 1987.

In order to highlight problems, the author and a computer analyst used the preliminary fact sheet to collect data from the pilot sample. The order of the cases was randomized for this phase of data collection.

4.8. The Prototype Fact Sheet

The requirements of the computerized system and feedback from the pilot application, were considered. This information was then used to modify the preliminary fact sheet to form the prototype fact sheet which is presented as Addendum I to this paper.

5. DISCUSSION OF THE PROTOTYPE FACT SHEET DESIGN

5.1. Introductory Comments

The central factors that informed the design of the prototype fact sheet, are discussed in the remainder of Section 5 below. Throughout this section, the reader will be referred to the fact sheet for clarification. These references take the form of numbers and letters in brackets, ie. (). Numbers presented before slashes indicate fact sheet page numbers. Letter-number combinations after slashes indicate fact sheet question numbers. For example, the reference (1/A4) indicates that the reader is to refer to question A4 on the first page of the fact sheet labeled 1A.

5.2. Aspects for Maintaining Confidentiality

The maintenance of the confidentiality of computerized psychiatric case material has become a serious concern. In response, the Royal College of Psychiatrists have drafted guidelines to ensure the confidentiality of psychiatric data in computer systems [BALWIN ET AL, 1976]. The range of safeguards that will be used to maintain the confidentiality of the case material in FOCIS, are not within the ambit of this brief paper, but the guidelines of the Royal College will be followed.

To maintain the confidentiality of the case material collected on the fact sheets, the following precautions will be taken :-

- * The assistants who complete the fact sheets and all other personnel involved in processing this data, will be fully informed as to the confidentiality requirements, and will sign a legal document reflecting their agreement to maintain confidentiality.

- * Once the case material has been transferred to the computer system, the completed fact sheets will be filed in the hospital folders and returned to the archives.

- * All case material that is not filed will be shredded.

5.3. Aspects for Promoting Ease of Use

The prototype fact sheet will be used by assistants to systematize material from approximately 7500 cases. This material is sometimes difficult to read and not always consistently organized. It is vital therefore, that the prototype fact sheet is structured so as to be easy to use and that it facilitates rapid, yet reliable recording of data. To achieve these ends, the prototype fact sheet has been structured in the following manner :-

- * The prototype fact sheet has a schematic layout with clearly defined areas for answers [MEZZICH ET AL, 1981 [a]].

- * The printing and layout of the prototype fact sheet are of high quality so as to decrease distractibility resulting from printing errors and poor legibility, and to instill a more careful approach on the part of users [JOHNSON ET AL, 1981 [a]].

- * The questions appear in the order in which the answers are most likely to be found in the case material. This means that the contents of the prototype fact sheet are not necessarily ordered in a clinically meaningful manner. The computerized system will however, be capable of reorganizing information to suit users' needs.

5.3. Aspects for Promoting Ease of Use - continued

- * Wherever applicable, users merely have to choose their answers from given sets of answer-options. This saves time and effort expended on recording and facilitates the pre-coding of data.
{ ANGLE, 1981; GREENES ET AL, 1969 1. (For example, see question 2/D6.)

- * To save the effort expended in answering questions that are irrelevant to a particular case, instructions have been included to omit such questions. At the time of input however, the computerized system will automatically code these questions as irrelevant. The system also has a built-in mechanism for ensuring that answers which are purposefully omitted are not confused with those that are erroneously omitted. (For example, see question 2/C12. The three letter-number codes under the answer-options, indicate that the user must omit the irrelevant, intervening questions between question 2/C12 and the questions indicated in the letter-number codes. In this example therefore, if the user chooses the 'Y' answer-option to indicate that the person was found to be fit to stand trial, the code 2/C14 under this option shows that the user must omit the irrelevant question C13, which asks for the reasons for unfitness to stand trial. The user must then move straight on to answer the next, relevant question C14.

5.3. Aspects for Promoting Ease of Use - continued

- * Questions that are repeated for different aspects of each case, but that may not be applicable in every case, have been included once only. Additional sheets containing these questions are used only when necessary, and users indicate for what purpose they have used these 'dual-purpose' sheets, by marking in the space provided at the top of each sheet. (For example, see 1/D which may be used to answer questions about the most recent or previous observations.)

- * To improve comprehensibility, the questions have been phrased succinctly and the fact sheet has been kept clear of definitions and contains few instructions [SHERMAN, 1981]. Comprehensive instructions and clarifications have been included in a separate manual, which can be discarded once users become accustomed to the fact sheet. All instructions that do appear on the fact sheet have been printed in capital letters between horizontal lines, to clearly distinguish them from the questions. Due to limited space, only part of the instruction manual has been included as Addendum II. This part of the manual explains the summarized questions and the answer-option codes, so that the reader is able to understand the fact sheet.

5.3. Aspects for Promoting Ease of Use - continued

- * To minimize computer storage space many of the answer-options have been numerically coded. To improve clarity however, these numerical codes are not printed on the fact sheet [PETRILA & HEDLUND, 1983].

- * To enable ongoing improvement of the computerized system, modification is possible with limited reprogramming and restructuring. One method of achieving this goal using the fact sheet, is the grouping of questions into structurally separate and individually numbered modules or sections. This means that changes to a section do not affect the entire fact sheet and problems can be rapidly localized [KAHN ET AL, 1981]. The technical design of the computerized system is based on the key concept of modularity and achieves the goal of flexibility in various ways [SEMPREVIVO, 1982]. A discussion of these methods however, was not within the ambit of this paper.

5.4. Aspects for Maintaining Data Integrity

- * One of the most serious criticisms of data collected by means of prestructured fact sheets, is that qualitative data loses meaning in the process of summarization [JOHNSON ET AL, 1981 [a]; PETRILA & HEDLUND, 1983]. To prevent this, only data that could be restructured into discrete elements without losing validity, was parsed in this manner. Wherever possible qualitative data is collected as verbatim quotes, eg. personality dynamics and reasons for psychiatric opinions. (For example see questions, 2/C13; C15; C18; 3/C23; 3/E12 to 5/E21.)

The immense variability however, in the quality and quantity of information about defendants' accounts of alleged offences and descriptions of the quality of relationships, made verbatim collection unmanageable. Consider that in some cases defendant's accounts spanned six pages and in others, accounts were absent. To construct the questions and answer-options pertaining to these topics, the central parameters of the information were derived from the literature. (For example, see questions 1/G1 to 2/G11; 4/H14 to H17; 1/N7 to N10.)

5.4. Aspects for Maintaining Data Integrity - continued

- * To improve the validity of the answer-options they were derived from the actual case material collected in the pilot study. Information that was shown to be relevant in the literature surveys and discussions conducted as part of this project, was added to avoid repeating the inadequacies of the original case material.

- * For questions having a wide range of possible answers, instead of answer-options, short answers are required. This reduces the chance of inappropriate answer-options being chosen and avoids cluttering the fact sheet with lengthy lists of answer-options. [COUPER ET AL, 1987]. (For example, see questions 1/C4; C7; 2/C11; 3/H12; H13.)

- * To overcome the problem of data being omitted or forced into inappropriate categories, open options have been included for answers that do not appear among the options provided, ie. the category of 'other' [COUPER ET AL, 1987]. (For example, see question 2/D6.)

5.4. Aspects for Maintaining Data Integrity - continued

- * The traditional method of using a single, catchall answer-option for questions that are not applicable, has not been used. The data that this category generates is often meaningless, because the reasons for the inapplicability are excluded [COUPER ET AL, 1987]. For the purposes of the fact sheet therefore, precisely defined answer-options that include the reasons as to why a particular question is not applicable, are provided.
(For example, see the Addendum II.)

- * For similar reasons to those mentioned in the paragraph above, the traditional category of 'missing data' has been subdivided. This provides two, more specific answer-options :-
 - * The first option indicates that a question couldn't be answered by the user, because the information necessary to answer the question was absent from the case material.
(For example, consider question 2/C14 which asks whether the defendant was found to have had adequate moral judgement at the time of the alleged offences. If there is no information in the case material stating whether or not the defendant was found to have had adequate moral judgement; then the user chooses this first answer-option.)

5.4. Aspects for Maintaining Data Integrity - continued

- * The second option indicates that the answer to a question has not been given by the user, because the answer involved an opinion from an authority that was not given, due to insufficient information at the time that this opinion was originally requested. (For example, consider question 2/C14 which asks whether a defendant was found to have had adequate moral judgement at the time of the alleged offence. If it is stated in the case material that no psychiatric decision was reached regarding the defendant's moral responsibility, because there was insufficient data available to the decision makers; then the user chooses this second answer-option.)

- * To increase the external validity of findings based on the computerized case material, it is important that the database provides results that are comparable with those generally accepted in psychiatry, both nationally and internationally [LEADER & KLEIN, 1977]. The use of internationally accepted data collection devices is one way of enhancing external validity. It also extends the application of a locally developed forensic system to the broader psychiatric field.

5.4. Aspects for Maintaining Data Integrity - continued

Where applicable therefore, such internationally accepted data collection devices have been incorporated :-

- # The internationally accepted DSM III multi-axial diagnostic system has been used. Diagnoses on all five of the axes and the diagnostic criteria for psychopathy or antisocial personality disorder, substance use, abuse and dependence are included. (For example, see questions
2/C11 - Axes I & II; 1/C5 to C8 - Axis III;
10/T15 & T16 - Axes IV & V;
4/K13; 2/L15; L16; 1/Q1 to Q3; 2/N13; N14; 2/H8;
3/M12 to M16; 3/N21 - Criteria for antisocial personality disorder;
9/P21; 10/P23; 11/P25; - Criteria for substance use.)

- # The internationally used Maudsley schedule for psychiatric history taking and the associated mental state examination, constitute the basis for most of the fact sheet. (See Sections 1/F to 10/T.) Further discussion of the Maudsley framework is presented in Section 5.8.2. on page 64.

5.5. Aspects for Maintaining Reliability - continued

* One means of achieving inter-rater reliability, is the inclusion of two existing data collection devices that have established high reliability levels :-

The first is the checklist of childhood and adolescent psychiatric symptoms, from the Bethlem Royal and Maudsley Hospitals' Clinical Data Register for Children and Adolescents, which has a 13 year track record of established reliability and validity [THORLEY, 1982].

The second is the checklist of mental state observations, from the Clinical Information System developed by the Western Psychiatric Institute, which has an inter-rater reliability level of between 80% and 90% [MEZZICH ET AL, 1981 [b]].

5.6. Methods for Estimating Reliability

The fact sheet includes a method for estimating the reliability of the case material from which users draw their answers to the fact sheet questions. Reliability will be estimated for all case material that is known to be of dubious credibility such as, information about substance use, criminal behavior, psychosexual history, financial matters, relationships with significant others, traumatic psycho-social events etc. In essence, this is information affected by social acceptability pressures and emotional repression (BIRTCHNELL, 1981). (For example, see the tables on the far right-hand side of question 2/M9.) Reliability estimates of the answers to the fact sheet questions will be made according to the following principles :-

- * An answer is always drawn from the source/s of highest reliability.

- * Should equally reliable sources contain contradictory answers to a question, users choose whatever answer they believe is most credible, and record the fact that there were contradictory answers.

5.7. General Criteria for Fact Sheet Data Selection

The computerized information system is to serve the disciplines that aim to understand human behavior. In these disciplines one of the fundamental premises is that the etiology of both adaptive and maladaptive behavior can be fully understood only by reference to multiple factors. This premise informed the selection of the information to be collected on the fact sheets [SPAULDING ET AL, 1981; EIDUSON ET AL, 1967]. To make the fact sheet useful yet economical, only information that had a clear value or purpose, was included [HAYES-ROTH ET AL, 1972; MEZZICH ET AL, 1981 [b]].

5.7. General Criteria for Fact Sheet Data Selection - continued

* The decision to include each piece of information was based on the answers to these three questions, put forward by SHERMAN [1981], to assist data selection :-

What purpose would this information serve ?

Is it important enough to include ?
ie, What is its priority relative to other information ?

Can the validity of this information be maintained using a fact sheet for data collection ?

* To aid in the selection of information, only those variables that empirical research and/or clinical experience, have shown to be of relevance to forensic psychiatry were included. This selection criterion is similar to that which has been effectively used in the development of both the Maudsley Psychiatric Interviewing Schedule and the DSM III. Since forensic psychiatry is interdisciplinary, relevant variables were sought in the fields of criminology, clinical psychology, general and forensic psychiatry.

5.7. General Criteria for Fact Sheet Data Selection - continued

- * Information useful to the routine functioning of the Valkenberg Forensic Unit is also included.

- * Information about the types of data that are missing from the case material was felt to be essential for evaluating existing, and for improving future data collection procedures. Thus, questions for which there will frequently be no answers in the case material; are included in the fact sheet.

5.8. A More Detailed Rationale for the Contents

5.8.1. Introductory comments

Since this paper is brief the detailed, empirical findings that informed the selection of each question for the fact sheet, have not been included. For further information, the interested reader is referred to the texts cited in the bibliography. Instead, the rationale for the inclusion of thematically-related groups of questions is presented in Sections 5.8.2. to 5.8.12. below.

5.8.2. The Maudsley framework

The planned system is to cater to forensic psychiatry, a prime function of which is to distinguish and manage the 'criminally insane' [SLOVENKO, 1973]. Much of the fact sheet therefore, focuses on data to inform our understanding of the etiology, diagnosis and management of psychiatric and psychological disorder. This part of the fact sheet consists of information that constitutes the Maudsley Psychiatric History. This schedule was chosen, due to its internationally established reputation for the systematic collection of psychiatric data [GELDER ET AL, 1983]. This schedule has also been used as the routine method for psychiatric history taking at Valkenberg and Lentegur Hospitals [GILLIS, 1986].

For these reasons, the fact sheet was constructed around the Maudsley framework. This means data collection is eased, because the psychiatric histories systematized during this project, have similar sections to the fact sheet. [SPAULDING ET AL, 1981]. The fact sheet sections are presented in Table I on the next page.

- TABLE I -

A Tabular Representation of the Fact Sheet Sections	
Fact Sheet References	Contents of the Sections
1/A1 to 2/A17	Identificatory data.
1/B1	Available source documents.
1/C1 to 3/C24	Observation court report data.
1/D1 to 6/D21	Legally-related data.
1/E1 to 5/E23	Psychometric test data.
1/F1 to 1/F9	Present financial and domestic circumstances.
1/G1 to 2/G11	Defendant's account of alleged offences.
1/H1 to 2/J13	Family history : Caretakers, Siblings & Relatives.
1/K1 to 4/K15	Birth and childhood development.
1/L1 to 2/L16	Educational history.
1/M1 to 3/M16	Military service and occupational history.
1/N1 to 3/N21	Psychosexual history.
1/P1 to 13/P31	Substance use history.
1/Q1 to 3/Q13	Criminal history and escapes.
1/R1 to 4/R19	Medical history.
1/S1 to 3/S12	Psychiatric history.
1/T1 to 10/T17	Mental state and adaptive functioning.

5.8.3. Modifications to the Maudsley framework

The Maudsley schedule was developed in Britain for general psychiatric history taking. Consequently it has certain shortcomings when applied in the South African context of forensic psychiatry. During the past three years, an ongoing evaluation of the shortcomings of this schedule has been conducted at the Child Guidance Clinic, of the University of Cape Town. Although this work has not yet been published, the central findings were used to modify the Maudsley schedule for use in the prototype fact sheet. Additional modifications were made on the basis of the author's experience of using this schedule in forensic practice at Valkenberg.

5.8.3. Modifications to the Maudsley framework. - continued.

The modifications made to the Maudsley schedule are discussed in the remainder of this section:

The fact sheet includes a large number of questions about substance use, over the period of alleged offences and general patterns of use. This is a reflection of the importance and complexity of the issue of substance use in forensic assessment. Involuntary, and even voluntary substance use should it cause 'legal insanity', provide complete defences against all criminal liability. Furthermore, voluntary substance use over the period of an offence can be advanced as a factor that diminishes criminal responsibility. [SCHIFFER, 1978; ZABOW, 1973]. Substance use is of even greater relevance in South Africa, due to the high incidence of alcohol, cannabis and methaqualone use [OFFEN, ET AL, 1986]. In South Africa, cannabis is commonly known as dagga, and methaqualone, as mandrax. More important is the significant correlation between substance use and violent crime, especially on the Cape Flats [BLOCH, 1975; SCHARF, 1984]. To illustrate this point, a recent study at Valkenberg showed that alcohol was implicated in 41%, and dagga in 15%, of all homicide cases referred to the Forensic Unit between 1977 and 1984 [OFFEN, 1986 [b]].

5.8.3. Modifications to the Maudsley framework - continued

- * One of the fundamental aims of the Maudsley schedule is to collect information about a range of universal, psychosocial variables that are assumed to be stressors predisposing individuals to disorder, and 'steeling' factors that protect individuals against maladaptation. Research has shown however, that the effects of psycho-social factors are influenced by developmental maturity, cultural and historical context, and numerous other variables [GARMEZY & RUTTER, 1983]. For the purposes of this project therefore, the assumption of universality has been rejected. The new conceptualization put forward by GARMEZY & RUTTER, [1983], has been operationalized in the fact sheet, by collecting detailed information specific to each type of psychosocial factor, and the age periods during which each psychosocial variable occurred.

To illustrate the importance of the age-factor, consider the example of a person who experiences multiple hospitalizations, whilst under the age of two years. It has been shown that such a person has a significantly higher chance of developing psychiatric disorder in adulthood, than a person who has the same experiences after two years of age [DOUGLAS, 1975; GARMEZY & RUTTER, 1983; QUINTON & RUTTER, 1976].

5.8.3. Modifications to the Maudsley framework - continued

- * The Maudsley schedule does not include sufficient questions about social and material factors that affect behavior. Recent findings show that social adjustment and intellectual functioning are better predictors of prognosis, than the traditional variables of diagnosis and symptomatology [SPAULDING ET AL, 1981]. In an attempt to address this problem, the fact sheet includes questions about individuals' financial, social and domestic support systems; their levels of and impairments in adaptive functioning; psycho-social stressors; and detailed findings from psychometric testing. (For example, see questions 1/F1 to F9; 1/N1 to 3/N21; 1/M1 to 3/M16; 10/T14 to T17; 2/E5 to 5/E23.)

- * The Maudsley schedule includes questions about the traditional nuclear family members and a general category of questions for significant others. In practice however, this has not served to collect valuable information about all parental substitutes and non-biologically related siblings. Research has indicated the importance of understanding the influence of these people on development [BIRTCHNELL, 1971; 1972 [a]; 1972 [b]].

5.8.3. Modifications to the Maudsley framework - continued

This is particularly relevant in South Africa where the nuclear family is rapidly becoming the exception to the rule. Factors such as, high divorce and desertion rates, working parents and the migrant labor system; appear to contribute to this process [BLOCH, 1975; SCHARF, 1984]. The fact sheet therefore includes systematic questions about all caretakers and all siblings. (For example, see questions 1/H1 to 1/J9.)

- * The Maudsley schedule includes a general section on occupational history, but this has not prompted the consistent collection of data about military service. This is particularly relevant in South Africa, due to the present policy of compulsory military service and the State of Emergency. A section of questions specific to military service has thus been added to the section on occupational history. (For example, see questions 1/M1 to M3.)

5.8.4. The focus on criminal behavior

" The outstanding feature of modern criminal psychiatry
is the recognition of the importance of the emotional
rather than the intellectual genesis of crime "

[ZABOW, 1983 : 250].

For the reason stated in the quote above, the body of the fact sheet
is concerned with psycho-social variables that function as stressors
and/or 'steeling' factors in shaping motivation, emotional functioning
and ultimately behavior [ANTHONY, 1974; BLOCH, 1975; BROWN &
HARRIS, 1980; COELHO ET AL, 1974; DOHRENWEND & DOHRENWEND, 1974;
GARMEZY & RUTTER; 1983].

The entire fact sheet has been designed to collect information about
the population who move between the criminal justice and mental health
systems. This information is useful in developing a detailed forensic
profile to inform etiological and descriptive research [OFFEN,
1986 [a]; [b]; PETRILA & HEDLUND, 1983; STEADMAN, 1980; ZABOW,
1983].

5.8.4. The focus on criminal behavior - continued

Etiological studies of patterns in criminal behavior also require detailed information about offences. For this reason questions are included about the characteristics of offences, the victims, the property involved, the place of occurrence and the weapons used [FELDMAN, 1977; OFFEN 1986 [a]; [b]; ZABOW, 1983].

(For example, see questions 3/D7 to 6/D20.)

The questions that reflect defendants' reasons for their criminal behavior have been included to provide something of a phenomenological perspective. (For example, see questions 1/G1 to 2/G11.)

5.8.5. Information on psycholegal issues

All data present in psychiatric court reports has been included in the fact sheet. This information is important, because it reflects the central issues in forensic assessment, ie. the decisions reached about psycholegal questions such as, legal certifiability or insanity, criminal responsibility, triability, extenuating circumstances, curability, deterability, recommendations for management and factors in mitigation of sentence [GRISSO, 1986; OFFEN, 1986 [a], [b]; SCHIFFER, 1978; SLOVENKO, 1973; ZABOW, 1983].

(For example, see questions 2/C9 to 3/C24.)

Questions have been included about the content and quality of the accounts of alleged offences given during forensic assessment. Information is also collected about the factors that influence these accounts such as, the conditions under which defendants were held before admission and the language in which interviews were conducted. [GRISSO, 1986; PETRILA & HEDLUND, 1983; SCHIFFER, 1978; ZABOW, 1983]. (For example, see questions 1/D5; 1/E1; 10/T13.)

5.8.6. Information on psychometric and EEG findings

Psychometric test findings play a central role in forensic assessment [GRISSO, 1986]. The fact sheet collects data about the findings from psychometric and EEG testing, because these can be used in the study of patterns of symptoms and psychodynamics that correlate with patterns of criminal behavior, different types of head injuries, medical and psychiatric conditions. This type of information can enhance the accuracy of forensic assessment [PETRILA & HEDLUND, 1983; SPACE, 1981]. (For example, see questions 1/E3 to 4/E23; 1/R1 to 4/R19; 3/S12; 2/C11.)

The author's experience of psychometric assessment highlighted the paucity of research into the reliability and validity of psychometric tests, especially those that have not been standardized for South African groups. This prompted the inclusion of questions about the types of tests that are used, the findings and whether the test scores are corrected for cultural bias. This data is crucial for the development of batteries of reliable and valid psychometric tests for forensic assessment [GRISSO, 1986; LEZAK, 1983].

The findings from personality testing have been included, because this is one of the few sources of detailed, systematic information about the possible motivations for criminal behavior [EYSENCK, 1977; FARRINGTON ET AL, 1982; TRASLER, 1978].

(For example, see questions 3/E10 to 5/E23.)

5.8.7. Information on dangerousness

The fact sheet contains questions reflecting professional opinion as to the dangerousness of defendants, information useful in assessing escape risks, dangerousness and recidivism. This is important, because the court frequently requests psychiatric opinion on these issues, and at present there is little empirical data to inform psychiatric decisions, or to systematically assess predictive accuracy [OFFEN, 1986 [a]]. To provide additional information on this issue, questions have been added regarding the degree to which defendants deny or admit culpability. This is the only information available to forensic professionals about whether a defendant committed the alleged offences [DUCKITT & DU TOIT, 1985; GRISSO, 1986; OFFEN, 1986 [a]; ZABOW, 1983].

(For example, see questions 2/D7; 5/D18; 1/Q1 to 3/Q13; 1/G2; 63.)

5.8.8. Information for service evaluation and planning

The fact sheet collects information for the evaluation of forensic service, eg. the time taken to complete assessments and reports, the extent to which psychiatric reports answer the court's questions, and the recency of the data used to inform psychiatric decisions [OFFEN, 1986 [a]; PETRILA & HEDLUND, 1983; SCHIFFER, 1978].

