

Purpose

This practice guide was developed to assist qualified mental health professionals conducting community evaluations pursuant to OAR 309-019-0160(2) for the purpose of assisting a court or the Psychiatric Security Review Board (PSRB) in determining whether an individual can be adequately controlled in the community with proper care, medication, supervision, and treatment, and whether the necessary supervision and treatment are available.

This guide provides a template for community evaluations. Each section identifies an area of information or analysis that should be included in the evaluation. The instructions explain what belongs in each section, why that information matters, and how it connects to the final recommendation regarding conditional release from Oregon State Hospital or transfer to a new community provider. Evaluator tips are included throughout the template to provide practical guidance and help evaluators approach the assessment process strategically.

The appendices provide additional reference material and examples. Appendix A describes common documents that may appear in a PSRB exhibit file and how those documents may inform the community evaluation. Appendix B provides risk-related, protective, responsivity, placement, and community-management factors for consideration in developing conditions of release. Appendix C provides a sample community evaluation template. Appendix D provides three fictional model community evaluation examples.

This guidance is provided as technical assistance only. It does not constitute legal advice, create new legal requirements, or replace applicable statutes, administrative rules, Board orders, professional judgment, agency policies, or case-specific consultation. PSRB's provision of this guidance does not make PSRB the evaluator's clinical, administrative, or program supervisor. Community providers and evaluators remain responsible for the content of their evaluations and for compliance with applicable legal, clinical, contractual, and professional obligations.

Community Evaluation Structure & Instruction

Section One: Nature of the Evaluation

Instruction: Review the Board’s order and use this section to clearly identify the legal authority and purpose of the evaluation. State that the evaluation is being completed pursuant to a PSRB order under ORS 161.336(3)(b) (or other applicable authority). Specify whether the evaluation is for:

- Conditional Release from Oregon State Hospital (OSH), or
- Transfer from a specific community program or level of care

Include a brief statement describing the purpose of the evaluation, including the statutory question being assessed (i.e., whether the individual can be adequately controlled in the community with proper care, medication, supervision, and treatment, and whether the necessary supervision and treatment are available in the community).

Section Two: Sources Used

Instruction: Identify all sources relied upon in forming your professional opinions. This section should reflect a thorough, balanced, and individualized review of the available information. It is sufficient to state that you reviewed PSRB Exhibits 1–X. For materials reviewed outside of the exhibit file, identify the title, date, and author/source of the document.

Also identify:

- Dates and duration of interviews conducted with the client
- Dates and nature of any collateral consultations or interviews
- Other Individuals consulted (e.g., treatment providers, case managers, residential staff, family/support persons)

If any significant information was unavailable, incomplete, or not reviewed, note that here.

Evaluator Tip: *Not every exhibit will be equally helpful to the community evaluation. Some documents provide current clinical information, risk formulation, treatment progress, medication history, or supervision data; others may be duplicative, procedural, outdated, or only minimally relevant to the specific conditional-release question. Refer to **Appendix A** for a description of common document types found in a PSRB exhibit file and the type of information each may contain.*

Section Three: Forensic Disclosure

Instruction: Document that a forensic disclosure was provided to the client prior to the evaluation. A forensic disclosure informs the client of the evaluator's role as an independent evaluator (i.e., not a treating provider), the purpose of the evaluation, the limits of confidentiality, and how information obtained during the evaluation may be used and shared with others, including the PSRB. Confirm that the client appeared to understand the disclosure.

***Evaluator Tip:** The forensic disclosure is similar to informed consent, but for a forensic evaluation. It helps establish role clarity at the outset: the evaluator is not acting as the client's treating provider or advocate, and the information may be used by the PSRB in its decision-making.*

Section Four: Legal History

Instruction: Summarize the client's legal history as it relates to risk and conditional release planning. At a minimum, include the instant offense underlying PSRB jurisdiction. Include any prior criminal history that may be relevant to understanding patterns of behavior, supervision needs/successes/failures, victim concerns, or risk management in the community.

This section does not need to be exhaustive. Its purpose is to demonstrate familiarity with the client's legal history and to identify aspects of that history that may be relevant to the proposed placement, treatment planning, or supervision structure.

***Evaluator Tip:** As you review the client's legal history, pay attention to recurring patterns or themes across incidents (e.g., substance use, interpersonal conflict, impulsivity, symptom escalation, or environmental stressors). These observations may assist you later in developing the Cause section and identifying factors relevant to risk management and conditional release planning.*

Section Five: How Risk Has Historically Developed (i.e. Precipitating Factors)

Instruction: This section provides a case formulation describing how dangerous behavior has manifested in the past for this individual. It should explain the sequence of events and conditions that precede periods of destabilization and dangerous or potentially dangerous behavior.

The primary focus is the instant offense (or qualifying act) establishing PSRB jurisdiction, including the circumstances leading up to it. However, evaluators should also incorporate other relevant events that inform pattern development, such as interactions with the legal system, prior revocations, conditional release violations and other significant incidents.

This section provides a concise case formulation describing how dangerous behavior has manifested in the past for this individual. It should explain the sequence of events and conditions that precede periods of destabilization and legally relevant behavior.

The purpose of this section is to clarify:

- What typically occurs before dangerous behavior
- How destabilization has developed over time
- What conditions or triggers are most associated with escalation

This formulation should describe how risk has historically presented, so that the evaluation can directly inform risk mitigation strategies and a conditional release plan that identifies and monitors these patterns in the community.

Evaluator Tip: *Do not limit the formulation to the instant offense. Other events such as prior convictions/arrests, revocations, serious incidents, conditional release or probation violations while under other jurisdictions may reveal the client's broader risk pathway and what your team will need to monitor and treat. Consider what tends to happen shortly before this person becomes unsafe, destabilized, or difficult to manage?*

Section Six: Risk Profile (What Risk Looks Like Now)

Instruction: Identify the current risk profile of the individual by describing the key factors most relevant to ongoing supervision, treatment, and safety in the community. The purpose of this section is to define the present conditions that shape risk and identify what must be monitored or managed in order to support safe community placement and inform the proposed Conditional Release Plan.

Unlike the Cause section, which explains how dangerous behavior has unfolded in the past, this section focuses on what risk looks like now and what factors make risk more or less likely in the community setting.

This section is not intended to function as a standalone risk assessment. Rather, it is a concise risk formulation based on synthesis of the available record, with emphasis on recent clinical documentation, current risk assessments, and specialty evaluations when available. The evaluator's task is to integrate this information into a brief, clinically meaningful summary of current risk, not to restate or list findings from individual reports.

The evaluator should use this section to provide an integrated narrative formulation (typically 1–3 paragraphs) describing the individual’s current risk profile. Appendix B provides a non-exhaustive list of factors to consider. Only include factors that are relevant to understanding current risk and supervision needs for the individual being evaluated.

***Evaluator Tip:** Evaluators should be especially careful not to over-rely on older information when more recent records show that a prior concern has been addressed, stabilized, or no longer presents in the same way. Historical information remains important for understanding risk patterns, but the evaluator should distinguish between historical risk factors, current active concerns, and issues that appear to have been mitigated or resolved through treatment, supervision, medication adherence, behavioral change, or environmental structure.*

Section Seven: What Structure, Treatment, Supervision, and Monitoring are Necessary to Manage Risk

Instruction: This section explains what must be in place in practice to maintain stability, support community functioning, and reduce the likelihood of mental health destabilization and future dangerous behavior while on conditional release. It is the more elaborate form of the proposed Conditional Release Plan (SCR) and represents the evaluator’s recommendations for how the individual can be safely and effectively managed in the community. It should describe the specific structure, treatment, supervision, and supports required to manage how risk has historically developed for this individual (Section Five) and what the individual’s risk looks like now (Section Six).

Components of this section should include the following, tailored to the individual client. Evaluators should integrate how relevant responsivity factors and protective factors are incorporated into the design of the plan to support its effectiveness. Appendix B provides a list of factors for consideration.

Recommended Placement and Rationale

Identify the proposed placement and level of care for conditional release (e.g., SRTF, RTH/F, AFH, Semi-Independent, etc.). Briefly describe the setting and its level of supervision, structure, and clinical oversight.

This section should explain how the features of the proposed placement are sufficient to manage the identified risks, including the relevant level of staffing, supervision, treatment access, and behavioral expectations. Focus only on the elements of the setting that are directly relevant to safe community management.

Include a brief statement regarding the provider's experience and familiarity with PSRB-ordered clients and conditional release supervision requirements, and, if applicable, any training, case-specific briefing, or coordination that has occurred to orient the provider to this individual's needs and risk profile.

Where applicable, explain why this placement represents the least restrictive level of care in which the individual can be safely managed at this time, considering the availability of structure and supervision in less or more restrictive settings.

Treatment Needs

Describe the treatment interventions required to support stabilization and reduce risk in the community. This should include the type and focus of services (e.g., psychiatric care, psychotherapy, substance use treatment, specialty programming) and the general intensity and frequency of treatment engagement.

Treatment recommendations should reflect what is necessary to support symptom stability, behavioral change, and sustained community functioning, based on the individual's identified needs.

Monitoring and Supervision

Describe the mechanisms used to monitor risk and ensure compliance with conditions of release. This may include, as applicable:

- Level of supervision and staffing oversight
- Pass or community access policies
- Observed, random urinalysis or other substance use monitoring
- Medication compliance monitoring
- Behavioral reporting and coordination between providers
- Other structured accountability measures

Monitoring expectations should be clearly linked to maintaining safety, identifying early warning signs of destabilization, and supporting timely intervention when concerns arise.

