CHAPTER 123 SECTION 15(b) REPORT GUIDELINES

Comment

This manual offering guidelines for MGL Chapter 123, section 15 (b) evaluations replaces earlier versions of the "style manual for reports." New sample reports have been included to more closely reflect current practice standards established by DMH's Forensic Services.

Copies of these Guidelines will be available through the Department of Mental Health Website.

I. PURPOSE:

This document is intended as a guide for writing understandable, complete, and legally-relevant forensic mental health reports of evaluations related to Competence to Stand Trial and Criminal Responsibility in the Commonwealth of Massachusetts. These evaluations are conducted under the provisions of Chapter 123, section 15(b) of the General Laws of the Commonwealth of Massachusetts.

The Guidelines represent the standards of the Department of Mental Health's Forensic Services concerning the nature and quality of forensic mental health reports. They are intended for use by forensic mental health professionals who are designated according to Department of Mental

Health regulations for performance of such court-ordered evaluations, and by professionals preparing for designation who are under the supervision of a Forensic Mental Health Supervisor.

Qualifications to these Guidelines: These guidelines were developed through a review process of forensic mental health professionals. They do not take into account all legal, clinical, and administrative circumstances for all cases, and there may be reasonable deviations from them in forensic clinical practice. They are not intended to define absolute standards of forensic assessment for all cases or to pre-determine clinical judgment related to forensic opinions.

Assumptions

Readers' understanding of these Guidelines will require that they already have knowledge concerning the statutes pertaining to the forensic mental health evaluation and involuntary hospitalization of mentally ill persons in the Commonwealth of Massachusetts. Further, they will need an adequate working understanding of the case law that bears on the issues discussed in those statutes. These issues include, but are not limited to, the legal standards for determining competence to stand trial and criminal responsibility.

The reader should also have an adequate working understanding of the Department of Mental Health regulations governing the definition of mental illness, and of the types of treatment available at facilities of the Department of Mental Health and Bridgewater State Hospital.

Use of this manual is not intended to be an equivalent of, or a substitute for, any DMH-approved program of training for forensic mental health professionals, or for any other training program.

II. GENERAL ISSUES IN WRITING CH.123, SECTION 15(b) REPORTS:

Quality of Reports: Ensuring the quality of a forensic mental health report begins long before the writing stage. For example, a good report requires that the mental health professional has begun with a clear understanding of the legal issue and the referral question, a logical selection of evaluation methods, adequate attention to protection of the rights of the defendant, careful collection of data, thoroughness in record-keeping, and expertise in the use of professional knowledge in the interpretation of the data in order to arrive at one's expert opinions.

Separate Competence to Stand Trial and Criminal Responsibility Reports: When the courts refer a defendant for an evaluation under Ch.123, sec. 15b, often they request that an evaluation be performed that will provide information regarding both competence to stand trial (CST) and criminal responsibility (CR). If this is the case, **two separate and distinct reports must be written.**

The primary reason that two reports are necessary is to facilitate the Court's efforts to protect the defendant's right to avoid self-incrimination. Specifically **the CST report must not contain information, provided by the defendant, that may be of a self-incriminating nature.**

Our current understanding is that courts commonly make the CST report available to both prosecution and defense upon receipt of the report. If the report contains the defendant's description of events at the time of the offense, this might jeopardize the defendant's right not to reveal any information that might be incriminating. Even if it were revealed, there are other legal protections against use of the information to prove guilt in a trial on the charges.

Nevertheless, including the defendant's statement regarding the alleged criminal conduct in the CST report presents some risk of jeopardy even if it cannot be used in the trial (for example, by having some influence during a negotiated plea). In contrast, in CR reports it will almost always be necessary to describe potentially incriminating information that is learned from a defendant.

Although two reports are necessary, the first several sections of both reports (as listed in Part III-A of this manual, "Defendant Identification" through "Current Mental Functioning") usually are virtually identical. The later sections (Parts III-B and III-C of this manual), which are specific to CST or to CR, complete the two separate reports.

It is not advisable to omit Part III-A (the sections that both reports have in common) to try to simplify or shorten the CR report and putting in its place a note that the reader should "refer to the CST report" for that information. Often the CST report will not be available to the reader; the two reports often are used at very different times (separated by months) in the trial process, and the CST reports might not even be entered as evidence at trial.

Professional and technical terminology: Unexplained jargon is to be avoided whenever possible. Professional or technical terms are often confusing or unfamiliar to the Court. Sometimes technical terms are necessary in order to anchor a statement in recognized clinical terms (e.g., providing a diagnosis). However, one should be aware that even words such as "agitated," "somatic," "hallucinations," and "labile" may not necessarily be understood by others in the same way that they are consensually understood by mental health professionals. When it seems necessary to use a technical term in a report, the term should be defined in common

language in parentheses. For example: “The defendant currently is prescribed Haldol (an antipsychotic medication) and Cogentin (a medication to reduce side effects of the Haldol).” “Nurses described his emotions as labile (shifting rapidly, frequently, and/or to different extremes).” At other times, however, clinical terminology that may be meaningful in a clinical context is simply unhelpful when writing for non-clinical readers. For example, even if it takes more words, “Recognized who she was, where she was, and the date” is better than “Oriented x3.”

Three essential classes of information: Forensic reports, like all clinical reports, contain three broad classes of information:

(a) clinical data;

(b) inferences or opinions; and

(c) logic explaining the relation between data and opinions.

It is **fundamentally essential** that forensic clinicians understand the differences between these classes of information, and that they learn how and when to provide them in a report. Lack of clarity regarding their differences and when to use them is the most frequent shortcoming of forensic mental health reports.

***Clinical Data*:** A forensic mental health report must include the relevant data on which any inference or opinions will be based.

Data are those things that the examiner has directly observed or read: things read in records, historical accounts by the defendant in clinical interviews; the defendant's behavior and affect during the interview; test scores; and so forth. Terms like "thought disorder," "schizophrenia," or "alcohol abuse" are not data; they can neither be seen nor heard. They are inferences about the meaning of what was seen or heard. Therefore, such inferences generally should not be included in sections of the report devoted to data and observations (unless the examiner is reporting them as things that were concluded by other mental health professionals in past contacts with the defendant, or as part of the defendant's self-report).

Generally, data (and **only** data) will appear in certain sections of the report, especially those devoted to history, past psychiatric treatment, current course of hospitalization. No more and no less data should be reported than is necessary to make the inferences and form the opinions that are described later in the report. In the mental status and psychological testing sections, inferences are appropriate when offered as interpretations of data provided.

For example:

"The defendant obtained an IQ score of 100 on the WAIS-IV, which indicates average intellectual functioning."

"He interpreted the proverb, 'That's the way the cookie crumbles' by responding 'you get crumbs on the floor and have to vacuum them up.' This, and similar responses, suggest difficulties in abstract thinking."

Finally, data should not appear for the first time in sections of the report that are reserved for inferences and opinions (see following discussion).

***Inferences and Opinions*: Inferences are interpretations about what the data mean**. They are clinical opinions, often requiring the use of specialized mental health expertise to make sense of data and observations. Inferences and opinions are generally reserved for the "conclusion" sections of the report (except as noted in the paragraph above). Interpreting each piece of data at the time it is presented in the report is wasteful, since one observation may mean something quite different in light of other observations appearing in other parts of the evaluation. Therefore, opinions generally should be presented in later sections, after all data are reported, particularly opinions about diagnosis and the relevant psycholegal issue (i.e., competence to stand trial abilities, capacities relevant to criminal responsibility, risk of harm to self and others, treatment needs).