(For example, see questions 2/A11; A12; 1/D1; 2/D6; 4/D10; 2/C9 to 3/C24; 1/B1 - dates.)

Information is also collected for the study of people's movements among mental health and legal facilities, forensic referral processes, and the geographic areas served by particular forensic and legal institutions, ie, systemic interaction. This type of work is useful in assessing the adequacy of existing services and planning new facilities [OFFEN, 1986 [a]; PETRILA & HEDLUND, 1983; SCHIFFER, 1978]. (For example, see questions 1/C3; C4; 1/D2; D3; D5; 6/D21; 2/A13; 1/Q1 to 3/Q13; 6/H31; 1/R1 to R4; 2/S5 to 3/S12.)

5.8.9. Information for cross-cultural comparisons

The entire fact sheet is designed to collect detailed information on symptoms and life history events. This data can be compared across the ethnic groups that comprise the forensic population. In the multi-ethnic context of South Africa comparative information is important, because the behavioral expression of psychopathology differs across cultural contexts [BUHRMANN, 1983; GILLIS, 1983].

5.8.10. Information for genetic studies

Questions have been included that distinguish biological from non-biological relatives, that indicate relatives' relationships to defendants and relatives' sexes. This information facilitates studies of the patterns of biological inheritance of predispositions to serious medical conditions, psychiatric disorders, substance abuse and criminal behavior [GILLIS, 1983; RUTTER & HERSOV, 1985].

(For example, see questions 2/J10 to J13; 3/H5; H10; H12; H13.)

5.8.11. Information for identification and follow-up

Information is collected to distinguish each case, so preventing data being attributed to the wrong person. This also ensures that all data about an individual is stored in the same computerized file. { For example, see questions 1/A3 to 1/A8 }.

Additionally, data is collected to enable the follow-up of individuals for longitudinal studies. Although such studies are important, they are infrequently conducted due to the difficulty of tracing people over extended time periods [BIRTCHNELL, 1981]. It should be emphasized however, that in the interests of confidentiality, careful vetting and authorization will have to be gained by anyone wishing to use this data for follow-up purposes. Criminal cases numbers, courts and districts are also included to allow for the follow-up of cases through the criminal justice system.

{ For example, see questions 2/A13 to A17; 1/C2 to C4. }

5.8.12. Information for future management

To enhance future management decisions, information is collected about all psychotropic medications, dosages and periods of use, as well as medical and psychiatric treatment received [MEZZICH ET AL, 1981 [a]]. (For example, see questions 1/S1 to S4; 1/R1 to 4/R19; 2/S5 to 3/S12.)

6. A BRIEF CRITIQUE OF THE PROTOTYPE FACT SHEET

6.1 The Idiographic-Nomothetic Data Controversy

The controversy over the relative values of nomothetic and idiographic data has dogged computerized psychiatric information systems [BIRCHNELL, 1981]. The criticism from those who favor idiographic data, has been that computerized systems are designed for nomothetic data that describes an individual as a point on a continuum relative to a background population, but which ignores the uniqueness of the individual [SPACE, 1981].

The central aim of the forensic computerized information system discussed in this paper, is to expand the empirical knowledge-base that undergirds South African forensic psychiatry. The retrospective database has been designed for nomothetic data for two reasons :-

- * First, nomothetic data was felt to be a priority given the inadequacy of our empirical knowledge-base, because this type of data can inform forensic opinion about groups of people, rather than only the individual.

6.2. Summary Feedback from the Pilot Study

Using the fact sheet, the author and a computer analyst were able to collect case material from a complete case in an average of 45 minutes. This time was felt to be feasible for the retrospective data collection from an estimated 7500 cases.

Although the pilot study did not include a formal assessment of inter-rater reliability, a crude estimate was made based on 10 cases. The average, estimated inter-rater reliability level was a generally acceptable, 82% [COUPER ET AL, 1987].

Since both of these estimates were based on users who were very familiar with the fact sheet, the speed and inter-rater reliability of other users remain to be assessed.

7. SUMMARY CONCLUSION

In the short term, it is anticipated that the prototype fact sheet will enable the development of the retrospective database, so as to begin to fulfill a part of the need for empirical data in South African forensic psychiatry. This will be a first step toward redressing the negative consequences of our inadequate, empirical knowledge-base. Furthermore it is hoped that in the longer term, FOCIS will motivate research to change this presently barren field into a dynamically developing discipline.

- The psychiatric hospital can be viewed as a social system which is evolving slowly by attempting to improve. In order to systematically study and learn about itself the mental hospital and its care providers need continuous pertinent information. Yet, at present the psychiatric hospital is not organized in a way that readily allows isolation of problems or systematic learning from prior experience. In that sense, the hospital is a non-system which lacks an information system necessary for meaningful feedback to the decision makers of the institution ▪

[HAYES-ROTH ET AL, 1972 : 27].

This quote embodies the spirit that gave rise to the forensic computerized information system discussed in this paper. The development of the first forensic computerized information system in South Africa, rests on the ethical responsibility of mental health professionals to evaluate what we have been doing in the past, and to apply this understanding to improving our future forensic practice. This is one of the fundamental reasons for expending the time and effort to establish the retrospective database, rather than leaping ahead with the prospective database. For, it would seem be irresponsible not to learn from our experience, both our mistakes and our achievements.

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- APPENDIX I -

The Computerized Systems for Psychiatric Case Material that were Considered for this Project	
System Name	Reference
SSQP - The Missouri Standard System of Psychiatry.	SLETTEN ET AL, [1972].
MSIS - The Rockland State Hospital Multistate System.	LASKA ET AL, [1980].
CIS - The Clinical Information System, developed by the Western Psychiatric Institute and Clinic at the University of Pittsburgh.	DOW & JAKIELO, [1981]; MEZZICH ET AL, [1981 [b]].
CMHC - The Ravenswood Hospital Community Mental Health System.	SHERMAN, [1981].
CRISP - The Clinical and Research Information System for Psychiatry, developed by the Medical Branch of the University of Texas.	BROOKS, [1981].

- APPENDIX I -

The Computerized Systems for Psychiatric Case Material that were Considered for this Project.	
System Name	Reference
The Bethlem Royal and Maudsley Hospitals' Clinical Data Register, for Children and Adolescents.	THORLEY, [1982].
The Forensic Computer Supported Information System, developed by the Missouri Institute of Psychiatry.	PETRILA & HEDLUND, [1983].
MEDISTAR - developed by the United States Naval Health Research Center and the Department of Environmental Medicine, at San Diego University.	UNITED STATES NAVAL HEALTH RESEARCH CENTER, [1985].

- A D D E N D U M I -

The FOCIS Prototype
Fact Sheet

DESIREE S HANSSON

SECTION A - IDENTIFICATORY DATA

A1. Date ->

d	d	m	m	y	y	y	y
				1	9		

A2. User's first 2 initials & surname ->

--	--	--	--	--	--	--	--	--	--

SEE : 1) OUTER FOLDER COVER, 2) INNER FILE COVERS.

A3. Most recent hospital number, for this hospital ->

--	--	--	--	--	--	--	--	--	--

A4. All other hospital numbers, for this hospital ->

--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--

66									
----	--	--	--	--	--	--	--	--	--

A5. P's first 2 forenames ->

									99
--	--	--	--	--	--	--	--	--	----

A6. P's surname ->

									99
--	--	--	--	--	--	--	--	--	----

A7. P's alias : Forenames ->

									99
--	--	--	--	--	--	--	--	--	----

A8. P's alias : Surnames ->

									99
--	--	--	--	--	--	--	--	--	----

A9. P's sex ->

F	M
---	---

A10. P's official ethnic group ->

Asian	Black	Coloured	White
-------	-------	----------	-------

SECTION B - SOURCE DOCUMENTS

B1.

DOCUMENTS PRESENT IN THE FOLDER	Y	Date of most recent doc						N
		m	d	y	y	y	y	
Charge sheet				1	9			
Transcripts of court proceedings								
Criminal record								
Post mortem report								
Court's request for observation								
Court's reasons for observation								
Alcohol/drug treatment report								
District surgeon's report								
Educational report								
EEG report								
Employer's report								
Escape report								
Independent mental health professional's report [not State employed]								
Military official's report								
Occupational record								
Occupational therapist's report								
Prison official's report								
Probation officer's report								
Psychiatrist's court report								
Psychologist's report								
Psychometric report								
Religious professional's report								
Social worker's report.								
Clinical history, including collateral & mental state examination								
Clinical summary								

SECTION C - COURT REPORT DATA

This sheet refers to ->

Most recent observation

Previous observation

C9. Was P found to have been mentally ill at the time of the alleged offences ? ->

Y	N	66	88	99
---	---	----	----	----

C10. Was P found to be certifiable ? ->

Y	N	99
---	---	----

C11. All psychiatric diagnoses given ->

88	99

C12. Was P found fit to stand trial ? ->

Y	N	66	88	99
2/C14		3/C20	2/C14	

C13. Reasons for unfitness to stand trial ->

99

C14. Was P found to have had adequate moral judgement at the time of the alleged offences ? ->

Y	N	88	99
2/C17		2/C17	

C15. Reasons for P's impaired moral judgement ->

99

C16. Types of substances alleged to have impaired P's moral judgement ->

None	99

C17. Was P found to have had the capacity to act in accordance with his/her moral judgement at the time of the alleged offences ? ->

Y	N	88	99
3/C20		3/C20	

C18. Reasons for P's impaired moral capacity to act ->

99

SECTION C - COURT REPORT DATA

This sheet refers to ->

Most recent observation

Previous observation

C19. Types of substances alleged to have impaired P's capacity to act in accordance with his/her moral appreciation ->

	None	99
--	------	----

C20. Recommendations made ->

--

	88	99
--	----	----

C21. Type of prognosis given ->

Good	Fair	Poor	Guarded	88	99
------	------	------	---------	----	----

Other		3/C24
-------	--	-------

C22. Factors upon which the prognosis depends ->

--

	99
--	----

C23. Reasons for the prognosis ->

--

	99
--	----

C24. Quality of P's account of the alleged offences ->

66

I	L	99
---	---	----

CT	C	99
----	---	----

V	AD	DD	99
---	----	----	----

Other	

SECTION D - LEGAL DATA

This sheet refers to ->

Most recent observation	Previous observation

- SEE :
- 1) COURT'S REQUEST FOR OBSERVATION
 - 2) COURT'S REASONS FOR OBSERVATION
 - 3) COURT TRANSCRIPT
 - 4) DISTRICT SURGEON'S REPORT.
 - 5) PRISON OFFICIAL'S REPORT.

D1. Due date of psychiatric observation report ->

d	d	m	m	y	y	y	y	
				1	9			99

D2. Who gave the reasons for P's observation ? ->

99

D3. Reasons for P's observation ->

99

- SEE :
- 1) CHARGE SHEET
 - 2) SOCIAL WORK REPORT.

D4. P's nationality ->

	SA	99
--	----	----

D5. P's legal status immediately before this observation ->

Pol custody	Prison	Bail	Free	99
-------------	--------	------	------	----

SECTION D - LEGAL DATA

This sheet refers to ->

Most recent observation	Previous observation

SEE : 1) COURT REQUEST FOR OBSERVATION.

D6	QUESTIONS ON WHICH THE COURT REQUESTED PSYCHIATRIC OPINION		
Certifiability	Y	N	99
Fitness to stand trial			
Moral judgement			
Capacity to act in accordance with moral judgement			
Recommendations fairest to the defendant & to society			
Prognosis for satisfactory adaptation to society			
Other			

SECTION D - LEGAL DATA

This sheet refers to ->

Most recent observation	Previous observation

- SEE : 1) CHARGE SHEET 2) COURT TRANSCRIPT
- 3) CLINICAL HISTORY : SUBSECTION - P'S ACCOUNT OF ALLEGED OFFENCES
- 4) SOCIAL WORK REPORT 5) PROBATION OFFICER'S REPORT.

1/E1 A/D10													
D7	66	99	D8		D9			D7		D8		D9	
TYPES OF CHARGES			COUNTS		PLEAS			REL.		REL.		REL.	
C			Num										
				99	6	NG	66	99					

SECTION D - LEGAL DATA

This sheet refers to ->

Most recent observation

--

Previous observation

--

D10	DATE OF EACH ALLEGED OFFENCE										D10
	C	CO	d	d	m	m	y	y	y	y	REL
						1	9			99	

IF THERE ARE NO CRIMES AGAINST PERSON, GO TO 5/D18.

D11					D12	5/D13		D11	D12
	C	CO	PLACE IN WHICH EACH OFFENCE OCCURRED		ROOMS			REL	REL
			Outside	Inside	99				

SECTION D - LEGAL DATA

This sheet refers to ->

Most recent observation	Previous observation

COMPLETE QUESTIONS 5/D13 TO D18, ONLY FOR CRIMES AGAINST PERSON.

IF THERE ARE NO CRIMES AGAINST PERSON, GO TO QUESTION 6/D19.

D13					D14				D15									
V KNEW PLACE					P KNEW PLACE				AGE-CATEGORY OF THE VICTIM									
C	CD	Y	N	99	Y	N	99	1	2	3	4	5	6	7	8	99		

D13	D14	D15
REL	REL	REL

D16					D17				D18				
VICTIM'S SEX					RELATIONSHIP BTW P & V				WEAPONS USED				
C	CD	F	M	99				99				66	99

D16	D17	D18
REL	REL	REL

SECTION D - LEGAL DATA

This sheet refers to ->

Most recent observation	Previous observation

COMPLETE QUESTIONS 6/D19 AND D20, ONLY FOR PROPERTY OFFENCES.

D19				D20				D19		D20	
TYPES OF GOODS				VALUES OF GOODS				REL		REL	
C	CD										
			99								99

SEE : 1) NURSING OBSERVATION NOTES.

D21. Numbers of the wards to which P was admitted during this observation ->

			99
			99

SECTION E - PSYCHOMETRIC DATA

SEE : 1) MOST RECENT PSYCHOMETRIC TEST REPORT.

E1. P's home language ->

	99
--	----

E2. When was the most recent psychometric testing? ->

This admission	Previously	66	99
		1/F1	

E3					E4					
C	NAMES OF PSYCHOMETRIC TESTS					CULT. CORRECTED				
				99	Y	N	66	99		

SECTION E - PSYCHOMETRIC DATA

E5		E6	
STRENGTHS FOUND ON TESTING		DEFICITS FOUND ON TESTING	
C		C	
	99		99

E7		2/E9 66		E8							
AREA OF BRAIN MALFUNCTIONING				SIDE OF BRAIN							
C				99	L	R	M	H	L+R	G	99

E9	
IQ RANGES	
C	
	99

SECTION E - PSYCHOMETRIC DATA

1/F1		E11		99		
E10	66	NAMES OF PERSONALITY TESTS			FINDING RE REALITY TEST	
C		99	Psych	Fragile	Unimp	

E12	99
C	TEST FINDINGS RE INTERPERSONAL RELATIONSHIPS

E13	99
C	TEST FINDINGS RE SOCIAL INSIGHT & JUDGEMENT

E14	99
C	TEST FINDINGS RE SEXUALITY

SECTION E - PSYCHOMETRIC DATA

E15	99
-----	----

TEST FINDINGS RE EMOTIONS

C	

E16	99
-----	----

TEST FINDINGS RE PERSONALITY TRAITS

C	

E17	99
-----	----

TEST FINDINGS RE RESPONSE TENDENCIES UNDER STRESS

C	

E18	99
-----	----

TEST FINDINGS RE PERCEPTIONS OF FATHER

C	

SECTION E - PSYCHOMETRIC DATA

E19	99
-----	----

TEST FINDINGS RE PERCEPTIONS OF MOTHER	
C	

E20	99
-----	----

TEST FINDINGS RE PERCEPTIONS OF SPOUSE	
C	

E21	99
-----	----

TEST FINDINGS RE ATTITUDES TOWARD PARENTHOOD	
C	

E22

TEST CONCLUSIONS							
Suicidal	99	Homicidal	99	Psychotic	99	Personality disorder	99
	88		88		88		88

E23. Type of personality disorder ->

	88	99
--	----	----

SECTION F - DOMESTIC CIRCUMSTANCES

SEE : 1) CLINICAL HISTORY : SUBSECTIONS - i) IDENTIFYING DATA ii) PRESENT DOMESTIC CIRCUMSTANCES
 2) SOCIAL WORK REPORT 3) PROBATION OFFICER'S REPORT.

F1. With whom does P live ? ->	66 99	FI	REL	FI	REL	FI	REL
F2. Number of people living with P ->	99						
F3. Type of permanent dwelling ->	66 99 1/F6						
F4. Number of living rooms in the dwelling ->	99						
F5. P's ownership of the dwelling in F3 ->	O R S F 99						
F6. Who supports P financially ? ->	Self 99 1/F8						
F7. How do the people in F6 gain this money ? ->	99						
F8. Number of people other than P, who are financially dependent upon the person in F6 ->	99						
F9. Approximate monthly income of the person who supports P in F6 ->	99						

SECTION 6 - ACCOUNT OF OFFENCES

This sheet refers to ->

Most recent observation	Previous observation

SEE : 1) CLINICAL HISTORY : SUBSECTION - P'S ACCOUNT OF ALLEGED OFFENCES.

61	1/H1 66					
TYPE OF ACCOUNT GIVEN BY P						
C	CO	D-R	D+R	A-E	A+E	99
		1/H1		1/62		1/H1

61						
TYPE OF ACCOUNT GIVEN BY P						
C	CO	D-R	D+R	A-E	A+E	99
		1/H1		1/62		1/H1

62	EXPRESSION OF REMORSE				63	CREDIBILITY OF REMORSE		
Y,spontan	Y - ?	N	99	Cred	Incred	88	99	
			1/64					

64			
RATIONALE AND EXTENUATING CIRCUMSTANCES GIVEN BY P			
C	CO		99

SECTION 6 - ACCOUNT OF OFFENCES

This sheet refers to ->

Most recent observation

--

Previous observation

--

65				66				68			
ALC BEFORE OFFENCES				VOLUNTARY				TIME BTW ALC & OFF			
C	CO	Y	N	99	Y	N	99			66	99
								2 /69			

IF THERE IS ALCOHOL USE BEFORE THE OFFENCES, COMPLETE QUESTIONS 4/P9 TO P14, THEN RETURN TO 2/69.

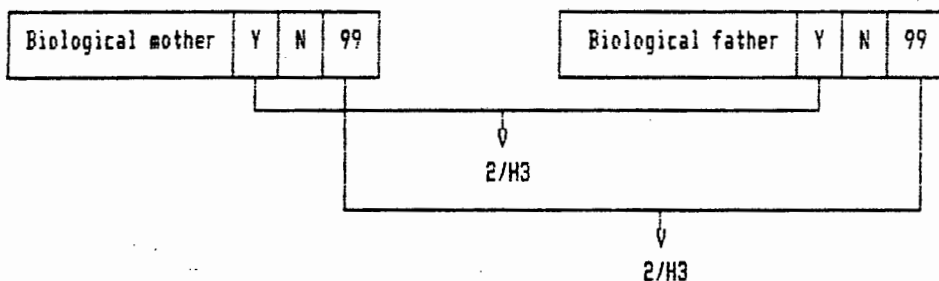
69				610				611			
DRUGS BEFORE OFFENCES				VOLUNTARY				TIME BTW DRUG & OFF			
C	CO	Y	N	99	Y	N	99			66	99
								1 /H1			

IF THERE IS DRUG USE BEFORE THE OFFENCES, COMPLETE QUESTIONS 7/P17 TO P20, THEN RETURN TO 1/H1.

SECTION H - FAMILY HISTORY: CARETAKERS

- SEE : 1) CLINICAL HISTORY : SUBSECTION - FAMILY HISTORY
 2) SOCIAL WORK REPORT
 3) PROBATION OFFICER'S REPORT
 4) INDEPENDENT MENTAL HEALTH PROFESSIONAL'S REPORT.

H1. Were P's biological mother and father caretakers ? ->



M	F
REL	REL

H2. Why weren't P's biological mother and/or father caretakers ? ->

Mother ->	99	66	
Father ->	99	66	

M	
REL	
F	

SECTION H - FAMILY HISTORY: CARETAKERS

H3		99		H4		H3		H4	
OTHER TYPES OF CARETAKERS				REASONS FOR OTHER CARETAKERS		REL		REL	
C		NUM							

SECTION H - FAMILY HISTORY : CARETAKERS & SIBLINGS

The information on this sheet refers to ->

Caretaker	
-----------	--

Sibling	
---------	--

H14				H15				H16				H17				
AFFECTION				COMMUNICATION				CONFLICT				GENERAL FEELING				
Y	N	?	99	Y	N	?	99	Y	N	?	99	+	-	?	Neu	99

H14	H15
REL	REL

H16	H17
REL	REL

H18					H19		
AMOUNT OF CONTACT					TYPE		
None	I	R	66	99	I	D	99
5/H20				5/H20			

H18	H19
REL	REL

SECTION H - FAMILY HISTORY : CARETAKERS

H27. Number of divorces/permanent separations between P's caretakers and spouses up to 21 years ->

		None	99
		6/R31	

H27
REL

H28			H29		H30		H28	H29	H30
WHICH CT'S SEPARATED			WHO LEFT		P'S AGE		REL	REL	REL
C	C		C						
		99		99		99			

H31			H32		H33		H31	H32	H33
NAMES & TYPES OF LIVE-IN INSTITUTIONS P ATTENDED			AGE BEGAN		AGE ENDED		REL	REL	REL
				99		99			

SECTION J - FAMILY HISTORY : SIBLINGS

J1. P's ordinal position ->

Only	Eldest	Middle	Multiple	Young	99
------	--------	--------	----------	-------	----

J2. Number of biologically related brothers ->

		99
--	--	----

J3. Number of biologically related sisters ->

		99
--	--	----

J4. Number of biologically related siblings ->

		99
--	--	----

J5	66														
P'S AGE AT EACH BIOLOGICAL SIBLING'S BIRTH															
C			99	C			99	C			99	C			99
C			99	C			99	C			99	C			99

J6. Number of non-biologically related brothers ->

		99
--	--	----

J7. Number of non-biologically related sisters ->

		99
--	--	----

J8. Number of non-biologically related siblings ->

		99
--	--	----

J9	66																		
DID P LIVE WITH EACH SIBLING FOR AT LEAST 6 MONTHS ?																			
C		Y	N	99	C		Y	N	99	C		Y	N	99	C		Y	N	99
C		Y	N	99	C		Y	N	99	C		Y	N	99	C		Y	N	99

SECTION J - FAMILY HISTORY: RELATIVES

COMPLETE QUESTIONS 3/H5 TO 4/H19 FOR EACH BIOLOGICAL SIBLING

AND EACH NON-BIOLOGICAL SIBLING WITH WITH WHOM P LIVED.

IF THERE ARE NO SIBLINGS, GO TO QUESTION 2/J10.

2/J12			J11		J10	
J10	None	99			REL	
PSYCHIATRIC DISORDERS - BIOL RELATIVES			RELATIONSHIP TO P			
			+			99

1/K1			J13		J12	
J12	None	99			REL	
SERIOUS MED DISORDERS - BIOL RELATIVES			RELATIONSHIP TO P			
			+			99

SECTION K - BIRTH & DEVELOPMENT

- SEE : 1) CLINICAL HISTORY : SUBSECTION - PERSONAL HISTORY 2) SOCIAL WORK REPORT
 3) PROBATION OFFICER'S REPORT 4) EDUCATOR'S REPORT
 5) INDEPENDENT MENTAL HEALTH PROFESSIONAL'S REPORT.