Practice Tip: Programs are encouraged to maintain a general program description that explains the program's model, level of care, staffing, supervision, treatment services, medication supports, community-access practices, reporting expectations, and experience with PSRB clients. In the individual evaluation, the evaluator does not need to repeat the full program description. Instead, Section Seven should highlight the specific program features that are most relevant to managing this client's identified risks and supporting safe conditional release.

Section Seven (Alternate): Denial of Conditional Release Readiness

Instruction: This section replaces Section Seven when the evaluator concludes that the individual cannot be adequately and safely managed in the community under conditional release at this time. This recommendation must clearly explain why the statutory standard for conditional release is not met.

Before finalizing a denial, consider whether the concern could be resolved through a different level of care, additional conditions, increased monitoring, provider training, specialty treatment, medication supports, transportation planning, pass restrictions, or other practical safeguards. If these options were considered and are not sufficient or available, briefly explain why.

Evaluators are strongly encouraged to consult with the referring provider, PSRB, and OHA prior to issuing a denial to ensure all options and resources have been considered. OHA reviews all denials as part of routine follow-up.

Common Bases for Denial (Non-Exhaustive)

- Unmitigated risk: Current risk factors cannot be sufficiently managed with available community structure, supervision, or treatment.
- Inadequate placement fit: No available or appropriate level of care can reasonably support the required structure or clinical needs.
- Insufficient supervision capacity: Staffing, oversight, or monitoring requirements cannot be reliably implemented in the proposed setting.
- Treatment gaps: Essential treatment services (including specialty or forensic services) are not available or cannot be operationalized.
- Clinical instability: Active symptoms, recent decompensation, or lack of sustained stability indicate the individual is not ready for community management.
- Unresolved risk formulation gaps: Significant uncertainty or inconsistency in understanding drivers of past dangerous behavior or current risk.
- Resource limitations not currently resolvable: Required supports cannot be reasonably secured through available system pathways or funding options.

Denial Rationale (Most Important!)

- Why the individual cannot be safely or adequately managed in the community at this time
- Which specific factors prevent safe community living
- Why these concerns cannot be resolved through adjustments in placement, level of care, or conditions
- What would need to change to support future reconsideration
- What efforts did you make/consultation did you have to reach a denial decision.

Evaluator Tip: *A helpful denial identifies a path forward. When possible, describe what would need to change before conditional release could be reconsidered, such as sustained clinical stability, an updated risk assessment, successful privileges or passes, medication adherence, substance-use treatment engagement, clarification of the risk formulation, a different placement type, or confirmation that essential services can be provided.*

Section Eight: Victim Analysis

Instruction: This section addresses whether victim-related or location-based factors present any concerns for the proposed Summary of Conditional Release Plan. The purpose is to determine whether the proposed placement creates any safety, proximity, or supervision issues related to known victims or impacted individuals.

Evaluators should describe the steps taken to review and assess victim-related and location-based considerations, including review of available records and consultation with relevant parties as appropriate.

Include, as applicable:

- Whether any known victims or impacted individuals reside in or near the proposed placement area
- Any identified proximity, contact, or safety concerns
- Any review of records, collateral information, or consultations used to assess these issues
- Any required conditions or safeguards to mitigate risk (e.g., location restrictions, supervision conditions, coordination with authorities)

Where no concerns are identified, the evaluator should briefly state that available records and consultations were reviewed and did not identify any victim-related or location-based barriers to the proposed placement at this time.

Evaluator Tip: *Victim-related concerns should be identified as early and carefully as possible so they do not first surface at a hearing. Evaluators should use available records, collateral information, provider knowledge, PSRB/OHA consultation, and other appropriate resources to assess whether the proposed plan could create inadvertent contact with a victim or other impacted person. The goal is not only to avoid intentional contact, but also to identify and prevent foreseeable accidental or proximity-based contact.*

Section Nine: Conclusions

Instruction: This section provides a brief summary of the evaluator’s final opinion. It should establish the qualifying mental disorder the team will be treating; provide an opinion regarding dangerousness when that disorder is active; and provide an opinion regarding whether the individual can be adequately and safely managed in the community under conditional release, consistent with the statutory criteria.

The evaluator should clearly state one of the following recommendations and a very brief summary:

- **Acceptance:** The individual can be adequately and safely managed in the community under the proposed plan. Briefly restate the program and level of care being recommended.
- **Contingent Acceptance:** The individual can be adequately and safely managed in the community, but only if specific implementation conditions are met (e.g., placement vacancy, screening approval, access to required services or resources). These must be operational/procedural, not additional assessment or planning.
- **Denial:** The individual cannot be adequately and safely managed in the community at this time. Briefly restate the reasons for the denial.

***Evaluator Tip:** Contingent acceptance should be used only when the plan is substantively complete and the remaining barriers are limited to implementation factors. If additional evaluation, planning, or risk clarification is needed, the appropriate recommendation is denial.*

Appendix A: Common Documents Contained in an Exhibit File

Purpose of this Appendix

Appendix A identifies common documents that may appear in a PSRB exhibit file and explains what each document is and how it may inform a community evaluation. The purpose is to help community evaluators understand the types of information available in the record and how those materials may assist with legal history, historical risk formulation, current clinical status, placement planning, supervision needs, victim-related considerations, and recommended conditions. Not every exhibit will be equally relevant in every case. Community evaluators should use this appendix as a reference for identifying the documents most useful to the specific conditional-release or transfer question before the court or the Board.

Document	What it is and How its Used
Original GEI Judgment	The court order that established the individual's GEI status and committed them to the PSRB. This outlines the charges and basis for the GEI adjudication.
Police Reports	These reports provide a detailed account of the instant offense, often including victim or witness statements. These reports are useful for understanding how the client's symptoms manifested or were observed by others at the time of the instant offense.
Criminal Responsibility Evaluation	This is a comprehensive forensic evaluation conducted prior to the GEI judgment, designed to determine whether the individual met the legal criteria for Guilty Except for Insanity (GEI) under ORS 161.295. These evaluations typically provide a multi-faceted analysis of the individual's mental state <i>at the time</i> of the offense. There will be at least one of these evaluations (defense is required to submit to assert the defense); however, in some cases there will be two (where the DA requests one). They include: • A detailed account of the instant offense from multiple sources (e.g., police reports, witness statements, self-report) • A clinical formulation examining whether a qualifying mental disorder (QMD) was present and materially impaired the person's capacity to appreciate the criminality of their conduct or conform their behavior to the law • Consideration of and distinction between qualifying vs. non-qualifying conditions (e.g., substance use disorders, antisocial traits) • An opinion about malingering or exaggeration of symptoms • A clear rationale for why the insanity defense is appropriate in the case These reports are foundational for understanding the original clinical and legal justification for PSRB jurisdiction.

Jurisdictional Report	This is a required clinical report that provides an expert opinion on whether the individual continues to meet PSRB jurisdictional criteria under ORS 161.351. Specifically, it addresses whether the person still has a qualifying mental disorder (QMD) and, if so, whether that disorder, if active, would cause the person to pose a substantial danger to others. These reports are typically authored by a treating psychologist or psychiatrist, who will also appear as an expert witness at the hearing. The report should provide a clinical and behavioral rationale for the recommendation, and in contested or complex cases, it should offer a thorough and nuanced analysis. These reports provide a preview of the opinion that will be offered at the hearing. However, report quality and depth vary significantly. It is not uncommon to encounter jurisdictional reports that are brief or conclusory, especially in cases where the clinician recommends continued jurisdiction and the record already contains extensive supporting documentation. While brevity may be reasonable when the opinion is to maintain jurisdiction, especially if prior reports support the same conclusion, it is less appropriate when recommending discharge, particularly if the report lacks detail or ignores complexity in the record. Community evaluators should use this report to understand the current clinical formulation and treatment needs, while keeping the community evaluation focused on whether the proposed placement and supports can manage the individual safely in the community.
Risk Assessments	These are in-depth, structured evaluations (often using tools like the HCR-20, VRAG, or similar instruments) that provide an estimate of an individual’s risk of future violence over a longer-term horizon, typically up to 12 months. They assess a combination of: • Historical/static risk factors (e.g., past violence, age at first offense) • Clinical/dynamic factors (e.g., insight, psychiatric symptoms, treatment engagement) • Risk management considerations (e.g., supports, supervision, stressors) These tools are designed to guide clinical judgment rather than provide exact predictions, but they offer detailed analyses of the interplay between the individual’s mental disorder, past behavior, and present functioning. The clinical formulation at the end typically provides a synthesized opinion about risk level (e.g., low/moderate/high), conditions under which risk may increase, and what interventions are needed to manage it. These assessments are crucial for hearings involving jurisdiction, conditional release, or discharge, and Community evaluators should be familiar with the most recent version available in the file.
START	The START is a structured clinical judgment tool designed to assess short-term risk and protective factors across multiple domains—violence, self-harm, victimization, substance use, and more. It evaluates the individual’s functioning and behavior over the prior 3 months to inform risk over the next 3 months, making it particularly valuable for assessing current clinical stability, recent behavioral trends, and treatment engagement.

