February 11, 2015

The Honorable Peter C. Bataillon
Douglas County District Court
1701 Farnam St.
Omaha, NE 68183-001

RE: JENKINS, NIKKO
CASE NO.: CR13-2768, CR13-2769

Your Honor:

Nikko Jenkins is a 28-year-old, African-American man, who was found incompetent for sentencing on four counts of First Degree Murder, four counts of Use of a Deadly Weapon to Commit a Felony, and four counts of being a Felon in Possession of a Firearm, in relation to three separate incidents that occurred in a two week period in August 2013. He was ultimately found incompetent to proceed with the sentencing phase of a death penalty case. In the 07/18/2014 court order, Judge Bataillon outlined that disagreement amongst the expert witnesses regarding whether Mr. Jenkins was mentally ill or malingering mental illness was a primary concern in the finding of incompetence. Judge Bataillon further ordered that the Lincoln Regional Center commence treatment to restore competency.

Additional background may be pertinent as during earlier phases of the trial, the competency to stand trial issue was addressed. He was found competent to stand trial in early 2014. Mr. Jenkins represented himself during the initial trial phase, and he pled no contest to the charges listed above. He was convicted on 04/08/2014, and Mr. Jenkins was re-appointed counsel to represent him during the sentencing phase. In May 2014, Mr. Jenkins' attorneys raised the question of competence again. Additional competency evaluations were completed, and Mr. Jenkins was ultimately found incompetent.

Mr. Jenkins is currently housed at the Lincoln Correctional Center (LCC). Lincoln Regional Center (LRC) personnel commenced competency restoration efforts on 08/15/2014, which were detailed in a letter to the Court dated 09/12/2014. Since 08/15/2014, Mr. Jenkins has been offered 4-5 sessions per week with LRC personnel to assess his competency abilities and diagnostic issues, and to treat or remediate any issues impeding competency to be sentenced. This report details observations from LRC sessions, differential diagnosis, and current competency related abilities.

SOURCES OF INFORMATION

- Available Methodist Richard Young records; dated 02/03/1995 - 02/24/1995
- Available Nebraska Department of Correctional Services (NDCS) records; dated 11/17/2003 -01/10/2015
- Available Douglas County Corrections (DCC) records; dated 02/13/2010 - 11/13/2013

- Competency and mental status at time of offense evaluation; Dr. Y. Scott Moore; dated 07/20/2010
- Letter from Mr. Jenkins to the 'Director of LRC,' stamped as received on 05/31/2012
- Letter from Mr. Jenkins to Rachel Johnson, Religious Coordinator at the Lincoln Regional Center, stamped as received on 06/06/2012
- Omaha Police Department audio records; dated 08/29/2013 and 09/03/2013
- Competency evaluations; Dr. Bruce Gutnik; dated 11/08/2013 and 05/07/2014
- Competency evaluation; Dr. Y. Scott Moore; dated 12/22/2013
- Mental status at time of offense evaluation; Dr. Bruce Gutnik; dated 02/06/2014
- Competency evaluation; Dr. Y. Scott Moore and Dr. Klaus Hartmann; dated 06/19/2014
- Current Lincoln Regional Center (LRC) records; dated 08/15/2014 to present
- Lancaster County Court filings from Mr. Jenkins; dated 04/28/2014 and 08/26/2014
- Letter from Mr. Jenkins to the Douglas County Attorney's Office; dated 10/01/2014
- Douglas County District Court filing from Mr. Jenkins; dated 01/15/2015

Methods of evaluation:

- Sessions with the undersigned evaluators (Dr. Cimpl: 08/19/2014, 08/22/2014, 08/26/2014, 09/01/2014, 09/04/2014, 09/18/2014, 09/26/2014, 09/30/2014, 10/09/2014, 10/13/2014, 10/22/2014, 11/06/2014, 11/18/2014, 11/20/2014, 11/26/2014, 11/28/2014, 12/05/2014, 12/11/2014, 12/19/2014, 12/26/2014, 12/31/2014, 01/09/2015, 01/16/2015, 01/20/2015, 01/22/2015, 01/29/2015, 02/05/2015; Drs. Cimpl and Scalora: 09/04/2014, 09/26/2014, 10/09/2014; Dr. Scalora: 01/08/2015)
- Structured Interview of Reported Symptoms, 2nd Edition (SIRS-2)
- Attempted administration of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2)
- Attempted administration of the Millon Clinical Multiaxial Inventory-III (MCMI-III)
- Communication with Mr. Tom Riley, Defense Attorney

LIMITS OF CONFIDENTIALITY

Mr. Jenkins has been notified of the limits of confidentiality and the purpose of treatment on numerous occasions. Specifically, he has been informed that the Court found him incompetent for sentencing, and that LRC was ordered to provide treatment aimed at restoring competency. He was informed that any information he disclosed could be included in a written report that would be distributed to the Court, his attorney, and the County Attorney. He was informed that he could choose not to divulge information that he wanted to be kept confidential. He indicated that he understood the limitations of confidentiality. His level of cooperation varied during the course of treatment.

MENTAL HEALTH HISTORY

Mr. Jenkins has interacted with mental health professionals at various facilities since the age of 8. Mental health professionals have consistently described his chaotic upbringing with exposure to multiple traumas, history of substance abuse, conduct problems, and antisocial personality characteristics. However, there has been disagreement amongst mental health professionals regarding whether Mr. Jenkins exhibits symptoms of major mood or psychotic disorders. Some mental health professionals viewed his reported symptoms as characteristic of bipolar or psychotic disorders, while other mental health professionals considered Mr. Jenkins' reported symptoms as

malingered for secondary gain. These differing interpretations of Mr. Jenkins' reported symptoms were also evidenced in competency evaluations following the charges currently pending sentencing.

As a result of these different conceptualizations, efforts were undertaken as part of competency restoration to conduct a thorough differential diagnosis to provide clarification for the Court and to guide treatment aimed at restoring competence. Mr. Jenkins discussed childhood, adolescent, and adult experiences during LRC competency restoration efforts, and his recent self-report is compared to available collateral records within this section. Mr. Jenkins' history of reported and observed mental health symptoms is useful in determining the veracity, consistency, and severity of his current difficulties.

Childhood

Mr. Jenkins reported witnessing and experiencing traumatic life events throughout his childhood. He recalled cleaning blood from the floor of his family home at age 4 after conflicts between his parents. Methodist Richard Young records indicate that his mother acknowledged that Mr. Jenkins once separated a marital fight by hitting his father in the head with a rock or brick. During LRC sessions, Mr. Jenkins volunteered that he called police and ran away from home during incidents when his mother was assaultive towards his stepfather. Mr. Jenkins reported being verbally and physically abused by several family members and sexually abused by his cousin. Methodist Richard Young records indicate that the content of his nightmares was associated with some of those traumatic family experiences.

Mr. Jenkins' tumultuous home environment and conduct problems as a child have been consistently documented. According to available records, he was removed from home and placed in emergency foster care at age 7 after bringing a handgun to school. He was expelled from school on numerous occasions for fighting, breaking windows, and going home without permission. Mr. Jenkins reported that he stopped attending school in 7th grade due to legal troubles, but later obtained a GED while incarcerated. Methodist Richard Young records indicate that he was in special education classes, and his IQ was assessed to be in the Low-Average range at age 8. NDCS records indicate that he reported that he began to carry a weapon and became involved in gang activity at age 11. According to NDCS records, Mr. Jenkins obtained five charges related to theft, one charge related to arson, one weapon charge, and two charges related to criminal mischief prior to age 12.

The earliest available documentation of Mr. Jenkins' mental health treatment involved an inpatient psychiatric evaluation and treatment at Methodist Richard Young Hospital at age 8. Those hospital records indicate that Mr. Jenkins' admission was primarily due to aggressive behavior at school and towards family members as well as due to suicidal statements. According to a 02/03/1995 Methodist Initial Clinical Assessment, he discussed having prior thoughts of stabbing himself and acts of self-harm (i.e., intentionally jumped off a tire swing to injure himself, attempted to choke himself), and he expressed intentions to shoot his peers and kill people that caused him difficulty. Records note that while hospitalized, he was verbally aggressive toward his mother and hospital staff. At Richard Young, Dr. Jane Dahlke diagnosed him with Oppositional Defiant Disorder; Attention-Deficit/Hyperactive Disorder (ADHD); and Functional Enuresis, Nocturnal (i.e., 02/27/1995 Discharge Summary).

In a 02/10/1995 Methodist Psychological Report, Mr. Jenkins was noted to have a "value system that varies" due to him being rewarded for misbehavior by family members and peers, while

conversely being punished for similar behaviors by legal and school authorities. During LRC sessions, Mr. Jenkins confirmed that others reinforced his antisocial behaviors. He discussed his father and uncles teaching him fighting and firearm use techniques. He indicated being shown how to make a Molotov cocktail and burning several buildings in his neighborhood. In addition, he reported shooting animals and carrying their remains in a plastic bag to present to family members. Mr. Jenkins described being spoiled by his mother and further commented about his ability to manipulate her.

While his conduct problems are consistently documented in collateral records, Mr. Jenkins' description of other mental health problems as a youth have been inconsistent. During LRC sessions, Mr. Jenkins reported that he first experienced auditory hallucinations at age 5 and heard voices daily since that age. He indicated originally believing the hallucinatory voices were his conscience acting in an "advisory" manner. He expressed that the voices encouraged wrongdoing, threatened to "kill [or] possess me if I didn't do bad things," and were responsible for his childhood misconduct, such as bringing a gun to school and vandalizing property. He reported his mother admitted him to the hospital at age 8 due to her concerns about the voices. Methodist Richard Young Hospital records provide some corroboration to that statement, although do not convey the same severity as his self-report. Those records indicate that upon admission, Mr. Jenkins reported that he heard "voices" telling him to steal. However, later during that hospitalization he clarified that the voices instructing him to steal were from actual older boys, "and he only hears them when the boys are there with him" (i.e., 02/09/1995 Psychological Report). In fact, Mr. Jenkins was described as displaying "no evidence of psychosis or auditory hallucination" in a psychological assessment, and it was documented that he may have misunderstood the question about auditory hallucinations in a previous interview (i.e., 02/10/1995 Psychological Report).

Regarding mood problems, Methodist Richard Young Hospital records indicate that Mr. Jenkins displayed labile moods during assessments and that his mother expressed concerns about his mood. However, over the course of that hospitalization, his mood fluctuations were conceptualized as distractibility and impulsivity, which were exacerbated by a high level of anxiety. Upon discharge from Richard Young, Mr. Jenkins' mood problems were attributed to anxiety, maladaptive coping techniques, and personality characteristics that made him inclined to seek "emotional stimulation" (i.e., 02/21/1995 Discharge Summary).

Methodist Richard Young records also indicate that his mother was concerned about Mr. Jenkins wetting his bed, trouble sleeping, and "carrying on a conversation with someone…saying stuff like leave me alone" (i.e., 02/04/1995 Psychiatric Admission Assessment). While hospitalized at Richard Young, Mr. Jenkins reported seeing black spirits in his room at night. Records indicate that his sleeping difficulties and talking at night were related to his fear and nightmares about violent events he had witnessed. While at Richard Young, he was prescribed Tofranil for enuresis, but no other psychotropic prescriptions were provided. Treatment recommendations included therapy and psychosocial interventions to address trauma, anger management, anxiety, and self-esteem. During LRC sessions, Mr. Jenkins reported that he agreed with Dr. Jane Dahlke's opinion, as provided in testimony during a 2014 hearing, in which she reported that, in hindsight, she believed he suffered from Bipolar Disorder as a child.

Mr. Jenkins' report about his childhood mental health treatment has varied over time, ranging from:

- Denial of any childhood mental health problems (12/04/2003 NDCS Initial Psychological Evaluation; 02/07/2007, 06/08/2007 NDCS Behavioral Observations and Suicide Assessments)
- Attribution of the hospitalization at age 8 to behavioral problems and ADHD (02/27/2006 NDCS Behavioral Observations and Suicide Assessments; 07/30/2009 NDCS Psychiatric Evaluation)
- Reporting that childhood mental health problems were limited to being abused and exposed to traumatic events (i.e., 03/03/2010 Douglas County Corrections Note)
- Assertion that auditory hallucinations precipitated his hospitalization at age 8 (LRC sessions; 03/14/2013 NDCS Psychiatric Consultation).