K1. Mother's age at P's birth ->

		99
--	--	----

K2. Father's age at P's birth ->

		99
--	--	----

2/K6

K3	None	99
----	------	----

EMOTIONAL AND/OR PHYSICAL PROBLEMS THAT MOTHER EXPERIENCED DURING PREGNANCY	
C	C

K3
REL

K3
REL

K4				K5		
STAGE PROBLEM BEGAN				STAGE PROBLEM ENDED		
C	C	C	C	C	C	C
		99			66	99

K4
REL

K5
REL

K6. Term of the pregnancy ->

		99
--	--	----

--	--

SECTION K - BIRTH & DEVELOPMENT

K10				
DISTURBANCES OF SPEECH AND LANGUAGE UP TO 18 YEARS				
Disorder of rhythm eg, stuttering & stammering	Y	N	88	99
Disorder of articulation				
Disorder of comprehension of spoken language				
Disorder of production of spoken language				
Delayed development of speech				

K10	
REL	

K11				
DISTURBANCES OF MOTOR BEHAVIOR UP TO 18 YEARS				
Tics	Y	N	88	99
Other abnormal repetitive movements eg, whirling, flapping				
Clumsiness or poor co-ordination				
Gross overactivity ie, hyperactivity				
Gross underactivity ie, hypoactivity				
Habitual manipulations eg, thumbsucking, nailbiting etc				
Delayed development of walking				

K11	
REL	

K12				
Disorder of sex role	Y	N	88	99
Disorder of sex object				
Gender identity disorder				

K12	

SECTION L - EDUCATIONAL HISTORY

SEE : 1) CLINICAL HISTORY : SUBSECTION - EDUCATION 2) EDUCATOR'S REPORT
 3) SOCIAL WORK REPORT 4) PROBATION OFFICER'S REPORT.

L1. Total number of schools P has attended ->

None		99
1/M1		

L2					L3			L4				L5		
PRIMARY-HIGH					DAY-BOARD			ORD - SPECIAL				GOVT-PRIV		
C	P	H	66	99	D	B	99	O	S	SC	99	G	P	99

L6	66
NAMES AND TYPES OF SPECIAL SCHOOLS ATTENDED	
C	99

L6
REL

SECTION L - EDUCATIONAL HISTORY

L7				L8			L9			L9				
AGE BEGAN				AGE LEFT			REASONS FOR LEAVING EACH SCHOOL					REL		
C			99		66	99								

2/L10

L10				L11				L12					
NUMBER FAILURES				STDS FAILED				SCHOLASTIC DIFFICULTIES					
None			99				99					None	99
2/L12													

L10	L11	L12
REL	REL	REL

L13				L14				L15					
HIGHEST EDUCATION				TYPE OF STD				NUMBER EXPULSIONS					
None			99	D	P	S	H	66	99	None			99
2/L15										1/M1			

L13	L14	L15
REL	REL	REL

L16														
REASONS FOR EXPULSIONS														
C														99

L16
REL

SECTION M - OCCUPATIONAL HISTORY

SEE : 1) CLINICAL HISTORY : SUBSECTION - OCCUPATION 2) MILITARY OFFICIAL'S REPORT
 3) SOCIAL WORK REPORT 4) PROBATION OFFICER'S REPORT.

M1. Present status re compulsory military service ->

	66	99
	1/M4	

REL	

M2. Has P ever been less than honorably discharged ? ->

Y	N	99
1/M4		

--	--

M3. Reasons for being less than honorably discharged ->

--

REL	
	99

SEE : 1) CLINICAL HISTORY : SUBSECTION - OCCUPATION 2) OCCUPATIONAL HISTORY
 3) EMPLOYER'S REPORT 4) SOCIAL WORK REPORT
 5) PROBATION OFFICER'S REPORT.

M4. Age P first began paid employment ->

	66	99
	2/M6	

SECTION M - OCCUPATIONAL HISTORY

M5		M6		M7		66		M8	
NUMBER PD JOBS		PR-OCCUP		FULL-PART TIME & REG-IRREG				TIME IN P-OCCUP	
		99		99	F/R	F/I	P/R	P/I	99
				2/M9					99

M5	M6
REL	REL

M7	M8
REL	REL

M9	66		
REASONS FOR LEAVING EACH JOB			
C		C	
	99		99

M9	M9
REL	REL

M10		M11	
6-OCCUP		FULL-PART TIME & IRREG-REG.	
	99	F/R	F/I
		P/R	P/I
			66
			1/N1
			99

M10	M11
REL	REL

SECTION M - OCCUPATIONAL HISTORY

M12		M13		66		M14	
NUM UNEMPLOY		LONGEST UNEMPLOY				LONGEST PD JOB	
		99			99		99

M12	M13	M14
REL	REL	REL

M.15 Has P ever been repeatedly absent or repeatedly late for work ? ->

Y	N	?	99
---	---	---	----

--	--

M16. Has P walked off at least 2 jobs without another job in sight ? ->

Y	N	?	99
---	---	---	----

--	--

SECTION N - PSYCHOSEXUAL HISTORY

SEE : 1) CLINICAL HISTORY : SUBSECTIONS - i) IDENTIFYING DATA ii) PSYCHOSEXUAL HISTORY

2) SOCIAL WORK REPORT

3) PROBATION OFFICER'S REPORT.

N1. Present marital status ->

Married	Div	Sep	Wid	Never mar	99
					1/N3

REL

N2. Number of previous marriages ->

		99
--	--	----

--	--

N3. Does P have a sexual relationship at present ? ->

Y	N	99
		2/N11

--	--

N4	N5	N6
LIVE WITH	LENGTH RELATION	OTHER SEX
Y N 99		Y N 99

N4
REL

N5
REL

N6
REL

N7	N8	N9	N10
AFFECTION	COMMUNICATION	CONFLICT	GENERAL FEELING
Y N ? 99	Y N ? 99	Y N ? 99	+ - ? Neu 99

N7
REL

N8
REL

N9
REL

N10
REL

SECTION N - PSYCHOSEXUAL HISTORY

N11	None	99	66
-----	------	----	----

SEXUAL DIFFICULTIES		
	Pres	Past

N11
REL

N12	None	66	99
-----	------	----	----

MOST COMMON ISSUES CAUSING CONFLICT		
	Pres	Past

N12
REL

N13

N14	66
-----	----

NUMBER OF SEXUAL PARTNERS IN THE PAST 6 YEARS								USUAL LENGTH RELS				
None	1	2-5	6-10	11-20	21-100	>100	99	L	M	S	V	99

N13
REL

N14
REL

N15. Has P ever had homosexual sex after the age of 18 years ? ->

Y	N	66	99
---	---	----	----

N16. P's present sexual preference ->

Asexual	Het	Het > Hom	Bisex	Hom > Het	Homo	?	99
---------	-----	-----------	-------	-----------	------	---	----

SECTION N - PSYCHOSEXUAL HISTORY

N17. P's number of biologically related children ->

None			99
1/P1			

N18			N19			N20		
CHILD-AGE			CHILD-SEX			LIVES WITH P		
		99	F	M	99	Y	N	99

N21								
SIGNS OF INABILITY TO FUNCTION AS A RESPONSIBLE PARENT								
Child being malnourished					Y	N	?	99
Child's illness resulting from lack of hygiene								
Failure to obtain medical care for seriously ill child								
Child left dependent on non-resident for food & shelter								
No caretaker for child under 6 yrs while parents away								
Repeated squandering of house-moneys on personal items								
Physically abusing child								
Sexually abusing child								

N21	
REL	

SECTION P - SUBSTANCE USE HISTORY

The information on this sheet refers to ->

ALCOHOL	
---------	--

DRUGS	
-------	--

- SEE :
- | | |
|---|----------------------------------|
| 1) CLINICAL HISTORY : SUBSECTION - HABITS | 2) ALCOHOL/DRUG TREATMENT REPORT |
| 3) SOCIAL WORK REPORT | 4) PROBATION OFFICER'S REPORT. |

P1. The approximate number of times P has used this substance during the past year ->

99	None	Available					
	1/P5	1/P4					

P1
REL

P2				P3				P4			
USUAL TIME OF USE				USUAL DAY OF USE				TIME WITHOUT S			
D	N	D+N	99	D	W	D+W	99				99

P2
REL

P3
REL

P4
REL

P5. Persons who consider P's substance use during the past year to have been problematic ->

None	P	99
------	---	----

--	--

REL

P6. Earliest age at which P's substance use became problematic ->

		Child	Adol	Adult	66	99
					1/01	

P6
REL

SECTION P - SUBSTANCE USE HISTORY

The information on this sheet refers to ->

ALCOHOL	
---------	--

DRUGS	
-------	--

P7				
FACTORS IN PAST YR INDICATIVE OF PATHOLOGICAL PATTERN OF USE	Y	88	N	99
Increasing amounts needed, ie. increased tolerance				
Decreasing amounts needed, ie. decreased tolerance				
Intoxication throughout most of the day				
Remaining intoxicated for at least 2 days				
Need for daily use				
Restricted usage to certain times of day				
Unsuccessful efforts to cut down or stop use				
Continued use despite exacerbation of physical condition				

P7	
REL	

SECTION P - SUBSTANCE USE HISTORY

The information on this sheet refers to ->

ALCOHOL	
---------	--

DRUGS	
-------	--

P8	SOCIAL & OCCUPATIONAL IMPAIR IN PAST YR DUE TO SUBSTANCE USE	Y	88	N	99		P8
							REL
	Repeated conflict with family						
	Rejection by family						
	Repeated conflict with friends						
	Rejection by friends						
	Increased physical aggression						
	Increased verbal aggression						
	Diminished ability to cope with parenting role						
	Diminished ability to cope with homemaker role						
	Diminished ability to cope with financial role						
	Diminished ability to cope with work role						
	Frequent absences from work						
	Loss of job						
	Police contact without conviction - not traffic offences						
	Criminal charges - not traffic offences						
	Traffic offences						

COMPLETE QUESTIONS 1/P1 TO 3/P8 FOR DRUG USE.

SECTION P - SUBSTANCE USE HISTORY

The information on this sheet refers to ->

Alcohol consumption before the offences

Usual alcohol consumption

--

--

P9. Types of alcohol consumed ->

None	Spirits	Wine	Beer	Homebrew	Nonbeverage	Available	99
7/P17	4/P10	4/P11	4/P12	4/P13	4/P14	5/P15	5/P15

REL

P10. Approximate amount of spirits consumed ->

			Available	99
--	--	--	-----------	----

--

P11. Approximate amount of wine consumed ->

			Available	99
--	--	--	-----------	----

--

P12. Approximate amount of beer consumed ->

			Available	99
--	--	--	-----------	----

--

P13. Approximate amount of homebrew consumed ->

			Available	99
--	--	--	-----------	----

--

P14. Approximate amount of nonbeverage alcohol consumed ->

			Available	99
--	--	--	-----------	----

--

SECTION P - SUBSTANCE USE HISTORY

P15	ALCOHOL ASSOCIATED SYMPTOMS							P15		P15		
	88	?	Y	Time since			N	99	SYMP		TIME	
Use of regmakers								99				
Coarse tremor of tongue, eyelids, hands												
Blackouts												
Delirium tremens												
Epileptic seizures and/or Rum fits												
Anxiety												
Depressed mood												
Irritability												
Fitful sleep and/or bad dreams												
Nausea and/or vomiting												
Gastritis												
Malaise and/or weakness												
Autonomic hyperactivity eg, sweating, tachycardia and elevated blood pressure												
Orthostatic hypotension												
Headaches												
Dry mouth												
Peripheral edema												

SECTION P - SUBSTANCE USE HISTORY

P15												
										Time since		
Delusions	88	?	Y				99	N	99			
Type												

SYMP	

TIME	

P15												
										Time since		
Hallucinations	88	?	Y				99	N	99			
Type												

SYMP	

TIME	

P15												
										Time since		
Misperceptions and/or illusions	88	?	Y				99	N	99			
Type												

SYMP	

TIME	

P16	None										
OTHER SYMPTOMS ASSOCIATED WITH ALCOHOL	88	?	Y				Time since	N	99		
							99				

P16	
SYMP	

P16	
TIME	

SECTION P - SUBSTANCE USE HISTORY

The information on this sheet refers to ->

Drug use before the offences	
------------------------------	--

Usual drug use	
----------------	--

P17	99	None	P18	P19				P17	P19
TYPES OF DRUGS			DRUG CATEGORIES	AMOUNTS				REL	REL
C						Available	99		

P20	METHODS OF SUBSTANCE USE	
C		99

SECTION P - SUBSTANCE USE HISTORY

IF THE DRUG CATEGORY IN 7/P18 IS :-		
AMPHETAMINES	complete ->	9 /P21 + P22
BARBITURATES	complete ->	10/P23 + P24
OPIOIDS	complete ->	11/P25 + P26
DAGGA	complete ->	12/P27
HALLUCINOGENS	complete ->	12/P28
VOLATILE SOLVENTS	complete ->	12/P29
PHENCYCLIDINE	complete ->	13/P30
OTHER DRUGS	complete ->	13/P31

COMPLETE EACH OF THESE QUESTIONS ONCE ONLY, CONSIDERING PAST SUBSTANCE USE

AND USE OVER THE PERIOD OF THE OFFENCES.

SECTION P - SUBSTANCE USE HISTORY

P21								
AMPHETAMINE ASSOCIATED SYMPTOMS	88	?	Y	Time since			N	99
Depressed mood								99
Suicidal ideation								
Psychomotor agitation								
Disturbed sleep								
Increased dreaming								
Fatigue								

P21		P21	
SYMP		TIME	

P22	BP									
None		OTHER AMPHETAMINE ASSOCIATED SYMPTOMS	88	?	Y	Time since			N	99
										99

P22		P22	
SYMP		TIME	

SECTION P - SUBSTANCE USE HISTORY

P23		88	?	Y	Time since	N	99
BARBITURATE ASSOCIATED SYMPTOMS							
Coarse tremor of tongue, eyelids, hands							99
Anxiety							
Depressed mood							
Irritability							
Fitful sleep and/or bad dreams							
Nausea and/or vomiting							
Malaise and/or weakness							
Autonomic hyperactivity eg, sweating, tachycardia & elevated blood pressure							
Orthostatic hypotension							
Delirium usually 1 week after use							

P23		P23	
SYMP		TIME	

P24		8P- None		88	?	Y	Time since	N	99
OTHER BARBITURATE ASSOCIATED SYMPTOMS									
									99

P24		P24	
SYMP		TIME	

SECTION P - SUBSTANCE USE HISTORY

P25	OPIOID ASSOCIATED SYMPTOMS								P25		P25	
	88	?	Y	Time since			N	99	SYMP	TIME		
Depressed mood								99				
Irritability												
Psychomotor agitation												
Insomnia												
Tremor												
Weakness												
Muscle and joint pains												
Tachycardia												
Mild hypertension												
Sweating and/or fever												
Yawning												
Nausea and/or vomiting												
Diarrhea												
Pupillary dilation												
Lacrimation ie, watering eyes												

P26	BP	None	OTHER OPIOID ASSOCIATED SYMPTOMS								P26		P26	
			88	?	Y	Time since			N	99	SYMP	TIME		
										99				

SECTION P - SUBSTANCE USE HISTORY

8P								
P27	None							
DAGGA ASSOCIATED SYMPTOMS		88	?	Y	Time since		N	99
								99

P27		P27	
SYMP		TIME	

8P								
P28	None							
HALLUCINOGEN ASSOCIATED SYMPTOMS		88	?	Y	Time since		N	99
								99

P28		P28	
SYMP		TIME	

8P								
P29	None							
VOLATILE SOLVENT ASSOCIATED SYMPTOMS		88	?	Y	Time since		N	99
								99

P29		P29	
SYMP		TIME	

SECTION P - SUBSTANCE USE HISTORY

BP												
P30	None											
PHENCYCLIDINE ASSOCIATED SYMPTOMS		88	?	Y	Time since			N	99			
											99	

P30		
P30		
SYMP	TIME	

BP												
P31	None											
OTHER DRUG ASSOCIATED SYMPTOMS		88	?	Y	Time since			N	99			
Drugs											99	

P31		
P31		
SYMP	TIME	

SECTION Q - CRIMINAL HISTORY

Q5				Q6		1/R1		Q5		Q6	
TYPES OF CUSTODY EXPERIENCED				NUM ESCAPE				REL		REL	
Juvenile detention - eg. reformatory	Y	N	99				99				
Psychiatric/mental institution											
Police custody											
Prison											

SEE : 1J CLINICAL NOTES : ESCAPE NOTES 2J LETTERS RE ESCAPES
 3J PROBATION OFFICER'S REPORTS 4J PRISON OFFICIAL'S REPORT.

Q7				Q8				Q7		Q8	
P'S AGES				METHODS OF ESCAPE				REL		REL	
C			99								

SECTION R - MEDICAL HISTORY

SEE : 1) CLINICAL HISTORY : SUBSECTIONS - 1) EARLY DEVELOPMENT 11) MEDICAL HISTORY
 2) INDEPENDENT MEDICAL REPORT 3) SOCIAL WORK REPORT 4) PROBATION OFFICER'S REPORT.

R1. Number of hospitalizations of
 at least 1 weeks duration ->

None			99
2/R5			

REL

R2				R3			
P-AGES AT HOSP				TYPE OF MEDICAL CONDITION			
C			99				99

R2
REL

R3
REL

R4									
TYPES OF TREATMENT RECEIVED DURING EACH HOSPITALIZATION									
C	Investigation			Surgery			Types of treatments		
	Y	N	99	Y	N	99			99

R4
REL

SECTION R - MEDICAL HISTORY

R5. Number of head injuries causing unconsciousness ->

None		+	99
3/R13			

REL

R6				R7				R8			
P-AGE AT EACH HEAD INJURY				TIME UNCONSCIOUS				LENGTH OF PTA			
C	Child	Adol	Adult	99			99			99	

R6
REL

R7
REL

R8
REL

R9				R10							
CLOSED-OPEN				SIDE OF HEAD INJURED							
C	CL	O	99	L	R	L+R	M	H	G	99	

R9
REL

R10
REL

SECTION R - MEDICAL HISTORY

R16		R17							
WAVE FREQUENCY ABNORMALITIES					EPILEPTIC				
C	None	L	H	L+H	99	Y	N	88	99
	4/R18				4/R18				

R18	1/S1 66		R19							
SIDES OF WAVE ABNORMALITIES								FOCUS OF ABNORMALITIES		
C	G	B	B+L	B+R	L	R	M	H	99	99
	1/S1									

SECTION 5 - PSYCHIATRIC HISTORY

CHECK ALL PREVIOUS ADMISSIONS

- SEE : 1) CLINICAL HISTORY : SUBSECTION - PSYCHIATRIC HISTORY
 2) INDEPENDENT MENTAL HEALTH PROFESSIONAL'S REPORT
 3) SOCIAL WORK REPORT 4) PROBATION OFFICER'S REPORT.

S5. Number of times P has received treatment for psychiatric and/or psychological problems ->

None			+	99
1/71				

REL

S6	NAME OF TREATMENT AGENCY FOR EACH TREATMENT	
C		99

S6
REL

S7					S8					
P-AGE WHEN EACH TREATMENT BEGAN					LENGTH OF TREATMENT					
C			Child	Adol	Adult	99			66	99

S7
REL

S8
REL

SECTION 5 - PSYCHIATRIC HISTORY

S9				S10					S11				S9		S10		S11	
IN-OUT PT				OBSERVATION-DRUG-ALC					STATE-PRI + INS-IND				REL		REL		REL	
C	I	D	99	OB	D	A	None	99	SI	PI	PF	99						

FOR EACH PREVIOUS OBSERVATION :
COMPLETE QUESTIONS 1/C1 TO 6/D21 [including 4/P9 to P14 if appropriate];
AND 1/G1 TO 2/G11 [including 7/P17 to P20 if appropriate].
THEN RETURN TO 3/S12.

S12		S12	
FINAL DIAGNOSES MADE AND/OR PROBLEMS IDENTIFIED DURING EACH TREATMENT		REL	
C			
	99		

**SECTION T - MENTAL STATE
AND FUNCTIONING**

SEE : 11 FIRST FULL MENTAL STATE EXAMINATION DURING P'S MOST RECENT OBSERVATION.

T1	ASPECTS OF P'S GENERAL APPEARANCE AND BEHAVIOR AT THE MSE INTERVIEW				
Neglected appearance	Y	N	88	99	
Unusual, idiosyncratic dress					
Pupillary constriction					
Pupillary dilation					
Lacrimation ie, watering eyes					
Yawning					
Sweating					
Tremor					
Psychomotor agitation ie, accelerated movement and/or restlessness					
Psychomotor retardation ie, slowed movement					
Catatonia ie, no movement					
Gait disturbance					
Inco-ordinated movement					
Stereotyped movement and/or mannerisms					
Copied movements ie, imitation					
Bizarre behavior					
Ritualistic behavior					
Disinhibited behavior					
Other notable aspects	None				

**SECTION T - MENTAL STATE
AND FUNCTIONING**

T2

ASPECTS OF THE P'S SPEECH AT THE MSE INTERVIEW

	Y	N	88	99
Muteness				
Slowed speech				
Restricted quantity of speech				
Vagueness and/or restricted content of speech				
Rapid speech				
Loquacity or overtalkativeness				
Pressure of speech				
Overly detailed or overly inclusive content of speech				
Illogical or incomprehensible content of speech				
Confused time sequencing				
Grandiosity				
Religiosity				
Negativistic				
Lack of spontaneous speech				
Articulation impediment				
Perseveration and/or repetition				
Echoing, rhyming and/or clanging				
Word finding difficulty				
Other notable aspects	None			

**SECTION T - MENTAL STATE
AND FUNCTIONING**

T5									
MOOD REPORTED BY P OVER THE PERIOD OF THE OFFENCES AND AT PRESENT MSE									
	Present				Offence				
	Y	N	88	99	Y	N	88	99	
Generalized anxiety									
Panic attacks									
Phobias and/or situational anxiety									
Perplexity									
Hostility and/or aggressiveness									
Suspiciousness									
Irritability									
Depression									
Euphoria or elation									
Incongruous or inappropriate mood									
Blunted or restricted mood									

T5	
Offence	
REL	

**SECTION T - MENTAL STATE
AND FUNCTIONING**

T12. Clinician's estimate of P's IQ at the MSE ->

			99
--	--	--	----

T13. Language in which the MSE interview was conducted ->

	99
--	----

T14. Psycho-social stressors experienced by P in the past year ->

	None 99 10/T16

T14
REL

T15. Overall severity of the psycho-social stressors ->

Cat	Ext	Sev	Mod	Mild	Min	99
-----	-----	-----	-----	------	-----	----

T16. P's highest level of adaptive functioning during the past year ->

Sup	VG	Good	Fair	Poor	VP	GI	99
-----	----	------	------	------	----	----	----

T17. What type of impairments in adaptive functioning did P experience ? ->

	None 99

T17
REL

- A D D E N D U M II -

GLOSSARY :

Explanation of the
Fact Sheet Questions
and Answer-Option Codes

DESIREE S HANSSON

INTRODUCTORY COMMENTS

INTRODUCTORY NOTE

To limit the length of this document, Addendum II includes only part of a comprehensive instruction manual. It does not therefore, contain all the necessary instructions for the use of the prototype fact sheet. For example, it excludes definitions of psychiatric/psychological terms and procedural guidelines. The purpose of Addendum II is to clarify the abbreviated questions and the answer-option codes, that appear on the prototype fact sheet in Addendum I.