***Logic Explaining the Relation between Data and Opinions*:** The well-written report of a forensic mental health evaluation does not include only data and clinical opinions. **Examiners should explain the reasoning or logic that links the data to the inference or opinion expressed.**

For example, if the examiner's opinion is that the defendant might present a significant risk of engaging in violent behavior in the near future, this opinion should be anchored in data (e.g., past violent behavior, offense charged, current mental status) and in a **process of reasoning** that links the data to the opinion (e.g., a presumed relation between past behavior and probable future

behavior; similarity of an anticipated situation to situations in which defendant has been violent in the past; an explanation that individuals who perceive themselves as threatened because of their active paranoid delusions present a greater risk of acting aggressively in response to that threat).

Enough reasoning should be offered so that the reader will be able to understand the basis of the opinions offered. Ordinarily the reasoning should accompany the opinions in the interpretation or conclusion sections of the report.

Reporting results of psychological tests:

If testing is very extensive (e.g., results of a full neuropsychological test battery), it may be presented as a separate section in the report, titled appropriately, and perhaps appearing right after the "Current Mental Functioning" section. Alternatively, often test results can be integrated easily and logically within the "Current Mental Functioning" section itself. For example, mental functioning sections sometimes offer an estimate of intellectual functioning, often based on a mental status exam; but if the examiner administered a WAIS, the results may be reported at that point in the section.

The suggestions above would apply when the examiner, or another mental health professional working on the case, has conducted the psychological testing. If the testing has been done by other clinicians during the course of the defendant's current hospitalization (for example, by a professional on a treatment team), it may be better to include the test results in the "Course of Hospitalization" section, because the test observations are not the examiner's. If the test results are derived from medical or psychological records related to past contacts (e.g., earlier

hospitalizations or outpatient treatment), it is best to put these results in the "Relevant History" section.

Some professionals prefer to report actual scores (e.g., IQ scores, scale elevations on the MMPI-2), while others prefer merely to offer a verbal substitute (e.g., "Her intellectual functioning was in the low average range. . ."). Either way is acceptable as long as one considers the following:

(a) If scores are offered, the report must also provide an adequate explanation of their meaning and their limitations, one that can be understood by non-psychologists or other clinical professionals.

(b) There are also circumstances in which test scores are important "for the record," and therefore may be desirable to include in the report. For example, sometimes a specific IQ score is relevant to a statutory or regulatory definition of intellectual disability (mental retardation). At other times, the scores may be relevant to treaters who will have access to the report (e.g., a defendant committed for treatment under §16(b)) and who will want the scores in order to make their own interpretations. In these and some other types of cases, the examiner may find good reason to include scores in the report.

Legal findings versus clinical opinions: When expressing one's professional opinion, the examiner should refer to it as a "clinical opinion," not a "finding." A "finding" is a legal

conclusion made by a court and no one else. For example, mental health professionals may write that they have formed a clinical opinion that the defendant "has significant deficits in abilities related to competence to stand trial," or "is incompetent to stand trial." But they should not write that they "*find* the defendant incompetent to stand trial."

Concerning a related question, there is considerable disagreement among forensic mental health professionals as to whether the clinician should even render a clinical opinion as to whether or not the defendant meets the legal standard, or an opinion that uses the words that define the legal concept itself, e.g.:

- "It is my clinical opinion that the defendant is **incompetent to stand trial**."
- "In my opinion she **was not criminally responsible** for her behavior."
- "In my opinion, the defendant's capacity **to conform his conduct to the requirements of the law** was substantially impaired."

Such testimony is referred to as an opinion on the "ultimate legal question." Forensic mental health professionals have an obligation to be thoroughly familiar with the arguments that have been made for and against this practice in the professional literature, before deciding for themselves where they stand on this matter. Please refer to the relevant sections later in this manual regarding competence to stand trial and criminal responsibility opinions. More specific discussion of this issue is offered on the forensic training website maintained by UMass Medical School and DMH (http://www.umassmed.edu/forensictraining/PracticeIssues.aspx). Also, for a good review of the arguments in this area, see: Tillbrook, C., Mumley, D., & Grisso, T. (2003). Avoiding expert opinions on the ultimate legal question: The case for integrity. *Journal of Forensic Psychology Practice, 3,* 77–87; and Rogers, R., & Ewing C. P (2003). The prohibition

of ultimate opinions: A misguided enterprise. *Journal of Forensic Psychology Practice, 3,* 65–75.

Reports are legal documents: The forensic mental health report offers evidence to a court of law. As such, it must be totally accurate to the best of the examiner's ability. This includes not only clinical features of the report, but also the simplest of identifying information: for example, a defendant's date of birth. The 15(b) report should have a professional appearance. Copies of the report retained by the examiner should be filed in a manner and place that ensures adequate security. The reports are property of the court, and should generally not be released by the examiner to any party, including attorneys and defendants. Upon court order, facilities or court clinics may release the reports. Oral comment on the contents of the report should be revealed upon request only to persons who are legally authorized to receive such comments (see *Commonwealth v. Stroyny*, 435 Mass. 635, (2002)), a case in which a psychiatrist, hired by the prosecution, inappropriately relayed incriminating information to the prosecutor prior to receiving authorization to do so).

Length of Reports: Section 15(b) CST and CR reports are somewhat longer in Massachusetts than in many other states, because our statutes require a report that deals not only with the forensic issues but also with the defendant's general need for care and treatment. This causes our reports to have somewhat more detail regarding clinical features and future treatment recommendations. No particular page length is suggested but the following guidelines are offered. Very short reports often do not include enough clinical data and explicit reasoning to be as helpful to the Court as they should be. Very long reports, on the other hand, may become onerous for the Court. It is important to examine all reports carefully to ensure that they do not

contain irrelevant data, redundancies, or more extensive discussion than is needed to address the clinical and legal issues in the case, clearly and adequately.

III. RECOMMENDED REPORT FORMAT:

A. <u>SECTIONS RELEVANT TO BOTH CST AND CR REPORTS</u>: As noted earlier in "Separate Competence to Stand Trial and Criminal Responsibility Reports," certain sections of these two reports contain almost identical information. The following is a list of those sections, and the titles given to them below are highly recommended as headings. Flexibility in the use of specific headings and their order is acceptable, but the contents associated with the following sections must appear in the report, and the organization of their presentation must be logical. The standard headings are:

- Identifying Information
- Legal Criteria for Determining Competence to Stand Trial (or) Criminal Responsibility
- Warning of Limits on Confidentiality/Privilege
- Sources of Information
- Relevant History
- Circumstances of Referral
- Course of Hospitalization
- Current Mental Functioning

Before beginning the headings, the report should have a major title identifying whether it is a CST or CR report. There also should be information (in whatever format the examiner wishes) which includes the defendant's name and the date of the report, and, if one wishes, the examiner's name (which is optional, since it will appear at the end of the report as well). Further

information, such as defendant's date of birth, the docket number and the place of the evaluation may be listed here, or may be included in identifying information.

Identifying Information: This first subheaded section of the report should begin with a brief identifying description of the defendant, purpose and place of the evaluation, referring court, and defendant's charges. A single paragraph for the whole will usually suffice. The description of the defendant should give basic demographic information. There should be a statement indicating the name of the referring Court, and the type(s) of evaluation that the Court requested (CST only, CR only, or both, even though the report is focused only on one or the other). This can be followed by the date of admission (if this was an inpatient evaluation), and the place where the evaluation was performed.