	STARTs use 20 dynamic items, each scored as both a strength and a vulnerability, enabling clinicians to identify how a person is actively managing risk and what supports are enhancing or undermining their stability. The tool is updated regularly at Oregon State Hospital (at a minimum, prior to Board hearings) and is the standard and required risk tool used across both hospital and community settings. In the community, it functions as a minimum threshold for structured risk monitoring and most often used when making a significant modification request. For Community evaluators, STARTs offer a high-level clinical formulation that synthesizes risk and protective factors and can help determine whether the individual has developed the skills and insight necessary to recognize and mitigate their own risk. These reports can also reveal changes in behavior, response to treatment, or signs of emerging instability.
Community Evaluations	These reports come from potential community placements tasked with assessing the client's appropriateness for conditional release. They typically include a clinical and risk formulation that considers the factors contributing to the instant offense, as well as the individual's current status and needs. The evaluation outlines the staffing resources, supervision strategies, and housing arrangements proposed to manage and mitigate the risk of re-offense or decompensation. These recommendations are used to develop the accompanying Summary of Conditional Release Plan (SCRП) that will result in the Board's Order for Conditional Release
Proposed Summary of Conditional Release Plans	The SCRП is the "verified plan" that translates the recommendations from the community evaluation into a structured set of conditions for the individual's release. It is the primary instrument used by the Board to craft its Order for Conditional Release under ORS 161.336. The SCRП outlines the specific terms and expectations the individual must follow upon transition to the community, including: • Placement details (e.g., housing, program site, region) • Supervision arrangements (e.g., 24-hour staffing, outpatient monitoring, PO contact) • Mental health and substance use treatment plans • Medication management procedures • Special conditions tailored to the individual's risk profile (e.g., restrictions on contact, GPS monitoring, prohibition on driving, employment limitations, etc.) The SCRП is a vital tool for both risk mitigation and accountability. It ensures that the individual's known risk factors are directly addressed through enforceable conditions. Community evaluators should ensure that any SCRП they author is aligned with their community evaluation.
Revocation Reports	These documents are generated in response to a client's revocation from conditional release. They typically include: • A report from the community provider outlining the behaviors, violations, or clinical deterioration that led to the revocation; and

	An affidavit authored and notarized by PSRB staff, which formally summarizes the factual and legal basis for the revocation action. These materials help the Board assess what went wrong during the period of community supervision. They are critical for identifying previously unknown or underestimated risk factors, such as emergent symptoms, poor insight, inadequate structure, or gaps in supervision. In addition to supporting decisions on whether to revoke conditional release, these documents also inform future conditional release planning by highlighting what conditions or supports may need to be strengthened if the individual is considered for release again. Community evaluators should use these reports to look for patterns in revocation history, gaps in treatment engagement, or environmental triggers that might be addressed in a revised plan
Risk Review Panel Minutes	The Risk Review Panel is a multidisciplinary body at Oregon State Hospital that operates separately from the client's treatment team. It is responsible for reviewing patient progress, making decisions about in-hospital privileges, and identifying or addressing barriers to conditional release. The panel serves as the hospital's central decision-making body on risk-related issues, and its written minutes typically reflect whether the hospital supports continued jurisdiction, conditional release, or discharge. These minutes are especially important because they represent the official position of the hospital on whether a client is ready for a less restrictive placement. Community evaluators should flag areas of agreement or disagreement between the treatment team and the panel and address them accordingly.
Victim Impact Statements	Under Oregon law, victims of a crime have the right to submit an oral or written statement describing the impact of the instant offense on their lives. These statements are submitted directly to the Board and may be read into the record during the hearing. Victim impact statements are not considered evidence: they are not made under oath, and there is no opportunity for examination or cross-examination. However, the Board may consider the content of these statements when evaluating the potential impact of a release on the victim's sense of safety and well-being. Most often, these statements can be used by the Community evaluator to help identify any victim considerations that need to be addressed in Section Eight and propose any additional special conditions, such as geographic restrictions, no-contact orders, or limits on employment, that may be necessary to prevent inadvertent or distressing contact with the victim.
Past Board Orders	These are the PSRB's official written decisions from previous hearings involving the individual. They contain the Board's findings of fact, conclusions of law, and the resulting legal determinations, such as whether to continue jurisdiction, grant or deny conditional release, impose special conditions, or revoke release.

	Community evaluators should become very familiar with these orders, as they reflect the Board’s prior reasoning, stated concerns, and decisions about the client’s risk, treatment progress, and readiness for community transition. These orders often summarize the evidence and testimony from past hearings, including how conflicting information was weighed. Although all hearings are audio recorded, no official transcript is retained as part of the case record. The written Board order serves as the official memorialization of the hearing: preserving the outcome, the legal and factual basis, and the rationale behind the Board’s decision. Past orders are also useful for identifying themes or patterns in the case, such as repeated discharge requests, evolving clinical opinions, or conditions that were key to earlier decisions. When a client is requesting a change previously denied, it important for the Community evaluator to understand the basis for the past denial and identify what has or hasn’t changed since that time.
Monthly Reports	These reports are standardized Board-issued progress templates submitted by community providers to document how an individual is functioning while on conditional release. They include information on the individual’s compliance with treatment and supervision conditions, medication adherence, symptom presentation, and any notable behaviors or incidents. Monthly reports serve multiple purposes: • They provide a narrative account over time, allowing the Board to track patterns in behavior, stability, engagement, and risk management. • They function as an ongoing clinical and administrative attestation that the person continues to be safely managed in the community. • They support future requests for modifications, including reduced supervision or changes to special conditions, by establishing a documented history of compliance and progress. While any single monthly report may appear routine or uneventful, they should be viewed cumulatively to identify trends, both positive (e.g., sustained engagement, increased insight) or concerning (e.g., medication nonadherence, boundary violations, interpersonal conflict). Community evaluators are encouraged to scan several months of reports prior to the request for an evaluation to understand how the client has been interacting in their current program.
Serious Incident Reports	These reports document significant violations or critical events involving individuals on conditional release that exceed routine progress notes. Serious incidents may include, but are not limited to, criminal behavior, threats or acts of violence, serious medication noncompliance, absconding, or violations of key Board-imposed conditions.

	Unlike Monthly Reports, which provide a regular summary of ongoing compliance and functioning, Serious Incident Reports should provide a detailed account of the specific incident, including: • What occurred and the context of the event • Immediate and follow-up interventions or corrective actions taken to mitigate risk, which may include adding new conditions to the conditional release order • Assessment of the individual's response to the interventions • Recommendations for adjustments in supervision or treatment to prevent recurrence These reports are critical for a Community evaluator's understanding of escalations in risk and the effectiveness of the community supervision structure. Community evaluators should carefully review Serious Incident Reports to understand the nature and severity of incidents, the effectiveness of applied interventions, how the client responds to interventions in crisis and address implications for future risk management in the evaluation.
Medication Change Letters	These letters document notable changes to an individual's psychotropic medication regimen, particularly those changes deemed clinically significant due to potential impact on symptom stability and risk. The letters include an attestation from the prescribing medical practitioner confirming familiarity with the individual's complete medication history and clinical status. They also outline a safety plan designed to monitor the individual's response to the medication change, anticipating possible side effects, destabilization, or risk escalation. These letters serve multiple critical purposes: • They provide a clear, documented history of medication changes, aiding future practitioners in understanding past pharmacological interventions. • They help the Board and treatment team track and evaluate the impact of medication adjustments on clinical stability and risk factors. • They act as an important risk mitigation tool, ensuring proactive monitoring and rapid response plans are in place following medication changes.
Pass Notifications & Requests	These documents apply to individuals on conditional release and record any approved overnights outside the residence where they are ordered to reside or when crossing a state border. All pass requests are made in accordance with Board orders and the Board's pass policy, ensuring consistent oversight and risk management. Pass documentation offers the Community evaluator insight into how well the individual is managing community integration, complying with conditions, and handling the challenges of less structured environments. Community evaluators should review pass histories carefully in developing recommendations for conditions in the new program. Successful outings may support recommendations for increased privileges, while problems may warrant heightened supervision or restrictions upon transfer.

Appendix B: Risk, Protective, Responsivity, and Community Management Factors for Consideration

Purpose of this Appendix

Appendix B is intended to provide a general survey of factors that may be relevant when developing a community evaluation and conditional-release recommendation. It is not a formal risk assessment tool and should not be used as a substitute for comprehensive risk assessments, structured professional judgment instruments, specialty evaluations, or clinical opinions already completed in the case.

Evaluators should first rely on and synthesize the formal risk assessments and clinical evaluations available in the exhibit file, such as the VRA, START, Risk Review, court-ordered evaluations, specialty assessments, hospital records, and other professional opinions. This appendix is meant to help evaluators identify themes, organize relevant information, and consider whether the proposed conditional-release plan adequately addresses the individual's historical risk pathway and current risk profile.

Not every factor listed below will apply in every case. Evaluators should focus on factors that are supported by the record, currently relevant, and useful in determining what structure, treatment, supervision, monitoring, and supports are necessary for safe community management. The goal is not to create a new risk score, but to help translate existing risk information into a practical, individualized conditional-release plan.

Important Note About Risk and Protective Factors

Some factors may be relevant because they are present, absent, improved, or mitigated. For example, a history of substance use may remain relevant as a historical risk factor, while sustained sobriety, treatment engagement, negative urinalysis results, and relapse-prevention planning may function as protective factors. Evaluators should avoid treating protective factors simply as the absence of risk. Protective factors are most useful when they are active, reliable, and available in the proposed community setting.

Similarly, responsivity factors are not necessarily risk factors by themselves. They are factors that affect how well the individual can understand, engage with, and benefit from treatment, supervision, and conditions of release. A strong conditional-release plan accounts for these factors so that expectations are realistic, supports are tailored, and early intervention is more likely to be successful.

A. Criminogenic and Supervision-Related Factors

These factors may be relevant when they are connected to the person's past dangerous behavior, legal involvement, supervision difficulties, conditional-release violations, or ability to comply with community expectations.