HOW TO USE ADDENDUM II

When a reader wishes to clarify the meaning of a fact sheet question or answer-option code :

- * Note the number-letter code in the bottom right hand corner of the fact sheet page on which the question or code appears.
For example, 1 A
 - * Turn to the page in Addendum II that indicates this number-letter code below the horizontal line in the bottom right hand corner.
For example, FS - 1 A -
 - * Note the letter-number code on the left hand side of the fact sheet question that you wish to clarify.
For example, A3.
 - * Look for this letter-number code above the horizontal line/s on the left hand side of the Addendum II page.
For example, A3
-

GENERAL ASPECTS

NOTE Remember that except when otherwise indicated, answers are drawn from the most recent document available in each case.

Except when otherwise indicated, each of the multiple choice answer-options is mutually exclusive, ie. you may choose only one option.

** = This code indicates that the term which follows has not been defined in this document. These terms are however, defined in the complete instruction manual.

This/The person = These two terms, used throughout Addendum II, refer to the person for whom a particular fact sheet is being completed.

P = This fact sheet abbreviation refers to the person for whom a particular fact sheet is being completed.

RELIABILITY TABLES

The two-columned tables on the far right hand side of some fact sheet questions are used to record the reliability of answers to these questions. In most cases these tables are headed 'REL' and indicate the number of the question to which they apply. To limit redundancy however, some tables have not been headed. Such tables should be assumed to apply to the question on the left of the table concerned.

Users enter one of the following codes to indicate the reliability level of an answer :-

- 1 = Highest reliability.
- 2 = Second highest reliability.
- 3 = Third highest reliability.
- 4 = Fourth highest reliability.
- 5 = Fifth highest reliability.
- 6 = Sixth or lowest reliability.
- C = Contradictory answers. This code is entered along with a code indicating the level of reliability.

The reader is referred to pages 58 and 59 of the dissertation for full definitions of these reliability levels.

SPECIFIC QUESTIONS

A1

QUESTION Enter the date you began this fact sheet.

CODES -d- = The day of the month.
For example : The third day would be entered as 03.

-m- = The month of the year.
For example : April would be entered as 04.

-y- = The year.
For example : 1980 would be entered as 80.

A2

QUESTION Enter your first two initials and surname.

A3

QUESTION Enter the person's most recent hospital admission number.
[For this hospital only].

A4

QUESTION Enter the person's other hospital admission numbers.
[For this hospital only].

CODE 66 = Not applicable, because the person has one hospital number only.

A5

QUESTION Enter the person's first two forenames.
If this person has only one forename, enter this and continue.

CODE 99 = The case material does not indicate the person's forenames.

A11

QUESTION Enter the date of the person's most recent admission for observation. [To this hospital only].

CODES

- d- = The day of the month.
For example : The third day would be entered as 03.
- m- = The month of the year.
For example : April would be entered as 04.
- y- = The year.
For example : 1980 would be entered as 80.
- 99 = The case material does not indicate this date.

A12

QUESTION Enter the date of the person's most recent discharge following observation. [From this hospital only].

CODES

- d- = The day of the month.
For example : The third day would be entered as 03.
- m- = The month of the year.
For example : April would be entered as 04.
- y- = The year.
For example : 1980 would be entered as 80.
- 99 = The case material does not indicate this date.

A13

QUESTION Enter the address at which this person can be contacted at present.

Contacted means by home visit and/or by post.
You need enter one address only.
Include a postal code if possible.

CODES

- 66 = Not applicable, because the case material states that this person has no such address.
- 99 = The case material does not indicate whether this person has such an address.

A14

QUESTION Enter the telephone numbers at which the person can be contacted at present.

If possible include whether the numbers are for office hours and/or after hours.

CODES 66 = Not applicable, because the case material states that this person cannot be contacted telephonically.

99 = The case material does not indicate whether this person has such telephone numbers.

A15

QUESTION Enter the first two initials and surname of the individual who is to be contacted on this person's behalf, in the case of an emergency.

You need enter one individual only.

CODES 66 = Not applicable, because the case material states that this person does not have such an individual.

99 = The case material does not indicate the name of such an individual.

1/B1 = Go to question B1 on page 1B.

A16

QUESTION Enter the address at which the individual can be contacted at present. [Indicated in A15].

Contacted means by home visit and/or by post.
You need enter one address only.
Include the postal code if possible.

CODES

66	=	Not applicable, because the case material states that this individual cannot be contacted at an address.
99	=	The case material does not indicate the address of this individual.

A17

QUESTION Enter the telephone numbers at which the individual can be contacted at present. [Indicated in A15].

If possible include whether the numbers are for office hours and/or after hours.

CODES

66	=	Not applicable, because the case material states that this individual cannot be contacted telephonically.
99	=	The case material does not indicate whether this individual has such telephone numbers.

QUESTION Indicate whether each of the following documents are present in this person's hospital folder.

Check all documents contained in all of the files in this person's hospital folder.
The hospital folder must belong to this hospital, but the documents may originate elsewhere.
If there is more than one document of a particular kind, enter the date of the most recent document.
If only one document of any particular kind is present, enter the date that this document was written.

CODES Y = Yes, this document is present.

Date of most recent doc = The date of the most recently written document of this type.

-m- = The month of the year.
 For example : April would be entered as 04.

-y- = The year.
 For example : 1980 would be entered as 80.

N = No, this document is absent.

C1

QUESTION Enter the person's age at the time of this admission for observation. [To this hospital].

Give answers in complete years. Round off part years to the nearest complete year by converting periods of six months and over to the next complete year; and by converting periods of less than six months to the previous complete year.
For example : 27 years and 5 months would be entered as 27 years.

CODE 99 = The case material does not indicate this age.

C2

QUESTION Enter the criminal case numbers associated with this admission for observation.

CODES 66 = Not applicable, because the case material states that this person was not referred in connection with alleged criminal offences.

1/C5 = Go to question C5 on page 1C.

99 = The case material does not indicate the criminal case numbers.

C3

QUESTION Indicate from which type of court the person was referred for this observation.

CODE 99 = The case material does not indicate the type of court.

C4

QUESTION Enter the district of the court that referred the person for this observation.

For example : Wynberg, Bellville.

CODE 99 = The case material does not indicate the court district.

C5

QUESTION	Indicate this person's general state of physical health.	
	Give answers as stated in the case material.	
CODES	G	= Good.
	S	= Satisfactory.
	D	= Deteriorated.
	P	= Poor.
	C	= Critical.
	99	= The case material does not indicate the general state of physical health.
	Other	= The general state of physical health is described in the case material using the following 'other' terms.

C6

QUESTION	Enter the physical problems mentioned.	
	Give answers as stated in the case material.	
	<u>For example</u> : Malnourishment, contusions to the face.	
CODES	Y	= Yes, physical problems are mentioned in the case material.
	N	= No, physical problems are not mentioned in the case material.
	2/C9	= Go to question C9 on page 20.

C7

QUESTION Enter the names of the physical conditions mentioned.

Give answers as stated in the case material.
For example : Diabetes, angina.

CODES -C- = Assign and enter a code for each condition
in C7.
99 = The case material does not indicate the name
of this condition.

C8

QUESTION Indicate what course characterizes each of the physical
conditions. [Indicated in C7].

Give the courses as stated in the case material.

CODES -C- = Enter the codes you assigned to each physical
condition in C7.
A = Acute.
I = Intermittent.
C = Chronic.
99 = The case material does not indicate the course
of this condition.

C9

QUESTION	Indicate whether this person was found to have been mentally ill at the time of the alleged offences.	
CODES	Y	= Yes, this person was found to have been mentally ill at the time of the alleged offences.
	N	= No, this person was not found to have been mentally ill at the time of the alleged offences.
	66	= Not applicable, because the case material states that this person was not referred in connection with alleged offences.
	88	= The case material states that no decision was reached about whether or not this person was mentally ill at the time of the alleged offences.
	99	= The case material does not state whether the person was found to have been mentally ill at the time of the alleged offences.

C10

QUESTION	Indicate whether this person was found to be legally certifiable.	
CODES	Y	= Yes, this person was found to be certifiable.
	N	= No, this person was not found to be certifiable.
	99	= The case material does not state whether the person was found to be certifiable.

C11

QUESTION	Enter the final psychiatric diagnoses made during this observation. Give answers as stated in the case material. <u>For example</u> : Schizophreniform disorder, Alcohol Dependence.	
CODES	88	= The case material states that no decision was reached about this person's psychiatric diagnoses.
	99	= The case material does not indicate this person's psychiatric diagnoses.

C12

QUESTION	Indicate whether this person was found to be fit to stand trial.	
CODES	Y	= Yes, this person was found to be triable.
	2/C14	= Go to question C14 on page 2C.
	N	= No, this person was not found to be triable.
	66	= Not applicable, because the case material states that this person was not referred in connection with alleged offences.
	3/C20	= Go to question C20 on page 3C.
	88	= The case material states that no decision was reached about this person's triability.
	99	= The case material does not state whether this person was found to be triable.

C13

QUESTION	Enter the reasons why this person was found to be unfit to stand trial.	
	<u>For example</u> : Severe mental retardation, presently psychotic.	
	Give the reasons as stated in the case material.	
CODE	99	= The case material does not indicate these reasons.

C14

QUESTION	Indicate whether this person was found to have had adequate moral judgement at the time of the alleged offences.	
CODES	Y	= Yes, this person was found to have had adequate moral judgement at the time of the alleged offences.
	N	= No, this person was not found to have had adequate moral judgement at the time of the alleged offences.
	88	= The case material states that no decision was reached about this person's moral judgement at the time of the alleged offences.
	99	= The case material does not state whether this person was found to have had adequate moral judgement at the time of the alleged offences.
	2/C17	= Go to question C17 on page 2C.

C15

QUESTION	Enter the reasons why this person was found to have had inadequate moral judgement at the time of the alleged offences. Give the reasons as stated in the case material. <u>For example</u> : Psychosis, post epileptic stupor.	
CODE	99	= The case material does not indicate these reasons.

C16

QUESTION	Enter all types of substances that allegedly impaired this person's moral judgement, at the time of the alleged offences. <u>For example</u> : Mandrax, dagga, alcohol.	
CODES	None	= The case material states that this person's moral judgement was not impaired by substances.
	99	= The case material does not indicate the types of substances.

C17

- QUESTION** Indicate whether this person was found to have had the capacity to act in accordance with his/her moral appreciation, at the time of the alleged offences.
- CODES**
- Y = Yes, this person was found to have had the capacity to act in accordance with his/her moral appreciation at the time of the alleged offences.
 - N = No, this person was not found to have had the capacity to act in accordance with his/her moral appreciation at the time of the alleged offences.
 - 88 = The case material states that no decision was reached about this person's capacity to act in accordance with his/her moral appreciation at the time of the alleged offences.
 - 99 = The case material does not state whether this person was found to have had the capacity to act in accordance with his/her moral appreciation at the time of the alleged offences.
 - 3/C20 = Go to question C20 on page 3C.

C18

QUESTION Enter the reasons why this person was found to have had impaired moral capacity to act in accordance with his/her moral appreciation, at the time of the alleged offences.

Give the reasons as stated in the case material.
For example : Drug intoxication, schizophrenic psychosis.

CODE 99 = The case material does not indicate the reasons why this person was found to have had impaired moral judgement, at the time of the alleged offences.

C19

QUESTION Enter the types of substances that allegedly impaired this person's capacity to act in accordance with his/her moral appreciation, at the time of the alleged offences.

CODES None = The case material states that this person's moral capacity to act was not impaired by substances.

99 = The case material does not indicate the types of substances.

C20

QUESTION Enter the recommendations made to the court about this person's future management.

Give the recommendations as stated in the case material.
For example : In-patient psychiatric treatment.

CODES 88 = The case material states that no decision was reached about the recommendations for future management.

99 = The case material does not indicate these recommendations.

C21

QUESTION Indicate the type of prognosis given.

Give the type of prognosis as stated in the case material.

CODES 88 = The case material states that no decision was reached about the prognosis.

99 = The case material does indicate the prognosis.

3/C24 = Go to question C24 on page 3C.

Other = The prognosis was given in the following 'other' terms.

C22

QUESTION Enter the factors upon which this person's prognosis is said to depend.

Give the factors as stated in the case material.
For example : Compliance with prescribed medication.

CODE 99 = The case material does not indicate these factors.

C23

QUESTION Enter the reasons for the type of prognosis given.
[In C21].

Give the reasons as stated in the case material.
For example : Poor, due to the chronic course of the disorder.

CODE 99 = The case material does not indicate these reasons.

C24

QUESTION Indicate the quality of this person's account of the alleged offences.

Give the quality as stated in the case material.

CODES 66 = Not applicable, because this person was not referred in connection with alleged offences, so did not give an account.
I = Illogical or confused logic.
L = Logical or comprehensible logic.
99 = The case material does not indicate whether the account was logical or illogical.

CT = Confused time sequencing or chronology.
C = Chronological or logical time sequencing.
99 = The case material does not indicate whether the time sequencing was chronological or not.

V = Vague or paucity of detail.
AD = Adequately detailed or sufficient detail to provide a thorough and comprehensible account.
DD = Overly detailed or overinclusive.
99 = The case material does not indicate whether the account was adequately detailed or not.
Other = The quality of the account is described in the following 'other' terms.

D 1

QUESTION. Enter the due date of the psychiatric court report for this observation.

CODES

-d- = The day of the month.
For example : The third day would be entered as 03.

-m- = The month of the year.
For example : April would be entered as 04.

-y- = The year.
For example : 1980 would be entered as 80.

99 = The case material does not indicate this date.

D 2

QUESTION Enter the individuals who gave the reasons for referral for this observation.

Be as specific as the information permits.
For example : Spouse, paternal grandmother, judge.

CODE 99 = The case material does not indicate these individuals.

D 3

QUESTION Enter the reasons for this referral for observation.

Be as specific as the information permits.
For example : Previous psychiatric treatment.

CODE 99 = The case material does not indicate the reasons for this referral.

D4

QUESTION . Enter this person's official nationality.
Official nationality refers to the person's country of birth.

CODES SA = South African.
99 = The case material does not indicate this person's nationality.

D5

QUESTION Indicate the person's legal status immediately prior to this admission for observation.

CODES Pol custody = Police custody.
99 = The case material does not indicate the legal status.

QUESTION Indicate the questions on which the court requested psychiatric opinion for this observation.

CODES Y = Yes, this question was asked by the court.

 N = No, this question was not asked by the court.

 99 = The case material does indicate whether or not this question was asked by the court.

 Other = The following 'other' questions were asked by the court.

D7

QUESTION Enter the charges against the person, that are related to this observation.

Give answers as stated in the case material.

For example : Murder, housebreaking with intent to steal.

CODES

66 = Not applicable, because this person was not referred in connection with alleged offences.

1/E1 = Go to question E1 on page 1E.

99 = The case material does not indicate the charges.

4/D10 = Go to question D10 on page 4D.

-C- = Assign and enter a code for each charge.

D8

QUESTION Enter the number of counts for each charge.
[Indicated in D7].

For example : 2 counts of murder, 4 counts of theft etc.

CODES

-Num- = Enter the number of counts.

99 = The case material does not indicate the number of counts for this charge.

D9

QUESTION Indicate the pleas that this person has made to each charge.
[In D7 and D8].

CODES

6 = Guilty.

NG = Not guilty.

66 = Not applicable, because this person had not pleaded to this charge by the time s/he was referred.

99 = The case material does not indicate the plea for this charge.

D10

- QUESTION Enter the date on which each of the alleged offences occurred.
[Indicated in D7 and D8].
- CODES
- C- = Enter the code you assigned to this charge in D7.
 - CO- = Enter the number of the count for this charge that you indicated in D8.
 - d- = The day of the month.
For example : The third day would be entered as 03.
 - m- = The month of the year.
For example : April would be entered as 04.
 - y- = The year.
For example : 1980 would be entered as 80.

D11

QUESTION Enter the place in which each of the alleged offences occurred.
[Indicated in D7 and D8].

Crimes against person include : murder, culpable homicide, assault with intent, common assault, rape, incest, sodomy, crimen injuria, robbery and infanticide etc.

Be as specific as the information permits.

For example : Inside the person's car, outside in the victim's garden.

If an offence occurred in a number of places, enter the first place it occurred. Additionally, indicate whether each place was inside or outside a covered structure.

- CODES
- C- = Enter the code you assigned to this charge in D7.
 - CO- = Enter the number of the count for this charge that you indicated in D8.
 - Outside = For each charge, enter a brief description of each place that was outside a covered structure.
 - Inside = For each charge, enter a brief description of each place that was inside a covered structure.
 - 99 = The case material does not indicate whether this place was inside or outside.
-

D12

QUESTION Enter the type of room in which each of the alleged offences occurred. [Indicated in D7 and D8].

For example : Bedroom, kitchen, garage.

CODES

66	=	Not applicable, because this offence did not occur inside a structure that had specified rooms.
5/D13	=	Go to question D13 on page 5D.
99	=	The case material does not indicate the room in which this alleged offence occurred.

D13

- QUESTION** Indicate whether each victim knew the place in which this alleged offence occurred.
- To know a place merely requires having been there at least twice previously.
- CODES**
- C- = Enter the code you assigned to this charge in D7.
 - CO- = Enter the number of the count that you indicated in D8.
 - Y = Yes, this victim knew the place in which this alleged offence occurred.
 - N = No, this victim did not know the place in which this alleged offence occurred.
 - 99 = The case material does not indicate whether this victim knew the place in which this alleged offence occurred.

D14

- QUESTION** Indicate whether the person knew the place in which each alleged offence occurred.
- To know a place merely requires having been there at least twice previously.
- Y = Yes, this person knew the place in which this alleged offence occurred.
 - N = No, this person did not know the place in which this alleged offence occurred.
 - 99 = The case material does not indicate whether this person knew the place in which this offence occurred.

D15

QUESTION	Indicate the age category of each victim, for each alleged offence. [Indicated in D11].	
CODES	1	= Young child, under 6 years.
	2	= Child, 6 years and over, but under 13 years.
	3	= Adolescent, 13 years and over, but under 19 years.
	4	= Young adult, 19 years and over, but under 30 years.
	5	= Adult, 30 years and over, but under 50 years.
	6	= Older adult, 50 years and over.
	7	= Non-adult, but the exact age is not known.
	8	= Adult, but the exact age is not known.
	99	= The case material does not indicate the age of this victim.

D16

QUESTION	Indicate the sex of each victim.	
CODES	-C-	= Enter the code you assigned to this charge in D7.
	-CO-	= Enter the number of the count that you indicated in D8.
	F	= Female.
	M	= Male.
	99	= The case material does not indicate the sex of this victim.

D17

QUESTION Enter the relationship between this person and each victim.

Be as specific as the information permits.
For example : Spouse, employer, stranger, acquaintance.

CODE 99 = The case material does not indicate this relationship.

D18

QUESTION Enter the weapons used by this person in each of the alleged offence. [indicated in D11].

Include parts of the body such as, fists, feet, hands etc.

CODES 66 = Not applicable, because this person did not use any weapon in this alleged offence.

 99 = The case material does not indicate the weapons for this offence.

D19

QUESTION Enter the types of goods and/or property involved in each of the alleged property offences.

Be as specific as the information permits.
For example : Bed linen, shoes, food, money.

CODES

-C-	=	Enter the code you assigned to this charge in D7.
-CO-	=	Enter the number of the count that you indicated in D8.
99	=	The case material does not indicate the types of goods involved in this alleged offence.

D20

QUESTION Enter the value of the goods involved in each of the alleged property offences.

Property offences include housebreaking, malicious damage to private property, theft, robbery, fraud etc.

If possible give answers in rands and cents.
Enter an 'R' to indicate rands and a 'c' to indicate cents.

99	=	The case material does not indicate the value of the goods involved in this alleged offence.
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D21

QUESTION Enter the numbers of all the wards to which the person was admitted during this observation. [For this hospital only].

CODE	99	=	The case material does not indicate the ward numbers.
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E 1

QUESTION Enter this person's home language.

If this person speaks more than one home language to equal degrees, give all these languages.

CODE 99 = The case material does not indicate this person's home language.

E 2

QUESTION Indicate whether the person's most recent psychometric testing was conducted during this observation or previously.

CODES 66 = Not applicable, because this person has never been psychometrically tested.

 99 = The case material does not indicate the date of the most recent psychometric testing.

 1/F1 = Go to question F1 on page 1F.

E3

QUESTION: Enter the names of the psychometric tests conducted with this person, during the most recent testing.

Exclude tests used solely for personality assessment.
Give the names as stated in the psychometric report.
For example: The Wechsler Adult Intelligence Scale.

CODES

-C- = Assign and enter a code for each psychometric test.

99 = The case material does not indicate the name of this psychometric test.

E4

QUESTION: Indicate whether the overall test score for each psychometric test was corrected for expected cultural bias.

(Indicated in E3) in the case material.

CODES

Y = Yes, the score for this test was corrected for expected cultural bias.

-C- = No, the score for this test was not corrected for expected cultural bias.

N = No, the score for this test was not corrected for expected cultural bias.

66 = Not applicable, because the score for this test is not expected to be culturally biased.

99 = The case material does not indicate whether this score was corrected for expected cultural bias.

E8

QUESTION	Indicate the side of the brain on which malfunctioning was shown on each psychometric test. [Indicated in E3].	
CODES	L	= Left side only.
	R	= Right side only.
	M	= Medially or in the Midbrain focus, with neither a right nor left focus.
	H	= Hindbrain focus only, with neither a left nor right focus..
	L+R	= Bilaterally, but localized.
	6	= Generalized.
	99	= The case material does not indicate the side of the malfunctioning for this test.

E9

QUESTION	Enter the ranges of the intelligence scores for each psychometric test. [Indicated in E3].	
CODES	-C-	= Enter the codes you assigned to this psychometric test in E3.
	1	= Very superior, 130 and greater.
	2	= Superior, 121 and greater, but less than 130.
	3	= Above average, 111 and greater, but less than 121.
	4	= Average or normal, 85 and greater, but less than 111.
	5	= Borderline, 71 and greater, but less than 85.
	6	= Mildly mentally retarded, 50 and greater, but less than 71.
	7	= Moderately mentally retarded, 35 and greater, but less than 50.
	8	= Severely mentally retarded, 20 and greater, but less than 35.
	9	= Profoundly mentally retarded, less than 20.
	99	= The case material does not indicate an IQ score for this test.

E10

- QUESTION** Enter the names of the tests conducted to assess this person's personality, during the most recent testing.
- Give the names as stated in the psychometric report.
For example : The Thematic Apperception Test.
- CODES**
- 66 = Not applicable, because no personality tests were conducted during this testing.
 - 1/F1 = Go to question F1 on page 1F.
 - C- = Assign and enter a code for each personality test.
 - 99 = The case material does not indicate the name of this test.

E11

- QUESTION** Indicate the finding regarding this person's reality testing, shown on each test. [Indicated in E10].
- CODES**
- 99 = The case material does not indicate a finding regarding reality testing for this test.
 - Psych = This test showed that this person was psychotic.
 - Fragile = This test showed that this person's reality testing could disintegrate easily.
 - Unimp = This test showed this person's reality testing to be unimpaired.

E12

- QUESTION** Enter the findings regarding this person's interpersonal relationships, shown on personality testing.
- Omit tests that do not show findings re interpersonal relationships.
Give the findings as stated in the psychometric report.
- CODES**
- 99 = The case material does not indicate findings regarding interpersonal relationships on any of the tests.
 - C- = Enter the code you assigned to this test in E10.

E13

QUESTION Enter the findings regarding this person's social insight and judgement, shown on personality testing.

 Omit tests that do not show findings re social insight and judgement.
 Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding social insight and judgement on any of the tests.

 -C- = Enter the code you assigned to this test in E10.

E14

QUESTION Enter the findings regarding this person's sexuality, shown on personality testing.

 Omit tests that do not show findings re social insight and judgement.
 Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding sexuality on any of the tests.

 -C- = Enter the code you assigned to this test in E10.