Finally, this section should state the offense(s) with which the defendant is charged, the date of the alleged offense(s), and the date of the arrest (if different from date of offense). It is helpful to add a *brief* description of what the defendant is alleged to have done. For example:

"He is charged with assault and battery with a dangerous weapon (shod foot), related to an alleged incident on April 4, 2010 when neighbors called police to intervene in a fight during which the defendant is said to have been kicking a man who was lying drunk in the street."

Legal Criteria for Determining Competence to Stand Trial (or) Criminal Responsibility:

This paragraph states the legal standard used by courts in the Commonwealth when determining a defendant's competence to stand trial (see Commonwealth v. Vailes, 1971) , or

criminal responsibility (see Commonwealth v. McHoul, 1967). This demonstrates that the examiner was aware of the question that the Court must address, and that therefore the collection of data to assist the Court was guided by anvawareness of the legal question. We recommend using verbatim quotes from the cases, rather than paraphrasing, or making it gender neutral.

Warning of Limits on Confidentiality/Privilege: This section should that the examiner informed the defendant about his/her role, the nature of the evaluation, its legal uses, with whom the information will be shared, and that the defendant is not obligated to participate in the interview. This section should also include a brief assessment of the defendant's understanding of the information provided. This warning is required by professional ethics and Commonwealth v. Lamb, 1974 (hence "the Lamb Warning," a term used in informal conversation and occasionally in oral testimony, but generally not in written reports). Collateral informants are not technically given "Lamb Warnings" because they are not at risk of self-incrimination. Nevertheless, collateral informants should also be told that information they share will not be confidential as it may be included in forensic reports or brought out in testimony.

Note that the description is entitled a "limits of confidentiality/privilege" warning, not "informed consent" or "waiver of rights." Defendants are not asked for permission for reports to be sent to the referring Court, because they have no legal right to prevent the Court from receiving this information. Of course, the defendant may decide not to participate in the evaluation. In that event, the examiner may still perform an evaluation and prepare a report, based on any other sources of information that are legally available (e.g., hospital records) and observations of the defendant in the act of refusing to participate or in other contexts.

Examiners themselves should remember that the limit on privilege to which Lamb refers is the fact that information will be reported to the Court. Confidentiality continues to protect the information from being communicated to others in many other circumstances; it is not available merely to anyone who might ask the examiner for information from the evaluation. This is why the section uses the phrase "limits of confidentiality" rather than "non-confidentiality."

The following delineates in more depth what is to be included in this section of the report. Ordinarily the examiner will indicate that he/she informed the defendant:

(1) about his/her professional status (including discipline) as a court-ordered examiner, and that he/she is performing the court-ordered evaluation in a role other than that of a professional involved in the defendant's treatment;

(2) that the evaluation was ordered by the court for purposes of (a) assessing whether he or she was mentally competent to stand trial, and/or (b) assessing his or her mental condition at the time of the alleged offense, and (c) assessing need for mental health treatment services, including commitment to a psychiatric facility (note: it is very important to include this last element, as the examiner may have to testify at a commitment hearing);

(3) that the information will be revealed to the court, and in that sense the evaluation is not privileged and confidential;

(4) that the defendant could refuse to answer questions or to participate in the interview, but that in that event the examiner would still be providing a report to the court and may need to testify, based on observations and other sources of information.

When the warning is given, it is standard practice to briefly assess the degree to which the defendant seems to have understood the warning. The report may include brief quotes from the defendant that suggest his or her understanding or confusion. Alternatively, the examiner may simply provide an opinion regarding whether the defendant appeared to comprehend the warning, if it is very clear that he or she did, for example by stating that "the defendant was able to accurately paraphrase the elements of this warning". This section of the report should be relatively abbreviated. In cases where the defendant's understanding is questionable, some additional data may be useful, but there is usually no need for this section to exceed one or two paragraphs.

Note that #3 above does not specifically identify the degree of privilege to disclose to the defendant. Some examiners prefer to provide detailed explanations (for instance, indicating that for competence to stand trial evaluations, the judge receiving the report will read it and is likely to show it to all parties in the case; for CR reports, the report will not be read by the court or the attorneys until the defense attorney formally asserts the insanity defense). This is an accurate description of the process laid out in Blaisdell v. Commonwealth. However, Blaisdell notwithstanding, criminal responsibility reports sometimes are read by the Court or made available to prosecutors without any decision by the defense to place the defendant's state of mind at issue in trial. Furthermore, these explanations are very complex, involving legal

explanations, and therefore most examiners simply inform the defendant that the report will be provided to the court, and that the examiner may be called to testify. It is then left up to the defense attorney to provide a more detailed and nuanced explanation to the defendant, if he or she chooses to do so.

There is no clear consensus on how much detail to review regarding where the various ways in which reports may be distributed or ways the information may be revealed to others. Clinicians must make their own decisions as to which procedure to follow. The best strategy, however, is to encourage and provide every opportunity for the defendant to consult with defense counsel about the defendant's participation in the evaluation prior to beginning the evaluation interviews. If a defendant asks questions concerning what he or she should do, the examiner should avoid giving legal advice, and instead suggest that he/she consult with the defense attorney, and postpone the interview if necessary. If the defendant (and/or the examiner) has contact with the attorney regarding these matters, this should be noted in the report.

<u>What to do when the defendant does not appear to understand the "Lamb" warning.</u>

When a defendant does not comprehend the "Lamb" warning, ethical and legal issues arise. For competence to stand trial evaluations, this lack of understanding should not prevent the examiner from proceeding with the evaluation, and asking all relevant questions. In such cases the examiner should be aware that it is likely that the defendant's statements will not be admissible as testimony regarding the issue of commitment (there are no such concerns about using the statements for purposes of determining competence to stand trial). However, testimony concerning *observations* of the defendant will likely be admitted. Other non-

privileged communications and information may also be admitted (subject to objections relating to hearsay). Accordingly, it is important as a general rule in all cases for the examiner to record and be prepared to testify to observations of the defendant's behavior, as well as other non-privileged communications or information received, in addition to any statements made by the defendant.

The situation is more complex in CR cases. In such circumstances, it is recommended that the examiner contact the defense attorney to apprise him or her of the issue. The defense attorney may consent to the evaluation on behalf of his or her client, and this should be noted in the report. If the attorney objects to the evaluation, the attorney should be asked to contact the court directly and have the order vacated. If the attorney does not follow through on having the order vacated, or if the attorney cannot be reached, the examiner can either: communicate with the court, apprising of the situation and asking for guidance, or proceed with the evaluation, documenting in detail information regarding the defendant's capacities related to comprehension of the "Lamb" warning. In all such cases, the examiner should document in the report all communications with the attorney and the judge regarding this issue. (Note: this issue is addressed in more detail on the UMMS/DMH forensic website: http://umassmed.edu/forensictraining/PracticeIssues.aspx)

Sources of Information: It is important for the court to know all of the sources of information that used in the evaluation. This is often done by listing:

- the dates and length of each of the interviews with the defendant;

- for all other persons interviewed in person or by telephone (e.g., defendant's attorney, a relative), their names, dates of contact, and relation to the defendant;
- all records v reviewed (e.g., medical, school, police, the 15(a) evaluation report)

Attempts to contact sources or obtain records should be noted after the list of sources of information utilized. For example, one might write, "Records were requested from Hospital, but have not yet been received."