Adolescence

During LRC sessions, Mr. Jenkins discussed being removed from home often as an adolescent. He reported living with his aunt for a period of time, with whom he described having a strong relationship. He noted that he struggled with her absence after her death, which occurred while he was incarcerated. NDCS records indicate that he was placed in several group homes and detention centers from ages 11 - 17. He received substance abuse treatment at a residential facility at approximately age 13. According to a 12/07/2003 NDCS Classification Study, he received seven charges between the ages of 12 and 17, including charges for arson, assault, theft, unlawful absence, and missing juvenile. He did not successfully complete juvenile probation, was described as a "continuous runaway for months at a time," and spent time at the Youth Rehabilitation and Treatment Center – Kearney. At age 17, Mr. Jenkins was convicted and sentenced as an adult for Robbery and Use of a Deadly Weapon to Commit a Felony after forcing owners from their cars at gunpoint in two separate incidents. He began serving his sentence on 11/17/2003 at a youth correctional facility.

Mr. Jenkins' antisocial behaviors continued while he was detained, and he obtained 13 misconduct reports at the youth correctional facility, two of which were related to violent incidents. He was involved in a riot situation on 07/04/2005 and evaded staff for approximately ten minutes to re-engage in attacks on other inmates. Mr. Jenkins described his involvement as defending a friend, stating "[he] was like a brother to me…I couldn't let the other guy win" (i.e., 08/16/2005 NDCS Mental Health Contact Note). Additionally, according to 01/05/2006 and 02/10/2006 NDCS Mental Health Contact Notes, Mr. Jenkins informed mental health professionals about his intentions to act upon his anger and be "remember[ed]" by correctional personnel once out of prison.

During LRC sessions, Mr. Jenkins indicated having "racing thoughts…all the time," except when using substances or taking Depakote and hearing voices "all the time" since age 5. However, collateral records do not support these assertions. Available records indicate Mr. Jenkins denied experiencing major mental health symptoms during his 11/17/2003 – 02/25/2006 imprisonment at the youth facility, despite regular participation in individual and group therapy sessions aimed at reducing criminal thinking and developing future plans. In the month prior to his transfer from the youth facility to an adult facility, Mr. Jenkins described feeling stressed and having difficulty sleeping on two occasions, but those were isolated reports. There is no indication that he expressed mental health difficulties in his remaining individual sessions at the youth facility, and he denied mental health concerns upon transfer to an adult facility in February 2006.

While at the youth correctional facility, Mr. Jenkins received an IQ score in the "high end of the Mentally Retarded range of intellectual functioning" (i.e., a 69 WAIS-R equivalent score on the Shipley Institute of Living Scale), but there were concerns about the validity of the obtained score due to Mr. Jenkins completing the test extremely fast (i.e., 12/04/2003 NDCS Initial Psychological Evaluation). According to that same psychological evaluation, Mr. Jenkins completed the Minnesota Multiphasic Personality Inventory-Adolescent, but the results were invalid "due to his attempt to present himself in an unrealistically positive light."

Adulthood

As previously noted, Mr. Jenkins moved to an adult correctional facility in February 2006, at which time he denied experiencing mental health symptoms. In August 2006, he was sentenced to additional prison time for an assault that occurred at the youth facility. He was moved to restrictive housing in early January 2007, following a misconduct report for fighting that was later dismissed. Once in restrictive housing, he described having "deep stages of depression," "angry and sad thoughts," a "sickness inside of [him]," and issues with his "sanity" (i.e., 01/08/2007, 01/21/2007, and 01/24/2007 Inmate Interview Requests). He noted "starting to see things" and being unable to sleep. However, according to a 01/22/2007 NDCS Mental Health Contact Note, he described these symptoms as experiences of reliving his mistreatment of other people. He initially asked for medication to aid sleep, but indicated feeling better after talking to the mental health professional. According NDCS records, Mr. Jenkins denied experiencing mental health symptoms upon transfer from this restrictive housing placement to a less restrictive setting a few weeks later.

However, he returned to restrictive housing within weeks (mid-February 2007), after involvement in two gang-related fights, and remained in that setting until 12/04/2008. He did not report significant mental health symptoms from February – October 2007, but after that, he reported difficulty sleeping, becoming "criminally insane," and intending to "attack innocent people" upon release (i.e., 10/19/2007 NDCS Mental Status Review; 11/02/2007 NDCS Mental Health Contact Note). Mr. Jenkins noted being highly upset with his placement in segregation at the time of these complaints and was assessed by Dr. Sell, a psychologist, to have "no overt psychopathology… [he] appears to be a poor candidate for mental health interventions." However, he reported having nightmares and anxiety in December 2007, and a case manager described him as agitated, "almost elated…somewhat manic," and he was referred to mental health professionals. A 12/14/2007 psychiatrist (illegible signature) note indicates that Mr. Jenkins complained of depression and insomnia. However, he refused to participate in a sleep study to clarify his reports of insomnia, stating, "I have no mental illness or reason to be treated for." Around that same time, Mr. Jenkins was noted to have appropriate speech and sleeping patterns by another mental health professional (i.e., 12/14/2007 NDCS Mental Status Review), and his affect and mood were deemed to be "marginal" due to his frustration about his placement within the facility.

During sessions with LRC, Mr. Jenkins stated that the voices of Apophis and other gods increased in intensity in 2007, although records make no mention of those reported symptoms until 2009. During sessions with LRC, he also described engaging in "rituals" to Apophis at the LCC during his first period of incarceration, such as cutting his face and smearing blood on his cell wall. However, a review of NDCS records indicates that Mr. Jenkins was at LCC from 02/27/2006 - 10/26/2006 and 02/07/2007 - 06/08/2007, and no reports of Mr. Jenkins engaging in rituals or self-harming behavior were discovered in available documentation during those time frames.

Throughout 2008, NDCS records indicate that Mr. Jenkins occasionally discussed having "rage," depression, and thoughts of hurting or "kill[ing] everyone." He also made general complaints about being in segregation. In a few incidents, he was described as angry, elevated, or agitated with rapid speech. Generally during 2008, Mr. Jenkins denied experiencing mental health concerns. Records do not indicate that he reported auditory hallucinations or delusions. However, 09/15/08 NDCS Special Needs Contact Note indicated that he thought he might have paranoid schizophrenia, but described "appropriate gang-related paranoia." He was "assessed as a [*sic*] angry, anti-social young man…with a strong sense of entitlement," without a major mental disorder by the Mental Illness Review Team.

In November 2008, NDCS records indicate that he was diagnosed with Antisocial Personality Disorder and took Depakote to address "behavior problems" for approximately 4 days, but it was discontinued due to him not taking the medicine. In December 2008, he reported that he was adjusting well to general population and described using adaptive coping skills. His thoughts were described as well-organized, and there was no indication of psychosis or major mood problems, although he endorsed feeling angry and irritable and requested therapy to address those issues. He attended one individual therapy session, in which he "vent[ed]" about the institution (i.e., 01/15/2009 Mental Health Contact Note). During that session, he described having no concerns and adjusting well to general population; however, he also indicated that his two years in segregation had made him "very mentally ill" and likely to "kill…when [he] g[o]t out" to the community.

NDCS records indicate that Mr. Jenkins was in the general population setting for approximately 1.5 months before returning to restrictive housing on 01/26/2009 after being found with a concealed, sharpened toilet brush. Within days of his return to restrictive housing, Mr. Jenkins requested help for mental health difficulties and frequently requested transfer to a mental health unit. In sessions with mental health professionals, he described ideation about harming others once released from prison, called himself a "homicidal maniac," asserted that NDCS personnel would be held responsible when he started "killing" people (i.e., 02/23/2009 NDCS Mental Health Contact Note), stated that he had schizophrenia and multiple personalities (i.e., 03/27/2009 NDCS Mental Health Contact Note), and complained of sleep problems. A sleep study was performed in March 2009, and no major problems were observed during the first night. Mr. Jenkins ended the sleep study before it was completed and stated that he did not need medicine. In an April 2009 Segregation Mental Status Review it is noted that Mr. Jenkins reported that he "read psychology books and diagnosed myself."

NDCS records indicate that Mr. Jenkins threatened to attack staff members on two occasions in the spring of 2009, for which he received misconduct reports. He reported hearing auditory hallucinations for the first time following these incidents (05/13/2009), specifically the voice of an "Egyptian god" who instructed him to massacre children and kill others in the days after one of those incidents, but mental health staff described his comments as likely related to a personality disorder and associated "attention-seeking." Those same records indicate that he was not psychotic, but seemed to use "the idea of a voice in his head to disown thoughts of harm to others" (i.e., 05/15/2009 NDCS Mental Health Contact Note). Unit staff were noted to "perceive he is angry about [his] current status" and being placed on "limited property." The Mental Illness Review Team supported that assessment, describing Mr. Jenkins as "more manipulative and criminal than mentally ill" (i.e., 08/18/2009 NDCS Special Needs Contact). That committee further indicated

that Mr. Jenkins "was not able to identify specific mental illness indicators when pressed for current symptoms."

Throughout the rest of 2009, Mr. Jenkins continued to report hearing the voice of Apophis, that Apophis was trying to control him, and described experiencing angry feelings. Around that same time period (July 2009), Dr. Natalie Baker psychiatrically evaluated Mr. Jenkins, and while she saw no signs of manic symptoms or disorganized thought processes, she conceptualized his reports of auditory hallucinations and fear of being poisoned by staff as indicative of a psychotic disorder. Dr. Baker also noted that Mr. Jenkins experienced nightmares and flashbacks of traumatic events. She offered the following diagnostic impressions: "Psychosis NOS, Possible SAD – bipolar type," and strong personality disorder traits. She further noted that Mr. Jenkins had Polysubstance Dependence, "probable" PTSD, and Adjustment Disorder. She indicated that a diagnosis of "BAD with [psychotic] features versus CPS" needed to be ruled out. *(Note: The abbreviations were not spelled out in that evaluation, although it is assumed that 'possible SAD – Bipolar Type' refers to possible Schizoaffective Disorder – Bipolar Type, and that 'R/O BAD' refers to Bipolar Affective Disorder. It is unknown to what diagnostic specifier 'CPS' refers.)*

Mr. Jenkins' threatened to commit suicide using a blanket in August 2009, but provided inconsistent statements about his motives (e.g., "there is a warrior in my head telling me what to do" and "I wasn't suicidal…I just wanted off the gallery…The people were bugging me"). A mental health professional (documented name illegible) interpreted his suicidal threat as a "manipulative…gesture," while Dr. Baker viewed the statement as indicative of mental illness (i.e., 08/18/2009 NDCS Mental Health Contact Note; 08/27/2009 NDCS Psychiatric Notes). In September of 2009, a sleep study was attempted again, but he again discontinued it after sleeping well on the first night of the study. By the fall of 2009, Mr. Jenkins was prescribed Risperdal, an antipsychotic, and Depakote, a mood stabilizer. At times he stated that the medication decreased the frequency and intensity of auditory hallucinations. Medication records indicate that he accepted the medicine for approximately 3 months, although there were concerns about compliance, as he reported flushing it down the toilet at times and on occasion directly refused it. In December 2009, he consistently began to refuse medicine.

Records indicate that in December 2009 Mr. Jenkins attempted to escape by threatening and assaulting correctional officers while on furlough to attend his grandmother's funeral. On that date and in the weeks after, Mr. Jenkins stated that he was "possessed" and "control[led]" by an "Egyptian god of death," had several personalities, and needed medication. By the end of 2009, Dr. Baker revised her conceptualization of Mr. Jenkins' difficulties, noting that his reported symptoms were "inconsistent" and "more behavioral/Axis II in nature." Furthermore, she noted that Mr. Jenkins appeared to be attempting to use symptoms and psychotropic medication "for secondary gain, including to avoid legal consequences in court for recent behaviors," and subsequently discontinued the antipsychotic medication. The Depakote initially was continued for "anger/mood," but was discontinued several weeks later, after Mr. Jenkins continued to refuse the medicine. In February 2010, Dr. Baker again noted that Mr. Jenkins "may be attempting to feign" mental illness, and that his symptoms were likely related to behavioral or personality characteristics. When further evaluation of his symptoms was attempted, Mr. Jenkins refused to participate in clinical interviews and psychological assessment.