E15

QUESTION Enter the findings regarding this person's emotions, shown on personality testing.

Omit tests that do not show findings re emotions.
Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding emotions on any of the tests.

-C- = Enter the code you assigned to this test in E10.

E16

QUESTION Enter the findings regarding this person's personality traits, shown on personality testing.

Omit tests that do not show findings re personality traits.
Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding personality traits on any of the tests.

-C- = Enter the code you assigned to this test in E10.

E17

QUESTION Enter the findings regarding this person's response tendencies under stress, shown on personality testing.

Omit tests that do not show findings re response tendencies under stress.

Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding response tendencies under stress on any of the tests.

-C- = Enter the code you assigned to this test in E10.

E18

QUESTION Enter the findings regarding this person's perceptions of his/her father, shown on personality testing.

Omit tests that do not show findings re perceptions of father.

Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding perceptions of father on any of the tests.

-C- = Enter the code you assigned to this test in E10.

E19

QUESTION Enter the findings regarding this person's perceptions of his/her mother, shown on personality testing.

Omit tests that do not show findings re perceptions of mother.
Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding perceptions of mother on any of the tests.

-C- = Enter the code you assigned to this test in E10.

E20

QUESTION Enter the findings regarding this person's perceptions of his/her spouse, shown on personality testing.

Spouse includes this person's present sexual partner/s.
Omit tests that do not show findings re perceptions of spouse.
Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding perceptions of spouse on any of the tests.

-C- = Enter the code you assigned to this test in E10.

E21

QUESTION Enter the findings regarding this person's attitudes to parenthood, shown on personality testing.

Omit tests that do not show findings re attitudes to parenthood.
Give the findings as stated in the psychometric report.

CODES 99 = The case material does not indicate findings regarding attitudes to parenthood on any of the tests.

-C- = Enter the code you assigned to this test in E10.

E22

QUESTION	Indicate which of the following conclusions were reached in the psychometric test report.	
CODES	99	= The case material does not indicate this conclusion.
	88	= The case material states that no decision was reached regarding this conclusion.

E23

QUESTION	Enter the type of personality disorder shown on testing. Give the findings as stated in the psychometric report. <u>For example</u> : Mixed personality disorder with avoidant and antisocial traits.	
CODES	99	= The case material does not indicate personality disorder.
	88	= The case material states that no decision was reached regarding the type of personality disorder.

F 1

QUESTION Enter the people with whom this person lives.

Include people with whom this person has lived for the past six months and those with whom this person usually lives for at least six months of the year.

If this person lives in an institution such as, a boarding house or hostel, exclude the people living in this institution, unless this person actually shares a sleeping area with these people. Be as specific as the information permits. Include the sex and whether each individual is biologically related to this person. For example : Maternal grandmother, unrelated landlady.

CODES 66 = Not applicable, because this person has not lived with anyone for these periods.

99 = The case material does not indicate the people with whom this person has lived for these periods.

F 2

QUESTION Enter the number of people with whom this person has lived. [Indicated in F 1].

CODES 99 = The case material does not indicate the people with whom this person has lived.

F 3

QUESTION Enter the type of permanent dwelling in which this person lives.

Permanent dwelling refers to the type of structure or shelter in which this person has lived for at least the past six months, or the structure in which this person usually lives for at least six months of the year.

Be as specific as the information permits. For example : Self-constructed shack, tent.

CODES 66 = Not applicable, because this person leads a vagrant or nomadic life-style.

1/F6 = Go to question F6 on page 1F.

99 = The case material does not indicate the type of permanent dwelling in which this person has lived.

F4

- QUESTION** Enter the number of living rooms in this person's permanent dwelling. [From F3].
- If the dwelling does not have rooms, enter the number of separate living spaces.
For example : A tent may have 2 'rooms' separated by canvass 'walls'.
- Living spaces/rooms exclude bathrooms, toilets kitchens and laundries, unless these spaces are not physically separated from the living areas.
- CODES** 99 = The case material does not indicate the number of living rooms in this person's permanent dwelling.

F5

- QUESTION** Indicate which of the following types of ownership apply to this person's permanent dwelling. [In F3].
- CODES** 0 = Owned, means that this person or any of the people who support this person financially [in F6], owns the permanent dwelling. Include cases in which a mortgage is still being repaid.
- R = Rented, means that this person or any of the people who support this person financially [in F6], rents the permanent dwelling.
- F = Free, means that this person or any of the people who support this person financially [in F6], do not pay rent for the permanent dwelling, and this free accommodation is not considered illegal such as, squatting.
For example : Accommodation in prison.
- S = Squatting, means that this person's permanent dwelling is considered illegal.
For example : The tents and shacks at Crossroads.
- 99 = The case material does not indicate the ownership of this person's permanent dwelling.

QUESTION Enter the people who support this person financially.

Include people who together have provided the majority of this person's living expenses during the past six months and those who usually provide this money.

For example : A mother who pays 70% of these expenses would be included, but a mother who is the only one assisting this person and contributes 10%, would be excluded. Three siblings who each contribute a third toward the living expenses, would be included.

Be as specific as the information permits. Include each contributors sex and relationship to this person.

For example : Paternal aunt, sister, half brother, step sister.

CODES Self = This person supports him/herself financially.

 1/F8 = Go to question F8 on page 1F.

 99 = The case material does not indicate the people who support this person financially.

F7

QUESTION Enter the way in which the person or contributors gain the money to support this person. [In F6].

Be as specific as the information permits.

For example : Begging, stealing, prostitution, disability grant.

CODE 99 = The case material does not indicate the way in which the money is gained.

F8

QUESTION Enter the number of people who are financially dependent on the people/person who support/s this person financially. [In F6].

Financially dependent means that the people/person pays for the majority of the living expenses [As explained in F6].

99 = The case material does not indicate the number of people who are financially dependent.

F9

QUESTION Enter the approximate monthly income of the people/person who support/s this person financially. [In F6].

If the amount is variable, enter a 'v' after the amount.

If the income is not monthly, convert the income to an estimated monthly figure.

Give the amount as complete rands. Round off cents to the nearest complete rand by converting 50 cents and over to the next complete rand; and by converting amounts under 50 cents to the previous complete rand.

For example : Convert R 125.58, to R 126.00.

Enter amounts as complete rands or other currencies.

For example : R 129.00 would be entered as R 129 and \$ 250.00 as \$ 250.

CODE 99 = The case material does not indicate this monthly income.

QUESTION Indicate the type of account that this person gave of the alleged offences during this observation.

Refer to the first, full account given. A full account is one that includes at least a response to the charges. When no such account exists, use the longest account given.

CODES 1/H1 = Go to question H1 on page 1H.

 66 = Not applicable, because this person was not referred in connection with criminal charges.

 -C- = Enter the code you assigned to this charge in 3/D7.

 -CO- = Enter the number you assigned to this count in 3/D8.

CODES D-R = Denial of this offence without a rationale or reasons for the denial.

 D+R = Denial of this offence with a rationale or reasons for the denial.

 A-E = Admission of this offence without extenuating circumstances or reasons that may diminish responsibility.

 1/62 = Go to question 62 on page 16.

 A+E = Admission of this offence with extenuating circumstances or reasons that may diminish responsibility.

 99 = The case material does not indicate the person's response to this charge.

62

QUESTION	Indicate whether this person expressed remorse regarding the alleged offences.	
CODES	Y,spontan	= Yes, this person expressed remorse without being questioned directly about remorse.
	Y - ?	= Yes, this person expressed remorse, only after being questioned about remorse.
	N	= No, this person did not express remorse even though s/he was questioned about remorse.
	99	= The case material does not indicate whether this person expressed remorse with or without questioning.
	1/64	= Go to question 64 on page 16.

63

QUESTION	Indicate whether the interviewer felt that the remorse expressed by this person was credible or incredible.	
CODES	Cred	= The interviewer felt that the remorse was credible, or honestly experienced by this person.
	Incred	= The interviewer felt that the remorse was incredible, or feigned by this person.
	88	= The case material states that the interviewer did not decide whether the remorse was credible or incredible.
	99	= The case material does not indicate whether the interviewer felt the remorse was credible or incredible.

64

QUESTION	Enter the rationale and extenuating circumstances given by the person in response to each alleged offence.	
CODES	-C-	= Enter the code you assigned to this charge in 3/D7.
	-CO-	= Enter the number you assigned to this count in 3/D8.
	99	= The case material does not indicate the rationale and extenuating circumstances for this alleged offence.

65

QUESTION Indicate whether this person drank alcohol before and/or during each alleged offence.

Before means within the 6 hours prior to each offence.

CODES -C- = Enter the code you assigned to this charge in 3/D7.

 -CD- = Enter the number you assigned to this count in 3/D8.

 Y = Yes, this person did drink alcohol before and/or during this alleged offence.

 N = No, this person did not drink alcohol before and/or during this alleged offence.

 99 = The case material does not indicate whether the person drank alcohol before and/or during this alleged offence.

 2/69 = Go to question 69 on page 26.

66

QUESTION Indicate whether the person drank the alcohol voluntarily [In 65].

Voluntarily means without being forced and knowing that s/he was drinking alcohol which could cause intoxication.

CODES Y = Yes, this person drank the alcohol voluntarily.

 N = No, this person did not drink the alcohol voluntarily.

 99 = The case material does not indicate whether the person drank the alcohol voluntarily.

NOTE THAT 67 HAS BEEN PURPOSEFULLY OMITTED. THIS QUESTION IS USED FOR COMPUTER PURPOSES ONLY.

G10

QUESTION Indicate whether this person took the drugs voluntarily.
[In 69].

Voluntarily means without being forced and knowing that taking this drug/s could alter his/her mental state.

CODES

Y	=	Yes, this person took the drug/s voluntarily.
N	=	No, this person did not take the drugs/s voluntarily.
99	=	The case material does not indicate whether this person took the drug/s voluntarily.

G11

QUESTION Enter the approximate length of time between this person's use of drug/s and each alleged offence.

Give the time in the most appropriate units.

For example : 300 minutes would be given as 5 hours.

Give the time in complete units. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

For example : 350 minutes would be given as 6 hours; and 20 minutes would be given as 20 minutes.

Remember to enter the type of time unit used.

For example : Add an 'H' to indicate hours, and an 'mi' for minutes.

CODES

66	=	Not applicable, because this person was still taking drug/s when this offence began.
99	=	The case material does not indicate the time between drug taking and this offence.

H1

QUESTION Indicate whether each biological parent was a caretaker to this person.

Caretaker includes taking a parenting role for at least 6 months whilst this person was under the age of 21 years. Parenting requires at least one of the following :-

- * Providing financial support.
- * Taking legal responsibility as parent or as guardian in place of the biological parents.
- * Disciplining and/or rule setting.
- * Caretaking whilst under the age of 6 years, or when ill, or disabled.
- * Caretaking for at least 3 hours per day.

CODES

Y	=	Yes, this biological parent was a caretaker.
N	=	No, this biological parent was not a caretaker.
99	=	The case material does not indicate whether this biological parent was a caretaker.
2/H3	=	Go to question H3 on page 2H.

H2

QUESTION Enter the reasons why each biological parent was not a caretaker to the person.

Be as specific as the information permits.

For example : Mother died, Father deserted the family.

CODES

99	=	The case material does not indicate these reasons.
66	=	Not applicable, because this biological parent was a caretaker.

H3

QUESTION Enter the types of caretakers that this person had in addition to the biological parents;

AND

Enter the number of each type of caretaker.

For example : 2 step fathers, 3 hired, unrelated nannies.

See 1/H1 for the meaning of caretakers.

Be as specific as the information permits. Include each caretaker's sex and relationship to the person.

For example : Unrelated, hired female nanny.

CODES 99 = The case material does not indicate these types of caretakers.

-C- = Assign and enter a code for each caretaker.

NUM = Enter the number of this type of caretaker.

H4

QUESTION Enter the reasons why this person had each of the additional caretakers. [In H3].

Be as specific as the information permits.

For example : Father and Mother died.

CODE 99 = The case material does not indicate these reasons.

H5

QUESTION	Indicate whether this individual is biologically related to the person.	
CODES	-C-	= Enter the code you assigned to this caretaker in 2/H3 or sibling in 1/J5.
	Y	= Yes, this individual is biologically related to the person.
	N	= No, this individual is not biologically related to the person.
	99	= The case material does not indicate whether this individual is biologically related to the person.

H6

QUESTION	Indicate whether this individual is alive or dead.	
CODES	L	= Living, this individual was alive.
	3/H8	= Go to question H8 on page 3H.
	D	= Dead, this individual was dead.
	99	= The case material does not indicate whether this individual is alive or dead.

H7

QUESTION	Enter the person's age when this individual died.	
	Give the age in complete years, by converting six months and above to the next complete year, and by converting less than six months to the previous complete year. <u>For example</u> : 18 months would be given as 2 years. For total ages lower than 6 months, give the age in months and add an 'M'.	
CODES	99	= The case material does not indicate this age.

QUESTION Enter the code for the individual's highest level of formal education.

If the highest level is a diploma, also enter the highest school standard achieved.

For ** foreign educational systems, convert to the South African equivalent.

- CODES
- 0 = Little formal education, but the exact level is not known.
 - 11 = Primary school education, but the exact level is not known.
 - 20 = Secondary school education, but the exact level is not known.
 - 30 = Tertiary or post school education, but the exact level is not known.
 - A = Sub A/ Grade 1.
 - B = Sub B/ Grade 2.
 - 1 = Std 1.
 - 2 = Std 2.
 - 3 = Std 3.
 - 4 = Std 4.
 - 5 = Std 5.
 - 6 = Std 6.
 - 7 = Std 7.
 - 8 = Std 8.
 - 9 = Std 9.
 - 10 = Std 10/ Matriculation certificate equivalent.
 - 31 = Post matric finishing school qualification.
 - 32 = Trade certificate/s.
 - 34 = Diploma/s.
 - 35 = Bachelor's degree/s.
 - 36 = Master's degree/s.
 - 37 = Doctorate degree/s.
 - 38 = Honorary degree/s.
 - None = No formal education.
 - 99 = The case material does not indicate the highest level of education.

QUESTION Enter the code for the individual's general occupational category.

General occupational category refers to the way in which this individual has earned his/her keep for the majority of his/her lifetime. If the individual has never had a paid job, it refers to the way in which s/he has spent the majority of his/her time.

CODES	00	= Unemployed, able to work, but chooses not to work [Exclude homemakers, scholars, students, the disabled].
	01	= Unemployed, able to work, but cannot find work.
	02	= Unemployed, unable to work due to disability.
	03	= Homemaker.
	04	= Student [Post school].
	05	= Scholar.
	06	= Preschooler.
	10	= Owner of business/es.
	11	= Company director/ Member of board of executives.
	20	= Professional.
	21	= Manager/ Administrator.
	22	= Administrative personnel/ Inspectors
	23	= Semiprofessionals [Include Nursing staff, Teachers, Social workers etc].
	30	= Sales worker.
	31	= Clerical/ Secretarial worker.
	32	= Supervisor/ Foreman.
	40	= Farmer/ Farm manager.
	41	= Arts and crafts worker [Include Artists etc].
	42	= Skilled trades worker or Artisan [Include Plumbers, Plasterers etc].
	50	= Semiskilled manual worker.
	51	= Semiskilled service worker [Include Domestic workers in organizations, Building caretakers, Security officers, Drivers etc].
	60	= Laborer [Non-farm].
	61	= Farm laborer.
	62	= Domestic worker in homes.
	73	= Legal informal sector worker [Include Hawkers etc].
	74	= Illegal informal sector worker [Include Drug peddlers, Shebeen keepers, Gangsters etc].
	80	= Permanent force [Include Police, Army, Navy and Airforce].
	77	= Other occupational category not listed here. Enter the occupation under this question.
	66	= Not applicable, because this individual has not spent the majority of his/her life in any single occupational category.
	99	= The case material does not indicate this individual's general occupational category.

H10

QUESTION	Indicate whether this individual has ever ** abused alcohol.	
CODES	Y	= Yes, this individual has abused alcohol.
	N	= No, this individual has never abused alcohol.
	99	= The case material does not indicate whether this individual has abused alcohol.

H11

QUESTION	Indicate whether this individual has ever ** abused drug/s.	
CODES	Y	= Yes, this individual has abused drug/s.
	N	= No, this individual has never abused drug/s.
	99	= The case material does not indicate whether this individual abused drug/s.

H12

- QUESTION** Enter the psychiatric diagnoses and/or psychological problems this individual has experienced.
- Include evidence that is suggestive of psychiatric/psychological disorder such as, electroconvulsive therapy or ECT, psychotropic medication, in patient psychiatric treatment, attempted and actual suicide etc.
Give answers as stated in the case material.
For example : Schizophreniform disorder.
- CODES**
- + = Yes, this individual has experienced psychiatric/psychological disorder, but the type is not known.
 - None = No, this individual has never experienced psychiatric/psychological disorder.
 - 99 = The case material does not indicate whether this individual has experienced psychiatric/psychological disorder.

H13

- QUESTION** Enter the types of criminal charges of which this individual has been convicted.
- CODES**
- + = Yes, this individual has been convicted, but the types of offences are not known.
 - None = No, this individual has never been convicted.
 - 99 = The case material does not indicate whether not this individual has ever been convicted.

H14

QUESTION	Indicate whether generally speaking, the relationship between this individual and the person has been physically and/or emotionally affectionate.	
CODES	Y	= Yes, the relationship has been affectionate.
	N	= No, the relationship has not been affectionate.
	?	= The case material is such that it is uncertain whether the relationship has been affectionate.
	99	= The case material does not indicate whether the relationship has been affectionate.

H15

QUESTION	Indicate whether generally speaking, the relationship between this individual and the person has been communicative. Communicative requires that the partners have talked about issues of importance to either or both parties.	
CODES	Y	= Yes, the relationship has been communicative.
	N	= No, the relationship has not been communicative.
	?	= The case material is such that it is uncertain whether the relationship has been communicative.
	99	= The case material does not indicate whether the relationship has been communicative.

H16

QUESTION	Indicate whether generally speaking, the relationship between this individual and the person has been physically and/or verbally and/or covertly conflictual.	
	Covert conflict includes rejection or ostracism.	
CODES	Y	= Yes, the relationship has been conflictual.
	N	= No, the relationship has not been conflictual.
	?	= The case material is such that it is uncertain whether the relationship has been conflictual.
	99	= The case material does not indicate whether the relationship has been conflictual.

H17

QUESTION	Indicate the person's overall feeling or attitude toward this individual at present.	
CODES	+	= An overall positive feeling.
	-	= An overall negative feeling.
	?	= The case material is such that the person's overall feeling is uncertain.
	Neu	= An overall neutral or indifferent feeling.
	99	= The case material does not indicate the person's overall feeling.

H18

QUESTION Indicate the frequency of contact between this individual and the person, during the past year.

CODES

- None = This individual has had no contact at all with the person.
- S/H20 = Go to question H20 on page 5H.
- I = Irregular, less than monthly.
- R = Regular, at least monthly.
- 66 = Not applicable, because the person lives with this individual.
- 99 = The case material does not indicate this contact.

H19

QUESTION Indicate the type of contact that this individual has had with the person during the past year.

CODES

- I = Indirect [Include telephonic contact and correspondence].
- D = Direct or face to face contact.
- 99 = The case material does not indicate the type of contact.

H20

QUESTION Enter the person's age at which this caretaker began parenting.

If a caretaker stopped and then resumed parenting at a later stage, enter the person's age at the beginning of each of these periods.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.

For example : 18 months would be given as 2 years.

For total ages lower than 6 months, give the age in months and add an 'M'.

CODES

66	=	Not applicable, because this biological parent was not a caretaker.
5/H23	=	Go to question H23 on page 5H.
99	=	The case material does not indicate this age.

H21

QUESTION Enter the person's age at which this caretaker stopped parenting.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.

For example : 18 months would be given as 2 years.

If a caretaker stopped and then resumed parenting at a later stage, enter the person's age at the end of each of these periods.

For total ages lower than 6 months, give the age in months and add an 'M'.

CODES

66	=	Not applicable, because this biological parent was not a caretaker.
5/H23	=	Go to question H23 on page 5H.
99	=	The case material does not indicate this age.

H22

QUESTION Enter the reasons why each caretaking period ended.

Be as specific as the information permits.

For example : The person left home to live independently.

CODES

66	=	Not applicable, because this caretaking period has not yet ended.
99	=	The case material does not indicate these reasons.

H23

QUESTION	Indicate whether the rules that this caretaker set for the person's behavior were generally consistent.	
CODES	C	= The rules were generally consistent.
	I	= The rules were generally inconsistent.
	?	= The case material is such that it is uncertain whether the rules were consistent.
	66	= Not applicable, because this caretaker did not set rules regarding the person's behavior.
	99	= The case material does not indicate whether the rules were consistent.

H24

QUESTION	Indicate the usual type of punishment that this caretaker used to discipline the person.	
CODES	P	= Physical punishment only.
	NP	= Non-physical punishment only.
	N+P	= Physical and non-physical, but the relative amounts are not known.
	N=P	= Equal amounts of non-physical and physical.
	P>N	= More physical than non-physical.
	N>P	= More non-physical than physical.
	?	= The case material is such that the general type of punishment is uncertain.
	66	= Not applicable, because this caretaker did not punish the person at all.
	99	= The case material does not indicate the usual type of punishment used by this caretaker.

H25

QUESTION	Indicate whether this caretaker physically abused the person on more than one occasion.	
	Physical abuse means that the person was physically injured in some way.	
CODES	Y	= Yes, this caretaker did physically abuse the person.
	N	= No, this caretaker did not physically abuse the person.
	99	= The case material does not indicate whether this caretaker physically abused the person.

H26

QUESTION	Indicate which of the following ** adverse intra-familial conditions the person experienced during this caretaker's period/s of parenting.	
CODES	Y	= Yes, the person experienced this condition.
	N	= No, the person did not experience this condition.
	?	= The case material is such that the user is uncertain whether the person experienced this condition.
	99	= The case material does not indicate whether the person experienced this condition.

H27

QUESTION Enter the number of divorces or permanent separations that this person experienced between pairs of caretakers, during their periods of parenting.

CODES None = None of the caretakers separated permanently/divorced.

99 = The case material does not indicate this number of permanent separations/divorces.

6/H31 = Go to question H31 on page 6H.

H28

QUESTION Enter the codes of the pairs of caretakers who separated/divorced.

CODES -C- = Enter the codes you assigned to each caretaker in 2/H3.

99 = The case material does not indicate the caretakers who separated/divorced.

H29

QUESTION Enter the code of each caretaker who left the person's home due to the divorce/permanent separation.

CODES -C- = Enter the code you assigned to this caretaker in 2/H3.

99 = The case material does not indicate the caretaker who left home.

H30

QUESTION Enter the person's age when this divorce/separation occurred.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.

For example : 18 months would be given as 2 years.

CODE 99 = The case material does not indicate this age.

H31

QUESTION Enter the names and types of all institutions in which the person lived for at least 6 months whilst under the age of 21 years.

Living requires that the person at least sleep at the institution the majority of the time.

Be as specific as the information permits.

For example : Tenderton reformatory, Marist Brothers boarding school, Lalanga place of safety.

CODES 1/J1 = Go to question J1 on page 1J.
66 = Not applicable, because the person never attended a live-in institution.
99 = The case material does not indicate these live-in institutions.

H32

QUESTION Enter the age at which the person began living in each institution.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.

For example : 18 months would be given as 2 years.

If the person stopped and then resumed living in any one institution, enter the person's age at the beginning of each of these periods.

CODE 99 = The case material does not indicate these ages.

H33

QUESTION Enter the age at which the person stopped living in each institution.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.

For example : 18 months would be given as 2 years.