Relevant History: The purpose of this section is to provide a sufficient historical and clinical data base to support interpretations, which will be offered in later sections, regarding the presence or absence of mental illness, diagnostic impression, and opinions such as likelihood of serious future harm to others due to mental illness.

Special attention should be given to the following types of information, although there is flexibility in the sequencing of the data:

- A brief description of any significant points regarding the defendant's history of family socialization and personality development
- History of social adaptations to (e.g.) school, work, peer relationships, marriage
- History of past mental difficulties, treatment (especially hospitalizations) and response to treatment
- History of substance abuse

- History of criminal justice involvements, including, when available, history of incarcerations with associated difficulties
- History of violence toward others and/or self
- Significant medical history

Ordinarily the history will be constructed with information obtained from a number of sources: for example, current and past records and other reports, the interview with the defendant, and interviews with other persons (e.g., the defendant's family or acquaintances). To the extent possible, it is helpful to bring together the information from various sources into one chronological "story" (either as an entire chronological account or a chronology within categories) rather than to present the defendant's account of his/her history, then the history as documented in records, and so forth. During this description, however, any discrepancies in information obtained from various sources should be noted.

When an examiner thinks that the defendant (or others, for example, a family member who provided information) was especially unreliable in recalling or reporting historical information it is often helpful to point this out at the beginning of the Relevant History section. In this way, the reader can better understand why parts of the history that may rely primarily on the defendant's account may seem "thin" or lacking in coherence.

In Massachusetts, the description of the defendant's history may be somewhat more extensive than for CST or CR reports in most other states. A lengthy social history ordinarily is not necessary, for example, to address questions of present mental state related to competence to

stand trial. The Commonwealth's statutes, however, require that CST and CR reports must also provide the court "with an opinion, supported by clinical findings, as to whether the defendant is in need of treatment and care offered by the department" (that is, the Department of Mental Health). An opinion on this matter will be included in the final section of the report ("Clinical Opinions Regarding Need for Care and Treatment"). Therefore, the history section of the report should contain sufficient data to support that opinion.

Although the Relevant History section should have enough information to address the statutory requirements, this section should not contain totally "unselected" information about the defendant. The guiding principle is that the examiner should selectively include information that may be considered relevant to the issues addressed (competence to stand trial, criminal responsibility, need for treatment). This includes, of course, not only data that support the examiner's opinion, but also data that could support an alternative conclusion. It should be kept in mind that this section is headed *relevant* history, not *complete* history. For instance, if the defendant is charged with rape, detailed information about his sexual history should be included. However, if the charge is shoplifting, such detail is not likely to be relevant. In addition, the level of detail included about family members should also be guided by relevancy considerations. It may be helpful to note if there is a significant family history of mental illness or criminal involvement but usually it is not necessary or appropriate to include names and identifying information about other individuals (e.g., "the defendant's sister, *Jane Smith*, has multiple arrests for prostitution").

When organizing the historical sections, the goal is to maximize clarity for the reader. It is often helpful to organize these sections categorically, with subheadings; for example, family/developmental, education, employment, social (including sexual, marital, relationship), legal, psychiatric, alcohol/substance abuse. The sequencing of these categories should be driven by the particulars of the case. For instance, if a defendant's only psychiatric hospitalizations have occurred during periods of incarceration, it will be clearer to the reader if legal history is provided prior to psychiatric history. It is also clearer, within categories, to present the information in chronologically ascending order. However, there may be other cases in which the information is clearer when presented chronologically, not categorically. There is no hard and fast rule, and examiners should use their own judgment about which format is most clear. (The sample reports included here exemplify both approaches.)

Circumstances of Referral: This section consists of a description of observations made by others in the context of the referral for the present court-ordered evaluation. If a §15(a) evaluation was performed at the Court prior to the §15(b) referral, this section should include observations and inferences recorded in the §15(a) examiner's report that appeared to be critical for raising the need for a §15(b) evaluation. If information has been obtained regarding the defendant's mental state or behavior while in jail prior to the present referral (e.g., a suicide attempt), it should be included here. It is not necessary to include the entire §15(a) report verbatim.

Course of Current Hospitalization: Summarize the course of the defendant's current hospitalization (if the evaluation is being performed in an inpatient facility). Pay special

attention to mental status at the time of admission and changes over time, responsiveness to treatment, interactions with treatment providers, and behavior in the facility. Provide a statement regarding the defendant's current treatment regimen, including a list of any medications he or she may be receiving, and a description of the defendant's involvement and/or adherence to treatment during the period of evaluation. It is neither necessary, nor helpful, to provide an overly detailed description of the hospital course (e.g., citing notes from each day). Rather, this section should convey a summary of the course of treatment (including improvement or lack of improvement in mental status, variability in mental state, as well as behaviors that may be relevant to risk), with judicious use of examples and quotes. Psychological or medical tests completed through the inpatient treatment team is often reviewed in this section.

Current Mental Functioning: This section presents data derived from a formal mental status exam and, if applicable, psychological testing that has been performed. (For including test results in this section, see above, "Reporting Results of Psychological Tests.")

Describe thoroughly the defendant's current mental status. Comment on the defendant's:

- attitude
- appearance
- behavior
- affect
- mood
- presence/absence of suicidal and violent thoughts/intentions

- speech
- thought processes
- content of thought/ideas
- perception (i.e., hallucinations)
- cognitive factors (orientation, attention, concentration, memory, intellectual functioning)
- insight about his or her disorder
- judgment

See section Professional and technical terminology above, regarding use of jargon and technical terms, which is particularly applicable to this section of the report.

Sections Specific to CST or CR: The report should include a data section and an interpretation section related to either CST or CR. The types of data and interpretation are quite different for these two types of evaluations. Therefore, their format and content are discussed separately, in detail, below.

Clinical Opinions Regarding Need for Care and Treatment: This is the very last section of the report. As noted earlier, in addition to addressing the matter of CST or CR, Ch. 123, Sec. 15(b) reports are required to offer an opinion on whether the defendant is in need of care and treatment provided by the Department of Mental Health. This is interpreted to mean that the examiner will offer also an opinion on:

- whether the person is suffering from a mental illness (as defined by state regulations), or other disorder (such as a developmental disability, mental retardation, dementia, etc.) and/or substance abuse;
- a formal diagnosis of the defendant's condition is not required, but many examiners find it useful to offer a diagnosis when appropriate;
- if a formal DSM diagnosis is offered, then this section should use the data presented in the earlier sections of the report to explain how the examiner arrived at the diagnosis;
- the type of treatment the defendant needs, including inpatient commitment if relevant
- if treatment is needed, suggestions for how that treatment might be obtained.

The latter often needs to be handled in light of various possible legal outcomes of the case. How might the defendant's treatment needs be addressed if the defendant is adjudicated incompetent? If the defendant is adjudicated competent? One must be careful, however, not to make recommendations that imply that the court should reach particular conclusions on the issue of CST or CR itself. Frequently, one's recommendations can be stated conditionally. For example:

- "If the Court finds the defendant incompetent to stand trial, a petition for his commitment pursuant to §16(b) is attached..."
- "If the Court finds the defendant competent to stand trial, it is recommended that …"
- "If the defendant is released by the court, the following recommendations for community treatment are recommended…An appointment has been arranged for [date and time] with [treater or agency]…"

- "If the defendant is held in jail, the following recommendations are offered… I contacted the court clinic on [date] to convey these recommendations."