Subsequently, Mr. Jenkins was transferred to Douglas County Corrections (DCC) to respond to charges related to the attempted escape and assault, where he remained from 02/13/2010 to 07/19/2011. DCC records indicate that he sought mental health treatment the day after his admission, and frequently reported hearing the voice of Apophis. Furthermore, DCC records indicate that he described having "other personalities that he fights to control" (i.e., 02/19/2010 note). Dr. Eugene Oliveto, a DCC psychiatrist, diagnosed Mr. Jenkins with "Schizoaffective versus Bipolar disorder, Grandiose persecutory delusions, Posttraumatic stress disorder – severe with dissociative episodes and possible DID, Antisocial/Impulsive/Dangerously obsessive" (i.e., 03/03/2010 DCC Psychiatric Provider Initial Evaluation Note). Dr. Oliveto generally maintained these same diagnoses with the exception of Dissociative Identity Disorder and PTSD in follow-up assessments and recommended Mr. Jenkins be transferred to the LRC. While at DCC, Mr. Jenkins requested and was prescribed Depakote and Risperdal, which records indicate that he nearly always refused to take.

Additionally, at DCC, Mr. Jenkins regularly saw a therapist, Ms. Denise Gaines, LIMHP. Occasionally, Ms. Gaines described Mr. Jenkins' thought processes as delusional or paranoid, although more frequently she noted Mr. Jenkins' mental status exam was unremarkable, despite his consistent talk about harming people as a result of Apophis' directives. During therapy sessions, Mr. Jenkins typically discussed issues related to grief and anger, while expressing frustration about his inability to receive "proper" mental health treatment. In a 07/20/2010 competency and insanity evaluation, Dr. Y. Scott Moore opined that Mr. Jenkins was competent and unlikely to have a psychotic illness, and the Court found him competent to stand trial on charges related to the attempted escape and assault. He was ultimately convicted and received an additional sentence of incarceration.

Mr. Jenkins returned to NDCS on 07/19/2011 and resided in a restrictive housing unit until he was released to the community on 07/30/2013. During those years, he wrote repeated requests to wardens and mental health professionals requesting transfer to another facility to receive mental health treatment for "severe psychosis." A portion of these documents included sideways writing, which Mr. Jenkins labeled as "psychosis state[s] of schizophrenia" (e.g., 02/04/2013 NDCS Inmate Interview Request). Mr. Jenkins informed several correctional staff of violent ideation (e.g., sacrificing children, cannibalism), asserted that he drank his semen, and had difficulty sleeping. In 2011, Mr. Jenkins' girlfriend contacted NDCS mental health professionals to describe Mr. Jenkins' multiple personalities (i.e., "he has four personalities and is always fighting it;" 07/22/2011 NDCS Mental Health Contact Note), and she sent letters to the Parole Board asserting that NDCS failed to treat Mr. Jenkins' mental health symptoms (i.e., dated 01/03/2011, 09/12/2011, and 09/14/2011).

In February 2012, the Mental Illness Review Team again assessed Mr. Jenkins' needs, and they found that his presentation was more consistent with Narcissistic and Antisocial Personality Disorders, than a psychotic or mood disorder. That committee report further states that Mr. Jenkins experienced traumatic experiences in his life, but his response to those experiences had not developed into a major mental illness, but "fostered the development and solidification" of personality disorders. That same record indicates that Mr. Jenkins referred to his presentation of symptoms as a "skit" in conversations with his mother and girlfriend.

Mr. Jenkins exhibited self-harming behaviors in 2012. Available records indicate that Mr. Jenkins' first incident of self-harm while in NDCS occurred on 04/28/2012. NDCS records indicate that Mr.

Jenkins' was found with contraband and had his property restricted preceding this event. Records indicate that on the day of the incident Mr. Jenkins reported thoughts of hurting himself and others and "stated that he could hit his head with the padlock on the drop chain or wrap the drop chain around his neck and straighten his legs out to choke himself." Shortly after making those statements, Mr. Jenkins wrapped a drop chain around his neck. Mr. Jenkins refused directives from staff and began speaking in what was assumed to be a different language. He indicated he would cease his behavior if the staff member expressed to the camera, "Inmate Jenkins is moving to the SMU B gallery for observation for…severe mental health needs." Mr. Jenkins described planning to "bust his [own] head open on the lock on the drop chain," after the staff member did not agree to his demand and he was ultimately escorted from his cell. According to records, the next day Mr. Jenkins broke a fire suppression sprinkler and flooded a large section of the unit. While moving Mr. Jenkins from the flooded cell, staff reported, "Jenkins…was stating that he would continue to act insane until he got the mental health treatment he was entitled to…Jenkins stated that he would continue to break sprinkler heads and smear feces because this kind of action would get immediate response[s] from mental health. He stated he was a smart man and knew how to get the responses from mental health so he could get the treatment he needed" (i.e., 04/29/2012 NDCS Memo).

In a subsequent session with Dr. Pearson, a psychologist, Mr. Jenkins denied having suicidal or homicidal ideation and reported his self-harm behavior was "the first time he…Apophis…told me to hurt myself." The following day, Mr. Jenkins was observed to have two larges cuts on his face and blood was located above the sink in his cell. He received 29 stitches as a result of his injuries. He reported that he "woke up writing on the wall in his blood," and staff relayed that "Mr. Jenkins reportedly [said] he was acting under the direction of a spiritual being…call[ed] Apophus" (i.e., 05/01/2012 NDCS Medical Note; 05/02/2012 NDCS Mental Health Contact Note). On 05/02/2012, Mr. Jenkins filed a grievance and requested emergency medical treatment in the mental health unit due to his "rapid deterioration" and "severe psychological disability." Throughout 2012, Dr. Baker saw Mr. Jenkins several times. He presented similarly each time, with talk of Apophis, rapid speech, some agitation, and significant narcissistic and antisocial personality issues.

Collateral records include several letters that Mr. Jenkins wrote in 2012 to the Parole Board, West Center Pediatrics (in Omaha), the Religious Coordinator at LRC, and the Director of LRC. Several of the letters were written in a pyramid design and included comments about having "schizophrenia and bipolar illnesses," self-mutilation, need for "emergency hearings" to determine eligibility for "mentally ill and dangerous legal criteria," and talk of Egyptian gods and goddesses. The following statement was written, in Mr. Jenkins' handwriting, on the front of the envelope enclosing the letter to the LRC Religious Coordinator: "1 page letter wrote to Rachel Johnson In pyramid formation mailed May 28th 2012 [*sic*]." That letter also had the corners of the page numbered to denote the order in which the letter should be read. In contrast to the letter to the Religious Coordinator, the letter to the Director of LRC was written in typical letter form, with a clear request for a copy of his records and stated that he suffered from a mental illness, was refusing prescribed medication, and was experiencing "more severe psychotic episodes of psychosis states of enragement." Despite the clear differences in the content and form of the letters to the Director of LRC and the Religious Coordinator, the envelope enclosing the letter to the Director of LRC contained a written statement, indicating that they had actually been written on the same day. That statement appeared to be Mr. Jenkins' handwriting, and noted "1 page letter wrote to director of LRC Requesting medical Records In pursuant to Freedom of Information Act mailed May 28th 2012 [*sic*]."

In January 2013, Mr. Jenkins again had access to some property restricted after he stated that Apophis wanted him to harm himself. Eight days after being placed on this status, Mr. Jenkins cut his face with a piece of floor tile and indicated Apophis told him to do so. He described intentions to tattoo his entire body in "red Aramic [*sic*]" and discussed engaging in rituals. Mr. Jenkins received sutures for his wounds and refused to have them removed once the wounds healed. Documentation regarding his refusal to remove the sutures indicated Mr. Jenkins "states he refuses to come out of [his] room, if [his] plan status [i.e., restrictive status] [is] not decreased...." According to a 01/25/2013 Mental Health Contact Note, he reported he could ignore Apophis if allowed access to ear buds or paper in his room. Correctional staff noted Mr. Jenkins was not sleeping and was exercising naked at night around the time of this self-harming act (i.e., 01/31/2013 NDCS Memo). Shortly thereafter, on 02/01/2013, Mr. Jenkins broke a fire suppression sprinkler in his room. NDCS staff reported, "Inmate Jenkins...had stated...that he...is hearing voices in his head and that if we put him back in to the same cell he'll break another sprinkler head."

Numerous psychiatrists offered differing opinions of Mr. Jenkins' presentation in the months after these self-harming actions. In February 2013, Dr. Baker again revised her diagnosis from suspected malingering to include Psychotic Disorder Not Otherwise Specified, Probable PTSD, and strong Antisocial and Narcissistic Traits. She also noted that there was a possibility of Bipolar Disorder, Delusional Disorder, Schizoaffective Disorder, or Malingering, and requested consultation for diagnostic clarification, treatment recommendations, and the potential need to pursue a civil commitment prior to his discharge to the community. In March 2013, Dr. Martin Wetzel, a consulting psychiatrist, noted that it was "unclear" if Mr. Jenkins had psychotic symptoms, as his purported symptoms were not typical of a psychotic disorder. He diagnosed Mr. Jenkins with Antisocial and Narcissistic Personality traits. However, he also noted that there was objective evidence of problems with "sleep..., mood, and behavior," suggesting the possibility of a major mood disorder. Dr. Wetzel offered diagnostic impressions of Probable Bipolar Disorder Not Otherwise Specified and Probable PTSD. However, he also noted that Mr. Jenkins' demands could be related to "a singular motive or a combination of motives, including malingering and/or a sense of disease." He recommended that future strategies include obtaining objective evidence, including potential psychological testing, to confirm or refute the presence of a major mental illness.

However, in April 2013 a different psychiatrist, Dr. C. B. Jack, indicated Mr. Jenkins appeared to be "performing" and treated the session as "a lecture platform," without any expectation of receiving input from her. During the session, Mr. Jenkins denied all symptoms of mental illness, made no requests for treatment, and no signs of mental illness were observed. Dr. Jack referred to a situation in which Mr. Jenkins told his mother that he was "going to try to get a psychiatric diagnosis so he could get paid," seemingly in reference to obtaining disability benefits. Dr. Jack described Mr. Jenkins as "severely character disordered," and diagnosed "Antisocial Personality with narcissistic features vs. Narcissistic Personality with antisocial features."

Throughout the spring of 2013, Mr. Jenkins made repeated statements about being "mentally ill," requested a social worker to "document if he was acting psychotic," predicted that "it will begin" and alluded to killing others after he was released, and threatened to file lawsuits against NDCS in the future. Similar to previous years' records, Mr. Jenkins was described as intimidating, narcissistic, and "hypomanic" (e.g., pressured speech, animated, grandiose, spoke at length about topics) at times. However, records repeatedly note that he did not present with disorganized thought processes, nor did he respond to internal stimuli. In the month prior to his release, Mr. Jenkins did

not report plans to harm others in the same elaborate ways, nor did he emphasize thoughts about Apophis. Similarly, Mr. Jenkins was noted to present "no current mental health issues or concerns" to a therapist in the month prior to his release date (i.e., 07/02/2013 NDCS Mental Health Contact Note).

Records indicate that in 2013, Mr. Jenkins' girlfriend sent a request to the Johnson County Attorney asking for Mr. Jenkins to be civilly committed. Mr. Jenkins made his mother his power of attorney to allow her to file similar paperwork. In a 03/11/2013 letter to NDCS, the Johnson County Attorney indicated that Mr. Jenkins had sent him related materials as well.

During LRC sessions, Mr. Jenkins denied seeking mental health assistance upon his discharge from prison in 2013, and asserted that his requests for mental health commitment while incarcerated were his "last chance to get help." He stated, "No animal goes back to captivity when they are released." He described interacting with his mother and sisters while in the community, but struggling with the absence of his aunt and father. He indicated feeling consistently distressed due to "fear and adrenaline" during "human interactions" and talking with Apophis and demons. At times, he stated that he was given orders from Apophis. He asserted that he thought police were following him and attempting to arrest him.