If the person stopped and then resumed living in any one institution, enter the person's age at the end of each of these periods.

CODE 99 = The case material does not indicate these ages.

J1

QUESTION	Indicate the person's ordinal position among his/her biological siblings who survived after birth.	
CODES	Only	= The person was an only child.
	Eldest	= The person was the eldest child.
	Middle	= The person was one of the middle children ie, s/he wasn't an only child, not one of a multiple birth, not eldest or youngest.
	Youngest	= The person was the youngest or last child born.
	Multiple	= The person was one of a multiple birth such as, twins, triplets etc.
	99	= The case material does not indicate the person's ordinal position.

J2

QUESTION	Enter the person's number of biologically related brothers. Include siblings who share only one parent.	
CODE	99	= The case material does not indicate this number.

J3

QUESTION	Enter the person's number of biologically related sisters. Include siblings who share only one parent.	
CODE	99	= The case material does not indicate this number.

J4

QUESTION	Enter the person's number of biologically related siblings. Include siblings who share only one parent.	
CODE	99	= The case material does not indicate this number.

J5

QUESTION Enter the person's age at each biological sibling's birth.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.
For example : 18 months would be given as 2 years.

CODES 66 = Not applicable, because this person has no biological siblings.

-C- = Assign and enter a code for each biological sibling indicated in 1/J2 & J3, or J4.

99 = The case material does not indicate this age.

J6

QUESTION Enter the person's number of legally related brothers.

Include siblings who are related by marriage, ie. step siblings.

CODE 99 = The case material does not indicate this number.

J7

QUESTION Enter the person's number of legally related sisters.

Include siblings who are related by marriage, ie. step siblings.

CODE 99 = The case material does not indicate this number.

J8

QUESTION Enter the person's number of legally related siblings.

Include siblings who are related by marriage, ie. step siblings.

CODE 99 = The case material does not indicate this number.

QUESTION Indicate whether or not the person lived with each sibling indicated in J1, J2, J6 & J7, or J4 & J8; for at least 6 months, at any time whilst s/he was under the age of 21 years.

CODES 66 = Not applicable, because this person does not have any siblings.

 -C- = Enter the code you assigned this biological siblings in J5, or assign a code to distinguish this legally related sibling.

 Y = Yes, the person did live with this siblings.

 N = No, the person did not live with this siblings.

 99 = The case material does not indicate whether the person lived with this sibling.

J10

QUESTION Enter the psychiatric/psychological disorders that this person's biological relatives have experienced.

Include all evidence suggestive of psychiatric/psychological such as, ECT, psychotropic medication, in patient psychiatric treatment, attempted and successful suicides etc.
Give answers as stated in the case material.

CODES 2/J12 = Go to question J12 on page 2J.

None = None of this person's biologically related relatives experienced psychiatric/psychological disorder.

99 = The case material does not indicate psychiatric/psychological disorder experienced by biological relatives.

+ = This relative experienced psychiatric/psychological disorder, but the type is not known.

J11

QUESTION Enter the relationship of each biological relative to this person. [Indicated in J10].

Be as specific as the information permits. Include each relatives sex.
For example : Paternal grandaother, maternal second cousin.

CODE 99 = The case material does not indicate this relatives relationship to the person.

J12

QUESTION Enter the serious medical disorders that this person's biological relatives have experienced.

Serious medical disorders include those that are fatal, debilitating, chronic and/or inherited.
Give answers as stated in the case material.

CODES

1/K1	=	Go to question K1 on page 1K.
None	=	None of this person's biologically related relatives experienced serious medical disorders.
99	=	The case material does not indicate serious medical disorder experienced by biological relatives.
+	=	This relative experienced serious medical disorder, but the type is not known.

J13

QUESTION Enter the relationship of each biological relative to this person. [Indicated in J12].

Be as specific as the information permits. Include each relative's sex.

For example : Paternal grandmother, maternal second cousin.

CODE

99	=	The case material does not indicate this relative's relationship to the person.
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K 1

QUESTION Enter the biological mother's age at the time of this person's birth.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.
For example : 18 months would be given as 2 years.

CODE 99 = The case material does not indicate this age.

K 2

QUESTION Enter the biological father's age at the time of this person's birth.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.
For example : 18 months would be given as 2 years.

CODE 99 = The case material does not indicate this age.

K 3

QUESTION Enter the emotional and/or physical problems experienced by the person's biological mother, during her pregnancy. \

CODES 2/K6 = Go to question K6 on page 2K.

 None = Mother did not experience any emotional and/or physical problems during this pregnancy.

 99 = The case material does not indicate such problems.

 -C- = Assign and enter a code for each problem.

K4

QUESTION

Enter the stage of pregnancy at which each problem began.
[Indicated in K3].

Give the stages in the most appropriate time units, months, weeks, days or hours.

Do not convert months to years, but convert part months, weeks, days and hours to the next complete time unit.

For example : Convert sixteen weeks to 4 months.

Remember to add an 'M' to indicate months; a 'W' for weeks; a 'D' for days and an 'H' for hours.

If the same problem stopped and then reoccurred, enter each stage of reoccurrence.

CODES

-C- = Enter the code you assigned this problem in K3.

99 = The case material does not indicate the stage this problem began.

K5

QUESTION

Enter the stage of pregnancy at which each problem ended.
[Indicated in K3].

Give stages in the most appropriate time units, months, weeks, days or hours.

Do not convert months to years, but convert part months, weeks, days and hours to the next complete time unit.

For example : Convert sixteen weeks to 4 months.

Remember to add an 'M' to indicate months; a 'W' for weeks; a 'D' for days and an 'H' for hours.

If the same problem stopped and then reoccurred, enter each stage at which it stopped.

CODES

-C- = Enter the code you assigned this problem in K3.

66 = Not applicable, because this problem had not ended by the time the person was born.

99 = The case material does not indicate the stage this problem began.

QUESTION Enter the term of the biological mother's pregnancy with this person.

 Give the term in the most appropriate time units, months or weeks.

 Do not convert months to years, but convert part months to full months and part weeks to full weeks

For example : Convert 16 weeks to 4 months.

 Remember to add an 'M' to indicate months and a 'W' for weeks.

CODE 99 = The case material does not indicate the term.

K7

QUESTION Enter the birth difficulties experienced by the biological mother at this person's birth.

Give the answers as stated in the case material.
For example : Anoxia due to prolonged labor, breech birth.

CODES None = Mother experienced no birth difficulties.

 99 = The case material does not indicate these birth difficulties.

K8

QUESTION Indicate which of the following ** emotional symptoms of psychiatric/psychological disorder, the person experienced, up to and including the age of 18 years.

CODES Y = Yes, the person experienced this symptom.

 N = No, the person did not experience this symptom.

 88 = The case material states that no decision was made as to whether the person experienced this symptom.

 99 = The case material does not indicate whether the person experienced this symptom.

K9

QUESTION Indicate which of the following ** somatic symptoms of psychiatric/psychological disorder the person experienced, up to and including the age of 18 years.

CODES Y = Yes, the person experienced this symptom.

 N = No, the person did not experience this symptom.

 88 = The case material states that no decision was made as to whether the person experienced this symptom.

 99 = The case material does not indicate whether the person experienced this symptom.

K10

QUESTION	Indicate which of the following ** disturbances of speech and language the person experienced, up to and including the age of 18 years.	
CODES	Y	= Yes, the person experienced this disturbance.
	N	= No, the person did not experience this disturbance.
	88	= The case material states that no decision was made as to whether the person experienced this disturbance.
	99	= The case material does not indicate whether the person experienced this disturbance.

K11

QUESTION	Indicate which of the following ** disturbances of motor behavior the person experienced, up to and including the age of 18 years.	
CODES	Y	= Yes, the person experienced this disturbance.
	N	= No, the person did not experience this disturbance.
	88	= The case material states that no decision was made as to whether the person experienced this disturbance.
	99	= The case material does not indicate whether the person experienced this disturbance.

K12

QUESTION	Indicate which of the following ** gender identity disorders the person experienced, up to and including the age of 18 years.	
CODES	Y	= Yes, the person experienced this disorder.
	N	= No, the person did not experience this disorder.
	88	= The case material states that no decision was made as to whether the person experienced this disorder.
	99	= The case material does not indicate whether the person experienced this disorder.

K13

QUESTION	Indicate which of the following ** symptoms of antisocial behavior the person exhibited, up to and including the age of 18 years.	
CODES	Y	= Yes, the person exhibited this symptom.
	N	= No, the person did not exhibit this symptom.
	88	= The case material states that no decision was made as to whether the person exhibited this symptom.
	99	= The case material does not indicate whether the person exhibited this symptom.

K14

QUESTION	Enter the number of permanent home moves that this person experienced, up to and including the age of 18 years. Permanent home moves require moving from a place where one lived for at least 6 months, to another place where the lives for at least six months. Living requires that one at least sleeps at a place the majority of the time.	
CODES	None	= This person did not experience any permanent home moves.
	1/L1	= Go to question L1 on page 1L.
	99	= The case material does not indicate this number.

K15

QUESTION	Enter the person's age at each of the home moves [indicated in K14]. Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year. <u>For example</u> : 18 months would be given as 2 years.	
CODE	-C-	= Assign and enter a code for each home move in K14.
	99	= The case material does not indicate this age.

L 1

QUESTION Enter the total number of schools that this person attended.

CODES None = This person did not attend any formal school.

 1/M1 = Go to question M1 on page 1M.

 99 = The case material does not indicate this number.

L 2

QUESTION Indicate whether each school was a primary or high/secondary school. [Indicated in L1].

 If the school included both a primary and secondary aspect, indicate under both options.

CODES -C- = Assign and enter a code for each school indicated in L1.

 P = This school was a primary school only.

 H = This school was a high or secondary school only.

 66 = Not applicable, because this school was neither a primary, nor a secondary school. For example : Schools for the mentally retarded.

 99 = The case material does not indicate whether this school was primary or secondary.

L3

QUESTION Indicate whether the person was a day-scholar or boarder at each school. [Indicated in L1].

If the person was a day-scholar and a boarder at the same school, but at different times, indicate both options.

CODES D = The person was a day-scholar at this school.

 B = The person was a boarder at this school.

 99 = The case material does not indicate whether the person was a day-scholar or boarder at this school.

L4

QUESTION Indicate whether each school was an ordinary or a special school for children with difficulties. [Indicated in L1].

Special schools cater specifically for children with difficulties.

CODES O = This was an ordinary school.

 S = This was a special school.

 SC = This was an ordinary school, but the person was placed in a special class for children with difficulties.

 99 = The case material does not indicate whether this was an ordinary or special school .

L7

- QUESTION** Enter the age at which the person began attending each school.
[Indicated in L2].
- If the person stopped and then resumed attendance at the same school, enter the ages at which attendance was resumed.
- Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.
For example : 18 months would be given as 2 years.
- CODES**
- C- = Enter the code you assigned to this school in L2.
 - 99 = The case material does not indicate this age.

L8

- QUESTION** Enter the age at which the person stopped attending each school
[Indicated in L2].
- If the person stopped and then resumed attendance at the same school, enter all the ages at which attendance was stopped.
- Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.
For example : 18 months would be given as 2 years.
- CODES**
- 66 = Not applicable, because the person has not yet left this school.
 - 99 = The case material does not indicate this age.
 - 2/L10 = Go to question L10 on page 2L.

L 9

QUESTION Enter the reasons why the person left each school.
[Indicated in L8].

Be as specific as the information permits.
For example : The family moved away from the area of the school.

CODE 99 = The case material does not indicate these reasons.

L 10

QUESTION Enter the total number of times the person failed an entire year of school education.

CODES None = The person never failed an entire year.

2/L12 = Go to question L12 on page 2L.

99 = The case material does not indicate this number.

L 1 1

QUESTION Enter the codes to indicate the school standards or grades the person failed.

For ** other educational systems convert to the South African equivalent.

CODES

A	=	Sub A/ Grade 1.
B	=	Sub B/ Grade 2.
1	=	Std 1.
2	=	Std 2.
3	=	Std 3.
4	=	Std 4.
5	=	Std 5.
6	=	Std 6.
7	=	Std 7.
8	=	Std 8.
9	=	Std 9.
10	=	Std 10/ Matric.
11	=	The standards failed were not ordinary school grades. <u>For example</u> : Grades at a school for the mentally retarded.
99	=	The case material does not indicate these standards.

QUESTION	Enter the codes to indicate the scholastic difficulties that the person experienced, during his/her formal school education.	
CODES	0	= Scholastic difficulties were experienced, but the exact type is not known.
	1	= General difficulty was experienced in all subjects.
	2	= Reading difficulty was experienced.
	3	= Writing difficulty was experienced.
	4	= Spelling difficulty was experienced.
	5	= Arithmetic difficulty was experienced.
	6	= Difficulty in pure scientific subjects was experienced. <u>For example</u> : Chemistry, physics, mathematics.
	7	= Difficulty in content subjects was experienced. <u>For example</u> : History and geography.
	8	= Difficulty was experienced in language subjects. <u>For example</u> : English, Afrikaans, French.
	77	= Difficulty was experienced in the following 'other' scholastic areas. Enter these under the question.
	None	= This person did not experience any scholastic difficulties.
	99	= The case material does not indicate these scholastic difficulties.

L13

QUESTION

Enter the code to indicate the highest level of formal education that the person achieved.

If the highest level is a diploma, add the code for the highest school standard achieved as well.

For ** foreign educational systems, convert to the South African equivalent.

CODES

0	=	Little formal education, but the exact level is not known.
11	=	Primary school education, but the exact level is not known.
20	=	Secondary school education, but the exact level is not known.
30	=	Tertiary or post school education, but the exact level is not known.
A	=	Sub A/ Grade 1.
B	=	Sub B/ Grade 2.
1	=	Std 1.
2	=	Std 2.
3	=	Std 3.
4	=	Std 4.
5	=	Std 5.
6	=	Std 6.
7	=	Std 7.
8	=	Std 8.
9	=	Std 9.
10	=	Std 10/ Matriculation certificate equivalent.
31	=	Post matric finishing school qualification.
32	=	Trade certificate/s.
34	=	Diploma/s.
35	=	Bachelor's degree/s.
36	=	Master's degree/s.
37	=	Doctorate degree/s.
38	=	Honorary degree/s.
None	=	No formal education.
2/L15	=	Go to question L15 on page 2L.
99	=	The case material does not indicate the highest level of education.

L 1 4

QUESTION	If the highest level of education is a school standard, indicate the type of standard.	
CODES	0	= The standard was ordinary.
	P	= The standard was practical, technical or commercial.
	S	= The standard was a special class for children with difficulties.
	H	= The standard was higher than ordinary, for gifted or talented children.
	66	= Not applicable, because this person achieved more than a school standard of education.
	99	= The case material does not indicate the type of standard.

L 1 5

QUESTION	Enter the total number of times this person has been formally expelled from school. Formal expulsion means that the head of the school instructed the person to leave and did not permit his/her return.	
CODES	None	= This person was never expelled.
	1/M1	= Go to question M1 on page 1M.
	99	= The case material does not indicate this number.

L 1 6

QUESTION	Enter the reasons for each expulsion. [Indicated in L15]. Be as specific as the information permits. <u>For example</u> : Sexual intercourse with an under aged girl.	
CODES	-C-	= Assign and enter a code for each expulsion in L15.
	99	= The case material does not indicate the reasons for this expulsion.

M1

QUESTION Enter the person's present status regarding compulsory, national military service.

Be as specific as the information permits.

For example : Completed first 3 years, but still has 6 monthly camps to complete.

CODES 66 = Not applicable, because this person was never required to do compulsory military service. Exclude people who were eligible, but exempted for some reason.

 1/M4 = Go to question M4 on page 1M.

 99 = The case material does not indicate this status.

M2

QUESTION Indicate whether this person has ever been less than honorably discharged from military service.

CODES Y = Yes, this person has been less than honorably discharged.

 N = No, this person has never been less than honorably discharged.

 99 = The case material does not indicate whether this person has been less than honorably discharged.

 1/M4 = Go to question M4 on page 1M.

M3

QUESTION Enter the reasons why this person was less than honorably discharged.

Be as specific as the information permits.
For example : Repeated mandrax abuse during service.

CODE 99 = The case material does not indicate these reasons.

M4

QUESTION Enter the age at which the person first began full time paid employment.

Give the age in complete years by converting six months and above to the next complete year, and by converting less than six months to the previous complete year.
For example : 18 months would be given as 2 years.

CODES 66 = Not applicable, because this person has never been gainfully employed in a full time capacity.

2/M6 = Go to question M6 on page 2M.

99 = The case material does not indicate this age.

QUESTION Enter the code that indicates the person's present occupational category.

Present occupational category refers to the way in which this person earns his/her keep at present. If the person has never had a paid job, it refers to the way in which s/he now spends the majority of his/her time.

CODES

00	= Unemployed, able to work, but chooses not to work [Exclude Homemakers, Scholars, Students, the Disabled].
01	= Unemployed, able to work, but cannot find work.
02	= Unemployed, unable to work due to disability
03	= Homemaker.
04	= Student [Post school].
05	= Scholar.
06	= Preschooler.
10	= Owner of business/es.
11	= Company director/ Member of board of executives.
20	= Professional.
21	= Manager/ Administrator.
22	= Administrative personnel/ Inspectors
23	= Semiprofessionals [Include Nursing staff, Teachers, Social workers etc].
30	= Sales worker.
31	= Clerical/ Secretarial worker.
32	= Supervisor/ Foreman.
40	= Farmer/ Farm manager.
41	= Arts and crafts worker [Include Artists etc].
42	= Skilled trades worker or Artisan [Include Plumbers, Plasterers etc].
50	= Semiskilled manual worker.
51	= Semiskilled service worker [Include domestic workers in organizations, Building caretakers, Security officers, Drivers etc].
60	= Laborer [Non-farm].
61	= Farm laborer.
62	= Domestic worker in homes.
73	= Legal informal sector worker [Include Hawkers etc].
74	= Illegal informal sector worker [Include Drug peddlers, Shebeen keepers, Gangsters etc].
77	= Other occupational category not listed here. Enter the occupation under this question.
80	= Permanent force [Include Police, Army, Navy and Airforce].
99	= The case material does not indicate the present occupational category of the person.
2/M9	= Go to question M9 on page 2M.

M7

QUESTION	If the person is gainfully employed at present, indicate whether the job is full time and regular.	
CODES	66	= Not applicable, because this person is not gainfully employed at present.
	F/R	= Full time and regular.
	F/I	= Full time, but irregular. This means that there are times other than holidays and weekends, when the person does not work and is not paid. <u>For example</u> : Contract workers.
	P/R	= Part time, regular. This means that the job does not take up all working days, but that the person does this job for a set time each week or month. <u>For example</u> : Shop assistants who work Saturday mornings only.
	P/I	= Part time, but irregular. This means that the job does not take up all working days, and that the person does not work set times each week or month. <u>For example</u> : A secretary who is called in to work only for relief purposes.
	99	= The case material does not indicate whether the job is full time and regular.

M8

QUESTION	Enter the total time the person has spent in his/her present job. [Indicated in M6].	
	Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit. Do not convert months to years. <u>For example</u> : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.	
	Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.	
CODE	99	= The case material does not indicate this time.

QUESTION

Enter the reasons why this person left each job.
[Indicated in M5].

Be as specific as the information permits.

For example : S/he was fired due to repeated lateness.

CODES

66 = Not applicable, because the person has not left his/her present job.

-C- = Assign and enter a code for each job indicated in M5.

99 = The case material does not indicate these reasons.

M12

QUESTION Enter the total number of times the person has been unemployed.

Include periods since the person began gainful employment.

Exclude periods in which the person has been unable to work due to disability, sickness etc.

CODE 99 = The case material does not indicate this number.

M13

QUESTION Enter the longest period of time for which this person has been unemployed.

Include periods since the person began gainful employment.

Exclude periods in which the person has been unable to work due to disability, sickness etc.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODE 66 = Not applicable, because this person has never been unemployed.

99 = The case material does not indicate this time.

QUESTION Enter the code that indicates the person's general occupational category.

General occupational category refers to the way in which this person has earned his/her keep for the majority of his/her lifetime. If the person has never had a paid job, it refers to the way in which s/he has spent the majority of his/her time.

CODES

00	= Unemployed, able to work, but chooses not to work [Exclude Homemakers, Scholars, Students, the Disabled].
01	= Unemployed, able to work, but cannot find work.
02	= Unemployed, unable to work due to disability
03	= Homemaker.
04	= Student [Post school].
05	= Scholar.
06	= Preschooler.
10	= Owner of business/es.
11	= Company director/ Member of board of executives.
20	= Professional.
21	= Manager/ Administrator.
22	= Administrative personnel/ Inspectors
23	= Semiprofessionals [Include nursing staff, Teachers, Social workers etc].
30	= Sales worker.
31	= Clerical/ Secretarial worker.
32	= Supervisor/ Foreman.
40	= Farmer/ Farm manager.
41	= Arts and crafts worker [include Artists etc].
42	= Skilled trades worker or artisan [Include Plumbers, Plasterers etc].
50	= Semiskilled manual worker.
51	= Semiskilled service worker [Include Domestic workers in organizations, Building caretakers, Security officers, Drivers etc].
60	= Laborer [Non-farm].
61	= Farm laborer.
62	= Domestic worker in homes.
73	= Legal informal sector worker [Include Hawkers etc].
74	= Illegal informal sector worker [Include Drug peddlers, Shebeen keepers, Gangsters etc].
80	= Permanent force [Include Police, Army, Navy and Airforce].
77	= Other occupational category not listed here. Enter the occupation under this question.
66	= Not applicable, because this person has has not spent the majority of his/her life in any single occupational category.
99	= The case material does not indicate the person's general occupational category.

QUESTION	If the person is gainfully employed at present, indicate whether the job is full time and regular.	
CODES	F/R	= Full time and regular.
	F/I	= Full time, but irregular. This means that there are times other than holidays and weekends, when the person does not work and is not paid. <u>For example</u> : Contract workers.
	P/R	= Part time, regular. This means that the job does not take up all working days, but that the person does this job for a set time each week or month. <u>For example</u> : Shop assistants who work Saturday mornings only.
	P/I	= Part time, but irregular. This means that the job does not take up all working days, and that the person does not work set times each week or month. <u>For example</u> : A secretary who is called in to work only for relief purposes.
	66	= Not applicable, because this person is not gainfully employed at present.
	1/N1	= Go to question N1 on page 1N.
	99	= The case material does not indicate whether the job is full time and regular.

M14

QUESTION Enter the longest period of time this person has spent in a single paid job.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODE 99 = The case material does not indicate this time.

M15

QUESTION Indicate whether this person has ever been repeatedly late and/or absent from a paid job.

Repeated lateness and absence requires an average of at least three instances per month.

CODES Y = Yes, this person has been repeatedly late and/ or absent.

N = No, this person has not been repeatedly late and/or absent.

? = The case material is such that it is uncertain whether this person has been repeatedly late and/or absent.

99 = The case material does not indicate whether this person has been repeatedly late and/or absent.

QUESTION

Indicate whether this person has walked off and/or resigned from at least two paid jobs, without having another job in reasonable sight.

CODES

- Y = Yes, this person has walked off jobs.
- N = No, this person has not walked off jobs.
- ? = The case material is such that it is uncertain whether this person has walked off jobs.
- 99 = The case material does not indicate whether this person has walked off jobs.

N4

QUESTION Indicate whether this person lives with any of his/her sexual partners. [Indicated in N3].

Living with someone requires that one at least sleeps and eats in the same place the majority of the time.

CODES Y = Yes, they do live together.

 N = No, they do not live together.

 99 = The case material does not indicate whether they live together.

N5

QUESTION Enter the length of each sexual relationship. [Indicated in N3].