[For more discussion, see: www.umassmed.edu/forensictraining/PracticeIssues.aspx]

If involuntary commitment appears warranted, the report must specify the reasoning for arriving at that recommendation. It is insufficient to recommend hospitalization solely on the grounds that the person experiences symptoms of mental illness; "likelihood of serious harm" related to the mental illness is also required. Therefore, the rationale for the opinion that the failure to hospitalize the person would create a substantial risk of serious physical harm either to self or to others as a result of mental illness must be articulated.

In some cases it is desirable to offer the court more than one dispositional option, depending on the legal outcome of the case. However, offering too long of a laundry list, without clarifying the recommendation may be confusing to the court. In choosing what to include in this section, the following guidelines are recommended:

- The examiner should first make clear to the court the specific dispositional recommendations that are consistent with the forensic opinion (e.g., if the examiner's opinion is that the defendant is incompetent to stand trial and requires further hospitalization, then the first recommendation should be commitment under §16(b) or further hospital-based evaluation under §16(a)).
- It may be advisable (depending on the setting) to offer the court alternative dispositional recommendations for hospitalization if the court finds contrary to the examiner's opinion about competence to stand trial (e.g., if the examiner opines

that the defendant is incompetent to stand trial, a recommendation can be included for how the defendant could be hospitalized if the court nevertheless adjudicates him/her competent - for example, §18(a), §12(e), §§7&8).

- It is not advisable to offer dispositional recommendations that conflict with the clinical opinion about need for hospitalization - e.g., if the recommendations is for inpatient commitment, it is generally not helpful to then add that if the court chooses to release the defendant then outpatient services may be obtained at a local community mental center.

- In this section, risk of harm to self and others should be addressed even if the examiner thinks that this is not due to mental illness (e.g., substance abuse, personality disorder).

Note: There are situations where the data do not suggest that the defendant poses a risk of harm to self or others but the examiner thinks that the person could nevertheless benefit from treatment. In making recommendations in such cases, examiners should be aware that some courts will impose this treatment as a condition of probation. Therefore, when making such recommendations, examiners should take into account the advantages and disadvantages of such enforced treatment. In some cases it may be helpful to provide pointers as to how to maximize the likelihood of successful linkage to treatment services (e.g., "Given Mr. Defendant's cognitive limitations, if he is ordered to comply with treatment as a condition of his probation, it may be

useful to educate him of the conditions with very simple instructions and offer reminder mechanisms to maximize his ability to adhere to the conditions.")

B. SECTIONS RELEVANT FOR COMPETENCE TO STAND TRIAL REPORTS

The two sections described here appear after the Mental Functioning section and before the Need For Care and Treatment section in the CST report.

Abilities Relevant to Competence to Stand Trial: The evaluation of CST requires making observations and collecting information that assess the defendant's knowledge, beliefs, behaviors, and affective responses related to preparedness to participate in the trial process. Generally these can be grouped into the following issues, which will be reported in separate subsections (as described later):

- Understanding of the charges, verdicts, and penalties
- Understanding of the trial participants and trial process
- Ability to assist counsel in preparing and implementing a defense
- Ability to make relevant decisions

The subsections reporting the defendant's status on each of the above **capacities should contain data and observations, not inferences or interpretations.** The examiner should describe what

the defendant actually did or did not know, could or could not do, or what the defendant believed, with regard to specific content within each of these areas.

Interpretation or opinions are not appropriate in this section. The main rationale for this statement is that a defendant's performance during collection of these data is not all that matters in reaching opinions related to CST. For example, the mere fact that a person fails to give adequate responses in this part of the evaluation does not mean that the person "is unable to understand" the matters in question. Data from other sections of the report might suggest that the person's performance cannot be interpreted that simply (e.g., the person is experiencing side-effects of recent medication, or has been malingering illness and exaggerating a limited understanding of what has been explained). This section, then, is merely one type of data to be used later in reaching opinions about CST.

For example, for "Understanding of Trial Participants," one describes what the defendant said when asked for his or her perceptions of the roles of various people in the trial process. Often this can be paraphrased; but especially when the defendant's perceptions are distorted, it is helpful for the court to hear what the person actually said (that is, use a quote). One can also use summaries of a person's descriptions, especially when they were relatively standard and non-problematic (e.g., "The defendant provided an accurate description of the opposing roles of defense and prosecution"). But note that if one used this type of summary when the defendant's responses were not accurate ("…defendant offered an <u>in</u>accurate description…"), it would be essential to describe, in addition, what it was, specifically, that the defendant said.

In contrast, it is not appropriate to report merely that "The defendant has a good understanding of (or does not understand) the roles of defense and prosecution." This is an interpretation or opinion, not data or observation, and should be left to the next subsection. Moreover, if this statement is made without anything else, it has been presented without supporting data or observation, and therefore does not allow the court to evaluate the reasoning for the opinion.

The following provides suggestions for the content of the four subsections in this section:

A. Understanding of Charges, Verdicts and Consequences

This subsection should contain data relevant to assessing the defendant's understanding of:

- what the charges are called
- what it is specifically that police are saying that he or she did to warrant these charges (the alleged behaviors underlying the charges)
- the relative seriousness of the charges
- the basic pleas and verdicts (guilty, not guilty, not guilt by reason of insanity, etc.)
- the possible consequences of each of the possible verdicts, given the charges in the case

B. Understanding of the Trial Participants and Process

This subsection contains data relevant to assessing the defendant's understanding and beliefs about relevant roles of trial participants and trial procedures. The examiner should attend not only to the defendant's understanding in the abstract, but also to the

defendant's beliefs about these matters in his or her own situation. (For example, a person might **know** that judges are supposed to weigh evidence impartially, but may believe that in his or her case the judge is part of a conspiracy.) The subsection should address the person's understanding and beliefs regarding:

- the adversarial nature of a trial process
- the pleading and plea bargaining process
- functions and roles of the various participants in a formal trial hearing (judge, jury, defense counsel, prosecutor or DA, witnesses); this includes an understanding of the advocacy role of defense counsel in relation to the defendant, in contrast to the role of the prosecution

C. Ability to Assist Counsel in Preparing and Implementing a Defense

This subsection contains data relevant to assessing the defendant's ability:

- to trust his or her attorney
- to communicate information to the attorney in a rational manner
- to rationally understand communications made by the attorney to the defendant
- to appraise the quality and quantity of evidence against the defense
- to be adequately motivated to assist the attorney in preparing a defense
- to attend to the trial process and to tolerate it emotionally

D. Ability to Make Relevant Decisions

This subsection contains data relevant to assessing the defendant's ability to make certain decisions relevant to the court process. Such decisions include deciding on

which plea to enter, acceptance or rejection of plea bargains, deciding on a bench vs. jury trial, and waiving or dismissing counsel. An important point is that we are assessing the defendant's ability to engage in rational decision making; we are not assessing the wisdom of the decision arrived at. Thus, we focus more on the thought processes involved, rather than the actual decisions arrived at. The subsection should therefore contain data relevant for assessing the defendant's ability, relative to the decisions noted above:

- to engage in the cognitive process of weighing simultaneously several options
- to arrive at decisions rationally, without significant distortion due to mental illness
- to consider defense counsel's advice in a rational manner

Note: In some cases, there may be significant overlap between the items in these last 2 subsections (ability to assist counsel and ability to make relevant decisions). In such cases, the examiner can use discretion to combine them into one subsection.