In a psychiatric evaluation performed at Douglas County Corrections following his arrest for the murders in September 2013, Mr. Jenkins reported being possessed by demons and being chosen by Apophis to kill others. Dr. Oliveto diagnosed him with Paranoia Schizophrenia, PTSD, Attention Deficit Disorder, and as a "Narcissistic psychopath with obsessive delusional thinking," and prescribed Lithium and Risperdal. After he continually refused those medicines, the Risperdal was discontinued and Seroquel was prescribed instead, although he refused that medicine as well. He was also prescribed Wellbutrin for a short period of time. He took prescribed medicines for approximately one week (i.e., 09/27/2013 until 10/02/2013), but otherwise refused them. Other DCC mental health records described Mr. Jenkins as "somewhat paranoid," but noted that he seemed to "play up" those symptoms. He received individual therapy sessions, but progress notes indicate that limited techniques could be employed due to Mr. Jenkins' focus on legal issues and desire for transfer to less restrictive facilities. DCC records indicate that Mr. Jenkins was on suicide watch status at the jail after ingesting hydrocortisone cream and making a statement about wanting to harm himself. He later stated that he ingested the hydrocortisone cream because he wanted to be moved from the segregation unit. While on the suicide watch status, he threatened to cause "issues for real" if he did not receive a holiday meal (i.e., 11/19/2013 DCC Informational Report). He also noted being "legally insane" and indicated "the state of Nebraska knows I am crazy because I am trying to plead guilty to something that involves capital punishment."

During competency and insanity evaluation for the charges currently pending sentencing (i.e., dated 11/08/2013, 12/22/2013, and 02/06/2014), Mr. Jenkins described experiencing severe mental health symptoms. According to Dr. Bruce Gutnik's 11/08/2013 evaluation, Mr. Jenkins described having variable mood and frequent suicidal ideation. He noted having nightmares about Apophis and demons and feeling afraid of these forces daily. He reported feeling nervous and paranoid and described engaging in rituals. He discussed treating his mental illness, at the request of Apophis, by snorting semen and drinking urine. In a 12/22/2013 evaluation by Dr. Y. Scott Moore, Mr. Jenkins made similar statements, which were characterized by Dr. Moore as "an effort to become thought of as insane." He expressed "delusions and reported hallucinations" in a 02/06/2014

insanity evaluation by Dr. Gutnik. In all these evaluations, Mr. Jenkins was described as "forceful," "loud," and difficult to "redirect." He was noted to "talk right over" evaluators and engage in "rapid" speech. While he presented similarly during these evaluations, Drs. Gutnik and Moore provided different interpretations of Mr. Jenkins' presentation. Dr. Moore indicated Mr. Jenkins was "mostly malingering" to appear "insane" and to blame his alleged crimes on "the fault of someone else." Additionally, Dr. Moore reported Mr. Jenkins' primary diagnosis was Antisocial Personality Disorder and opined that "the likelihood of him having a psychotic illness other than that is very slim." On the other hand, Dr. Gutnik described Mr. Jenkins as "psychotic" with "manic...mood swings". He diagnosed Mr. Jenkins with Schizoaffective Disorder, Bipolar Type and indicated "Other Specified Personality Disorder[s] (Cluster B and Obsessive/Compulsive Features)" needed to be ruled-out (i.e., 11/08/2013 and 02/06/2014 evaluations).

In April 2014, following his conviction in the current case, Mr. Jenkins was transferred from Douglas County Corrections to the Lincoln Correctional Center. Mr. Jenkins interacted with Corrections' mental health professionals while at LCC from April 2014 until beginning treatment with LRC in August 2014. Mr. Jenkins was prescribed Seroquel, an antipsychotic, on 05/03/2014, and he nearly always refused to take that medication. Dr. Gutnik re-assessed competency on 05/17/2014 and maintained his opinion that Mr. Jenkins had a psychotic illness and was not competent to proceed. Drs. Moore and Klaus Hartmann also evaluated competence for sentencing in June 2014. Mr. Jenkins' "psychotic presentation" was described as malingered by Drs. Moore and Hartmann. They further noted that Mr. Jenkins "claim[ed] delusions, mostly of grandeur, which do not comport with the sort of delusions characteristic of schizophrenia."

Drs. Moore and Hartmann's June 2014 evaluation indicates that Mr. Jenkins engaged in self-harming behavior by cutting his mouth with a staple and required medical attention on two occasions in May 2014. During their competency evaluation, Mr. Jenkins reported being psychotic at the time of the self-harming incidents. According to 15-minute checks performed by NDCS staff, after engaging in self-harm behavior, Mr. Jenkins was placed in "5-point restraints," and he was observed to be lying in bed, engaging in range of motion exercises, or talking with NDCS professionals. There was no indication that Mr. Jenkins engaged in any unusual behaviors or made bizarre statements following those incidents. When asked about the reasons for his self-harm during LRC competency restoration efforts, Mr. Jenkins offered a variety of reasons for those behaviors, including being overly "enraged," enjoying the pain from cutting his face, and participating in "rituals" to "Apophis." Mr. Jenkins further noted that he harmed himself in May 2014 after learning that his mother had received a federal prison sentence.

In addition to the incidents of self-harm, Mr. Jenkins exhibited other disruptive behaviors on 05/31/2014 and 07/03/2014. The 05/31/2014 incident included Mr. Jenkins using "cups" to break a sprinkler head and resulted in Mr. Jenkins being placed in "5-point" restraints due to self-harm concerns. No other concerns or reported symptoms were noted in the frequent checks following this incident. The 07/03/2014 incident involved Mr. Jenkins "refus[ing] to lockdown in his cell when going out to yard," "ma[king] a weapon," "barricade[ing] himself," and "br[eaking] sprinkler heads in the runway area." Mr. Jenkins made "statements of self-harm" on 07/03/2014 after the above incident and was put into "5-point" restraints. Staff observations indicate that Mr. Jenkins was lying in bed, praying, and eating following that incident. Records make no other notations of bizarre behavior, unusual statements, or other reported symptoms following that incident.

SUBSTANCE USE HISTORY

According to records, Mr. Jenkins was placed at Cooper Village for substance abuse treatment in 1999 (approximately age 13). He was diagnosed with Alcohol Abuse and Cannabis Abuse during a substance abuse evaluation in 2001. As an adult, he was diagnosed with Polysubstance Dependence due to his past reported abuse of marijuana, "wet" (marijuana soaked in embalming fluid), phencyclidine (PCP), and alcohol. Mr. Jenkins has provided inconsistent descriptions of the age he first began using substances. For instance, Mr. Jenkins has, at times, indicated beginning to use tobacco, cannabis, and alcohol at age 7; however, he denied using alcohol and drugs while at Richard Young Hospital at age 8. In other records, Mr. Jenkins provided the following ages for the onset of substance use: age 8 (i.e., 11/08/2013 competency evaluation), age 12 (i.e., 12/04/2003 NDCS Initial Psychological Evaluation), and age 15 (i.e., 11/21/2003 NDCS Initial Treatment Interview). He has been similarly inconsistent in his description of the types of substances he has used. For example, he sometimes described abusing PCP and animal tranquilizers, but denied use of these drugs at other times. Furthermore, Mr. Jenkins has been inconsistent in his description of the frequency of substance use, at times stating that while living in the community he used illicit substances four times per week, every day, or four times per day. Mr. Jenkins reported that he dealt drugs as an adolescent, and collateral records indicate that he may have been dealing drugs during his brief time in the community in 2013.

During LRC competency restoration efforts, Mr. Jenkins reported using substances in the past to alleviate persistent "racing thoughts" and to numb his emotions. He was found to have used substances while incarcerated in 2005. At that time, he described abusing substances due to pessimism about his ability to obtain parole (i.e., "because I wasn't going to say no…I'm not going to parole") and valuing relationships with criminal peers (i.e., 10/20/2005 NDCS Mental Health Note).

LRC COMPETENCY RESTORATION EFFORTS

Since competency restoration efforts commenced on 08/15/2014, LRC personnel have offered treatment and assessment sessions to Mr. Jenkins 4-5 days per week, with an exception during a week in the fall of 2014 when he was at Douglas County Corrections for a court hearing and 3 sessions were held. Specifically, a treating psychiatrist has offered sessions to assess mental health problems and need for medication. A treating psychologist has offered sessions to focus on development of adaptive coping strategies to better manage behavioral issues or distress. A social worker and doctoral level psychology graduate student have offered sessions to remediate any knowledge deficits related to legal proceedings. Additionally, the undersigned evaluators have offered sessions to further assess competency-related abilities. In addition, LRC personnel have received frequent updates from LCC nursing staff regarding Mr. Jenkins' safety and mental well-being. Mr. Jenkins' attorney, Tom Riley, has been consulted on several occasions to review difficulties in the attorney-client relationship. Repeated efforts were made to arrange for Mr. Jenkins' legal counsel to participate in sessions to observe the quality of interactions between the defendant and counsel, but the undersigned were unsuccessful in that endeavor.

Mr. Jenkins has resided at the Lincoln Correctional Center (LCC) and attended sessions within his housing unit (i.e., the C2 unit). For the initial Psychiatric Assessment on 08/15/2014, he was met with in a small caseworker office accompanied by a LCC correctional officer. Since 08/22/2014, Mr. Jenkins has been met with in the LCC C2 unit group therapy room without LCC correctional officers being present inside the room. Since that date, officers have remained outside the closed

door of the group therapy room during sessions, although Mr. Jenkins has been in restraints during meetings with LRC personnel. On occasion, the door to the group therapy room remained open at Mr. Jenkins' request to assist in maintaining a comfortable temperature in the room.

Mr. Jenkins has been asked to participate in clinical interviews and psychological testing to clarify diagnosis and associated treatment needs. He has been offered psychiatric and psychological treatment to address issues that seemed to impact his competency-related abilities. He has been prescribed psychotropic medications to aid in coping with stress related to his legal circumstances, but he has consistently refused such medication. He has been offered therapy incorporating cognitive-behavioral techniques, including the Transdiagnostic Unified Protocol and Dialectical Behavioral Therapy (DBT) skills, to address emotion regulation problems and to improve his ability to manage stressors. In addition, some sessions have focused on assessing his understanding of legal proceedings and improving his ability to function effectively within these proceedings.

COURSE OF TREATMENT/BEHAVIORAL OBSERVATIONS

During the course of LRC treatment, Mr. Jenkins repeatedly was asked to discuss issues for which he believed he needed treatment. He consistently had difficulty identifying specific treatment needs, aside from simply needing to be placed in a different environment (e.g., different prison, psychiatric hospital, Douglas County Corrections, different unit at LCC). When asked how a hospital environment would assist him, he offered contradictory responses. At times he stated that he felt his current setting was a "dehumanizing environment" with "restraints and seclusion," which was resulting in "rapid deterioration." However, he almost always immediately countered with statements about how he was "elevating and accelerating" instead of deteriorating. When inconsistencies in his self-report were pointed out, Mr. Jenkins stated that being inconsistent was reflective of a mental illness. Mr. Jenkins was never able to provide specific examples of how he was "deteriorating," instead he used labels such as "psychologically and emotionally" without being able to explain what those terms meant for him. At times, Mr. Jenkins talked of needing "intense psychotherapy," but when informed that could be offered by the LRC professionals currently working with him, he generally changed his response to "group therapy" or "human interaction therapy" but still had difficulty identifying what problems he wanted those techniques to address. In addition, he frequently noted having non-priority activities (e.g., writing letters, engaging in hygiene activities, exercising) to complete during regularly scheduled LRC sessions, thereby refusing the opportunity to partake in the interventions requested.