If the person has more than one, ongoing relationship, include the lengths of all of these relationships. Include marriages.

Give the time in the most appropriate complete time units, years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit. Do not convert months to years. For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year. Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODE 99 = The case material does not indicate this length.

N6

QUESTION Indicate whether this person and/or his/her sexual partner have had sexual intercourse with any third party, during the period of their relationship.

CODES Y = Yes, there has been sex outside this relationship.

 N = No, there has not been sex outside this relationship.

 99 = The case material does not indicate whether there has been sex outside this relationship.

N7

QUESTION Indicate whether generally speaking, the relationship between this sexual partner and the person has been physically and/or emotionally affectionate.

If there is more than one regular sexual partner, complete this question for each partner.

CODES

Y	=	Yes, the relationship has been affectionate.
N	=	No, the relationship has not been affectionate.
?	=	The case material is such that it is uncertain whether or not the relationship has been affectionate.
99	=	The case material does not indicate whether the relationship has been affectionate.

N8

QUESTION Indicate whether generally speaking, the relationship between this sexual partner and the person has been communicative.

Communicative requires that the partners have talked about issues of importance to either or both parties.

If there is more than one regular sexual partner, complete this question for each partner.

CODES

Y	=	Yes, the relationship has been communicative.
N	=	No, the relationship has not been communicative.
?	=	The case material is such that it is uncertain whether or not the relationship has been communicative.
99	=	The case material does not indicate whether the relationship has been communicative.

N9

QUESTION Indicate whether generally speaking, the relationship between this sexual partner and the person has been physically, and/or verbally, and/or covertly conflictual.

Covert conflict includes rejection or ostracism.
If there is more than one regular sexual partner, complete this question for each partner.

CODES

Y	=	Yes, the relationship has been conflictual.
N	=	No, the relationship has not been conflictual.
?	=	The case material is such that it is uncertain whether or not the relationship has been conflictual.
99	=	The case material does not indicate whether the relationship has been conflictual.

N10

QUESTION Indicate the person's overall feeling or attitude toward this sexual partner at this time.

If there is more than one regular sexual partner, complete this question for each partner.

CODES

+	=	An overall positive feeling.
-	=	An overall negative feeling.
?	=	The case material is such that the person's overall feeling is uncertain.
Neu	=	An overall neutral or indifferent feeling.
99	=	The case material does not indicate the person's overall feeling.

N11

QUESTION Enter the sexual difficulties the person has experienced.

Indicate whether each difficulties was experienced in the past but not at present, or is being experienced at present.

Give answers as stated in the case material.
For example : Impotent unless s/he engages in sadisā.

CODES

None	=	This person has not experienced any sexual difficulties.
99	=	The case material does not indicate sexual difficulties.
66	=	Not applicable, because this person has never had sexual intercourse.
Pres	=	This difficulty is being experienced at present.
Past	=	This difficulty was experienced in the past, but not at present.

N12

QUESTION Enter the issues that have most frequently cause/d verbal and/or physical conflict between this person and his/her sexual partners.

Indicate whether each issue caused conflict in the past but not at present, or still causes conflict at present.

Give answers as stated in the case material.
For example : Sexual partner having sexual intercourse with a third party.

CODES

None	=	There are no such conflictual issues.
66	=	Not applicable, because this person has never had a regular sexual partner.
99	=	The case material does not indicate such conflictual issues.
Pres	=	This issue still causes conflict.
Past	=	This issue caused conflict in the past, but not at present.

N13

QUESTION Indicate the number of sexual partners the person has had during the past six years.

Include marriage partners.

CODES 99 The case material does not indicate this number.

N14

QUESTION Indicate the usual length of the person's sexual relationships.

If there is no usual length and the relationships are each of different of a different length, indicate the longest period for which any relationship has lasted and add a 'V'.

CODES L = Long term, ie. over 10 years.
M = Medium term, ie. from 6 to 10 years inclusive.
S = Short term, ie. from 1 to 5 years inclusive.
V = Very short term, ie. under 1 year.
99 = The case material does not indicate this length.

N15

QUESTION Indicate whether this person has had sexual relations with the same sex after the age of 18 years.

CODES Y = Yes, this person has had homosexual relations.
N = No, this person has not had homosexual relations.
66 = Not applicable, because this person is under the age of 18 years.
99 = The case material does not indicate whether this person has had homosexual relations.

QUESTION	Indicate the person's present sexual preference.	
	Preference requires that the person actually engages in sexual relations with the partners indicated.	
CODES	Asexual	= This person abstains from sexual relations.
	Het	= Heterosexual, the person prefers the opposite sex only.
	Het > Hom	= This person has a greater preference for the opposite sex, but does have sexual relations with the same sex.
	Bisex	= This person has an equal preference for both the same and opposite sexes.
	Hom > Het	= This person has a greater preference for the same sex, but does have sexual relations with the opposite sex.
	Homo	= This person prefers the same sex only.
	?	= The case material is such that the user is uncertain of the person's sexual preference.
	99	= The case material does not indicate this person's sexual preference.

N17

QUESTION Enter the person's total number of biologically related children.

Include only those children who are still living.

CODES None = This person has no children.

 1/P1 = Go to question P1 on page 1P.

 99 = The case material does not indicate this number.

N18

QUESTION Enter the age of each child. [Indicated in N17].

Give answers in complete years. Round off part years to the nearest complete year by converting periods of six months and over to the next complete year; and by converting periods of less than six months to the previous complete year.
For example : 7 years 5 months would be entered as 7 years.

CODE 99 = This age is missing from the case material.

N19

QUESTION Indicate the sex of each child. [Indicated in N17].

CODES F = Female.

 M = Male.

 99 = The case material does not indicate this child's sex.

N20

QUESTION Indicate whether each child lives with the person permanently.
[Indicated in N17].

To live permanently requires that the child has at least slept
and eaten at a place the majority of the time, for at least 6
months of the year.

CODES Y = Yes, this child lives with the person.
 N = No, this child does not live with the person.
 99 = The case material does not indicate whether or
 not this child lives with the person.

N21

QUESTION Indicate which of the following ** signs of inability to
function as a responsible parent, have been exhibited by the
person, and/or his/her children.

Include only those signs present during periods in which this
person was responsible for parenting each child.

CODES Y = Yes, this sign was exhibited.
 N = No, this sign was not exhibited.
 ? = The case material is such that the user is
 uncertain whether this sign was exhibited.
 99 = The case material does not indicate whether
 this sign was exhibited.

P 1

QUESTION Enter the approximate number of times the person has taken this substance during the past year.

Substances include either alcohol or drugs that can alter the mental state. Refer to the top of fact sheet page 1P.

CODES

99 The case material does not indicate this frequency.

None The person has not used this substance at all.

1/P5 Go to question P5 on page 1P.

Available The person takes this substance whenever available, so the exact frequency is not known.

1/P4 Go to question P4 on page 1P.

P 2

QUESTION Indicate the usual time that the person takes this substance.

CODES

D = Day, the person usually takes this substance during the daytime only, ie. before 6 pm.

N = Night, the person usually takes this substance during the night only, ie. between 6 pm and 6am.

D+N = Day and night, the person usually takes this substance during both the day and the night.

99 The case material does not indicate this time.

P 3

QUESTION Indicate the usual day that the person takes this substance.

CODES

D = The person usually takes this substance on weekdays/nights only, ie. Monday to Friday.

W = The person usually takes this substance on weekends only, ie. Saturday to Sunday including days and/or nights.

D+W = The person usually takes this substance on both weekdays and weekends, including days and/or nights.

99 = The case material does not indicate this day.

QUESTION Enter the age at which the person's use of this substance first became problematic to him/herself and/or others.

Give answers in complete years. Round off part years to the nearest complete year by converting periods of six months and over to the next complete year; and by converting periods of less than six months to the previous complete year.
For example : 16 years and 7 months would be entered as 17 years.

CODE Child = Substance use first became problematic during childhood, but the exact age is not known, ie. under 13 years.

 Adol = Substance use first became problematic during adolescence, but the exact age is not known, ie. between 13 and 18 years inclusive.

 Adult = Substance use first became problematic during adulthood, but the exact age is not known, ie. over 18 years.

 66 = Not applicable, because the person's substance use has never been problematic.

 1/01 = Go to question 01 on page 10.

 99 = The case material does not indicate this age.

QUESTION Indicate which of the following ** factors indicative of a pathological pattern of substance use, the person has exhibited during the past year.

- CODES
- Y = Yes, the person has exhibited this factor.
 - 88 = The case material is such that no decision was made as to whether the person exhibited this factor.
 - N = No, the person has not exhibited this factor.
 - 99 = The case material does not indicate whether the person exhibited this factor.

QUESTION Indicate which of the following ** factors indicative of impaired social and occupational functioning due to substance use, the person has exhibited during the past year.

- CODES
- Y = Yes, the person has exhibited this factor.
 - 88 = The case material is such that no decision was made as to whether the person exhibited this factor.
 - N = No, the person has not exhibited this factor.
 - 99 = The case material does not indicate whether the person exhibited this factor.

QUESTION	Indicate which of the following types of alcohol the person usually drinks.	
CODES	None	= The person does not drink alcohol at all.
	7/P17	= Go to question P17 on page 7P.
	Spirits	= The person usually drinks spirits that are produced for consumption, ie. whisky etc.
	4/P10	= Go to question P10 on page 4P.
	4/P11	= Go to question P11 on page 4P.
	Beer	= The person usually drinks commercially brewed beer.
	4/P12	= Go to question P12 on page 4P.
	Homebrew	= The person usually drinks homebrewed or homemade alcohol.
	4/P13	= Go to question P13 on page 4P.
	Nonbeverage	= The person usually drinks alcohol that has not been produced for general consumption such as, methylated spirits, cough medicines etc.
	4/P14	= Go to question P14 on page 4P.
	Available	= The person usually drinks whatever alcohol is available, so the exact types are not known.
	5/P15	= Go to question P15 on page 5P.
	99	= The case material does not indicate the usual types of alcohol.

P10

QUESTION Enter the approximate amount of spirits the person usually drinks on a single occasion.

Give the amount in the most specific units possible.
The most preferable units are milliliters and liters.
Remember to add : a 'B' for bottle, a 'T' for tots, a 'G' for glasses, an 'L' for liters, an 'ml' for milliliters.
Give the amount in complete units, by converting half and greater units to the next complete unit, and by converting less than half units to the previous complete unit.
Do not convert liters and milliliters, unless there is a fraction of a liter or milliliter.
For example : Half a tot would be entered as 1 tot, but 750 milliliters would not be converted to 1 liter.

CODES

Available	=	The person drinks whatever quantity is available, so the usual amount is not known.
99	=	The case material does not indicate this amount.

P11

QUESTION Enter the approximate amount of wine the person usually drinks on a single occasion.

Give the amount in the most specific units possible.
The most preferable units are milliliters and liters.
Remember to add : a 'B' for bottle, a 'T' for tots, a 'G' for glasses, an 'L' for liters, an 'ml' for milliliters.
Give the amount in complete units, by converting half and greater units to the next complete unit, and by converting less than half units to the previous complete unit.
Do not convert liters and milliliters, unless there is a fraction of a liter or milliliter.
For example : Half a tot would be entered as 1 tot, but 750 milliliters would not be converted to 1 liter.

CODES

Available	=	The person drinks whatever quantity is available, so the usual amount is not known.
99	=	The case material does not indicate this amount.

P 12

QUESTION Enter the approximate amount of beer the person usually drinks on a single occasion.

Give the amount in the most specific units possible.
The most preferable units are milliliters and liters.
Remember to add : a 'B' for bottle, a 'T' for tots, a 'G' for glasses, an 'L' for liters, an 'ml' for milliliters.
Give the amount in complete units, by converting half and greater units to the next complete unit, and by converting less than half units to the previous complete unit.
Do not convert liters and milliliters, unless there is a fraction of a liter or milliliter.
For example : Half a tot would be entered as 1 tot, but 750 milliliters would not be converted to 1 liter.

CODES

Available	=	The person drinks whatever quantity is available, so the usual amount is not known.
99	=	The case material does not indicate this amount.

P 13

QUESTION Enter the approximate amount of homebrewed alcohol the person usually drinks on a single occasion.

Give the amount in the most specific units possible.
The most preferable units are milliliters and liters.
Remember to add : a 'B' for bottle, a 'T' for tots, a 'G' for glasses, an 'L' for liters, an 'ml' for milliliters.
Give the amount in complete units, by converting half and greater units to the next complete unit, and by converting less than half units to the previous complete unit.
Do not convert liters and milliliters, unless there is a fraction of a liter or milliliter.
For example : Half a tot would be entered as 1 tot, but 750 milliliters would not be converted to 1 liter.

CODES

Available	=	The person drinks whatever quantity is available, so the usual amount is not known.
99	=	The case material does not indicate this amount.

QUESTION Enter the approximate amount of nonbeverage alcohol the person usually drinks on a single occasion.

Give the amount in the most specific units possible.
The most preferable units are milliliters and liters.
Remember to add : a 'B' for bottle, a 'T' for tots, a 'G' for glasses, an 'L' for liters, an 'ml' for milliliters.
Give the amount in complete units, by converting half and greater units to the next complete unit, and by converting less than half units to the previous complete unit.
Do not convert liters and milliliters, unless there is a fraction of a liter or milliliter.

For example : Half a tot would be entered as 1 tot, but 750 milliliters would not be converted to 1 liter.

CODES Available = The person drinks whatever quantity is available, so the usual amount is not known.

 99 = The case material does not indicate this amount.

QUESTION

Indicate which of the following ** alcohol associated symptoms the person has exhibited.

If a symptom is present, indicate the time period since this symptom was last exhibited.

If ** delusions, and/or ** hallucinations, and/or ** misperceptions/illusions are present, enter a brief description thereof. Give answers as stated in the case material.

Give the time in the most appropriate, complete time unit, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

- 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
- ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
- Y = Yes, this symptom was exhibited.
- Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
- 99 [1st] = The case material does not indicate this time period.
- N = No, this symptom was not exhibited.
- 99 [2nd] = The case material does not indicate whether this symptom was exhibited.
- Type = Enter a brief description of this symptom if present.

QUESTION

Enter the other alcohol associated symptoms the person has exhibited. [That are not listed in P15].

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

- None = The person has not exhibited any other alcohol associated symptoms.
- 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
- ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
- Y = Yes, this symptom was exhibited.
- Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
- 99 [1st] = The case material does not indicate this time period.
- N = No, this symptom was not exhibited.
- 99 [2nd] = The case material does not indicate whether this symptom was exhibited.

P17

QUESTION Enter the types of drugs this person has used.
Include any substance that can alter the mental state that is not taken for medical purposes.

CODES 99 = The case material does not indicate any drug types.
None = The person does not take any drugs.
-C- = Assign and enter a code for each drug type indicated.

P18

QUESTION Enter the ** drug category to which each type of drug belongs. [Indicated in P17].

If a drug type does not appear under any of the given drug categories;

AND

If more than one drug type is taken in combination; enter 'other drug' under the column for drug categories.

P19

QUESTION Enter the approximate amount of each type of drug taken.
[Indicated in P17].

Give the amount in the most specific units possible.
The most preferable units are milliliters, liters, grams and milligrams.

Remember to add : a 'T' for tablets, an 'S' for solids, stopps, skyfs and cigarettes, an 'I' for inhalations or sniffs, an 'L' for liters, an 'ml' for milliliters, a 'G' for grams and an 'MG' for milligrams.

Give the amount in complete unit, by converting half and greater units to the next complete unit, and by converting less than half units to the previous complete unit.

Do not convert liters, milliliters, grams and milligrams, unless there is a fraction of a unit.

For example : Half a cigarette would be entered as 1 cigarette but 750 milligrams would not be converted to 1 gram.

CODES

Available	=	The person takes whatever amount is available, so the exact amount is not known.
99	=	The case material does not indicate this amount.

P20

QUESTION Enter the method the person uses to take each type of drug.
[Indicated in P17].

Be as specific as the information permits.

For example : Inhaled without combustion, intravenously injected, smoked in a bottle neck, smoked in paper.

CODES

-C-	=	Enter the code you assigned to this drug type in P17.
99	=	The case material does not indicate this method of intake.

QUESTION Indicate which of the following ** amphetamine associated symptoms the person has exhibited.

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

88 = The case material states that a decision was not reached as to whether this symptom was exhibited.

? = The case material is such that the user is uncertain as to whether this symptom was exhibited.

Y = Yes, this symptom was exhibited.

Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.

99 [1st] = The case material does not indicate this time period.

N = No, this symptom was not exhibited.

99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION

Enter the other amphetamine associated symptoms the person has exhibited. [That are not listed in P21].

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

- None = This person has not exhibited any other associated symptoms.
- 8/P = Go back to the instructions on page 8/P.
- 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
- ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
- Y = Yes, this symptom was exhibited.
- Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
- 99 [1st] = The case material does not indicate this time period.
- N = No, this symptom was not exhibited.
- 99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION

Indicate which of the following ** barbiturate associated symptoms the person has exhibited.

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

- 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
- ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
- Y = Yes, this symptom was exhibited.
- Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
- 99 [1st] = The case material does not indicate this time period.
- N = No, this symptom was not exhibited.
- 99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION Enter the other barbiturate associated symptoms the person has exhibited. [That are not listed in P23].

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

- CODES
- None = This person has not exhibited any other associated symptoms.
 - 8/P = Go back to the instructions on page 8/P.
 - 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
 - ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
 - Y = Yes, this symptom was exhibited.
 - Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
 - 99 [1st] = The case material does not indicate this time period.
 - N = No, this symptom was not exhibited.
 - 99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION

Indicate which of the following ** opioid associated symptoms the person has exhibited.

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

- 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
- ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
- Y = Yes, this symptom was exhibited.
- Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
- 99 [1st] = The case material does not indicate this time period.
- N = No, this symptom was not exhibited.
- 99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION

Enter the other opioid associated symptoms the person has exhibited. [That are not listed in P25].

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

- None = This person has not exhibited any other associated symptoms.
- 8/P = Go back to the instructions on page 8/P.
- 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
- ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
- Y = Yes, this symptom was exhibited.
- Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
- 99 [1st] = The case material does not indicate this time period.
- N = No, this symptom was not exhibited.
- 99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION Enter the ** dagga/cannabis associated symptoms the person has exhibited.

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES None = This person has not exhibited any other associated symptoms.

8/P = Go back to the instructions on page 8/P.

88 = The case material states that a decision was not reached as to whether this symptom was exhibited.

? = The case material is such that the user is uncertain as to whether this symptom was exhibited.

Y = Yes, this symptom was exhibited.

Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.

99 [1st] = The case material does not indicate this time period.

N = No, this symptom was not exhibited.

99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION Enter the ** hallucinogen associated symptoms the person has exhibited.

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

None	=	This person has not exhibited any other associated symptoms.
B/P	=	Go back to the instructions on page B/P.
BB	=	The case material states that a decision was not reached as to whether this symptom was exhibited.
?	=	The case material is such that the user is uncertain as to whether this symptom was exhibited.
Y	=	Yes, this symptom was exhibited.
Time since	=	If a symptom was exhibited, enter the time period since this symptom was last exhibited.
99 [1st]	=	The case material does not indicate this time period.
N	=	No, this symptom was not exhibited.
99 [2nd]	=	The case material does not indicate whether this symptom was exhibited.

QUESTION

Enter the ** symptoms associated with volatile solvent use, that the person has exhibited.

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

- None = This person has not exhibited any other associated symptoms.
- B/P = Go back to the instructions on page B/P.
- 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
- ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
- Y = Yes, this symptom was exhibited.
- Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
- 99 [1st] = The case material does not indicate this time period.
- N = No, this symptom was not exhibited.
- 99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION Enter the ** phencyclidine associated symptoms, that the person has exhibited.

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES None = This person has not exhibited any other associated symptoms.

8/P = Go back to the instructions on page 8/P.

88 = The case material states that a decision was not reached as to whether this symptom was exhibited.

? = The case material is such that the user is uncertain as to whether this symptom was exhibited.

Y = Yes, this symptom was exhibited.

Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.

99 [1st] = The case material does not indicate this time period.

N = No, this symptom was not exhibited.

99 [2nd] = The case material does not indicate whether this symptom was exhibited.

QUESTION Enter the ** symptoms associated with the use of drugs categorized as 'other', that the person has exhibited

AND

All symptoms associated with combinations of drugs, that the person has experienced.

If a symptom is present, indicate the time period since this symptom was last exhibited.

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES

- None = This person has not exhibited any other associated symptoms.
- 8/P = Go back to the instructions on page 8/P.
- 88 = The case material states that a decision was not reached as to whether this symptom was exhibited.
- ? = The case material is such that the user is uncertain as to whether this symptom was exhibited.
- Y = Yes, this symptom was exhibited.
- Time since = If a symptom was exhibited, enter the time period since this symptom was last exhibited.
- 99 [1st] = The case material does not indicate this time period.
- N = No, this symptom was not exhibited.
- 99 [2nd] = The case material does not indicate whether this symptom was exhibited.
- Drugs = Enter the type of drug or drug combination.

Q1

QUESTION Enter the criminal offences of which the person has been convicted.

Give answers as stated in the case material.
For example : Housebreaking with intent to steal.

CODES None = This person has never been convicted of a criminal offence.

2/Q5 = Go to question Q5 on page 20.

-C- = Assign and enter a code for each offence.

99 = The case material does not indicate this offence.

Q2

QUESTION Enter the number of counts of each type of offence.
[Indicated in Q1].

CODES -Num- = Enter the number of counts.

99 = The case material does not indicate the number of counts of this offence.

Q3

QUESTION Enter the person's age at which each conviction took place.
[Indicated in Q1 and Q2].

Give answers in complete years. Round off part years to the nearest complete year by converting periods of six months and over to the next complete year; and by converting periods of less than six months to the previous complete year.
For example : 35 years and 3 months would be enter as 35 years.

CODE 99 = The case material does not indicate this age.

Q4

QUESTION Enter the type of sentence that this person received for each conviction. [Indicated in Q1 and Q2].

Give answers as stated in the case material.
Include warnings.
For example : Three lashes with a cane, suspended for 6 months.

CODES -C- Enter the code you assigned to this conviction in Q1 and Q2.

99 The case material does not indicate the sentence received for this conviction.

Q5

QUESTION Indicate which of the following institutional forms of custody has this person has experienced.

CODES Y = Yes, the person has experienced this form of custody.

 N = No, the person has not experienced this form of custody.

 99 = The case material does not indicate whether the person has experienced this form of custody.

 1/R1 = Go to question R1 on page 1R.

Q6

QUESTION Enter the number of times the person has escaped or absconded from each form of custody. [Indicated in Q5].

CODES None = Although this person has been in custody, s/he has never escaped/absconded from any of these forms of custody.

 1/R1 = Go to question R1 on page 1R.

 99 = The case material does not indicate whether the person has escaped/absconded from this form of custody.

Q7

QUESTION Enter the person's age at which each escape/absconding took place. [Indicated in Q6].

Give answers in complete years. Round off part years to the nearest complete year by converting periods of six months and over to the next complete year; and by converting periods of less than six months to the previous complete year.
For example : 37 years and 3 months would be entered as 37 years.

CODE 99 = This age is missing from the case material.

Q8

QUESTION Enter the method by which the person escaped/absconded on each occasion [Indicated in Q6].

Be as specific as the information permits.
For example : The person dug a tunnel under a wall, s/he assaulted 3 custodians, s/he picked a lock and broke a window.

CODE 99 = The case material does not indicate the method for this escape/absconding.

Q9**QUESTION**

Enter the total time that the person spent out of custody after each escape/absconding [Indicated in Q6].

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES**-C-**

= Enter the code you assigned to this escape/absconding in Q7.

