Mental Illness/Problematic Sexual Behavior (MI/PSB) Program
Department of Mental Health – Forensic Services Division

Referral Guidelines

A complete MI/PSB assessment referral consists of four components (actual forms are attached below):

I. Informed Consent Form (if applicable)
II. Identifying Information Form
III. Collateral Contacts and Documents***
IV. MI/PSB Specific Referral Information Form

The steps associated with the above components are described in greater detail below:

I. Inform the client, and his/her guardian of person if applicable, that you are making a referral for an MI/PSB assessment.

(a) If the client has a guardian of person, review Informed Consent Form with guardian and have him/her sign form (attached). If guardian consents, review Informed Consent Form with client and get client's assent. A full MI/PSB assessment *cannot* be completed without the guardian's consent *and* the client's assent.

(b) If the client does not have a guardian of person, review Informed Consent Form (attached) with the client and have him/her sign the form to indicate his/her consent.

(c) If the client/guardian decline to consent to an assessment, please submit the referral for a Record Review Assessment. In some cases, the MI/PSB site, area, or statewide coordinator may recommend that additional efforts to obtain informed consent may be warranted to obtain a valid assessment of treatment and risk management needs.

Note: Even if the client/guardian give consent to do a Full Assessment, the MI/PSB evaluator will need to review the Informed Consent Form with the client and/or guardian. In some cases, a client or guardian may change his/her mind and decide not to consent/assent to the assessment.

II. Please ensure you indicate whether a Full Assessment, Record Review Assessment, or Consultation Assessment is being requested as well as all necessary contact information for the client, guardian (if applicable), and referring person.

III. It is essential that the referral source **include all of the available, pertinent collateral contacts and documents.** If contact information is provided for collateral sources, please include **signed releases of information for any non-DMH contacts**. Please attach copies of the documents listed on the **Collateral Contacts and Documents Form** and indicate which documents are included with the referral you are sending to the MI/PSB team. An evaluator will be assigned after the completed packet (including all supporting documents) is submitted. Please note that incomplete collateral information or records

will limit the evaluator's ability to make accurate and individualized recommendations about treatment and risk management needs. Additionally, documented information pertaining to problematic sexual behavior that is omitted from the referral can significantly impact the treatment and risk management assessment and the appropriateness of the recommendations. Referrals with incomplete packets will not be assigned until all the supporting documents are submitted.

IV. Complete the attached **MI/PSB Specific Referral Information Form**. Please state your specific referral questions on the form.

Please retain a copy of the referral form in the client's DMH/medical record and send completed referral forms and the supporting documents to the MI/PSB coordinator for your DMH region, area, or site.

Boston-Metro Referrals:

Kerry Nelligan, Psy.D.
Licensed Psychologist
MI/PSB Assessment Coordinator
Assistant Director of Clinical Services
Massachusetts Mental Health Center
75 Fenwood Road
Boston, MA 02115

E-mail: kerry.nelligan2@state.ma.us
Office: (617) 626-9774
Fax: (617) 626-9531

Central Massachusetts Referrals:

Matthew Robinson, Ph.D.
MI/PSB Psychologist
Central-Western Region
25 Staniford Street
Boston, MA 02114

E-mail: matthew.robinson@state.ma.us
Office: (617) 626-8103
Mobile: (617) 372-3009
Fax: (617) 626-8077

Northeast Massachusetts Referrals:

Drew J. Miller, Ph.D.
MI/PSB Program Director
DMH Central Office
25 Staniford Street
Boston, MA 02114

E-mail: drew.miller@state.ma.us
Office: (617) 626-8071
Mobile: (857) 315-8665
Fax: (617) 626-8077

Southeast Massachusetts Referrals:

Kim Bistis, Psy.D.
Community Clinical Psychologist
DMH Southeastern Area Office
165 Quincy Street

E-mail: kimberly.bistis@state.ma.us
Office: (508) 897-2193
Mobile: (508) 562-0562
Fax: (508) 897-2024

Brockton, MA 02302

Western Massachusetts Referrals:

John C. Barber, LICSW
Area Forensic Director
DMH Central – West Area
PO Box 389
1 Prince Street
Northampton, MA 01060

E-mail: john.barber@state.ma.us
Office: (413) 587-6244
Mobile: (413) 537-8001
Fax: (413) 587-6272

If you are unclear about who your MI/PSB coordinator is, or if you have questions or concerns about referring a client to the MI/PSB Program, please contact:

Drew J. Miller, Ph.D.
MI/PSB Program Director
DMH Central Office
25 Staniford Street
Boston, MA 02114

E-mail: drew.miller@state.ma.us
Office: (617) 626-8071
Mobile: (857) 315-8665
Fax: (617) 626-8077

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INFORMED CONSENT FORM

Client's Consent for MI/PSB Assessment

1. I understand that my DMH record shows that I may have a sexual behavior problem and that my treatment team is concerned about my sexual behavior.