Legal and Supervision History

- Prior criminal history
- Pattern of repeated legal involvement
- Prior probation, parole, or conditional-release violations
- Prior revocations or failed community placements
- Pending charges or unresolved legal matters
- Civil legal matters relevant to stability, supervision, housing, victim contact, or treatment engagement
- Protective orders, restraining orders, or no-contact orders
- History of absconding, unauthorized leave, or failure to report
- History of unsuccessful passes, privileges, or community access
- Pattern of police contact or emergency response involvement

Behavioral Regulation and Rule Compliance

- Impulsivity
- Poor behavioral controls
- Aggression, threats, intimidation, or coercive behavior
- Rule-breaking behavior
- Difficulty accepting limits or redirection
- Disregard for supervision expectations
- Resistance to authority or external structure
- Failure to disclose relevant information to providers or supervisors
- Manipulation, concealment, or splitting among providers
- Escalation when confronted or redirected

Attitudes, Insight, and Accountability

- Minimization of harmful behavior
- Limited accountability for past conduct
- Hostility toward supervision, treatment, victims, or authorities
- Beliefs supporting violence, retaliation, or rule-breaking
- Poor insight into risk-related behavior
- Limited understanding of the relationship between symptoms, behavior, and risk
- Unrealistic expectations about community living or independence
- Difficulty recognizing the need for supervision, treatment, or medication

Peers, Relationships, and Social Network

- Association with individuals engaged in criminal behavior
- Social supports that encourage substance use, violence, instability, or noncompliance
- Lack of prosocial supports
- Unsafe or destabilizing relationships
- Interpersonal conflict with family, peers, roommates, providers, or authority figures
- Dependency on unstable or exploitative relationships
- Domestic violence history or relationship violence concerns
- Boundary issues
- Victim-contact concerns
- Rejection sensitivity or interpersonal triggers

Substance Use and Relapse Risk

- Substance use connected to prior dangerous behavior, destabilization, or violations
- Relapse history
- Poor insight into substance-use risk
- Refusal or inconsistent engagement in substance-use treatment
- Access to substances in the proposed environment
- Positive, missed, diluted, or refused urinalysis testing
- Substance-related peers, locations, or routines
- Co-occurring substance use and psychiatric destabilization
- Need for structured recovery supports or relapse-prevention planning

Daily Structure, Employment, Education, and Activity

- Lack of daily structure
- Poor follow-through with work, school, treatment, or programming
- Financial instability connected to stress, exploitation, or illegal behavior
- Lack of meaningful prosocial activity
- Excessive unstructured time
- Isolation or lack of routine
- Difficulty using community time appropriately
- Need for supported employment, day treatment, volunteering, or structured activities

B. Clinical and Mental Health Factors

These factors may be relevant when they are connected to destabilization, impaired judgment, supervision problems, or dangerous behavior.

Psychiatric Symptoms and Stability

- Psychosis, paranoia, delusions, or hallucinations
- Mania or severe mood instability
- Severe depression
- Suicidality or self-harm risk
- Trauma-related symptoms
- Anxiety, agitation, or emotional dysregulation
- Cognitive disorganization
- Sleep disruption connected to symptom worsening
- Recent increase in symptoms
- Recent hospitalization, seclusion, restraint, or serious incident
- Lack of sustained stability over time
- Pattern of decompensation during transitions or reduced structure

Medication-Related Factors

- Medication nonadherence
- Refusal of medication
- History of decompensation after medication changes or missed doses
- Side effects that affect willingness to continue medication
- Limited insight into need for medication
- Need for observed medication administration

- Need for medication storage, reminders, or staff monitoring
- Recent medication changes requiring close follow-up
- History of stopping medication after discharge, transfer, or increased independence

Treatment Engagement

- Inconsistent participation in treatment
- Refusal of recommended services
- Poor therapeutic alliance
- History of disengagement after discharge, transfer, or reduction in structure
- Need for specialized treatment
- Need for culturally responsive or developmentally appropriate services
- Difficulty applying treatment skills outside structured settings
- Limited willingness to discuss warning signs, relapse, or prior dangerous behavior
- Positive response to specific providers, approaches, or treatment settings

Insight, Judgment, and Self-Management

- Limited understanding of mental disorder
- Limited understanding of risk factors
- Poor appreciation of early warning signs
- Difficulty accepting feedback or redirection
- Poor decision-making under stress
- Unrealistic view of community readiness
- Difficulty asking for help before crisis
- Difficulty following written or verbal instructions
- Poor problem-solving when routines change
- Limited ability to independently manage appointments, medications, transportation, or daily needs

C. Violence and Dangerousness-Related Factors

These factors may be especially important when evaluating whether the person can be adequately managed in the community.

- History of violence or threats
- Use or threatened use of weapons
- Fire-setting behavior
- Stalking, harassment, or fixation
- Sexual behavior concerns, when relevant
- Victim-specific risk
- Targeted threats or ideation
- History of impulsive aggression
- History of planned or predatory aggression
- Aggression during psychotic, manic, intoxicated, or highly dysregulated states
- Escalation when limits are set
- Escalation during interpersonal conflict
- Property destruction connected to risk
- Access to potential victims or vulnerable persons

- Access to weapons or dangerous items
- Preoccupation with prior offense, victim, grievance, or perceived injustice
- History of threats or aggression toward treatment providers, staff, peers, family, or community members

D. Protective Factors

Protective factors should be considered when they are reliable, current, and available in the proposed community setting. Protective factors are most useful when the evaluator explains how they reduce risk or support safe community management.

Clinical and Treatment Protective Factors

- Sustained psychiatric stability
- Medication adherence
- Acceptance of observed medication administration
- Ability to report side effects or request medication support
- Positive treatment engagement
- Strong therapeutic alliance
- Willingness to participate in recommended services
- Demonstrated use of coping skills
- Ability to identify early warning signs
- Ability to seek help before crisis
- Positive response to redirection
- Insight into mental disorder and risk factors
- Understanding of relapse or decompensation patterns

Behavioral and Supervision Protective Factors

- Demonstrated ability to follow rules and conditions
- Successful passes, privileges, or community access
- No recent incidents, violations, or behavioral concerns
- Willingness to accept supervision
- Willingness to be transparent with providers and supervisors
- History of responding appropriately to increased structure
- History of reporting concerns before escalation
- Ability to tolerate limits, delays, or disappointment
- Demonstrated ability to manage conflict safely

Environmental and Social Protective Factors

- Stable housing
- Supportive and informed residential provider
- Prosocial family or community support
- Substance-use recovery supports
- Employment, education, volunteering, day treatment, or other structured activity
- Religious, cultural, or community connection, if meaningful to the client
- Positive peer relationships
- Reliable transportation plan
- Financial or benefits stability

- Access to crisis services or step-up care
- Provider familiarity with the client's risk pattern and early warning signs

Protective Factors Related to the Proposed Plan

- Placement can provide the necessary level of structure
- Staff are trained or oriented to PSRB expectations
- Provider understands the individual's risk pathway
- Medication monitoring can be implemented
- Substance-use monitoring can be implemented
- Community access can be supervised or restricted as needed
- Communication expectations are clear among providers
- The plan identifies what should happen if early warning signs emerge
- The plan includes practical safeguards for victim, location, or pass-related concerns

E. Responsivity Factors

Responsivity factors affect how well the individual can understand, engage with, and benefit from treatment, supervision, and conditions of release. They should be used to tailor the conditional-release plan.

Cognitive, Developmental, and Communication Factors

- Cognitive limitations
- Intellectual or developmental disability
- Traumatic brain injury
- Neurocognitive impairment
- Memory impairment
- Difficulty understanding complex instructions
- Need for repetition, reminders, or written instructions
- Need for visual supports or simplified expectations
- Literacy limitations
- Language access needs
- Hearing, vision, or other communication barriers

Mental Health, Trauma, and Engagement Factors

- Trauma history affecting engagement
- Distrust of providers, systems, or authority figures
- Anxiety or paranoia that interferes with treatment participation
- Difficulty participating in groups
- Difficulty with confrontation or direct feedback
- Shame, avoidance, or withdrawal when discussing risk behavior
- Need for motivational interviewing or engagement-focused approach
- Need for consistent staffing or predictable routines
- Need for culturally responsive services
- Need for gender-responsive, trauma-informed, or developmentally appropriate services

Practical and Functional Factors

- Difficulty with transportation

- Difficulty keeping appointments
- Difficulty managing medications independently
- Difficulty managing money or benefits
- Limited activities of daily living skills
- Difficulty navigating community settings
- Need for support with scheduling, reminders, or follow-through
- Need for structured daily routine
- Need for assistance understanding PSRB conditions
- Need for staff to check comprehension of expectations

Applying Responsivity Factors to the Plan

When responsivity factors are present, the evaluator should explain how the conditional-release plan accounts for them. Examples may include simplified written rules, repeated review of conditions, observed medication administration, appointment reminders, transportation support, culturally responsive treatment, trauma-informed communication, increased staff check-ins, supported decision-making, or coordination with guardians, representatives, family, or other support persons when appropriate.

F. Environmental, Placement, and Community-Access Factors

These factors are especially important because conditional release depends on whether the proposed setting can actually manage the person's risk in practice.

Placement Capacity and Structure

- Level of staffing
- Awake overnight staff availability
- Staff training and experience
- Provider familiarity with PSRB expectations
- Ability to monitor symptoms and behavior
- Ability to administer or observe medication
- Ability to safely store medication
- Ability to restrict or supervise passes
- Ability to monitor community access
- Ability to respond to decompensation
- Ability to report concerns promptly
- Ability to coordinate with treatment providers, PSRB, OHA, and other supervising entities
- Availability of crisis response or step-up care
- Roommate or peer compatibility
- Housing stability
- Behavioral expectations of the setting

Community Access and Location

- Access to substances
- Access to weapons or dangerous items
- Access to victims or impacted persons
- Proximity to known victims or impacted persons
- Proximity to destabilizing locations

- Transportation routes
- Treatment locations
- Employment, school, volunteer, or day-program locations
- Pass structure
- Unsupervised time in the community
- Internet, phone, or social media access, when relevant
- Ability to avoid foreseeable inadvertent victim contact

Provider Coordination and Communication

- Clear reporting expectations
- Clear contact person for concerns
- Communication between residential provider, treatment team, prescriber, case manager, PSRB, OHA, and other involved entities
- Process for reporting medication refusal, missed appointments, substance use, police contact, unauthorized absence, hospitalization, or symptom escalation
- Process for requesting pass changes or treatment changes
- Plan for urgent reassessment if risk increases
- Staff understanding of the client's early warning signs and risk pathway

G. Early Warning Signs and Destabilization Indicators

These are not always risk factors by themselves, but they are important because they help the conditional-release plan identify when intervention is needed.