General comments about Competence to Stand Trial Data Sections

1. Distinguishing lack of legal knowledge from impaired capacity

When a defendant manifests poor or confused understanding about factual matters (or simply says "I don't know"), the examiner should engage in a process of "educating" the defendant, then questioning him or her again in order to determine whether this improves the defendant's understanding. Examples of such education and re-testing can be found in the MacArthur Competence Assessment Tool – Criminal Adjudication (MacCAT-CA). If this is done, the examiner should note in the relevant subsection that he/she educated the defendant about the

matter and describe his or her response. This allows for a distinction between a defendant who simply does not initially have the requisite factual knowledge, versus one who is impaired in his or her ability to learn or maintain the knowledge. The response style of the defendant may also provide some data for a defendant who may be feigning a lack of understanding.

2. Not revealing specific information that may be incriminating or reveal defense strategy

The issue here is that in the context of a competency to stand trial evaluation, in order to address all the issues, it is often necessary to discuss elements of the alleged offense with the defendant, as well as ask questions about how he or she may plead. Although there are some who recommend not even asking the defendant for his/her version of the alleged offense, most forensic examiners agree that in most cases, it is necessary to ask the defendant for at least some information about the alleged offense. It is not necessary to ask for detailed information, however some inquiry is usually necessary in order to:

a. assess whether the defendant can communicate information relevant to the defense in a coherent, rational manner (assessing not only general communication abilities but the defendant's ability to communicate information related to the alleged offense that may engender significant stress/anxiety);

b. determine whether the defendant maintains distorted beliefs about the alleged offense which specifically impact his/her ability to make rational decisions about the particular case, to realistically assess the quality of the prosecution's evidence, and to work rationally with the defense attorney; or

c. determine other aspects of the evaluation. In some cases, this information may be highly relevant to the assessment of need for care and treatment. For example, a defendant acknowledges that he shot his father, but insists that his father is not really dead (even though in reality he is), and therefore insists that he cannot really be charged with murder. His attorney tries in vain to convince him that this defense is not viable, but the defendant rigidly maintains his delusion. In this case, even if the defendant has a full factual understanding of the trial process, this delusional belief could render him incompetent to stand trial. It would not be possible to complete the competence to stand trial evaluation without eliciting information related to the alleged offense.

However, although this information is elicited in the interview, there are limits regarding including some of these statements in the report. For some of the competence to stand trial domains, the interest of avoiding inclusion of incriminating statements and defense strategy will require modification of the general principle of providing sufficient data to support conclusions arrived at. The following provide examples of how these competing needs can be balanced:

1) (Using the example referenced above): “Mr. Smith understands that he is charged with killing his father. However, he insists that his father is still alive, despite clear evidence to the contrary. He insists that therefore he cannot be charged with murder.” [Note that the report did NOT say “Mr. Smith acknowledges shooting his father, but claims that his father is not really dead.”]

2) "Ms. Jones was able to provide a coherent, rational account of the alleged offense, including a description of her behavior and state of mind." [Note that the report did NOT say: "Ms. Jones stated that she robbed the bank, but did so because she thought the bank had discriminated against her by not offering her a mortgage."]
3) "When presented with possible plea bargain options in his case, Mr. Doe was able to describe, in a rational manner how he would make the decisions." [Note that the report did not say whether he stated that he would enter a guilty plea, or the conditions under which he would do so. Such information would be revealing too much to the prosecution].

Clinical Opinion Regarding Competence to Stand Trial: This section includes the examiner's interpretations and opinions regarding the defendant's abilities related to the question of CST. Usually it will use data not only from the previous section, but also from the sections on History, Hospitalization, and Mental Functioning.

As discussed above, there are differing opinions among forensic mental health professionals regarding the issue of offering an "ultimate opinion." Some examiners use ultimate opinion language such as: "In my clinical opinion, the defendant is/is not competent to stand trial." Other examiners use language that does not contain an ultimate opinion statement, such as: "In my clinical opinion, symptoms of the defendant's mental illness do/do not significantly impact his competence to stand trial abilities," or "In my clinical opinion, the defendant demonstrates an understanding of the court process, an ability to assist counsel, and an ability to make rational decisions about her case." Given these differences, examiners should decide for themselves the style with which they are most comfortable. Examiners should also be aware that some courts

may have a particular preference for a more direct opinion on competence to stand trial, while others are accepting of the more nuanced language.

The discussion should contain a clear explanation of the reasoning for the opinion offered**. If there were no significant deficits in abilities related to CST**, this is relatively simple and the section may be quite short. It may refer to the previous CST data sections as a documentation of the lack of deficits.

If there are significant deficits relevant to CST abilities, usually the first step is to offer an opinion on the presence or absence of mental illness/intellectual disability (e.g., mental retardation) or other mental impairment. The nature of the disorder should be explained, referencing the critical data presented in earlier parts of the report, followed by an explanation of how the features of the defendant's mental impairment result in the deficits observed in the CST data sections. This explanation is important; the relationship between symptoms and functional competence impairments should be clearly articulated. For example, the following exemplifies an inadequately stated nexus between symptoms and competence impairment: "The defendant's ability to relate to her attorney will be compromised by her delusional thought processes." In contrast, the following is fully articulated: "The defendant is committed to a delusional system that includes a belief that her attorney is receiving commands from God to ensure that she is punished. This delusion compromises her trust in and ability to relate to her attorney."

If the examiner's opinion is that there are significant deficits in competence to stand trial abilities, but <u>not</u> due to mental illness or intellectual disability, then the reasons for the poor

performance (such as simple lack of knowledge, a defendant raised in a different culture with a different legal system, or a defendant whose personality style makes him or her emotionally labile, angry, or hostile) should be explained. It should also be noted that in Massachusetts, unlike with CR, for CST there is no requirement that a defendant have a mental illness or developmental disability as a basis for incompetence. In situations where defendants manifest significant deficits in abilities related to CST that do not appear to be due to mental illness or developmental disabilities the opinion should focus also on whether the defendant actually lacks capacities as opposed to having a lack of experience, knowledge, frustration tolerance, etc. Further, the opinion may include suggestions that can help facilitate the defendant's capacity to participate in his or her own defense (e.g., suggestions related to educational needs, limit setting, or other active involvement by the defense attorney).

The following are some additional points relevant to preparing this section of the report:

- In some cases in which the defendant appears currently to be competent, there is a risk that the defendant's condition may deteriorate in the course of the trial process. If so, this should be noted and the reasoning explained. For example, if the defendant has stabilized on medication, but in the examiner's opinion would likely decompensate if medications are discontinued, this should be noted.

- Not all deficits need to be equally emphasized or elaborated in one's interpretation section, because not all defendants face the same kinds of task demands in terms of the trial process they are most likely to encounter.

For example, some cases stand a good possibility of requiring a lengthy formal trial; others are more likely to amount to briefer hearings, while most criminal cases will involve no formal trial at all (e.g., due to plea-bargaining). Such differences in probable circumstances create different demands on defendants, so that various deficits may have different significance or importance from one case to another. For example, if a defendant's mental illness creates a serious deficit for maintaining attention to events beyond 15-30 minutes, one might want to elaborate on the implications of this in the event that a lengthy formal trial may be necessary, while noting that the deficit will be of lesser significance in the context of other types of briefer legal procedures.