Mr. Jenkins reported that he has heard auditory hallucinations at all times since age 5, but they increased in intensity in 2007. He reported only hearing "big booming" male voices as a child and being unsure of the identity of these voices until 2007, when gods and demons "revealed" themselves to him. He described hearing "yelling and screaming" from innumerable "paranormal" sources since 2007, such as Apophis, demons, demonesses, gods, and goddesses. Mr. Jenkins sporadically stated that LCC staff were poisoning his food. However, LCC staff reports indicate that his behavior was not consistent with those assertions, as he never appeared distracted as if responding to internal stimuli during conversations, and consistently ate his meals. His assertions about being poisoned stopped spontaneously, without outside intervention. Additionally, he described having "destructive…up and down" mood swings, "racing thoughts," and "detaching" from reality (in reference to communications with gods/goddesses) to cope with negative emotions. At times Mr. Jenkins reported receiving commands from Apophis to harm himself or others, while at other times, he reported being empowered and comforted by Apophis. Sometimes he referred to

Apophis as an outside force, while at other times he made reference to being possessed by Apophis. On rare occasions he asserted that hearing the voices of "spirits" was distressing, although generally he discussed these purported experiences as enjoyable. He often discussed how he channeled his negative emotions into productive and helpful activities, such as reading, writing, and exercising. He reported being able to sing and recite movie quotes to laugh and improve his mood, if negative emotions became distressing. He described no current difficulties with appetite or sleep, which was confirmed by LCC staff reports.

Mr. Jenkins exhibited some bizarre verbalizations and behaviors during LRC sessions. For instance, he frequently gasped loudly upon entering sessions with LRC professionals. He responded to questions about this behavior by indicating that the action allows him to have a "fast breath in [his] mouth" and an opportunity to smell the pheromones of the treatment providers. Mr. Jenkins occasionally uttered statements in what sounded to be a foreign language when asked about his mental health difficulties. However, when asked immediately after these verbalizations, he either encouraged LRC personnel to research them to expand their knowledge or translated the statements to demonstrate that they were related to the topic at hand. In one instance, Mr. Jenkins uttered Sanskrit words about energy and sin to a psychiatrist and indicated the psychiatrist was aware of the meaning of these words due to his ethnicity.

Mr. Jenkins reported ingesting or snorting his semen or urine, which he noted allows him to increase his testosterone and various neurotransmitters, which in turn enhance his physical strength. He talked at length, in a rambling fashion, about these behaviors and other biological and neurochemical processes, in an effort to support to his assertion that he is a superior male species, but he often mispronounced words and misused concepts. Along those same lines, he frequently spoke of his intent to form a "pride of lionesses (women)," and establish a Chthonian church (related to worship of the underworld) in the future. Alternatively, he also spoke of moving to Cuba or Russia in the future, as he asserted those governments would want to use his "killing talents." While at other times, Mr. Jenkins spoke of using his "brilliance" to become a scientist or doctor and cure various diseases.

Mr. Jenkins's treating psychiatrist, Dr. Rajeev Chaturvedi, prescribed him medication, namely Zoloft and Inderal, to aid in coping with situational stress, anxiety, and agitation. However, Mr. Jenkins has consistently refused those medications. At times, he requested specific psychotropic medicine to be prescribed (e.g., an "antipsychotic," a mood stabilizer, Wellbutrin), but he also adamantly stated that he would never actually take such "artificial substances." In late December 2014, Mr. Jenkins stated, "They'll say you (LRC personnel) didn't prescribe antipsychotics…It'll be in your interest to give me a psychotic diagnosis and antipsychotic medication." On numerous occasions, Mr. Jenkins specifically requested that he be diagnosed with Schizoaffective Disorder, and has sought to intimidate LRC professionals into doing so by making statements that they are "incompetent" and "unprofessional" as compared to previous psychiatrists who have offered such a diagnosis. He has been challenged that those types of statements suggest that he is more interested in the prescription and diagnosis being documented, as opposed to actually receiving treatment for mental health problems. However, when challenged, he has generally changed the topic or grinned and remained silent. In fact, Mr. Jenkins noted in other sessions that asking for certain medications from NDCS psychiatrists in the past resulted in him obtaining diagnoses that he perceives as favorable for his legal strategies. He presented as frustrated with the diagnostic impressions and

the lack of a specific diagnostic label presented by LRC professionals in an October 2014 court testimony and a September 2014 report submitted to the Court.

At times, Mr. Jenkins reported that he did not need mental health treatment at all, but instead needed a "right frontal lobotomy" or an "exorcism" from a Catholic priest. Furthermore, he asserted, "There is no cure for the mental illness I have" and referred to his mental illness as being "brilliant in an evil and sinister way," and compared himself to Hannibal Lector. He frequently characterized his mental illness as being "evil" and marked by "forward panicking," which he referenced as being the mind frame of serial killers. At times, Mr. Jenkins denied the need for mental health treatment for the purpose of competency restoration, stating, "I am competent," "I am not mentally ill," and pointed to how "productive" he was in relation to pursuit of legal goals (e.g., court filings, letters, and lawsuits) as evidence supporting those assertions.

During LRC sessions, Mr. Jenkins described potential methods of harming himself and others and threatened to engage in these behaviors unless his demands (e.g., move to a different cell/unit, transfer to LRC, access to evidence) were met. He described intentions to engage in "very bizarre" behavior to secure a transfer to a different cell, including threatening others, breaking items in his cell to cut himself, and paying an inmate to stab him. Despite these statements, when asked direct questions about his thoughts or plans to harm himself or others, he typically described having no imminent thoughts of such actions. Nonetheless, the risk corresponding with these vague threats and his history of self-harm resulted in his placement on sharps restriction early during the course of treatment. He continuously asserted this restriction was unwarranted and a violation of his religious rights as a "Zen Buddhist." He challenged the sharps restriction throughout the course of treatment, asserting that his ability to "eas[ily]…obtain" razors through illegitimate means made the restriction unwarranted, as did his months of "safe" behavior. While simultaneously pointing to his ability to control his behavior and exhibit "safe" behavior for months, Mr. Jenkins made ongoing veiled verbal threats that LRC professionals and others would be held liable for harm that he inflicted on himself. For example, at times he talked about engaging in ritualistic self-harming for Apophis, compared his reported emotional distress to previous situations that resulted in self-harm, and talked about the power of being in a place where previous "rituals" (e.g., cutting his face) had taken place. In recent weeks, he informed a LCC nurse that he superficially scratched his face, but later denied making those statements. However, a few days later, he made veiled comments about having a "dream" about an attorney receiving a "bloody rag" in the mail. When asked if he had mailed such an item to an attorney, he repeatedly stated that it was "just a dream;" however, it was later learned that Mr. Jenkins had sent such an item to Mr. Riley.

Regarding harming others, Mr. Jenkins frequently made veiled threats about his ability to harm others. At times, Mr. Jenkins used these statements as evidence that he was in control of his behavior and should be moved to a less restrictive environment. For example, he cited that if he so desired, he could have harmed two female LCC staff with the chain on his restraints during escort to and from his cell, but since he had consistently behaved safely since August 2014, that should provide evidence that he was in control of his behavior. Similarly, he reported that his restraints are "still a weapon" and could be used to injure LRC professionals if he wanted to do so.

Throughout the course of treatment, Mr. Jenkins frequently made comments aimed at intimidating the LRC professionals working with him. Often, he threatened to pursue legal action against LRC personnel if an opinion is offered that he is competent to proceed, and for what he describes as

inappropriate treatment to restore his competence. He stated, "You can say I'm competent, but be careful, you'd throw your career away…People get called to the legislative floor." Similarly, on 10/09/2014, he stated, "if you sign an evaluation [saying I'm competent], you're signing your careers away." He reported intending to act out in court and "get shot" by an electroshock weapon, if an evaluation expressing an opinion that he was competent was submitted to the Court. He has expressed disingenuous concern as he advised LRC personnel that he was warning them that he does not want them to get caught in the middle of his legal filings. He repeatedly threatened to sue LRC professionals for what he alleges to be mistreatment. Throughout the course of treatment, Mr. Jenkins was frequently asked to clarify his concerns so they could be problem solved. He reported that he believes LRC professionals "racist" and part of a "rac[ist]" system. He was asked to elaborate on these statements, and he expressed, "Where I grew up, I was taught that all crackers are racist."

Mr. Jenkins refused to engage in structured diagnostic assessments and treatment interventions to meet his espoused needs. He frequently remained silent, changed subjects, uttered what sounded like foreign phrases, and reviewed unrelated grievances following questions aimed to clarify his reported symptoms. Oftentimes, Mr. Jenkins made overly personal comments to LRC personnel, referring to individuals by first names or nicknames or calling to female personnel "sweet face" or goddesses. At other times, he has made derogatory statements about the competence, intelligence, or appearance of LRC providers. When therapeutic limits were set or he was pushed to directly answer questions he appeared to be avoiding, occasionally he would gesture to correctional officers to end the session. Other times, Mr. Jenkins was more explicit, indicating that diagnostic clarification was counterproductive to his legal goals, stating, "I don't want to be competent…I don't want to die;" "If I am found competent, I'll go to the Douglas County hole;" and "I've told you, I'm not doing that [psychological] testing…It can be used against me."

Frequent attempts were made to establish rapport and work through issues interfering with treatment, but Mr. Jenkins generally was unengaged in these techniques, seemed to lack motivation to address identified concerns, and artificially set new goals if attempts to meet his requests were made. Despite varied efforts, he often referred to LRC treatment efforts as "useless," "not helpful," and "not therapeutic," but struggled to identify how these interventions could be more helpful with the exception of being freed from confinement. Mr. Jenkins often reported his placement in restrictive housing was wholly responsible for his mental health difficulties. For instance, he indicated that movement to a psychiatric hospital would make the voices of Apophis and other gods/demons go away, but also asserted that he "always" heard those voices since childhood. Although he requested use of the Transdiagnostic Unified Protocol in therapy, he declined to participate in sessions using those strategies, which aimed to improve his response to stress and anxiety, stating, "I don't need mental training on the A-B-Cs and the 1-2-3s. My mind has greater training than my physical body…I don't need those things. I need socialization…and freedom from restraint and seclusion." Mr. Jenkins has not used therapeutic coping strategies offered to him to assist with the stress of incarceration and his difficult legal circumstances.

Mr. Jenkins has written letters to the prosecutor involved in his case. The 10/01/2014 letter was written in a pyramid design, and included statements about Apophis and sexual comments directed toward the prosecutor. He was asked about this letter in a subsequent session and laughed in response. He reported the letter would result in the prosecutor considering him "crazy." In a review of other available writings done by Mr. Jenkins, similar patterned writing has been observed in

some letters, while others are in a traditional letter format. The content has generally been similar to that which he discussed during sessions with LRC personnel. When asked about the purpose of the pyramid design in his letters, he reported that it shows that he is "intelligently brilliant."

Throughout the majority of the course of treatment, Mr. Jenkins described having positive interactions with his attorneys, although since mid-December 2014 he began making comments about filing a lawsuit against his public defenders due to his belief that they did not provide him assistance in his desired legal strategies (e.g., obtaining access to the evidence he was requesting; habeas corpus motion). He expressed grievances about his inability to contact the media, as he stated, the "only reason to keep me from [that] is if I were so psychotic, manic, mentally ill…but I'm not." Mr. Jenkins focused on a variety of outside events during sessions, including news stories about him, the Legislative Committee hearings on NDCS' treatment of him, and a national political campaign ad that featured him. He tracked these events well, and provided detailed accounts of the media coverage and analyzed the potential impact of these issues throughout sessions.

At times, Mr. Jenkins asserted that he is the victim of a "conspiracy" involving the Judge, prosecutor, police, and NDCS. Yet, Mr. Jenkins provided non-delusional examples of events that have provided fodder for his perceptions. For example, he asserted the Corrections' "conspiracy" involved him not receiving appropriate treatment, which he stated was revealed through the "Legislative 424 committee" exposing the "illegal shit," including "withh[olding of] [Dr.] Baker's diagnosis." He further asserted that he has experienced "due process" violations, which he claimed included the police "tampering with evidence" through mislabeling bullets found in his residence, and "perjury" through police officers lying about this evidence during court proceedings. He asserted that the Douglas County Crime Lab was found to have made errors with evidence in other cases, which he reported gives credence to his beliefs about evidence tampering. He noted the acceptance of this evidence by the prosecutor and Judge reveals that they have "b[ought] into the conspiracy." He stated that he plans to challenge the use of this evidence in his case, which could result in his conviction being overturned. Mr. Jenkins regularly used legal terminology, cited federal and state laws, and case law to support his assertions.