66

= Not applicable, because this person has not been returned to custody since this escape/absconding.

99

= The case material does not indicate this time period.

3/Q11

= Go to question Q11 on page 30.

Q10**QUESTION**

Enter the individuals who returned the person to custody after each escape/absconding [Indicated in Q6].

Be as specific as the information permits. Include each individual's relationship to the person or his/her role.

For example : Policeman, the person's biological mother.

CODES**P**

= The person him/herself returned to custody on his/her own initiative.

99

= The case material does not indicate these individuals.

R1

QUESTION Enter the total number of times the person has been hospitalized for at least 1 weeks duration.

CODES

None = The person has never been hospitalized for over a weeks duration.

2/R5 = Go to question R5 on page 2R.

99 = The case material does not indicate this number.

R2

QUESTION Enter the person's age at each hospitalization [Indicated in R1].

Give answers in complete years. Round off part years to the nearest complete year by converting periods of six months and over to the next complete year; and by converting periods of less than six months to the previous complete year.
For example : 35 years and 7 months would be entered as 36 years.

CODE

-C- = Assign and enter a code for each hospitalization in R1.

99 = The case material does not indicate this age.

R3

QUESTION Enter the names of the medical conditions for which the person was hospitalized on each occasion [Indicated in R1].

Give the names as stated in the case material.
For example : Replacement of two heart valves.

CODE

99 = The case material does not indicate the name of this medical condition.

QUESTION Indicate whether the central purpose of each hospitalization was investigatory, or surgery, or other types of treatment.

If it was other types of treatment, enter these types.

Give answers as stated in the case material.

For example : A blood transfusion, radium therapy.

CODES -C- = Enter the code you assigned to each hospitalization in R2.

Y [1st] = Yes, the central purpose of this hospitalization was investigatory.

N [1st] = No, the central purpose of this hospitalization was not investigatory.

99 [1st] = The case material does not indicate whether the central purpose of this hospitalization was investigatory.

Y [2nd] = Yes, the central purpose of this hospitalization was surgery.

N [2nd] = No, the central purpose of this hospitalization was not surgery.

99 [1st] = The case material does not indicate whether the central purpose of this hospitalization was surgery.

99 [3rd] = The case material does not indicate the other central treatments received during this hospitalization.

R5

QUESTION	Enter the total number of head injuries the person has experienced, that have caused a ** loss of consciousness.	
CODES	None	= This person has experienced no such head injuries.
	3/R13	= Go to question R13 on page 3R.
	+	= This person has experienced at least one such head injury, but the exact number is not known.
	99	= The case material does not indicate this number.

R6

QUESTION	Enter the person's age at each head injury. [Indicated in R5].	
	Give answers in complete years. Round off part years to the nearest complete year by converting periods of six months and over to the next complete year; and by converting periods of less than six months to the previous complete year. <u>For example</u> : 25 years and 9 months would be entered as 26 years.	
CODES	-C-	= Assign and enter a code for each head injury in R5.
	Child	= The person had this head injury during childhood, but the exact age is not known, ie. under 13 years of age.
	Adol	= The person had this head injury during adolescence, but the exact age is not known, ie. between 13 and 18 years of age inclusive.
	Adult	= The person had this head injury during adulthood, but the exact age is not known, ie. over 18 years of age.
	99	= The case material does not indicate the age at this head injury.

R7

QUESTION Enter the total length of time that the person was
** unconscious following each head injury [Indicated in R5].

Give the time in the most appropriate, complete time units, ie.
years, months, weeks, days or hours. Convert half units and
greater to the next complete unit, and convert less than half
units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15
months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months,
a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODE 99 = The case material does not indicate the period
of unconsciousness for this head injury.

R8

QUESTION Enter the total length of time that the person experienced
** post traumatic amnesia following each head injury
[Indicated in R5].

Give the time in the most appropriate, complete time units, ie.
years, months, weeks, days or hours. Convert half units and
greater to the next complete unit, and convert less than half
units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15
months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months,
a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODE 99 = The case material does not indicate the
PTA period for this head injury.

R9

QUESTION	Indicate whether each head injury was a ** closed or open injury [Indicated in R5].	
CODES	-C-	= Enter the code you assigned to this head injury in R6.
	CL	= This head injury was closed.
	0	= This head injury was open.
	99	= The case material does not indicate whether this head injury was closed or open.

R10

QUESTION	Indicate the side of the head injured in each head injury. [Indicated in R5].	
CODES	L	= Only the left side of the head was injured.
	R	= Only the right side of the head was injured.
	L+R	= Both the left and right sides of the head were injured.
	M	= Only the middle or medial section of the head was injured, with no left or right focus.
	H	= Only the back or hind side of the head was injured, with no left or right focus.
	G	= The injury was generalized with no focus.
	99	= The case material does not indicate the side of the head injured in this injury.

R 1 1

- QUESTION** Enter the areas of the brain injured in each head injury.
[Indicated in R5].
- Give answers as stated in the case material.
For example : The hippocampus,, the left, frontal lobe.
- CODES**
- C- = Enter the code you assigned to this head injury in R6.
 - None = No area of the brain was injured in this head injury.
 - 99 = The case material does not indicate which brain areas were injured in this head injury.
 - 3/R13 = Go to question R13 on page 3R.

R 1 2

- QUESTION** Enter all the ** deficits that resulted from each head injury
[Indicated in R5].
- Give answers as stated in the case material.
Include physical, intellectual and emotional/personality deficits.
For example : impaired visuospatial tracking, paralysis to the left side of the body, social disinhibition.
- CODES**
- None = No deficits resulted from this head injury.
 - 99 = The case material does not indicate deficits resulting from this head injury.

R 1 3

- QUESTION** Enter the conditions under which electroencephalograms or EEG's
were conducted on this person.
- Give answers as stated in the case material.
For example : Food deprivation, during sleep, whilst resting.
- CODES**
- 66 = Not applicable, because this person has never had an EEG.
 - 1/S1 = Go to question S1 on page 1S.
 - 99 = The case material does not indicate the conditions under which EEG's have been conducted.

R14

QUESTION	Indicate the ** types of wave amplitude abnormalities shown on EEG.	
CODES	-C-	= Assign and enter a code for each abnormality.
	None	= No such abnormalities were shown on the EEG report.
	L	= A lowered amplitude abnormality was shown.
	H	= A highered amplitude abnormality was shown.
	L+H	= A combined highered and lowered amplitude abnormality was shown.
	99	= The case material does not indicate these types of abnormalities.
	4/R16	= Go to question R16 on page 4R.

R15

QUESTION	Indicate whether each abnormality was considered to be ** epileptogenic [Indicated in R4].	
CODES	Y	= Yes, this abnormality was considered to be epileptogenic.
	N	= No, this abnormality was not considered to be epileptogenic.
	88	= The case material states that no decision was made as to whether this abnormality was epileptogenic.
	99	= The case material does not state whether this abnormality was epileptogenic.

R16

QUESTION	Indicate the ** types of wave frequency abnormalities shown on EEG.	
CODES	-C-	= Assign and enter a code for each abnormality.
	None	= No such abnormalities were shown on the EEG report.
	L	= A lowered frequency abnormality was shown.
	H	= A highered frequency abnormality was shown.
	L+H	= A combined highered and lowered frequency abnormality was shown.
	99	= The case material does not indicate these types of abnormalities.
	4/R18	= Go to question R18 on page 4R.

R17

QUESTION	Indicate whether each abnormality was considered to be ** epileptogenic [Indicated in R4].	
CODES	Y	= Yes, this abnormality was considered to be epileptogenic.
	N	= No, this abnormality was not considered to be epileptogenic.
	88	= The case material states that no decision was made as to whether this abnormality was epileptogenic.
	99	= The case material does not state whether this abnormality was epileptogenic.

R18

QUESTION	Indicate the side of the brain on which each wave abnormality was focused [Indicated in R14 and R16].	
CODES	-C-	= Enter the code you assigned to this abnormality in either R14 or R16.
	G	= This abnormality had no focus, it was generalized.
	B	= This abnormality had a bilateral focus, ie. an equal focus on both the left and right sides.
	B+L	= This abnormality occurred on both sides, but had a left sided focus.
	B+R	= This abnormality occurred on both sides, but had a right sided focus.
	L	= This abnormality had a left sided focus only.
	R	= This abnormality had a right sided focus only.
	M	= This abnormality had a medial or middle focus only, neither on the left or right side.
	H	= This abnormality had a focus on the hindside only, neither on the left or right side.
	99	= The case material does not indicate the side of the focus for this abnormality.
	1/S1	= Go to question S1 on page 15.

R19

QUESTION	Enter the ** brain areas in which each abnormality was focused [Indicated in R14 and R16].	
	Give answers as stated in the case material. <u>For example</u> : Left temporal lobe, basal ganglia.	
CODES	99	= The case material does not indicate the area of focus for this abnormality.

S1

QUESTION Enter the types of ** psychotropic medication that have been prescribed for the person.

CODES

None = This person has never been prescribed psychotropic medication.

99 = The case material does not indicate the types of psychotropic medication prescribed.

2/S5 = Go to question S5 on page 2S.

-C- = Assign and enter a code for each type of psychotropic medication.

S2

QUESTION Enter the ** dosages prescribed for each psychotropic medication [Indicated in S1].

Give answers as stated in the case material.
Include the amount and the frequency.
For example : 20 mg's Diazepam morning and evening.

CODE 99 = The case material does not indicate the dosage for this medication.

QUESTION Enter the date each psychotropic medication was started.

 If a medication was stopped and then resumed, enter the dates it was resumed.

CODES -C- = Enter the code you assigned to this medication in S1.

 -d- = Enter the day of the month.
 For example : The 3rd day would be entered as 03.

 -m- = Enter the month of the year.
 For example : April would be entered as 04.

 -y- = Enter the year.
 For example : 1980 would be entered as 80.

 99 = The case material does not indicate this date.

QUESTION Enter the date each psychotropic medication was stopped.

 If a medication was stopped and then resumed, enter the dates it was stopped.

CODES -d- = Enter the day of the month.
 For example : The 3rd day would be entered as 03.

 -m- = Enter the month of the year.
 For example : April would be entered as 04.

 -y- = Enter the year.
 For example : 1980 would be entered as 80.

 66 = Not applicable, because this medication has not yet been stopped.

 99 = The case material does not indicate this date.

55

QUESTION Enter the total number of times this person has received
treatment for ** psychiatric/psychological problems.

CODES None = This person has never received such treatment.

 1/T1 = Go to question T1 on page 1T.

 + = This person has received such treatment, but
 the exact number of times is not known.

 99 = The case material does not indicate whether
 this person has received such treatment.

56

QUESTION Enter the name of each treatment agency from which the person
received each treatment. [Indicated in 55].

 Treatment agencies include all sources that provide
 psychiatric/psychological treatment.
 Give answers as stated in the case material.
 For example : Zonderwater Prison Hospital for Psychopaths.

CODES -C- = Assign and enter a code for each period of
 treatment indicated in 55.

 99 = The case material does not indicate the name
 of this treatment agency.

QUESTION Enter the person's age at each treatment.
[Indicated in S5].

Give answers in complete years. Round off part years to the nearest complete year by converting periods of six months and over to the next complete year; and by converting periods of less than six months to the previous complete year.
For example : 27 years and 4 months would be entered as 27 years.

CODE -C- = Enter the code you assigned to this treatment in S6.

Child = This treatment occurred during childhood, but the exact act is not known, ie. under 13 years of age.

Adol = This treatment occurred during adolescence, but the exact act is not known, ie. between 13 and 18 years of age.

Adult = This treatment occurred during adulthood, but the exact act is not known, ie. over 18 years of age.

99 = The case material does not indicate this age.

QUESTION Enter the length of time for which this person received each treatment [Indicated in S5].

Give the time in the most appropriate, complete time units, ie. years, months, weeks, days or hours. Convert half units and greater to the next complete unit, and convert less than half units to the previous complete unit.

Do not convert months to years.

For example : Convert 27 hours to 2 days, but do not convert 15 months to 1 year.

Remember to add a 'Y' to indicate years, an 'M' for months, a 'W' for weeks, a 'D' for days and an 'H' for hours.

CODES 66 = Not applicable, because the person is still receiving this treatment.

99 = The case material does not indicate this time.

S9

QUESTION Indicate whether each treatment was on an in-patient or out-patient basis [Indicated in S5].

If a single treatment involved both in and out patient treatment, then indicate both.

CODES -C- = Enter the code you assigned to this treatment in S6.

 I = This treatment was in-patient.

 0 = This treatment was out-patient.

 99 = The case material does not indicate whether this treatment was in or out-patient.

S10

QUESTION Indicate whether each contact with an agency was for forensic observation, and/or the treatment of drug and/or alcohol related problems [Indicated in S6].

If a single contact involved more than one of these purposes, indicate all of these purposes.

CODES 0B = This contact was for forensic observation.

 D = This contact was for the treatment of drug related problems.

 A = This contact was for the treatment of alcohol related problems.

 None = This contact was not for any of these three purposes.

 99 = The case material does not indicate the purpose of this contact.

S11

QUESTION	Indicate whether each treatment agency was an institution or an individual, and whether it was State or privately run.	
CODES	SI	= This agency was a State run institution.
	PI	= This agency was a privately run institution. <u>For example</u> : A private nursing home.
	PP	= This was a private professional.
	99	= The case material does not indicate the type of treatment agency.

S12

QUESTION Enter the ** final diagnoses and/or problems identified during each treatment period [Indicated in S5].

If differential diagnoses are given without final diagnoses, include these diagnoses.

Give answers as stated in the case material.

For example : Chronic schizophrenic disorder, of the simple sub-type, with an acute relapse.

CODES	-C-	= Enter the code you assigned to this treatment in S6.
	99	= The case material does not include diagnoses or problems for this treatment.

QUESTION Indicate which of the following aspects of the person's
** relationship with the interviewer were noted, at the first
full mental state examination after admission for the most
recent observation.

- CODES
- Y = Yes, this aspect was noted.
 - N = No, this aspect was not noted.
 - 98 = The case material states that no decision was
 reached as to whether this aspect was present.
 - 99 = The case material does not indicate whether
 this aspect was noted.

-
- QUESTION Indicate which of the following ** symptoms the person experienced over the period of the alleged offences,
- AND
- Which were noted by the interviewer, at the first full mental state examination after admission for the most recent observation.
- Over the period of the offences means from the month before to the week after each offence.
- If other symptoms were experienced that do not appear on this list, enter these alongside the terms 'present' and/or 'offence' at the bottom of question T4.
- CODES Present = Enter answers pertaining to symptoms noted at the MSE, in this column.
- Y [Present] = Yes, this symptom was noted at the MSE.
- N [Present] = No, this symptom was not noted at the MSE.
- 88 [Present] = The case material states that no decision was reached as to whether this symptom was present at the MSE.
- 99 [Present] = The case material does not indicate whether this symptom was noted at the MSE.
- Offence = Enter answers pertaining to symptoms noted over the period of the alleged offences, in this column.
- Y [Offence] = Yes, this symptom was noted over the period of the alleged offences.
- N [Offence] = No, this symptom was not noted over the period of the alleged offences.
- 88 [Offence] = The case material states that no decision was reached as to whether this symptom was noted over the period of the alleged offences.
- 99 [Offence] = The case material does not indicate whether this symptom was noted over the period of the alleged offences.
- None = No other notable aspects were present at the MSE or over the period of the alleged offences.
-

QUESTION Indicate which of the following ** mood states the person reported over the period of the alleged offences,

AND

Which were reported at the first full mental state examination after admission for the most recent observation.

Over the period of the offences means from the month before to the week after each offence.

- CODES
- Present = Enter the mood state reported at the MSE in this column.
 - Y [Present] = Yes, this mood was reported at the MSE.
 - N [Present] = No, this mood was not reported at the MSE.
 - 88 [Present] = The case material states that no decision was reached as to whether this mood was reported at the MSE.
 - 99 [Present] = The case material does not indicate whether this mood was reported at the MSE.
 - Offence = Enter the mood state reported over the period of the alleged offences in this column.
 - Y [Offence] = Yes, this mood was reported over the period of the alleged offences.
 - N [Offence] = No, this mood was not reported over the period of the alleged offences.
 - 88 [Offence] = The case material states that no decision was reached as to whether this mood was reported over the period of the alleged offences.
 - 99 [Offence] = The case material does not indicate whether this mood was reported over the period of the alleged offences.

QUESTION Indicate which of the following ** affects were observed regarding the person, over the period of the alleged offences,

AND

Which were observed at the first full mental state examination after admission for the most recent observation.

Over the period of the offences means from the month before to the week after each offence.

CODES Present = Enter person's affect observed at the MSE in this column.

Y [Present] = Yes, this affect was observed at the MSE.

N [Present] = No, this affect was not observed at the MSE.

88 [Present] = The case material states that no decision was reached as to whether this affect was observed at the MSE.

99 [Present] = The case material does not indicate whether this affect was observed at the MSE.

Offence = Enter person's affect observed over the period of the alleged offences in this column.

Y [Offence] = Yes, this affect was observed over the period of the alleged offences.

N [Offence] = No, this affect was not observed over the period of the alleged offences.

88 [Offence] = The case material states that no decision was reached as to whether this affect was observed over the period of the alleged offences.

99 [Offence] = The case material does not indicate whether this affect was observed over the period of the alleged offences.

QUESTION

Indicate which of the following ** aspects of the person's thinking, were noted over the period of the alleged offences,

AND

Which were noted by the interviewer at the first full mental state examination after admission for the most recent observation, ie. the MSE.

Over the period of the offences means from the month before to the week after each offence.

If there are ** delusions, enter the types alongside the terms 'present' and/or 'offence' at the bottom of T7.

CODES

Present = Enter the aspects noted at the MSE in this column.

Y [Present] = Yes, this aspect was noted at the MSE.

N [Present] = No, this aspect was not noted at the MSE.

88 [Present] = The case material states that no decision was reached as to whether this aspect was present at the MSE.

99 [Present] = The case material does not indicate whether this aspect was noted at the MSE.

Offence = Enter the aspects noted over the period of the alleged offences in this column.

Y [Offence] = Yes, this aspect was noted over the period of the alleged offences.

N [Offence] = No, this aspect was not noted over the period of the alleged offences.

88 [Offence] = The case material states that no decision was reached as to whether this aspect was noted over the period of the alleged offences.

99 [Offence] = The case material does not indicate whether this aspect was noted over the period of the alleged offences.

None = Delusions were not noted at the MSE or over period of the alleged offences.

8/T9 = Go to question T9 on page 8T.

QUESTION Enter a brief description of each ** delusion.
[Indicated in T7].

Give answers as stated in the case material.

For example : A belief that s/he was Jesus who had to save the world from nuclear destruction by destroying Koeberg nuclear power station.

CODES Present = This delusion was reported at the MSE.

 Offence = This delusion was reported over the time of the alleged offences.

 99 = The case material did not indicate a description of this delusion.

QUESTION Indicate which of the following ** aspects of the person's perception, were noted over the period of the alleged offences,

AND

Which were noted by the interviewer, at the first full mental state examination after admission for the most recent observation, ie. the MSE.

Over the period of the offences means from the month before to the week after each offence.

CODES Present = Enter the aspects noted at the MSE in this column.

Y [Present] = Yes, this aspect was noted at the MSE.

N [Present] = No, this aspect was not noted at the MSE.

88 [Present] = The case material states that no decision was reached as to whether this aspect was present at the MSE.

99 [Present] = The case material does not indicate whether this aspect was noted at the MSE.

Offence = Enter the aspects noted over the period of the alleged offences in this column.

Y [Offence] = Yes, this aspect was noted over the period of the alleged offences.

N [Offence] = No, this aspect was not noted over the period of the alleged offences.

88 [Offence] = The case material states that no decision was reached as to whether this aspect was noted over the period of the alleged offences.

99 [Offence] = The case material does not indicate whether this aspect was noted over the period of the alleged offences.

QUESTION Indicate which of the following ** aspects of the person's cognition, were noted over the period of the alleged offences,

AND

Which were noted by the interviewer, at the first full mental state examination after admission for the most recent observation.

Over the period of the offences means from the month before to the week after each offence.

CODES Present = Enter the aspects noted at the MSE in this column.

Y [Present] = Yes, this aspect was noted at the MSE.

N [Present] = No, this aspect was not noted at the MSE.

88 [Present] = The case material states that no decision was reached as to whether this aspect was present at the MSE.

99 [Present] = The case material does not indicate whether this aspect was noted at the MSE.

Offence = Enter the aspects noted over the period of the alleged offences in this column.

Y [Offence] = Yes, this aspect was noted over the period of the alleged offences.

N [Offence] = No, this aspect was not noted over the period of the alleged offences.

88 [Offence] = The case material states that no decision was reached as to whether this aspect was noted over the period of the alleged offences.

99 [Offence] = The case material does not indicate whether this aspect was noted over the period of the alleged offences.

T12

QUESTION	Enter the code to indicate the clinician's estimate of the person's overall intelligence. [From the first full mental state examination after admission for the most recent observation].	
CODES	1	= Very superior, 130 and greater.
	2	= Superior, 121 and greater, but less than 130.
	3	= Above average, 111 and greater, but less than 121.
	4	= Average or normal, 85 and greater, but less than 111.
	5	= Borderline, 71 and greater, but less than 85.
	6	= Mildly mentally retarded, 50 and greater, but less than 71.
	7	= Moderately mentally retarded, 35 and greater, but less than 50.
	8	= Severely mentally retarded, 20 and greater, but less than 35.
	9	= Profoundly mentally retarded, less than 20.
	99	= The case material does not indicate an IQ estimate.

T13

QUESTION	Enter the language in which the interview was conducted. The interview refers to the first full mental state after the most recent admission for observation. Note if an interpreter was used, and if more than one language was used.	
CODE	99	= The case material does not indicate this language.

T 14

QUESTION Enter all ** psycho-social stressors experienced by the person during the past year.

Give answers as stated in the case material.

For example : The person was fired due to intoxication at work.

CODES

None	=	The person has not experienced any psycho-social stressors, during the past year.
99	=	The case material does not indicate these psycho-social stressors.
10/T16	=	Go to question T16 on page 10T.

T 15

QUESTION Indicate the ** overall severity of the psycho-social stressors experienced by the person during the past year.
[Indicated in T14].

Give answers as stated in the case material. Do not make your own assessment.

CODES

Cat	=	The psycho-social stressors were of catastrophic severity.
Ext	=	The psycho-social stressors were of extreme severity.
Sev	=	The psycho-social stressors were of severe severity.
Mod	=	The psycho-social stressors were of moderate severity.
Mild	=	The psycho-social stressors were of mild severity.
Min	=	The psycho-social stressors were of minimal severity.
99	=	The case material does not indicate the overall severity of the psycho-social stressors.

T16

QUESTION Indicate the person's ** highest level of adaptive functioning during the past year.

Give answers as stated in the case material. Do not make your own assessment.

- CODES
- Sup = This person's has functioned at a superior level.
 - VG = This person's has functioned at a very good level.
 - Good = This person's has functioned at a good level.
 - Fair = This person's has functioned at a fair level.
 - Poor = This person's has functioned at a poor level.
 - VP = This person's has functioned at a very poor level.
 - GI = This person's has functioned at a grossly impaired level.
 - 99 = The case material does not indicate the person's highest level of adaptive functioning during the past year.

T17

QUESTION Enter the types of ** impairments that this person has experienced in his/her adaptive functioning during the past year.

Give answers as stated in the case material.
Include information on use of leisure time, occupational and social functioning.
For example : The person has avoided contact with others, has no friends, has resigned from his/her job and spends all of his/her spare time watching TV.

- CODES
- None = This person has not experienced any impairments in adaptive functioning during the past year.
 - 99 = The case material does not indicate these impairments.