- If the person appears to have deficits that could form the basis for a finding of incompetence, the examiner should offer an opinion on remediation of those deficits. This would include a description of the general type of treatment needed to regain competence (after articulating the basis for the deficits), and an opinion concerning the likelihood that the treatment will be successful in restoring competence. In writing the opinion related to restorability, there is no expectation of probabilities or percentages. Often it is helpful to write something that is known about the impact of treatment for a particular condition (e.g., generally individuals with manic symptoms respond to medication and therapy within six to eight weeks, and Mr. Jones has a history of similar responses when hospitalized. Thus, in my opinion it is likely that

his competence deficits, which seem to stem from his manic symptoms, will improve during this same time period.")

- In some cases in which the defendant appears currently to have significant deficits in abilities related to competence to stand trial, the reason for these deficits offers little prospect that the defendant can gain competence in the course of future treatment. If so, this should be noted and the reasoning explained (e.g., irreversible dementia).

If this section becomes very lengthy, it is helpful to conclude with a one-sentence paragraph that clearly repeats the opinion summary statement that was made at the beginning of the section.

C. SECTIONS RELEVANT FOR CRIMINAL RESPONSIBILITY REPORTS

The four sections described here appear after the Mental Functioning section and before the last Need for Care and Treatment section in the CR report.

Police Report of Alleged Offense: This section should include the police officer's description of the alleged offense, based on the written police report, the examiner's telephone contacts with police, and/or any other official report of the events. Rather than quoting the whole report, it is best to paraphrase the report, conveying the relevant information. When there is lack of clarity, the examiner should try to follow up by attempting to contact the police or collateral informants.

Additional Information Related to the Alleged Incident: This section reports other persons' accounts of the events surrounding the alleged incident. This might include information, for example, from witnesses or family members. It also may include information from others who did not directly observe the alleged incident, but who have information related to the defendant's mental condition in the hours or days prior to or after the alleged event. The focus of such collateral inquiries should be on (a) others' descriptions of the defendant's behaviors on that date, and (b) others' observations which allow for inferences about the defendant's mental state at the time of the alleged crime.

Defendant's Account: This section should include the defendant's account of the circumstances surrounding the alleged offense. This would include events and circumstances leading up to the alleged offense (for example, relevant things that were happening in the defendant's life during the previous week) as well as the defendant's report of his or her actions and thoughts on the date in question. The defendant's recollection of his or her state of mind on the date in question should be included, as well as (when relevant) his or her account of the events that followed the alleged crime. In this section, examiners should avoid offering interpretations of what the defendant has said, the likelihood of the accuracy of the information, or the implications for CR (as these will be discussed in the opinion sections).

In order to obtain the defendant's account, it is usually best to begin with an open-ended style (asking the defendant for his or her account) and then follow up with more detailed questions. The questions should include clarification of issues relevant to the cognitive and volitional prongs. In presenting the data in this section it is best to combine (a) paraphrasing of the

defendant's account with (b) short quotations of the defendant's actual words (especially when they are of special importance), and including (c) descriptions of questions posed to challenge or seek clarification from the defendant, especially if they led to significant revelations by the defendant. For example: "When he reported that he happened to see her on the street, I noted that the woman claimed that he had been following her for several blocks. He then admitted that he had: "Yes, I guess I was – actually, every afternoon that week – I was obsessed." Use of one long, uninterrupted quotation of the defendant's version is not recommended since, unless the interview was taped and transcribed, it is unlikely that such a lengthy quote is completely accurate. Furthermore, even if accurate, this is usually not a format that is easily absorbed by the reader.

The defendant's report of alcohol or substance use around the time of the alleged offense should always be a point of inquiry and also be included in the report, even if the defendant reports no use of drugs or alcohol at the time (e.g., "the defendant reported that she had not been drinking for a week prior to the alleged offense"). In addition, this section should include the defendant's responses to questions regarding information obtained from the police report and/or collateral sources. If inconsistencies or discrepancies exist between the defendant's statements over the course of the interview, these should be noted as well. Any data or statements about the defendant's version that are referenced and used later in the conclusion section must first be documented in this section.

Clinical Opinion Relevant to Criminal Responsibility: This section interprets the information from the previous sections with regard to its relevance for the question of the defendant's criminal responsibility. Generally this begins with a summary statement of clinical opinion concerning:

- whether or not the defendant was experiencing a mental illness (or mental retardation) at the time of the alleged offense; and if he or she did, then:

- whether this significantly influenced his or her ability to appreciate the wrongfulness (addressing both legal and moral wrongfulness when appropriate) of the conduct (the "cognitive prong"); and

- whether this significantly influenced his or her ability to conform his or her conduct (exercise self control) to the requirements of the law (the "volitional prong").

The examiner should then proceed, one by one for each of these clinical opinions, to explain the rationales for the opinions. The explanation should use and identify data presented in previous clinical and "version of offense" sections, and the nexus linking the data to opinions should be clearly articulated.

There are cases for which an examiner cannot reasonably form a confident clinical opinion on one or more of the three matters noted above. Sometimes this is due to:

- the patient's unwillingness or inability to provide a comprehensible account of his or her behavior
- the absence of corollary accounts of the patient's actions and mental state
- the inherent difficulty of attempting to form retrospective assessments about complex clinical material.

When one's data are insufficient to form a reasonably clear opinion on any matter, the proper approach is to say just that in the initial summary of one's opinions, and then proceed to explain the difficulty. If this section becomes very lengthy, it is helpful to conclude with a one- or two-sentence paragraph that clearly repeats the opinion summary statement made at the beginning of the section.

<u>Guidance when a defendant cannot or will not provide an account of the alleged offense</u>

Situations arise in which a CR evaluation has been ordered but the examiner cannot obtain the defendant's version of the alleged offense (either due to denial on the part of the defendant, the defendant's refusal to discuss the alleged offense, the defendant's report of no memory for the alleged offense, or because the defendant is so impaired that he/she cannot provide an account). In such situations, examiners must decide whether to submit a report based on other sources of data, offering an opinion on relevant issues to the extent possible (e.g. mental state at the time of the offense), or to write a letter to the court, stating that the examiner cannot complete or conduct the evaluation. The following guidelines are offered:

1. The defendant's inability or unwillingness to provide an account of the alleged offense does not *per se* prevent an examiner from submitting a report, although it may result in a qualified or limited opinion.

2. If there is adequate information from other sources (including collateral sources, records, and the defendant's clinical presentation) to address the presence/absence of mental illness at the time of the alleged offense, the examiner could aid the court by providing the relevant data and analysis (even if a full analysis of the defendant's abilities to appreciate wrongfulness and conform conduct cannot be offered). The examiner should make clear in the report the limits due to lack of information from the defendant and qualify the opinion accordingly.

3. In some cases, it may be possible for the examiner to render an opinion based on available data even without a full account by the defendant.

4. If there is no meaningful information relevant to the presence or absence of mental illness at the time of the alleged offense, a letter to the court explaining the situation briefly, rather than a full report would be appropriate.

Note on the Form in which Examiners Should Express their Opinions

As discussed above, there are differing professional opinions about the desired form for reporting one's opinions on the ultimate issue (in cases of CR, this would refer to whether or not clinicians should use the specific language of the standard, i.e., " the defendant lacked substantial

capacity" to appreciate wrongfulness/conform conduct). A full discussion can be found at: http://www.umassmed.edu/forensictraining/PracticeIssues.aspx However, there is consensus that mental health examiners *should not* write or testify that in their opinion: "the defendant should (should not) be found **criminally responsible** for the alleged offense." Use of this language is similar to opining that a defendant is "guilty" or "not guilty," which is beyond the realm of clinical expertise and improperly places the clinician in the role of the trier of fact.