- Sleep disruption
- Increased paranoia or suspiciousness
- Increased agitation or irritability
- Social withdrawal or isolation
- Refusal of medication
- Missed medication doses
- Missed appointments
- Substance-use cravings or relapse indicators
- Positive, missed, diluted, or refused urinalysis testing
- Increased conflict with staff, peers, family, or providers
- Preoccupation with victims, offense, grievances, or perceived injustice
- Decline in hygiene, routine, or daily functioning
- Increased impulsivity
- Leaving placement without permission
- Avoiding supervision
- Changes in speech, behavior, or affect noticed by staff
- Increased hopelessness, suicidality, or self-harm risk
- New stressors such as grief, rejection, housing conflict, financial problems, or legal problems
- Increased secrecy or withholding information from providers
- Attempts to access restricted locations, people, substances, or items
- Resistance to increased support or supervision when concerns are raised

Appendix C: Sample Community Evaluation Template

Insert Agency Logo Here

Evaluator Name:	
Agency/Program:	
Date of Evaluation:	
Client Name:	
PSRB Case Number:	
Type of Evaluation:	
Referral Question:	

Section One: Nature of the Evaluation

Section Two: Sources Used

Section Three: Forensic Disclosure

Section Four: Legal History

Section Five: How Risk Has Historically Developed (i.e. Precipitating Factors)

Section Six: Risk Profile (What Risk Looks Like Now)

Section Seven: What Structure, Treatment, Supervision, and Monitoring are Necessary to Manage Risk

Section Seven (Alternate): Denial of Conditional Release Readiness

Section Eight: Victim Analysis

Section Nine: Conclusions

Appendix D: Model Community Evaluation Examples

Important Use Note

These examples are fictional and are intended to illustrate how to apply the PSRB's community evaluation instruction template. They are not clinical opinions, not legal advice, and not language that should be copied into an actual evaluation without individualized analysis. Community evaluators should use the examples to understand structure, reasoning, and connection of risk and protective factors in developing a conditional release plan.

How These Examples Are Organized

Each example follows the same general structure as the community evaluation template: nature of the evaluation, sources used, forensic disclosure, legal history, how risk has historically developed, current risk profile, conditional release planning or denial rationale, victim analysis, and conclusion. The examples intentionally use different instant offenses, different risk pathways, different protective factors, and different recommendations.

Example One: Murder instant offense; acceptance at the proposed Secured Residential Treatment Facility (SRTF).

Example Two: Burglary instant offense; acceptance for conditional release, but only at a higher level of care than the referring proposal due to robust substance-use relapse risk.

Example Three: Assault IV instant offense; denial of conditional release readiness due to extensive criminal history, recent incidents, prior revocation, and unresolved supervision and treatment concerns.

The goal is to demonstrate how the evaluator moves from facts and risk formulation to practical community-management recommendations. A useful shorthand is: Section Five explains how risk historically developed; Section Six explains what risk looks like now; Section Seven explains what must be in place to manage that risk in the community.

Example One: Acceptance at the Proposed Level of Care

Training Focus

This example illustrates why the seriousness of the instant offense does not automatically determine the current community recommendation. The evaluation accepts the proposed SRTF because the historical risk pathway is well understood, the current risk factors are mitigated by available structure, and the proposed placement can implement the needed supervision, treatment, and monitoring.



WILLAMETTE
COMMUNITY FORENSIC SERVICES

Evaluator Name:	Jordan Smith, LCSW, Community Forensic Evaluator
Agency/Program:	Willamette Community Forensic Services
Date of Evaluation:	June 18, 2026
Client Name:	Client A (fictional training example)
PSRB Case Number:	PSRB 20180000
Type of Evaluation:	Conditional Release from Oregon State Hospital
Referral Question:	Whether Client A can be adequately controlled in the community with proper care, medication, supervision, and treatment under ORS 161.336.

Section One: Nature of the Evaluation

This community evaluation was completed pursuant to a PSRB order under ORS 161.336(3)(b). The purpose of the evaluation is to determine whether Client A, who is currently committed to Oregon State Hospital under the jurisdiction of the Psychiatric Security Review Board following a GEI adjudication, can be adequately controlled in the community with proper care, medication, supervision, and treatment, and whether the necessary supervision and treatment are available in the community. The proposed conditional release placement is Willow Creek, a Secure Residential Treatment Facility (SRTF).

Section Two: Sources Used

The evaluator reviewed PSRB Exhibits 1-86

Materials reviewed outside the exhibit file included the Willow Creek SRTF screening packet, program description, proposed staffing schedule, medication-administration policy, and transportation plan.

Client A was interviewed by video for approximately 80 minutes on May 22, 2026.

Collateral consultations were conducted with the OSH treating psychiatrist, OSH social worker, unit psychologist, Willow Creek program director, Willow Creek residential supervisor, the proposed outpatient prescriber, and Client A's sister [include dates].

The evaluator also consulted with PSRB staff regarding victim-location information and reviewed available records regarding known victim-related restrictions.

Section Three: Forensic Disclosure

Prior to the interview, the evaluator provided a forensic disclosure. Client A was informed that the evaluator was not acting as his treating provider or advocate, that the purpose of the evaluation was to provide information and opinions to the PSRB regarding conditional release, that the evaluation was not confidential in the same manner as treatment, and that information provided could be included in the written report and discussed at a hearing. Client A stated that he understood the evaluator's role and was able to explain, in his own words, that the evaluator was "checking if the placement has enough supervision for me to be safe."

Section Four: Legal History

Client A was adjudicated GEI for Murder in the Second Degree after the death of a neighbor during a period of untreated psychosis. The records describe that Client A believed the neighbor was part of a group surveilling him and intended to harm him. The offense involved a direct physical attack with a household tool after several weeks of increasing paranoia and social withdrawal. The instant offense is the only known felony conviction in Client A's history. His earlier legal history includes one disorderly conduct arrest several years before the offense, which appears to have occurred during a period of psychiatric instability but did not involve injury to another person.

Client A has not previously been conditionally released from OSH. He has participated in gradual hospital privileges and supervised community outings without incident for approximately 18 months. The legal history is therefore less notable for repeated justice-system involvement and more notable for the severity of violence that occurred when psychosis was active, untreated, and unmonitored.

Section Five: How Risk Has Historically Developed

Client A's historical risk pathway is most clearly associated with the recurrence of paranoid psychotic symptoms in the context of medication nonadherence, sleep disruption, isolation, and perceived threat. The instant offense occurred after Client A stopped taking prescribed antipsychotic medication for several weeks. Family members reported that he was sleeping two to three hours per night, rarely leaving his apartment, covering windows, and increasingly interpreting ordinary neighborhood activity as surveillance. He declined family efforts to reconnect him with outpatient care and became more guarded when asked about medication.

The offense was not described as impulsive in the sense of sudden anger without warning. Rather, the record shows a period of progressive destabilization in which Client A's delusional beliefs became more fixed, his social contact narrowed, and his ability to reality-test deteriorated. The victim became incorporated into Client A's persecutory beliefs. The available record does not indicate that substance use, antisocial peer involvement, or general criminal conduct were primary contributors to the instant offense.

Other events in the record are consistent with the same risk pathway. During an early hospital medication adjustment, Client A became more suspicious, isolated in his room, and accused a peer of watching him. Staff intervened, medication was adjusted, sleep improved, and the episode resolved without violence. The significance of this later event is that staff were able to observe the early warning signs and intervene before escalation. This history suggests that the most important community-management task is early detection of medication refusal, sleep disruption, increased suspiciousness, withdrawal, and perceived threat toward specific people.

Client A's risk has historically increased when he is disconnected from treatment, unmedicated, isolated, and left to interpret symptoms without external reality testing. His risk decreases when medication is observed, sleep is monitored, staff ask directly about suspiciousness, and providers respond quickly to early changes.

Section Six: Risk Profile (What Risk Looks Like Now)

Client A continues to be affected by Schizophrenia, which is the qualifying mental disorder identified in the most recent jurisdictional report. When active and untreated, the disorder is associated with persecutory delusions, impaired judgment, and substantial danger to others. At the time of this evaluation, however, Client A's symptoms appear stable. He has remained medication adherent for more than three years, has had no aggression during that period, and has successfully participated in supervised privileges. Risk review minutes describe improved insight, including his ability to state that stopping medication and not sleeping were "the start of things going wrong."

In review of the Violence Risk Assessment and most recent Start, the current risk profile is best characterized as low in the highly structured hospital setting and manageable in a highly structured community setting that can provide medication observation, symptom monitoring, sleep monitoring, and controlled community access. Risk would increase if Client A were placed in a setting that relied primarily on self-administered medication, independent appointment follow-through, or self-report of early paranoia. He remains somewhat reluctant to disclose suspicious thoughts until staff ask directly, which is an important responsivity factor. His insight is improved but not complete; he understands that medication helps him remain stable, but he underestimates how quickly suspiciousness can increase when sleep deteriorates.