2. I agree to take part in an assessment to see if I need treatment for a sexual behavior problem.

3. I understand that I can stop taking part in this assessment at any time. If I want to stop, I will tell the evaluator.

4. I understand that this assessment will be done by clinicians specifically trained in treating sexual behavior disorders.

5. I understand that if I sign this paper:

    - The evaluator will ask me about my personal life and sexual behavior and will review my DMH medical record.

    - The evaluator may ask me to sign a paper allowing review of records from other places where I have been treated.

    - The evaluator will give me psychological tests. Information about these tests is attached to this paper. The evaluator has reviewed this information about the tests with me.

    - The evaluator may ask my permission to administer me other tests.

6. I understand that during this assessment I will be asked about past sexual behavior. If I talk about inappropriate or illegal sexual behavior for which I have not been charged or convicted and I provide specific details (e.g., the victim's name or address, the offense date or location, etc.), the evaluator may be mandated to report this information and this information could possibly be used against me in court at some time in the future.

7. I understand that information from the assessment will go into my DMH medical record.

8. A clinician has reviewed the attached information about confidentiality with me.

9. I understand that I have the right to have a copy of this Informed Consent after it has been signed.

****

I have been informed that I have the right to consult with an attorney and/or Human Rights Officer, _____ at telephone #: _____ to assist me in making a decision to participate in this assessment.

Patient _____ Date _____

****

I agree to take part in this assessment.

Patient: _____ Date:_____

Guardian: _____ Date:_____

Witness: _____ Date: _____

Clinician: _____ Date:_____

****

Clinician Please Check One:

☐ I believe that this patient understands the information presented to him regarding this assessment and is capable of consenting to the assessment.
☐ I do not believe that this patient understands the information presented to him regarding this assessment and/or is not capable of deciding whether or not to participate.

☐ The patient's guardian has consented to the assessment and the patient is willing to participate.

Briefly describe the level of the patient's understanding.

_____
_____
_____
_____

Clinician:_____ Date:_____

****

INFORMATION ABOUT PSYCHOLOGICAL TESTS

****

During the assessment, you will be asked to complete some paper and pencil tests. These psychological tests will help us learn about your:

Personality	Sexual interests
Thinking	Sexual functioning
Mental well-being	Beliefs and attitudes about sex
Self-esteem	Knowledge about sex

At the end of the evaluation we will talk with you about the results of the tests.

Later on you may be asked to participate in testing that will help us assess your pattern of sexual arousal. At that time, a clinician will explain this type of test to you. You will then be asked whether or not you want to participate in this type of test. If you decide to participate, you will need to sign a separate consent form.

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INFORMATION ABOUT CONFIDENTIALITY

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Information about your treatment will become part of your DMH medical record. Your DMH medical record is confidential (private), except in special situations. Massachusetts law provides that your lawyer and/or guardian may see your records, a judge may order your records to be released, and under certain circumstances, the Commissioner of DMH may permit your records to be released if it is determined that releasing those records is in your best interest.

In addition, Massachusetts law requires that in the special situations listed below, your medical record is disclosed to other people.

Conviction of a Sex Crime

If you have been convicted of certain sexual crimes named in the Massachusetts Sex Offender Law M. G. L. c. 6 sec. (178C-178Q), or if in the future you are convicted of a sexual crime specified in this law, you may be required to register as a sex offender. Under this law, the Sex Offender Registry Board can access your DMH medical record, including information about your treatment.

If you have been, or if in the future you are convicted of, or charged with and found incompetent to stand trial for, certain sexual crimes named in the Massachusetts Sex Offender Law, the District Attorney can ask the court to commit you to the Treatment Center for the Sexually Dangerous at Bridgewater. The District Attorney may be permitted to see information from your

DMH record, including information about your treatment. The District Attorney may use this information in court to try to prove that you are sexually dangerous and/or that you have committed other sexual crimes.

Abuse of a Child, Elderly or Disabled Person

If your clinicians have information that you are abusing a child, an elderly person or a disabled person or there is a risk that you might abuse a child, an elderly person or a disabled person, Massachusetts law requires your clinicians to tell the appropriate state agency.

Risk of Harm to Another Person

If your clinicians believe that you pose a serious risk of harm to another person, Massachusetts law requires your clinicians to take steps to warn or protect that person.