When asked how being found incompetent in his criminal case would affect his ability to proceed with the civil filings he prepared (e.g., habeas corpus, filing against his attorneys, due process complaints), Mr. Jenkins stated that he would call Drs. Hartmann and Moore, who he believes would testify that he is malingering and not mentally ill, and would not call the doctors that testified that he was mentally ill. He asserted that strategy would result in him being found competent, which is his desired outcome in his civil cases.

Mr. Jenkins frequently made grandiose statements, although these comments were tied to his inflated view of himself consistent with narcissistic traits. For example, he often cited how "brilliant" he was and boasted about how his legal strategies would disgrace various people. Mr. Jenkins repeatedly made statements about being a "mastermind," "strategist," "chess player," and engaging in "psychological warfare," in reference to the legal proceedings and his assertions that he will be able to have governmental agencies held liable for his actions by stating certain things (e.g., that he needs treatment in a different placement), obtaining a documentation trail, and then exhibiting certain behaviors (e.g., self-harm). When describing his actions to have others held liable for his actions, he demonstrated significant forethought, outlining how he strategizes to achieve his goals, and that the fruits of his labor have been realized by NDCS being criticized for their actions.

Mr. Jenkins also repeatedly made comments about "never" being restored to competence and not wanting to be competent. He described how it was his intent to be found competent for trial because he wanted to enter a guilty plea so he would have grounds to appeal later on, but wanted to be found incompetent after the conviction, and as a result, behaved in such a way to achieve that goal. In a similar manner, Mr. Jenkins repeatedly highlighted how being diagnosed with a mental illness by Drs. Baker, Oliveto, and Gutnik has benefitted him, and sought to pressure LRC personnel into providing a similar diagnosis by stating that those were "medical doctors" with many years of experience. While he repeatedly asserted suffering from "severe" mental illness, Mr. Jenkins never appeared bothered by the symptoms. At times, Mr. Jenkins became confrontational and intimidating. There was no indication of psychotic process throughout these discussions, and he sporadically, almost as an afterthought, would assert that he heard auditory hallucinations and suffered from delusions (e.g., reference to returning to his cell to "bask in [his] insanities," or that he would go to his cell to converse with "the spiritual realm").

MENTAL STATUS EXAM

Mr. Jenkins was fully oriented throughout the course of treatment. He tracked the time of sessions to accommodate his routine and other appointments. He was fully aware of his location, as well as the purpose of treatment. Mr. Jenkins has visible tattoos covering most of his face and neck, as well as some on his arms. Mr. Jenkins consistently presented with good hygiene, and he takes great pride in maintaining a daily routine consisting of scheduled sleep, meals, exercise, writing, pursuing legal activities, and visits. While he labels these activities as "rituals" and "obsessive" and sometimes relates them to beliefs about Apophis, there is no indication that they are significantly different than a daily routine. Mr. Jenkins wears eyeglasses, and his eye contact has been mostly appropriate. He has occasionally squinted at LRC personnel, typically when asked questions he seems to not want to answer. He frequently made overly personal comments (e.g., nicknames, derogatory names) to LRC professionals.

Mr. Jenkins' psychomotor activity has been normal. His speech has generally been within normal limits. Any agitation noted was related to feelings of discontent about situational factors. At times, Mr. Jenkins demonstrated dramatic behavioral displays (e.g., squinting at the camera in the group room, gasping breaths), but these behaviors seemed to be 'for show,' were fleeting, and did not affect his behavior throughout the remainder of the session.

Mr. Jenkins has not displayed observable positive or negative symptoms suggestive of a psychotic disorder or symptoms of major mood disorders throughout LRC sessions. He has been fully oriented with logical, goal-oriented thought processes in all sessions. There was no evidence of disorganized thought processes or loose associations. Early in the course of treatment, Mr. Jenkins verbalized seemingly delusional thought content (e.g., Apophis, gods/goddesses); however, such verbalizations decreased over time to the point that such topics were sometimes not discussed at all during sessions. Even when those asserted delusional and hallucinatory experiences were discussed, Mr. Jenkins has not exhibited behaviors consistent with those experiences and beliefs. Furthermore, when he espoused symptoms of mental illness, he labeled such things as evidence of mental illness without showing any interference from such claimed symptoms. For instance, he consistently attended to conversations and demonstrated behaviors that were tied to other motivators. He did not talk of these reported psychotic experiences as if they were at the forefront of his mind or currently happening. Instead, he conveniently asserted thoughts about Apophis and other "spirits" when he perceived that it would further his claim that he was "mentally ill" or

"decompensating" and needed some request fulfilled (e.g., placement, access to property). Instead, his concerns have been primarily about reality-based, situational concerns (e.g., his placement, privileges, legal situation). Additionally, Mr. Jenkins has not demonstrated that he experiences distress or functional impairment associated with these symptoms, despite his report that the symptoms are unbearable.

While he reported experiencing severe mood swings (e.g., "rapid deterioration"), such variations were not apparent during the course of treatment. Mr. Jenkins displayed a normal range of mood fluctuations (e.g., frustrated, angry, irritated, pleasant) appropriate to his circumstances, albeit sometimes with exaggerated indignation or anger about perceived slights. Concerns affecting his mood explicitly have been about placement in a less restrictive setting or legal filings. His affect has consistently been full and congruent with mood. He has laughed at times when discussing situations in which he believes that others will be discredited, seems gratified when he espouses a plan to discredit LRC personnel and others, and appears to revel when discussing how others might suffer as a result of his actions. Changes in affect have not been in apparent response to internal stimuli (e.g., laughing as a result of auditory hallucinations), but instead are clearly related to his statements during sessions.

Although Mr. Jenkins often changed topics during sessions, rambled about certain topics, and discussed an agenda of items that he seemed to have mentally prepared, there was no evidence of racing thoughts despite his report of such symptoms. At times, he shifted the focus of the session, but this appeared to be an attempt to control the discussion. He could generally be re-directed back to previous topics or questions, although when treatment topics were brought to his attention, he often changed the topic to various complaints about governmental agencies and his perception that he has been mistreated. At other times, he continued to talk over the other person.

There has been no indication of memory problems, and he has demonstrated a good ability to attend to discussed material. He consistently demonstrated the ability to keep track of the conversation in a goal-oriented fashion. Intellectual functioning appeared to be in the low average to average range.

PSYCHOLOGICAL TEST RESULTS

Mr. Jenkins' self-report of mood and psychotic symptoms have been identified as malingered by some mental health professionals and as reflective of a major mood or psychotic disorder by other mental health professionals. These differing conceptualizations have been noted in collateral records, including recent competency evaluations, and was a primary factor in the Court's recent finding that Mr. Jenkins was incompetent for sentencing (i.e., 07/18/2014 Court Order). As such, Mr. Jenkins was administered the Structured Interview of Reported Symptoms, 2nd Edition (SIRS-2, an instrument designed to assess endorsement of a range of common and less common symptoms of mental illness) on 08/22/2014 to assess his self-report of symptoms. He appeared to provide a reasonable effort when completing the test. Mr. Jenkins attempted to elaborate on his answers to test items several times, but was prompted back to the questions in line with standard test administration procedures, with reminders that he would have time following the test to provide additional information about difficulties that he endorsed. He had no difficulty following these cues to return to test items and provide concise responses.

On the SIRS-2, Mr. Jenkins obtained a pattern of markedly elevated sub-scores that is strongly characteristic of an individual feigning a mental disorder. Out of 8 primary scales, Mr. Jenkins'

scores on 4 of those scales were in the definite feigning range (above the 98th percentile when compared to a clinical group), and an additional 3 primary scales were in the probable feigning range. Only one of the primary scales was in the indeterminate range. This pattern is rarely observed in examinees with genuine disorders that endeavor to present themselves accurately. The SIRS-2 uses a variety of detection strategies for the classification of mental disorders. Specifically, Mr. Jenkins reported a high proportion of unusual symptoms on two separate scales that are typically observed in feigners, but not in genuine patients. He also obtained an elevation on a sub-scale for improbable or absurd symptoms that, by definition, are outlandish and almost never observed in clinical populations. Mr. Jenkins reported an unexpectedly high proportion of symptoms associated with a major mental disorder. This proportion is not typically characteristic of patients with only genuine disorders. Furthermore, he reported a higher-than-expected proportion of symptoms that were occurring with extreme intensity, which is consistent with individuals fabricating or exaggerating their symptom presentation.

Mr. Jenkins was requested to complete the Minnesota Multiphasic Personality Inventory – 2 (MMPI-2), a well validated measure of psychopathology and personality functioning, to further clarify diagnoses on numerous occasions (i.e., 09/08/2014, 09/09/2014, 09/16/2014, 09/18/2014, 10/31/2014, 12/19/2014). Administration of the Millon Clinical Multiaxial Inventory – III (MCMI-III), an inventory designed to identify emotional, behavioral, and interpersonal difficulties, was also attempted for diagnostic clarification purposes (i.e., 12/18/2014). He began to complete the MMPI-2 on 08/26/2014, but after answering five items, he tilted his chair, hid his answer sheet, and wrote letters down the first column of the answer sheet prior to being informed that the testing would be ceased on that date since he was not taking it seriously. Such behavior is not characteristic of psychotic persons taking the MMPI-2, and there was no indication that mental illness symptoms were motivating his behavior as it related to the test administration.

After the SIRS-2 administration (08/22/2014) and the first attempted MMPI-2 administration (08/26/2014), Mr. Jenkins refused to attend meetings that would have included psychological testing or refused to participate in test administration, despite reminders that doing so would assist in identifying his mental health problems and clarify treatment needs. Mr. Jenkins offered various explanations for his refusal to complete further psychological testing, including concerns about the test results "being used against [him]" (i.e., 10/31/2014 LRC Patient Note), that LRC professionals would alter his answers, and that he wanted the test administration to be videotaped. Despite each of these concerns being addressed, Mr. Jenkins continued to decline to participate in further psychological testing. This refusal was strikingly similar to his refusal to take medicine, in that each time a concern was addressed, the target shifted and either new concerns were raised or he outright rejected the intervention/attempt.

DIAGNOSTIC IMPRESSIONS

Psychosis

Overall, Mr. Jenkins has been inconsistent in his report of psychotic symptoms. Records indicate that Mr. Jenkins first reported hallucinatory experiences as a child, but Richard Young providers characterized those symptoms as reactions to traumatic experiences (i.e., nightmares) or real experiences (i.e., older boys who instructed him to steal). The lack of further report of such symptoms until over a decade later provides credence to that initial conceptualization of those symptoms. As an adult, his self-report has been inconsistent over time, with the exception of a common theme of hearing the voices of Apophis and other gods/demons in the last few years. Mr.

Jenkins' assertions that he "always" hears these voices and has since childhood lack credibility for several reasons. First, throughout restoration treatment, there has been no indication that he is responding to such internal stimuli, which would have been expected if they were occurring at all times. Second, collateral documentation repeatedly indicates that he previously denied such symptoms most of the time over the course of his life, making his current assertion suspect given the potential for secondary gain. Thirdly, Mr. Jenkins calls attention to these reported symptoms, labels them as symptoms, requests treatment for them, but then habitually refuses treatments offered. Similarly, he made requests for antipsychotic medication to be prescribed (while noting that he would not take it if it were prescribed) and for a diagnosis of Schizoaffective Disorder to be documented, suggesting that, at this time, he is more interested in how the documentation can serve his legal interests than in actually receiving treatment. Additionally, Mr. Jenkins reports significant problems with delusions and hallucinations regarding Apophis; however, there is no observed decrease in functional abilities (e.g., hygiene, self-care, communication, planning) or apparent associated distress or disorganized thinking, as would be expected in a person genuinely experiencing such intrusive symptoms. Furthermore, psychological test results demonstrated a pattern of responding that is characteristic of feigning symptoms. His refusal to complete additional psychological assessment measures because of his concerns that the results would be "used against" him also raises suspicions about the veracity of his reported symptoms.