Protective factors include sustained stability, demonstrated medication adherence, absence of recent aggression, positive response to staff redirection, successful hospital privileges, supportive family involvement, willingness to reside at Willow Creek, and acceptance of observed medication administration. The proposed SRTF has experience with PSRB clients and can monitor the specific early warning signs identified above.

Section Seven: What Structure, Treatment, Supervision, and Monitoring Is Necessary to Manage Risk

Recommended Placement and Rationale

Client A is recommended for conditional release to Willow Creek SRTF, the placement proposed by the referring team. The SRTF is appropriate because the client's risk pathway requires a locked or egress-controlled setting, 24-hour staff oversight, observed medication administration, structured community access, and staff capable of responding quickly to early psychiatric destabilization. These features directly address the historical sequence leading to the instant offense: medication nonadherence, sleep disruption, isolation, increasing paranoia, and fixation on a perceived threat.

A less restrictive setting, such as an RTH, adult foster home, semi-independent housing, or independent living, would not provide sufficient medication control or early symptom observation at this stage. More restrictive care at OSH is no longer necessary if the SRTF plan is implemented because Client A has demonstrated sustained stability, successful privileges, and willingness to accept the core safeguards that mitigate his risk. The proposed SRTF therefore represents the least restrictive level of care in which he can currently be adequately managed.

Treatment Needs

Client A should receive psychiatric medication management at least monthly, with immediate prescriber consultation for any medication refusal, side effects, sleep disruption, or increase in suspiciousness. Individual therapy should focus on relapse prevention, insight, early warning signs, coping with suspicious thoughts, communication with staff before symptoms escalate, and maintaining structured routine. Group treatment should be used as clinically appropriate but should not substitute for individualized monitoring of psychosis-related risk.

The treatment plan should include a written early-warning plan using simple language. The plan should identify the client's specific signs of risk increase: missed medication, reduced sleep, social withdrawal, increased suspiciousness, accusations that others are monitoring him, fixation on a particular person,

refusal to discuss symptoms, or irritability when staff ask about medication. Because Client A tends not to volunteer early symptoms, staff should ask direct, routine questions rather than relying only on self-report.

Monitoring and Supervision

Medication should be observed and documented by staff. Missed, refused, or partially taken medication should be reported immediately to the residential supervisor, prescriber, and case monitor. Sleep should be monitored daily during the first 90 days and thereafter as clinically indicated. Any pattern of reduced sleep should trigger increased staff check-ins and prescriber consultation. Community access should begin with staff-supervised outings only and should expand gradually based on sustained stability, compliance, and PSRB approval where required.

The SRTF should maintain regular communication with the outpatient prescriber, therapist, and PSRB case monitor. Staff should document changes in mood, sleep, social withdrawal, suspiciousness, conflict with peers, and any statements suggesting perceived threat. If early warning signs emerge, the plan should require increased observation, treatment-team consultation, possible suspension of passes, medication review, and consideration of hospital-level evaluation if symptoms continue or risk escalates.

Family contact should be supported because it is a protective factor, but visits should be planned through the SRTF and not used as unsupervised community access at the outset. Client A's sister should receive general education, within confidentiality limits and with appropriate authorization, about warning signs and whom to contact if concerns arise.

Section Eight: Victim Analysis

The evaluator reviewed available victim-related information, prior Board orders, and placement-location information. The victim is deceased. Known impacted family members do not reside near Willow Creek SRTF. The proposed placement is in a different community from the location of the instant offense. There is no indication that Client A has attempted to contact the victim's family or has maintained a current fixation on them. However, because the offense involved a neighbor whom Client A incorporated into persecutory beliefs, the plan should include a no-contact condition with known impacted persons and a restriction against travel to the neighborhood where the offense occurred unless specifically approved and supervised.

Transportation routes for medical appointments, family visits, and community outings should be reviewed by the provider to avoid foreseeable proximity-based contact with impacted persons or the offense location. No victim-related barrier to Willow Creek SRTF was identified at this time, provided the recommended safeguards are included.

Section Nine: Conclusions

Client A continues to have Schizophrenia, a qualifying mental disorder. When active and untreated, that disorder has caused Client A to present a substantial danger to others. Based on the records reviewed, interview, collateral consultation, and proposed conditional-release structure, it is the evaluator's opinion that Client A can be adequately controlled in the community with proper care, medication, supervision, and treatment at Willow Creek SRTF.

The recommendation is acceptance at the proposed level of care. This opinion is based on Client A's sustained stability, medication adherence, absence of recent aggression, successful supervised privileges, improved insight, and the SRTF's ability to implement the specific safeguards needed to manage his risk pathway. Please refer to the proposed Summary of Conditional Release Plan for details on the specific recommended conditions.

If there are any questions, please contact me at Jordan.Smith@Willamette.org or 541-888-8888.

SIGNATURE BLOCK

Example Two: Acceptance, But Not at the Proposed Placement

Training Focus

This example illustrates an acceptance: the evaluator agrees that conditional release is clinically supportable, but does not recommend the specific placement proposed by the referring team. The reasoning turns on substance-use relapse risk and whether the proposed level of care can actually implement the required monitoring and structure.



Evaluator Name:	Morgan Lee, LPC, Community Forensic Evaluator
Agency/Program:	Cascade Community Behavioral Health
Date of Evaluation:	June 18, 2026
Client Name:	Client B (fictional training example)
PSRB Case Number:	PSRB 2020300
Type of Evaluation:	Conditional Release from Oregon State Hospital
Referral Question:	Whether Client B can be adequately controlled in the community with proper care, medication, supervision, and treatment under ORS 161.336, and whether the proposed supported-housing placement is sufficient.

Section One: Nature of the Evaluation

This evaluation was completed pursuant to a PSRB order under ORS 161.336(3)(b). The question is whether Client B can be adequately controlled in the community with proper care, medication, supervision, and treatment, and whether those services are available in the proposed community setting. The referring team proposed conditional release to a semi-independent supported-housing apartment with intensive case-management contacts. This evaluation concludes that Client B can be conditionally released, but not to the proposed level of care. A higher level of care, specifically a Residential Treatment Facility or Residential Treatment Home with 24-hour awake supervision and structured substance-use monitoring, is recommended.

Section Two: Sources Used

The evaluator reviewed PSRB Exhibits 1-72

Additional materials included the supported-housing program description, case-management service description, proposed outpatient treatment schedule, and written communication from the proposed landlord and case-management supervisor.

Client B was interviewed for approximately 90 minutes on May 29, 2026.

Collateral consultations occurred with the OSH psychiatrist, OSH substance-use counselor, unit psychologist, social worker, proposed case manager, supported-housing supervisor, and Client B's sister. The evaluator also reviewed records of prior outpatient substance-use treatment and two earlier detoxification admissions (indicate dates).

Section Three: Forensic Disclosure

A forensic disclosure was provided before the interview. Client B was informed that the evaluator was independent from her treatment team, that the evaluator was not providing therapy, that the purpose of the interview was to assess community-management needs for PSRB, and that information could be included in a report and shared with the Board. Client B stated that she understood and agreed to participate.

Section Four: Legal History

Client B was adjudicated GEI for Burglary in the First Degree after entering an occupied residence during a period of manic and psychotic symptoms. Records describe that Client B believed the home contained evidence that a former employer and family member were conspiring against her. The offense occurred after several days of methamphetamine use, little sleep, and escalating suspiciousness. When confronted by the resident, Client B fled but later returned to the area, leading to police contact. No physical injury occurred, but the offense created significant fear for the resident.

Client B's broader legal history includes theft-related offenses, two probation violations, and multiple police contacts associated with intoxication, trespass, and disorderly conduct. Although the instant offense is the basis for PSRB jurisdiction, her legal history shows a repeated pattern of destabilization when substance use, poor sleep, and impulsive decision-making coincide. Prior community supervision was complicated by missed appointments, unstable housing, and association with substance-using peers.

Section Five: How Risk Has Historically Developed

Client B's historical risk pathway is best understood as the interaction between a severe and persistent mental illness, substance use, medication nonadherence, and escalating disorganization in the community. The qualifying mental disorder has been the foundation of Client B's dangerousness. However, the record indicates that substance use has repeatedly exacerbated psychiatric symptoms, disrupted treatment engagement, reduced judgment, and made it more difficult for providers or family members to intervene before behavior escalated.

The instant offense, Burglary in the First Degree, occurred during a period when Client B was psychiatrically unstable and using methamphetamine and cannabis. In the weeks before the offense, Client B reportedly stopped taking prescribed medication, missed outpatient appointments, slept very little, and became increasingly paranoid and disorganized. Records describe that Client B believed people were entering his apartment, stealing from him, and leaving messages intended to threaten him. His thinking became more rigid and suspicious, and he began spending time with substance-using peers who reinforced his belief that others were "setting him up."

The burglary occurred when Client B entered an occupied residence that he believed was connected to the people he thought were stealing from him. Although the offense involved unlawful entry and confrontation with the resident, the available record suggests that the behavior was driven by a psychotic and disorganized belief system that was intensified by substance use, sleep deprivation, and medication nonadherence. Recurring psychotic symptoms impaired reality testing and resulted in the loss of treatment structure, and subsequent substance use increased the speed and severity of deterioration.

Client B's broader history reflects a similar pattern. Prior community instability has typically followed a sequence of missed medication, increased substance use, reduced sleep, withdrawal from treatment providers, association with unsafe peers, increased suspiciousness, and escalating property-related or confrontational behavior. Past incidents include trespassing at businesses after believing staff were withholding personal property, attempting to enter a relative's home after becoming convinced family members were hiding documents from him, and leaving treatment appointments when providers questioned his substance use. These incidents did not always result in new charges, but they show a recurring pattern of psychiatric destabilization combined with substance-related disinhibition and poor judgment.

