MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

FORENSIC SERVICES

M.G.L. c. 123, s.15 (a) Report Writing Guidelines

These guidelines were developed by the Massachusetts Department of Mental Health (DMH) Forensic Services and the University of Massachusetts Law and Psychiatry Department, and pertain only to court ordered evaluations pursuant to M.G.L. c.123, s.15 (a). These guidelines are not meant to define any forensic report absolutely; individual cases may require deviations from this format. The guidelines presuppose appropriate forensic mental health training and clinical judgment.

CHAPTER 123, Section 15(a) SCREENING EVALUATION REPORT GUIDELINES
September 19, 2008

I. PURPOSE

This document is intended as a Guide for writing forensic mental health reports of Competence to Stand Trial (CST) and Criminal Responsibility (CR) conducted under the provisions of M.G.L. chapter 123, section 15(a). These guidelines are promulgated by the Department of Mental Health's Forensic Service concerning the nature and quality of s. 15(a) reports. They are intended for use by forensic mental health professionals designated according to DMH regulations in the performance of such court ordered evaluations, professionals preparing for such designation who are under the supervision of a Forensic Mental Health Supervisor, post-doctoral psychology fellows participating in a DMH approved forensic psychology training program, and successful graduates of such programs who are not yet licensed but otherwise meet all other threshold requirements for entrance into candidacy.

These guidelines apply to s. 15(a) screening evaluations, and presume knowledge of, and adherence to, the applicable standards delineated elsewhere, including those set forth in the September, 1994 revision of the Guidelines for Written Reports of Forensic Evaluations Conducted Under M G.L. chapter 123, section 15(b), and all relevant DMH policies (e.g., CORI regulations). Note: Guidelines for "extended" s. 15(a) evaluations have not yet been developed.

II. GENERAL

Guidelines regarding the types of information that should and should not be included in s. 15(a) evaluations are delineated in Section III on "Report Content" of this document. The following are general guidelines regarding approaches to reports for screening evaluations under s. 15(a).

Use of a narrative format is encouraged. However, use of a format that contains a combination of a narrative and a checklist is acceptable provided that the essential information detailed below is included. Some forensic clinicians have developed face sheets that include blanks for all the relevant demographic information. This may be a helpful tool. Checklists alone (i.e., without narrative components) are not acceptable, because they do not include documentation of "raw clinical data."

When the referral is for evaluation of both Competency to Stand Trial (CST) and Criminal Responsibility (CR), there is no requirement to write separate reports unless you are documenting the defendant's account of the alleged offense (which should not be included in the Competency report). When two reports are deemed necessary, this might be accomplished simply by writing different final sections, one addressing issues related to CST and one addressing issues related to CR (and appending each to copies of the previous sections of the report).

III. REPORT CONTENT for Evaluation of Competence, to Stand Trial and for Criminal Responsibility Pursuant to M.G.L. c.123, s. 15(a)

Identifying Data: The report must include the defendant's name, date of birth, sex, the formal charge(s), date(s) of alleged offense(s), referring court, and docket number. Also note whether defendant was referred for evaluation of CST, CR or both. If known, include the reason for referral (e.g. behavior in court, mental health history, etc.). It is also helpful to include a brief description of the alleged incident(s). Include the names and telephone numbers of the defense attorney and, if available, names and telephone numbers of the D.A. and any other collateral informants.

Structure of the Evaluation: Document that you informed the defendant of the limits of confidentiality, and note your clinical impression of the defendant's understanding of this information. Also, describe your data base (i.e. length of interview of defendant, where, who present, documents reviewed, collateral sources contacted). Describe any pertinent contact you have had with defense counsel (including, for example, the attorney's observations and concerns with the defendant).

Background Information/Clinical History: The historical information may be very brief or more extensive depending on the circumstances of the case. The report must include reported psychiatric history, substance abuse history, and history of harm to self and others. Provide additional relevant information such as; involvement with the criminal justice system, history of relationship to alleged victim (if any), present living situation, acute precipitants, when possible. There is no expectation that a brief "screening" s.15(a) report contain a comprehensive history.

Mental Status/Clinical Observations of Defendant: This portion of the report should focus on the defendant's current mental status and presentation. Focus should be on positive and negative clinical findings relevant to CST, CR and disposition recommendations. Direct quotes and objective behavioral descriptions should be included as available. All reports should include statements about current suicidal/homicidal ideation and psychosis, or absence thereof, or a rationale as to why there is no information related to those areas.

Data Relevant to Competence to Stand Trial: Focus on pertinent positives and negatives; most cases will not require comments on every competency related ability. Give concrete examples to illustrate abilities and deficits. It is not necessary to break this into separate sections as in s. 15(b) reports. If it is clear that the defendant does not suffer from mental disease or defect that brings competency into question, summary statements about the defendant's capacities are acceptable. Self-incriminating statements made by the defendant regarding the alleged offense should not be included in Competence to Stand Trial Reports.

Data Relevant to Criminal Responsibility: This area should only be addressed if there is a specific s. 15(a) order for a screening evaluation of Criminal Responsibility. Otherwise, the forensic examiner should not address this issue. (Defense counsel may not want the issue of CR to be raised for any number of reasons, even when there is an apparent question of CR). In contrast, if only a CR evaluation has been ordered, but you have significant concerns about the defendant's competency to stand trial, it is appropriate to bring this to the attention of the court.

This section should include data suggesting presence/absence of symptoms of mental illness and/or substance abuse at the time of the incident, and observations of others (e.g., police, family, victim).

The question of how to deal with data pertinent to CR issues at this stage is complex. Various approaches may be indicated depending on the specific clinical and legal circumstances of the case. If the report contains the defendant's account of the alleged offense, a separate report should be written regarding CR, and the defendant's account should not be included in the CST report. It is up to the individual examiner to decide how much detail of the defendant's account and other information to include in the CR report.

Assessment and Recommendations: Always phrase your conclusions as opinions or recommendations, not as findings. All conclusions and recommendations should follow from (or be supported by) the data presented.

Include opinions regarding:

1) Mental illness/Mental defect.

2) Need for further evaluation of CST, if screening evaluation of CST was ordered or if CST deficits are noted.

NOTE: If the opinion of the evaluator is that further evaluation is not necessary because the defendant is clearly incompetent to stand trial, and the defendant appears in need of hospital level of care, the evaluator may recommend that if the court were to so adjudicate the defendant (IST), the court might wish to admit the defendant to an inpatient facility under s. 16(a).

3) Need for further evaluation of CR, if screening evaluation of CR was ordered.

NOTE: Some professionals feel that if either party raises the question of CR, it is never (or rarely) appropriate for the Court clinician to rule this out on the basis of a screening (s. 15a) evaluation.

4) Recommended disposition (i.e., no further clinical or forensic evaluation indicated, civil hospitalization, further forensic evaluation on either an out-patient or in-patient

basis).

5) If the recommendation is for inpatient hospitalization for further forensic evaluation note the reasons for this recommendation, as opposed to an outpatient more extended s. 15(a) evaluation.

6) If the recommendation is for in-patient hospitalization for forensic evaluation under conditions of strict security, note the reason(s) for this recommendation.

Disposition: If possible, document the outcome (i.e., no further forensic evaluation was ordered, extended outpatient evaluation was ordered, or inpatient commitment ordered). If inpatient evaluation was ordered, specify legal section and facility. Note if your recommendation is not followed by the court and why. If information regarding the reason why the recommendation was not followed becomes available after the report was completed, write a brief addendum to the original report explaining the reason. This addendum should be sent to the receiving facility and a copy kept with the original report.