While Mr. Jenkins may indeed hold some beliefs about idealizing the "sacred evil," these do not appear delusional in nature. Furthermore, the rituals related to Apophis that he reportedly engages in (e.g., consumption of body fluids, exercising, prayer), do not significantly affect his ability to function on a daily basis, and may actually be strategies to cope with his current circumstances. While he inconsistently attributed his past self-harming behaviors to rituals, he nonetheless appears to have good control over his behaviors, as he consistently cited such control when requesting a decrease in restrictions and has demonstrated such behavioral control throughout competency restoration treatment. There has been one recent exception to this when he sent material with blood on it to his attorney. However, his discussion about that behavior strongly suggested that it was volitional and intended to manipulate the actions of LRC personnel and/or his attorney.

Mr. Jenkins has asserted that individuals involved in the judicial system and other governmental organizations are involved in a "conspiracy" against him. However, he has provided plausible reasoning to support his beliefs, related to being treated unfairly due to racism, his previous legal history, and his current legal filings against others (e.g., lawsuit against NDCS), even if it is erroneous. While it is unknown if there is any credibility to his statements about tampered evidence or false testimony, these beliefs are not inherently delusional and are – in his mind - bolstered by reality-based examples in which errors in handling evidence in other cases were made. Further, his assertions about a conspiracy clearly are not tied to his asserted beliefs about Egyptian gods or reported hallucinations.

At times, Mr. Jenkins asserts that he will be exonerated. Regarding his reasoning, sometimes he states that Apophis has "shown" him that it will be so, although he has also consistently asserted non-delusional reasons he believes this will occur. For example, he talks extensively of the legal foundation for his belief (e.g., assertions that there was police misconduct, legal errors) and openly discusses the steps he is taking to pursue this end (e.g., motions, requests for evidence). Regardless of the likelihood of success of these endeavors, and the possibility that it may simply reflect wishful thinking, he provides ample non-delusional reasons for this belief.

Based on available records, previous psychotic diagnoses seem to be primarily as a result of Mr. Jenkins' self-report of hallucinations and delusions as opposed to objective confirmation of symptoms, and malingering has been questioned for several years. However, it is conceivable that Mr. Jenkins could have had transient psychotic episode(s) while under great stress in the past (related to borderline personality symptoms), although he does not appear to have a chronic psychotic disorder and does not appear to suffer from psychotic symptoms at this time.

Mood

Mr. Jenkins does not present with significant mood-related symptoms at this time. During the course of competency restoration, Mr. Jenkins has demonstrated normal fluctuations in mood, which has been largely consistent with situational factors. He has not demonstrated significant mood swings. At times, he has presented with somewhat elevated mood, seeming almost elated, although these episodes have not persisted for more than a few minutes at a time and have consistently been related to situations in which Mr. Jenkins believes that others will be discredited in relation to him (e.g., testimony of Corrections' personnel at Legislative hearings; when recounting how he will use testimony of expert witnesses against them).

There has been no indication of manic or hypomanic symptoms during LRC sessions. Mr. Jenkins does present as grandiose, although this is a stable characteristic that has not fluctuated for many years and indicative of a personality trait as opposed to a mood disturbance. Although Mr. Jenkins referred to having "racing thoughts," there has been no objective evidence during the course of LRC treatment to suggest that he experiences a pressure to talk, flight of ideas, or thoughts that race faster than they can be expressed verbally. He frequently came to sessions with a mental agenda of topics he wanted to talk about, as if he had rehearsed a monologue prior to the session. However, in general, it was possible to interrupt him, re-direct him, and disrupt his flow of thoughts. There has been no indication of distractibility; instead, Mr. Jenkins demonstrated a good ability to sustain attention to matters that he thought important. He also reported experiencing "manic enragement," but provided no description of actual symptoms when asked to explain what the term meant for him. Mr. Jenkins' attorney has described that he "rants" when discussing his case with counsel, and then sometimes breaks down in tears and apologizes for his behavior. This pattern has not been evident during LRC sessions, suggesting that situational factors as opposed to major mental illness are driving that behavior. There has been no indication of an increase in goal-directed activity, although he does maintain a routine of exercise, sleep, legal preparations, hygiene activities, and reading. Mr. Jenkins has maintained a good appetite and has not experienced any sleep difficulties throughout the course of treatment.

Records describe mood fluctuations during his brief hospitalization at age 8, although the professionals at Richard Young ultimately conceptualized his difficulties as indicative of anxiety, maladaptive coping strategies, and personality characteristics. Records also indicate that Mr. Jenkins reported isolated incidents of difficulty sleeping on other occasions, although these generally coincided with situational factors that were causing stress. NDCS records indicate that he discontinued several sleep studies to confirm and clarify his reports of insomnia after sleeping adequately on the first night of the studies. NDCS records indicate that he was reported to experience a disruption in sleep in January 2013, although this problem seemingly remitted within a short time without intervention. NDCS records also note that numerous individuals described him as "hypomanic" at times, highlighting lengthy monologues, animated behavior, and rapidly shifting topics. It is possible that, in the past, he may have experienced brief mood disturbances

related to situational stressors that remitted without treatment. However, personality characteristics (most likely borderline or narcissistic traits) could have mimicked, and in brief interactions easily been mistaken for, hypomanic-like episodes.

As for depressive symptoms, Mr. Jenkins has not exhibited depressed mood during the course of LRC treatment. He has maintained interest in activities that he values (e.g., exercise, reading, legal motions) and has described feeling as if he has adequate energy to complete tasks and pursue his priorities. During LRC treatment, there have been no significant signs of psychomotor agitation or retardation. At times, he has made veiled threats of self-harm, but the circumstances in which these statements have been made suggest that he does not have suicidal ideation. Instead, these comments have largely been aimed at attempting to influence the actions of others in a way that he perceives is favorable to him (e.g., trying to be moved to a less restrictive placement by intimating that LRC personnel will be held "liable" if he harms himself). In LRC sessions, he has infrequently endorsed "self-hatred" and feeling emotionally "broken down." However, upon further explanation these experiences appear related to characterological issues, and absent other depressive symptoms are not sufficient for a diagnosis of a major depressive episode. Records indicate that there was some concern of depression in 2007, but the only noted symptom was insomnia, for which he refused the follow-up sleep study.

Antisocial Personality Traits

Mr. Jenkins presents with obvious symptoms of Antisocial Personality Disorder. He has demonstrated a pervasive pattern of disregard for and violation of the rights of others since childhood. He has consistently failed to conform to social norms in regards to lawful behavior. He has demonstrated a pattern of deceitfulness, as evidenced by habitually lying and conning others. Mr. Jenkins presents with irritability and a history of assaultive behaviors. He behaves in ways that demonstrate a reckless disregard for his own safety and that of others. Additionally, he demonstrates a lack of remorse for behaviors, either by rationalizing how others were harmed (e.g., blamed the homicides on Corrections' personnel, blamed a previous assault on the officers who took him on the furlough), intellectualizing his harmful behavior, minimizing aggressive behaviors and threats of harm, or glorifying violent acts he has committed. Based on available records, Mr. Jenkins exhibited behaviors, such as burning buildings, breaking windows, theft, truancy, assaultive behavior, killing animals, and robbing others at gunpoint, which met criteria for Conduct Disorder as a child. These antisocial behaviors have not occurred exclusively during the course of another major mental illness.

Narcissistic Personality Traits

Mr. Jenkins also demonstrates strong narcissistic characteristics. He maintains a grandiose sense of self-importance, marked by expectations that others will recognize his superiority despite the lack of commensurate accomplishments. He frequently talks of how physically superior or "brilliant" he is, refers to himself as a "mastermind," and consistently brags about ways in which he intends to 'one up' others (e.g., judges, homicide detectives, Corrections' personnel, LRC professionals). Mr. Jenkins exhibits a sense of entitlement, often making demands of others or trying to secure special treatment. During sessions, he frequently attempts to control the interview and seems to view it as a platform from which to express his views. He demonstrates a significant lack of empathy for others and has difficulty recognizing the emotions or needs of others. On the rare occasions he does talk of others' experiences, he does so in an intellectualized way or in a manner that suggests he enjoys recalling incidents in which he has inflicted harm upon others.

Borderline Personality Traits

Mr. Jenkins also exhibits traits associated with Borderline Personality Disorder. He has demonstrated problems in the way in which he views relationships, at times ranging between idealizing the other person, while at other times devaluing that individual. For example, within treatment sessions with LRC personnel, at times he will state that he reveres the females working with him (Drs. Abel and Cimpl), as they represent the "goddess," while at other times referring to them in derogatory terms (e.g., ugly, stupid, incompetent). Mr. Jenkins also exhibits some characteristics that may be related to identity disturbance, in that at times he talks of wanting to be "good," although he mostly highlights how he admires "evil." It is unclear if this behavior is related to borderline traits, as his presentation must be viewed in the light of his attempts at secondary gain. He has engaged in self-harming behaviors and endorsed suicidal ideation, which could be indicative of borderline personality traits. It is also possible that self-harming behaviors have been motivated by attempts to manipulate others (e.g., demanding moves to other units/facilities), and he has reported that he "mastermind[ed]" the situation in order to have NDCS held liable for him not receiving mental health treatment. Mr. Jenkins also demonstrated some reactivity of mood, and associated changes in affect (e.g., elation, agitation, irritability). These affect and mood changes only last for short periods of time, consistent with borderline traits as opposed to a major mood disorder. In addition, Mr. Jenkins has presented with significant anger inappropriate to the situation, although he seems to have relatively good behavioral control. Records confirm that anger has been a reported problem for numerous years. Lastly, it is possible that as a result of borderline traits, Mr. Jenkins may have exhibited transient, stress-related paranoid thoughts or limited psychotic symptoms in the past, although it is expected that such symptoms would have been short in duration. If he did present with such symptoms, it could have been mistaken for other psychotic disorders in the past. There has been no indication that he has experienced these types of transient psychotic symptoms during the current course of treatment.

Posttraumatic Stress Disorder

Mr. Jenkins witnessed significant traumatic events as a young child, raising the question of about whether his reaction to such events caused a clinical disturbance, such as Posttraumatic Stress Disorder (PTSD). As a child, records indicate that he experienced nightmares about the family violence he witnessed. However, there is no information to suggest that, at this time, Mr. Jenkins experiences intrusive memories (e.g., nightmares, flashbacks) associated with those traumatic events, although he did report such symptoms to Dr. Baker several years ago. At this time, there is no indication that Mr. Jenkins attempts to avoid reminders of the traumatic events; instead, he provided graphic details about those experiences during sessions with LRC personnel. It is plausible that Mr. Jenkins may have negative changes in his thoughts and mood in relation to those traumatic events, but there is not a clear and obvious link. It is also plausible that Mr. Jenkins may have experienced changes in his level of arousal and reactivity following childhood trauma. Records indicate that he demonstrated some hypervigilance at age 8, although there are no other clear indicators of heightened arousal or reactivity. As such, Mr. Jenkins may have experienced some PTSD in the past, but he does not currently meet criteria for that disorder.

Adjustment Disorder

Mr. Jenkins' current treating psychiatrist, Dr. Chaturvedi, initially offered a diagnosis of Adjustment Disorder based on concerns that the gravity of his legal circumstances were causing undue stress and possible anxiety. However, over the course of treatment, there has not been evidence to support the presence of marked distress that is out of proportion with the severity of his

situation. Furthermore, Mr. Jenkins has not demonstrated significant impairment in important areas of functioning associated with reported mental health symptoms.