The most important historical warning signs are medication nonadherence, relapse to stimulant or cannabis use, reduced sleep, missed appointments, increased paranoia about theft or surveillance, association with substance-using peers, and increasing efforts to "investigate," confront, or retrieve property based on delusional beliefs. These factors are important because they indicate that community risk is not adequately managed by sobriety alone. The conditional-release plan must address the underlying qualifying mental disorder while also providing robust substance-use monitoring and relapse-prevention supports because substance use has historically accelerated psychiatric destabilization and increased the likelihood of unlawful entry, confrontation, and supervision failure.

Section Six: Risk Profile (What Risk Looks Like Now)

Client B is currently psychiatrically stable at OSH. She is medication adherent, attends treatment, and has had no aggression or serious behavioral incidents for approximately 14 months. Her current mood is stable, and she denies active psychotic symptoms. She has participated in substance-use groups and can describe the relationship between stimulant use, sleep disruption, paranoia, and the burglary offense. These are meaningful protective factors.

Despite this progress, substance-use relapse remains a robust current risk-management concern. Client B reports confidence that she can avoid prior peers but also minimizes the speed of her previous relapses and describes drug testing as "probably not necessary if I am doing well." She has not yet demonstrated sobriety in an unsupervised community setting. Her relapse risk is especially relevant because stimulant use has historically preceded sleep disruption, mania, paranoia, trespass behavior, and disregard of boundaries.

The proposed semi-independent apartment does not provide sufficient structure for this stage of release. The proposed case-management model includes frequent contact but does not include 24-hour awake staffing, observed medication administration, routine monitoring of sleep, immediate response to cravings or relapse indicators, or reliable observed random urinalysis outside business hours. Client B's protective are strongest in structured settings. Her current risk profile supports conditional release only if the community placement can provide a higher level of supervision and substance-use accountability than the proposed supported-housing plan.

Section Seven: What Structure, Treatment, Supervision, and Monitoring Is Necessary to Manage Risk

Recommended Placement and Rationale

Client B is recommended for conditional release to a Residential Treatment Facility or Residential Treatment Home with 24-hour awake supervision, rather than the proposed semi-independent supported-housing apartment. A higher level of care is necessary because Client B's community risk involves recurrence of symptoms associated with Client B's qualifying mental disorder, with substance use serving as a significant destabilizing factor that has accelerated sleep disruption, mood activation, paranoia, disinhibition, impaired judgment, and intrusive or unlawful behavior.

The recommended RTF/RTH level of care can provide daily structure, observed medication administration, staff monitoring of sleep and behavior changes, immediate response to suspected substance-use relapse, transportation support, and close coordination with psychiatric and substance-use treatment. Importantly, an RTF/RTH can also provide a structured and gradual pass system, allowing community access to increase over time based on demonstrated stability, sobriety, treatment engagement, and responsible use of privileges. This level of care allows staff to intervene earlier if Client B begins missing appointments, associating with substance-using peers, showing increased suspiciousness, or attempting to act on paranoid beliefs.

The proposed semi-independent setting does not appear sufficient at this time because it would allow too much unsupervised access to the community and would require Client B to independently manage too many of the conditions that have historically preceded destabilization, including sobriety, medication adherence, appointment follow-through, sleep routine, peer associations, and community access. Semi-independent supported housing may become appropriate in the future if Client B demonstrates sustained stability in a structured community setting, including continued medication adherence, negative UAs, substance-use treatment engagement, responsible community access through a gradual pass system, and the ability to seek help before symptoms or relapse risk escalate.

Treatment Needs

Treatment should include psychiatric medication management, individual therapy focused on mood stability and early warning signs, integrated co-occurring-disorders treatment, and structured substance-use programming. Substance-use treatment should be treated as central to risk management because substance use has historically exacerbated Client B's qualifying mental disorder, disrupted sleep and treatment engagement, and accelerated paranoia, mood activation, disinhibition, impaired judgment, and unlawful behavior.

The plan should identify relapse triggers, high-risk peers and locations, money-management concerns, transportation boundaries, sleep disruption, cravings, and steps to take if relapse indicators or psychiatric warning signs emerge. Treatment should specifically address how substance use, missed medication, reduced sleep, and increased suspiciousness interact for Client B, rather than treating sobriety and psychiatric stability as separate issues.

Client B should participate in recovery supports at a frequency determined by the treatment team, with the initial plan including multiple weekly contacts. Treatment should also address shame and avoidance, as she has a pattern of disengaging after relapse or symptom increase rather than asking for help. The treatment approach should use motivational interviewing, concrete relapse-prevention planning, and early-warning-sign planning rather than relying on general statements that she intends to remain sober or remain stable.

Monitoring and Supervision

The conditional-release plan should require observed medication administration, random observed urinalysis, breathalyzer testing as clinically indicated, monitoring of sleep and activity patterns, staff review of community-access plans, and immediate reporting of positive, missed, diluted, or refused drug tests. These measures are necessary because relapse indicators may also signal increased risk of psychiatric destabilization, including mood activation, paranoia, disinhibition, impaired judgment, and intrusive or unlawful behavior.

The plan should prohibit contact with known substance-using peers and restrict access to high-risk locations associated with prior relapse or psychiatric destabilization unless specifically approved and supervised. Community access should be structured and gradually expanded through the RTF/RTH pass system. During the initial transition period, Client B should not have unsupervised overnight passes, unstructured access to prior neighborhoods, or independent management of large amounts of cash.

Staff should monitor changes in sleep, increased energy, irritability, pressured speech, suspiciousness, missed appointments, cravings, secrecy, or renewed contact with prior peers. If any of these warning signs emerge, the plan should require increased supervision, treatment-team consultation, suspension of passes or community access as appropriate, immediate substance-use assessment, and prescriber review.

The residential provider should communicate promptly with the PSRB case monitor, outpatient prescriber, substance-use provider, and treatment team regarding any relapse indicators, missed medication, unauthorized leave, police contact, or symptom escalation. These communication loops are essential because Client B has historically deteriorated quickly when substance use, medication disruption, sleep disturbance, and symptoms of the qualifying mental disorder begin to interact, and she has not reliably self-disclosed early concerns

Section Eight: Victim Analysis

The burglary victim resides in the county where Client B's prior substance-using peer group and proposed supported-housing apartment are located. The proposed supported-housing location would not place Client B in the victim's immediate neighborhood, but public transportation routes and common commercial areas could create foreseeable proximity concerns. The recommended RTF/RTH option should be located outside the immediate area of the victim's residence and outside the area where Client B historically obtained substances, if feasible.

The plan should include no contact with the burglary victim, no entry onto the victim's property, and transportation planning to avoid inadvertent contact. Community passes should identify destinations and routes during the initial transition period. No additional victim-related barrier to conditional release was identified if the higher-level placement and transportation safeguards are used.

Section Nine: Conclusions

Client B continues to have Bipolar I Disorder with psychotic features, which is the qualifying mental disorder identified in the Oregon State Hospital's most recent progress notes. When active, especially in combination with stimulant use and sleep deprivation, the disorder has caused her to present a substantial danger to others. Based on the record, interview, and collateral consultation, the evaluator concludes that Client B can be adequately controlled in the community with proper care, medication, supervision, and treatment, but not at the proposed semi-independent supported-housing placement.

The recommendation is acceptance for conditional release only to a higher level of care, specifically an RTF/RTH with 24-hour awake supervision, observed medication administration, structured substance-use monitoring, and restricted community access during transition. The proposed supported-housing plan should be denied as insufficient because it does not provide the supervision and accountability necessary to manage Client B's substance-use relapse risk and associated psychiatric destabilization pathway. The proposed Summary of Conditional Release outlines the recommended conditions consistent with this evaluation.

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Example Three: Denial of Conditional Release Readiness

Training Focus

This example illustrates a full denial. The instant offense is less severe than the other examples, but the broader record shows extensive criminal history, repeated supervision problems, recent incidents, and a prior conditional-release revocation. The recommendation is based on current manageability, not just the title of the instant offense.



Evaluator Name:	Taylor Nguyen, LMFT, Community Forensic Evaluator
Agency/Program:	North Valley Behavioral Health
Date of Evaluation:	June 18, 2026
Client Name:	Client C (fictional training example)
PSRB Case Number:	PSRB 19770500
Type of Evaluation:	Conditional Release from Oregon State Hospital
Referral Question:	Whether Client C can be adequately controlled in the community with proper care, medication, supervision, and treatment under ORS 161.336.

Section One: Nature of the Evaluation

This evaluation was completed pursuant to a PSRB order under ORS 161.336(3)(b). The purpose is to assess whether Client C can be adequately controlled in the community with proper care, medication, supervision, and treatment, and whether necessary supervision and treatment are available in the community. The referring team requested consideration of conditional release to an Adult Foster Home with outpatient mental health and substance-use treatment.

This evaluation concludes that Client C cannot be adequately and safely managed in the community under conditional release at this time. The evaluator considered whether a higher level of care, additional conditions, increased monitoring, provider training, medication supports, pass restrictions, and substance-use treatment could resolve the concerns. Based on the current record, those safeguards are not sufficient because the risk formulation remains active and incompletely mitigated.

Section Two: Sources Used

The evaluator reviewed PSRB Exhibits 1-104.

Client C was interviewed for approximately 65 minutes on June 3, 2026.

Collateral consultations occurred with the OSH psychiatrist, unit psychologist, social worker, prior community case monitor, prior residential provider, proposed Adult Foster Home provider, substance-use counselor, and PSRB staff regarding the prior revocation. Client C's adult sibling was contacted with consent and provided collateral information regarding past community behavior (indicate dates).