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Identifying Information Form

Date of Referral: _____

Type of Referral: ☐ **Full Assessment (client consent/assent required)**
☐ **Record Review Assessment**
☐ **Consultation Assessment**

Identifying Information:

Client Name: _____ DOB: _____ Age: _____

Contact Person (for setting up assessment meetings with client if necessary):

_____ (name, phone number, email)

_____

Name of Referring Person (☐ check here if same as contact person)

_____ (name, phone number, email)

Is client currently DMH eligible? ☐ Yes ☐ No
If No, has eligibility application been filed? ☐ Yes ☐ No

DMH Area: _____ Site assignment: _____

DMH Service Providers:

Case Manager? ☐ **Yes** ☐ **No** **If yes, specify: _____**
CBFS/ACCS? ☐ **Yes** ☐ **No** **If yes, specify: _____**
Residential? ☐ **Yes** ☐ **No** **If yes, specify: _____**

Guardian of Person Name and Phone Number (if applicable):
_____

Relationship to Client: _____

Client's Current Address and type of housing:
_____
_____

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Collateral Sources and Documents Form

Collateral Sources:

Name: _____ Title: _____
E-Mail: _____ Phone: _____
Relationship to Client: _____ DMH Employee: ☐ Yes ☐ No
Signed Release of Information Included: ☐ Yes ☐ No ☐ N/A

Name: _____ Title: _____
E-Mail: _____ Phone: _____
Relationship to Client: _____ DMH Employee: ☐ Yes ☐ No
Signed Release of Information Included: ☐ Yes ☐ No ☐ N/A

Documents:

☐ **Formal sex offender-specific evaluations**
- Psychosexual evaluations conducted by community providers
- Past MI/PSB evaluations
- Past PPG test results
- Intakes or evaluations completed by sex offender specific treatment providers

☐ **Forensic evaluations/Risk assessments (as available)**
- Reports from Bridgewater State Hospital
- MFRs or IFRAs

☐ **Psychological testing**
- Cognitive/IQ testing
- Neuropsych testing
- Personality/psychodiagnostic testing

☐ **Psychosocial evaluations/Intake evaluations**
- Reports from community hospitals
- Reports from outpatient programs
- Reports from DMH inpatient facilities

☐ **Hospital admission and discharge summaries**
- Reports from community hospitals
- Reports from DMH facilities

☐ **Recent treatment notes including diagnosis and medication**
- Most recent treatment plan
- Case management notes
- Progress reports from sex offender-specific treatment (community or inpatient)
- Most recent CARC report

*****All supporting documents must be submitted before assessment can begin.**

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MI/PSB Specific Referral Information

1. **Client Legal Status: (check all that apply)**

   ☐ **On Parole** ☐ **Section 15(b)** ☐ **Sections 7&8** ☐ **NGI** ☐ **ICST**
   ☐ **Open legal charge – sexual** ☐ **Open legal charge – non-sexual**
   ☐ **On Probation**

   SORB Level ☐ **3** ☐ **Pending**
   ☐ **2** ☐ **Not Leveled**
   ☐ **1** ☐ **Unknown**

2. **Primary Language:** _____

3. **Why is the client now being referred for an MI/PSB assessment? Do you have a specific issue or question you would like addressed by the evaluator? Briefly describe Reason for Referral and Referral Questions:**

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

4. **Current Psychiatric Diagnoses:**

   _____
   _____
   _____
   _____
   _____

5. **List of Medications and doses:**

   _____
   _____
   _____
   _____
   _____
   _____

Is Client currently medication adherent?

☐ Always ☐ Mostly ☐ Mostly Not ☐ Not Adherent

Is client under Roger's Guardianship? ☐ Yes ☐ No

If yes, name and phone number of Roger's Guardian:
_____

6. **Has the client ever been charged and/or convicted of a sexual crime?**
   ☐ Yes ☐ No

   If so, please state charges, disposition, and sentence and, if known, describe the circumstances of the offense including the age and gender of the victim and nature, if any, of the relationship between the client and the victim:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

7. **Has the client ever been committed or evaluated for commitment to the Treatment Center for the Sexually Dangerous at Bridgewater?**
   ☐ Yes ☐ No

8. **Briefly describe the sexual behavior concerns for which the client is being referred (including any additional history of problematic sexual behavior not reported in #2). Include, when available, gender, age and relationship of client to the known or alleged victim. (Use the back of this form if necessary.)**
   _____
   _____
   _____
   _____
   _____
   _____

9. **Is the client's mental status currently stable? ☐ Yes ☐ No**

10. **Describe the client's baseline mental status:**_____
    _____
    _____
    _____

11. Briefly describe the client's current level of cognitive functioning (include IQ or other cognitive data if available):_____
_____
_____

12. Does the client have a history of one or more specific learning disabilities?
☐ **Yes** ☐ **No** ☐ **Not known**

13. Has the client previously received an assessment for problematic sexual behavior?

☐ **Yes** ☐ **No** ☐ **Not known**

14. Has the client previously received treatment for problematic sexual behavior?

☐ **Yes** ☐ **No** ☐ **Not known**

15. If yes to either #13 or #14 above, please state where, when and with whom:
_____
_____

Referral completed by:

_____ **Date:** _____

****

To be completed by MI/PSB Staff only:

RESPONSE TO REFERRAL/CONSULT REQUEST

Date Referral Received: _____

Date Completed packet received: _____

Date of assignment to MI/PSB Clinician: _____