DIAGNOSIS

Other Specified Personality Disorder (e.g., Mixed Personality Features - Antisocial, Narcissistic, and Borderline)
Malingering
Polysubstance Dependence (by history)
History of Posttraumatic Stress Disorder

COMPETENCY-RELATED ABILITIES

With respect to the criteria outlined in *State v. Guatney*, Mr. Jenkins has demonstrated sufficient mental capacity to appreciate his presence in relation to time, place, and things. Mr. Jenkins described representing himself in his trial and pleading no contest to the charges currently pending sentencing. He is aware that he has been found not competent for the sentencing phase, which could include the death penalty. He understands that he is in a court of law, convicted of four counts of murder and eight other associated felony charges, and is able to describe the details of those offenses. He realizes that there is a Judge on the bench, a prosecutor who will argue for the death penalty, and defense attorneys who will defend him. Mr. Jenkins has spoken of a "conspiracy" involving various legal actors, although upon further investigation, this does not comport with paranoia reflective of a mental illness. Instead, these beliefs are indicative of his general mistrust of governmental agencies and institutions, some reality-based suspicion frequently exhibited by individuals with prior involvement in criminal behavior, and some cultural beliefs based on his views that he will not be treated fairly as a result of his race. In some ways his mistrust of others in the judicial system is also self-fulfilling, as he attributes any failure of his efforts to a "conspiracy" within the system in order to maintain his narcissistic views of himself.

Mr. Jenkins understands he is expected to tell his lawyers all he knows and remembers about the events involved in the offenses, although he has demonstrated variable cooperation with counsel. This variable cooperation is driven by his personality characteristics, as opposed to symptoms of a major mental illness. He is aware that a panel of judicial officers will be present to pass upon evidence in determining sentencing in a death penalty hearing. Mr. Jenkins understands the appellate process, should he be sentenced to death. He has demonstrated sufficient memory to relate answers to questions posed to him. Mr. Jenkins is capable of following testimony reasonably well and testifying on his own behalf if necessary.

Mr. Jenkins appears capable of meeting the stresses of a trial without having a breakdown in rationality or judgment. Mr. Jenkins has described having effective coping strategies to manage his emotions in future court proceedings, such as prayer and writing. Furthermore, he described being capable of maintaining appropriate behavior in Court, even when he has thoughts of being disruptive. He discussed being able to manage himself appropriately in prior legal proceedings, although he has not always done so. Similarly, Mr. Jenkins has reported intent to engage in disruptive behaviors during future court proceedings, but described these acts as volitional attempts to discredit LRC professionals or to thwart being found competent to proceed, as opposed to being related to a psychotic or mood disorder. Treatment sessions have focused on assisting him in developing further skills to manage stressful situations. Mr. Jenkins' motivation to gain new skills

and engagement in treatment has been poor; however, he has demonstrated the ability to comport himself appropriately should he desire to do so.

Mr. Jenkins has at least minimum contact with reality and does not present with disorganized thought processes or significant symptoms indicative of a major mental illness at this time. While he discusses Apophis and other topics that are seemingly delusional, these purported beliefs seem to have little, if any, bearing on his legal strategies. Talk of Apophis minimally interfered with sessions; instead, he spoke at length about legal strategies, often without ever bringing Apophis or other purported hallucinations or delusions into the conversation. When he does bring up those ideas, he does so in a way that appears contrived (e.g., when asserting that his placement is inappropriate due to the "voices"). While he discusses how he would achieve lofty, unrealistic goals after his conviction is overturned, these claims appear more related to narcissistic traits than any other illness. Furthermore, Mr. Jenkins did not tie topics about Apophis to his thoughts or strategies related to his current criminal case. Instead, he elaborately discusses his desired legal strategies based on statutes, case law, and other assertions about evidence. He has the minimum level of intelligence necessary to grasp the events taking place. He can confer coherently with an appreciation of the legal proceedings, as evidenced by his ability to provide detailed accounts of past proceedings, including the testimony of witnesses, motions by both sides, and the Judge's rulings.

Mr. Jenkins has identified his attorneys as Tom Riley, Scott Sladek, and Thomas Wakely. He previously described having positive interactions with counsel and referred to Mr. Riley as a "lion," who asked difficult questions to witnesses. However, in recent weeks he reported that he has filed a civil suit against his attorneys, as a result of his perception that they are not pursuing legal strategies he believes they should. There is no indication that his expressed dissatisfaction with legal counsel is related to a mental illness, with the exception of a personality disorder. Mr. Jenkins asserted that as a result of his legal filing, it would be a conflict of interest for them to continue to represent him and he anticipates that a new attorney will be appointed. While he has not yet demonstrated rapport with legal counsel, this seems primarily related to his inflated view of himself, as he does not believe that anyone is more "intelligent" or "brilliant" than he. As such, it appears he is capable of establishing rapport should he desire to do so, although his personality style is such that he is likely to find error with any strategy that person(s) should undertake.

Mr. Jenkins appears capable of both giving and receiving advice from his lawyers and assisting them in making a rational defense, if he chooses to do so. He has cited several legal standards, statutes, and rights relevant to his case and has identified specific evidence (e.g., certain mental health records, transcripts from legislative hearings) that he believes could be used to support his case in the future. Moreover, he has reviewed civil strategies that he is pursuing, which he believes would allow for further review of the legalities of previous judicial decisions and processes. While Mr. Jenkins may misuse some legal concepts or misinterpret statutes, he is certainly capable of learning new information to correct these errors. However, his personality is such that he may have difficulty receiving feedback from others (including counsel) that is contradictory to his position. Furthermore, he is likely to find fault, place blame, and claim ineptitude on the part of others if they do not provide unconditional acceptance of his statements or agreement with his desired strategies. He is able to divulge facts and discuss the ramifications of different strategies without paranoid distress. He is capable of making simple decisions at this time. He has demonstrated a desire for justice, rather than undeserved punishment.

CONCLUSION

Mr. Jenkins has been found incompetent for sentencing for four counts of murder, four counts of use of a weapon to commit a felony, and four counts of being a felon in possession of a firearm. The case has been highly contentious as a result of the nature of the offenses, the potential for the sentence to include the death penalty as well as discrepant diagnoses over several years. As a result of these complicated issues, the undersigned evaluators aimed to comprehensively conduct a differential diagnosis as part of competency restoration to provide clarity to the Court.

Competency restoration efforts have been complicated by several factors, including the defendant's: 1) general lack of motivation to engage in offered treatments; 2) lack of cooperation with assessment techniques; 3) stated aim to not be found competent; and 4) use of peripheral issues, such as legislative hearings and investigations into NDCS, civil claims, and his placement, as distractions from competency restoration and the ongoing criminal case. As detailed throughout this report, over the course of treatment, numerous strategies were attempted to improve cooperation, although Mr. Jenkins remained steadfast in tactics to usurp these efforts. Nonetheless, frequent sessions with LRC personnel, behavioral observations over the course of 6 months, psychological test results, and a thorough record review have assisted in clarifying diagnosis and the reasons for Mr. Jenkins' challenging presentation throughout legal proceedings.

Diagnostic impressions have varied over the years, although he has been consistently identified as having significant characterological problems, namely antisocial and narcissistic traits. Those diagnoses remain prominent in his current presentation. Historically, there has been disagreement about whether Mr. Jenkins has a psychotic or major mood disorder, or was malingering those symptoms. Some providers offered tentative diagnoses of psychosis largely based on Mr. Jenkins' self-report of hallucinations and delusions, but also noted the possibility of malingering and requested additional objective data to support their diagnostic impressions. Historical diagnoses of mood problems appeared to be more reliant on observable symptoms (such as agitation, rapid speech, and intense emotions), than on his self-report.

At this time, Mr. Jenkins does not appear to suffer from a psychotic disorder. Any such reported symptoms (e.g., constant auditory hallucinations) do not comport with what is known about genuine psychotic symptoms, appear to be largely contrived, and do not interfere with legal strategies or day-to-day functioning. This conclusion is supported by months of observation during sessions with LRC personnel, frequent consultation with LCC staff who observe Mr. Jenkins at 15-minute intervals around the clock, objective psychological assessment results, and the lack of functional impairments that would be evident if such intrusive symptoms were present. During all of these efforts, there has been no indication of disorganized thoughts processes or distraction by internal stimuli. Further, Mr. Jenkins calls attention to and labels what he asserts are his diagnoses and symptoms, suggesting that, if they are really occurring, he has insight into these issues as symptoms. However, he has not been able to provide descriptions of those experiences, as would be expected by someone who has actually experienced those problems. An individual who genuinely suffers from psychotic symptoms, and has the insight that such experiences are symptoms, generally wants to ease their suffering. While Mr. Jenkins reports that he wants treatment, he has consistently declined to accept treatment offered (both during recent competency restoration efforts and historically). Furthermore, he contradictorily describes purported psychotic symptoms as experiences that "empower" him. Instead, his statements and behavior suggest that secondary gain related to obtaining a psychotic disorder diagnosis and prescriptions for antipsychotic medication

(that he intends to refuse) is motivating him to feign symptoms. If any such symptoms happen to be present, Mr. Jenkins is most certainly over-reporting the severity, frequency, and associated impairments they cause, and they are generally unrelated to his legal strategies. It is unknown if he has consistently malingered such symptoms over the last several years, and the undersigned recognize that other professionals have identified the presence of psychotic symptoms. As such, it is possible that such symptoms could have been the result of sporadic, brief micro-psychotic episodes secondary to borderline personality traits that manifest in rare moments under extreme stress.

At this time, Mr. Jenkins does not present with symptoms of a major mood disorder. There has been no indication of manic or depressive symptoms during competency restoration efforts. At times, he presents as animated, agitated, or irritable, although these mood fluctuations have consistently been in response to situational factors. While he reports "racing thoughts," there has been no indication that he actually suffers from this symptom. Instead, he appears to have a topic that he wants to discuss, often attempts to control the session and offers long monologues. These behaviors appear volitional and largely related to a personality disorder, rather than a mood impairment.

Mr. Jenkins' personality characteristics (antisocial, narcissistic, and borderline) appear to primarily account for his disruptive behaviors during court proceedings and difficulty communicating with others. This combination of personality traits, in addition to feigning of symptoms and lack of cooperation, has complicated the diagnostic picture, and it is understandable that professionals have conceptualized problems in differing ways. His narcissistic traits are believed to account for the grandiose beliefs he asserts, as well as the fault he finds with any strategies that others (e.g., LRC personnel, legal counsel) recommend or pursue. He is generally unwilling to listen to others' ideas or suggestions because of his elevated view of himself. During competency assessments, the undersigned attempted to assist Mr. Jenkins in developing more effective communication skills and working with counsel to prioritize legal strategies. However, he consistently was unwilling to engage in such efforts, seemingly as a result of his belief that no one is smarter or more "brilliant" than he. The presence of borderline personality traits may explain why previous diagnostic impressions have included such a wide range of disorders. Borderline traits might account for emotional reactivity observed by others (that was labeled as mood disordered in the past), as well as his use of self-harm and suicidal ideation (as maladaptive coping strategies or attempts to manipulate others). Furthermore, it is possible that individuals with borderline traits can decompensate under severe stress and exhibit transient psychotic symptoms, although he does not currently appear to be suffering in that manner. In fact, despite his lack of cooperation with competency restoration efforts and assertions that he is decompensating in his current environment, Mr. Jenkins has not demonstrated an objective deterioration in mental state during the past several months.

To conclude, it is the opinion of the undersigned that Mr. Jenkins is currently competent to proceed with sentencing. The defendant has demonstrated an adequate factual understanding of the proceedings. Additionally, Mr. Jenkins has demonstrated the ability to rationally apply such knowledge to his own case. He can coherently discuss previous proceedings in detail and is able to extensively describe the purpose of upcoming hearings and potential legal strategies. Lastly, if he desires to do so, he has the ability to consult with counsel with a reasonable degree of rational understanding. While Mr. Jenkins' may behave in ways that that disrupt the proceedings and

ineffectively communicate with counsel, these behaviors are largely volitional and related to personality characteristics, as opposed to a major mental illness.

Based on past behaviors, his continued vague threats about self-harm and harming others, and comments about others being held liable for any injury he inflicts, it is probable that Mr. Jenkins will threaten and/or engage in acts to harm himself or others, or dramatic behavioral displays if he perceives that it could benefit him in some manner (e.g., placement, attention, having others view him in a certain way – mentally ill/incompetent/powerful). As such, it is strongly recommended that safety precautions be taken in any setting that he may be housed in, during transport to/from court hearings/appointments, and during court proceedings.

Respectfully submitted,

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