Section Three: Forensic Disclosure

A forensic disclosure was provided before the interview. Client C was informed that the evaluator was not acting as a treating provider or advocate, that the purpose of the evaluation was to assist PSRB in determining conditional-release readiness, and that the evaluator's opinions and information from the interview could be included in a report. Client C stated, "You are here to decide if I can leave," and the evaluator clarified that PSRB makes the final decision. Client C appeared to understand the evaluator's role sufficiently to proceed.

Section Four: Legal History

Client C was adjudicated GEI for Assault IV after striking an acquaintance during a period of psychiatric destabilization. Although the instant offense is less severe than the instant offenses in many PSRB cases, it does not fully capture Client C's risk and supervision history. The broader record includes prior arrests or convictions for menacing, harassment, disorderly conduct, criminal trespass, theft-related conduct, DUI, and multiple supervision violations. Several incidents involved threats toward partners, peers, providers, or law enforcement. The record also includes protective-order history and repeated police contact during periods of intoxication, housing instability, or medication nonadherence.

Client C was previously conditionally released to a residential treatment home. That release was revoked after a pattern of missed medication, increased irritability, unauthorized absence, suspected substance use, threats toward a roommate, and failure to return to the placement. The revocation materials indicate that the community provider attempted increased check-ins and treatment engagement, but Client C became increasingly hostile toward staff and denied that any support was needed. The prior revocation is highly relevant because it shows how risk emerged in a community setting and how the available structure was unable to interrupt the pattern before escalation.

Section Five: How Risk Has Historically Developed

Client C's historical risk pathway is multifactorial. The instant assault occurred during a period of irritability, paranoid interpretation of others' behavior, alcohol use, and conflict with an acquaintance. The assault itself was not severe, but it was part of a broader pattern in which Client C becomes threatening or assaultive when psychiatric symptoms, substance use, perceived disrespect, and limit-setting converge.

Across the broader record, risk tends to develop through a recognizable sequence. Client C first becomes dissatisfied with placement rules or treatment expectations, then misses appointments or medication, begins using alcohol or other substances, becomes more suspicious or grievance-focused, and escalates when staff, peers, family, or authorities attempt to set limits. This pattern has occurred in criminal matters, hospital incidents, and the prior conditional-release revocation. Risk is not limited to the instant Assault IV offense.

Client C also has criminogenic and supervision-related risk factors that complicate the formulation. He has a history of rule-breaking, poor response to external authority, limited accountability, impulsive aggression, and association with destabilizing peers. He tends to minimize the role of substance use and describes prior violations as misunderstandings or staff overreaction. These factors do not replace the role of the qualifying mental disorder, but they affect whether the community plan can actually manage risk.

The prior revocation is especially important. During that release, early warning signs included missed medication, missed appointments, increased irritability, peer conflict, suspected alcohol use, and unauthorized leave. The provider's response plan relied heavily on verbal redirection and voluntary cooperation. Client C did not respond reliably to those interventions. The available record does not show that Client C has since developed a different pattern of help-seeking or compliance when under stress.

Section Six: Risk Profile (What Risk Looks Like Now)

Client C continues to be affected by Schizoaffective Disorder, bipolar type, which is identified as the qualifying mental disorder. When active, particularly with substance use and nonadherence, the disorder contributes to paranoia, mood instability, irritability, impaired judgment, and threatening behavior. At the time of this evaluation, Client C has shown only a brief period of improved medication adherence following a recent medication adjustment. He has had two hospital incidents within the past four months: one involving threats toward a peer after a dispute over television use and another involving property damage after staff denied a request for increased privileges.

Client C's current risk profile remains active and insufficiently mitigated. He denies current intent to harm anyone, but he continues to externalize responsibility, minimize the prior revocation, and describe community supervision as unnecessary. He cannot consistently identify early warning signs beyond saying that he should "walk away." He has not demonstrated sustained use of that skill in the hospital, and recent incident reports show escalation when limits are set. His current substance-use insight is limited; he reports that alcohol is "not the real problem" despite repeated records linking alcohol use to police contact, threats, and supervision violations.

Protective factors are present but not yet reliable enough to support conditional release. Client C has a supportive sibling, has attended some groups, and has recently accepted medication. However, the family support is limited by past conflict and cannot provide supervision. Treatment attendance has been inconsistent. Medication adherence has improved only recently and has not yet been tested during privileges or increased autonomy. The proposed AFH provider is supportive but has limited experience with PSRB clients and could not describe a practical response to unauthorized leave, suspected substance use, peer conflict, or medication refusal.

Section Seven: Denial of Conditional Release Readiness

Client C cannot be adequately and safely managed in the community under conditional release at this time. The statutory standard is not met because the available community structure, treatment, supervision, and monitoring cannot sufficiently manage the current risk profile. The denial is based not on the title of the instant offense alone, but on the broader pattern of community failure, current clinical instability, recent hospital incidents, unresolved substance-use risk, limited insight, and lack of a viable placement response plan.

Specific Factors Preventing Safe Community Management

First, Client C has not demonstrated sustained stability. The recent period of medication adherence is encouraging but too brief to establish that the risk pathway has been mitigated. Two recent hospital incidents show that Client C continues to escalate when limits are set, which is one of the same patterns present during prior community failure.

Second, substance-use risk remains insufficiently addressed. Substance use has repeatedly appeared in the record before legal incidents, threats, and supervision violations. Client C minimizes this relationship and has not completed a meaningful relapse-prevention plan. There is no current evidence that he would comply with substance-use monitoring in the community, and the proposed AFH has no written plan for observed random testing, response to refusal, or immediate intervention following suspected use.

Third, Client C has a prior conditional-release revocation with a risk pattern similar to the one currently observed. The prior provider attempted redirection and increased support, but Client C did not reliably cooperate. The current proposed placement offers less forensic experience and has not identified safeguards that would materially improve on the previous failed release.

Fourth, the proposed AFH is not an adequate placement fit. The provider is willing to work with Client C but cannot provide the level of structure needed to monitor medication refusal, peer conflict, unauthorized absence, substance-use relapse, and rapid escalation. The provider does not have awake overnight staffing

and has limited experience with PSRB reporting, revocation thresholds, or immediate response to high-risk behavior.

Consideration of Alternatives

The evaluator considered whether Client C could be conditionally released to a higher level of care, such as an RTH, RTF, or SRTF. At this time, a higher level of care alone does not resolve the concern because Client C's current risk pathway remains active and he has not demonstrated sufficient treatment engagement, medication stability, substance-use insight, or response to redirection. An SRTF may eventually be the appropriate first community step, but the current record does not support release even to that level unless there is additional evidence of sustained stability and a provider-specific plan capable of addressing the identified concerns.

Additional conditions, pass restrictions, increased testing, or provider training were also considered. These safeguards are necessary components of any future plan, but they are not sufficient now because the core clinical and behavioral readiness concerns remain unresolved. Conditions are only effective if the person can be monitored and the provider can intervene before escalation. The record does not yet show that Client C will accept intervention or that a proposed placement can interrupt the pattern that previously resulted in revocation.

What Would Need to Change

Conditional release could be reconsidered after Client C demonstrates sustained clinical stability, consistent medication adherence, absence of threatening or aggressive incidents, meaningful engagement in substance-use treatment, and successful completion of a written relapse-prevention plan. He should demonstrate the ability to accept limits and redirection in the hospital setting and progress through privileges without incident. An updated risk assessment and START should address whether the recent hospital incidents and substance-use concerns have been mitigated.

A future community plan should likely begin at a highly structured level of care and include observed medication administration, random observed urinalysis, clear response steps for missed medication or suspected substance use, immediate reporting expectations, pass restrictions, and a provider-specific plan for peer conflict, unauthorized absence, and escalation when limits are set. The provider should be briefed on Client C's prior revocation and specific early warning signs before any future acceptance recommendation.

Consultation and Problem-Solving Efforts

Before finalizing this denial, the evaluator consulted with the referring OSH team, prior community provider, proposed AFH provider, substance-use counselor, and PSRB staff. These consultations did not identify an available plan that could adequately manage the current risk profile. The proposed AFH provider expressed willingness but could not operationalize the level of structure and response needed. The OSH team acknowledged recent improvement but also acknowledged that the improvement has been brief and has not yet been tested through privileges or increased autonomy.

Section Eight: Victim Analysis

Because conditional release is not recommended, the victim analysis is limited to future planning considerations. The instant Assault IV involved an acquaintance, and records identify additional impacted persons from prior threatening incidents, including a former partner and a prior roommate. Any future release plan should include a careful review of victim and impacted-person locations, no-contact restrictions, and transportation or geographic safeguards to avoid foreseeable contact. The proposed AFH is in the same general region as several prior incidents, which would require additional analysis if release is reconsidered.

Section Nine: Conclusions

Client C continues to have Schizoaffective Disorder, bipolar type, a qualifying mental disorder. When active, especially in combination with substance use, nonadherence, and interpersonal conflict, the disorder contributes to substantial danger to others. Based on the record, interview, collateral consultation, recent incidents, prior revocation history, and limitations of the proposed placement, it is the evaluator's opinion that Client C cannot be adequately controlled in the community with proper care, medication, supervision, and treatment at this time.

The recommendation is denial of conditional release readiness. The reasons include active and insufficiently mitigated risk factors, recent hospital incidents, limited insight, unresolved substance-use risk, prior conditional-release revocation, and lack of an available placement plan capable of managing the known risk pathway. The evaluator recommends continued hospital-level treatment and reconsideration after sustained stability, demonstrated response to limits, substance-use treatment engagement, updated risk assessment, and development of a more robust provider-specific community plan.

If there are any questions, please contact me at Taylor.Nguyen@NorthValley.org or 541-888-8888.

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