Whatever form of opinion statement is used, however, it is *essential* for the examiner to delineate clearly the data on which one's opinion is based, and the logical inferences that link one's data to one's opinion.

APPENDIX A

SAMPLE 15b REPORT: COMPETENCE TO STAND TRIAL

COMPETENCE TO STAND TRIAL EVALUATION

NAME: John Doe
DATE OF BIRTH: January 16, 1985
EXAMINER: Jane Smith, Ph.D.
DATE OF REPORT: February 2, 2010

IDENTIFYING INFORMATION:

This is the first Massachusetts State Hospital admission for this 25 year old single man. Mr. Doe was admitted on January 8, 2010 from the Town District Court, with orders for evaluations of competence to stand trial and criminal responsibility pursuant to the provisions of M.G.L. c.123 §15(b). It is alleged that on January 5, 2010, Mr. Doe destroyed his father's office fax machine, and later left the area in the family car, leading to the current charges of Malicious Destruction of Property valued over $250.00 (the fax machine) and Unauthorized Use of a Motor Vehicle (the family car).

LEGAL CRITERIA FOR DETERMINING COMPETENCE TO STAND TRIAL:

In Commonwealth of Massachusetts courts, a defendant is found competent to stand trial if "he has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and if he has a rational as well as factual understanding of the proceedings against him" (Commonwealth v. Vailes, 1971).

WARNING OF LIMITS OF CONFIDENTIALITY/PRIVILEGE:

At the beginning of the first interview, I informed Mr. Doe that I am a psychologist and that I wanted to examine him, per order of the Court, to gather information that the Court could use in determining his competence to stand trial and criminal responsibility in reference to the alleged offenses. I told Mr. Doe that as part of these evaluations, I would also be making recommendations to the Court regarding his need for further care and treatment for mental illness, including psychiatric hospitalization. I explained that my observations and the information he provided would not be held confidential but could be included in a written report which I would submit to the Court, and possibly in oral testimony. I told him that his participation in the evaluation was voluntary but that I would submit a report to the Court whether or not he chose to speak with me.

I then asked Mr. Doe to repeat the substance of the warning described above. He said:

“The evaluation is to see if I understand the court and to see if I was in my right mind at the time. You also said you would be deciding if you think I still need to be in the hospital." He further indicated that he understood that his participation was voluntary and that I would be submitting a report to the court whether or not he choose to participate in the evaluation. He then said "I told you I know all that, my lawyer said I should tell you anything you want to know.” In my clinical opinion, Mr. Doe understood the purpose of the evaluation and the limits of confidentiality.

I reviewed this information with him prior to all subsequent interviews, and Mr. Doe had no difficulty retaining this information across sessions. I provided a similar explanation of my role and the limits of confidentiality to the other persons with whom I spoke.

SOURCES OF INFORMATION:

1. Interviews with Mr. Doe on 1/19/10, 1/21/10 and 1/25/10 for a total of approximately 3 1/2 hours.

2. Consultation with Mr. Doe's clinical treatment team at Massachusetts State Hospital.

3. Review of Mr. Doe's current Massachusetts State Hospital record.

4. Review of Mental Health Center records from a 2005 admission.

5. Review of Mr. Doe’s CORI record.

6. Telephone interview with Susan and Jack Doe, the defendant’s parents, on 1/19/10.

7. Telephone interview with Dr. Sam Jones, who performed the 15(a) evaluation at the Town District Court, on 1/18/10.

8. Telephone interview with Ms. Nancy Adams, the attorney who has been assigned to represent Mr. Doe, on 1/18/10.

9. Town Police Department booking sheet and arrest report both dated 1/5/10 and signed by Officer Thomas Johnson.

10.Review of 15(a) evaluation completed on 1/8/10 by Dr. Sam Jones.

RELEVANT HISTORY:

The following history was obtained primarily from Mr. Doe, supplemented with information provided by his mother. For the most part, the two accounts are consistent, although there are some significant discrepancies, as indicated below.

Mr. Doe is the older of two children, born and raised in an intact family in Town, Massachusetts. His mother's pregnancy and the delivery were without complication. He

achieved all developmental milestones within the range of average time-frames, and without difficulty. He suffered the usual childhood illnesses with unremarkable course. When he was three years old, he fell from a swing, with a superficial scalp abrasion requiring suturing. He did not lose consciousness. His medical history is otherwise uneventful.

Mr. Doe attended the public school system in Town, graduating from high school in 2005. His mother reported that his academic performance was consistently above average, that he participated in numerous extra-curricular activities, and that he had a small group of close friends. No behavioral problems were reported, and Mr. Doe was well liked by peers and teachers. Throughout his life, both parents have worked outside the home, mother as a teacher and father as an attorney in private practice.

After graduating from high school, Mr. Doe attended Private University, but dropped out after one semester. He said that he left school because he was "bored," but his mother said that he was unable to complete his assignments and that his further attendance was made contingent on his participation in counseling, which he declined. For the next two years, Mr. Doe lived in his parents' home, working sporadically in various unskilled labor positions. His mother reports that he socialized less and less over time and gradually lost contact with all of his high school friends.

In August of 2005, his parents returned home from a two-week vacation to find that, in their absence, Mr. Doe had spray painted swastikas and depictions of the devil on the living room walls. He was subsequently admitted to the Mental Health Center, where he remained for three weeks. Records from that hospitalization indicate that although expressing strong convictions of a religious nature, Mr. Doe did not manifest overt evidence of a psychotic disorder. He was treated with Klonopin (for anxiety), which was discontinued after a week. His diagnosis on discharge was Mixed Personality Disorder, and he was referred for out-patient therapy. He did not follow through with that recommendation, and has received no subsequent mental health intervention until the current hospitalization.

Since that time, Mr. Doe has been unemployed and has lived in a room in the basement of his father's office, supported by his parents. He said that he spends most of his time in this room, building model airplanes and writing a novel. On occasion he joins his parents in the family home for meals, but more often he eats in his room, with food provided by his mother. Mr. Doe believes that he is not allowed to live-in his parents' home because they are “fed up” with him and do not value his contributions to the family. When asked why he has been unemployed for so long he answered: "I'm sick of working for minimum wage. I can't get a place of my own on minimum wage."

In contrast to Mr. Doe's report, his mother said that her son has displayed very erratic and at times explosive and threatening behavior during the last several years, and that these outbursts have increased in frequency and severity in recent months. She describes many instances in which he screamed at her in a very threatening manner (e.g. "You will not need anything after tomorrow..."). She said that he has never physically harmed her in any way, nor to her knowledge has he ever engaged in violence towards others. There is no history of violence towards others mentioned in available records. Nevertheless, she said that she now

is quite frightened of him when he is agitated. Mr. Doe reports no previous involvement with the criminal justice system, which is confirmed by mother and his CORI record. There is no known history of suicidal thoughts, plans, or attempts.

Mr. Doe acknowledges use of alcohol on a daily basis, stating that he drinks only a glass or two of wine in the evening. However, his mother reported that she frequently sees empty bottles of gin in his room, and that he has often appeared to be intoxicated when she visits during the day. Mr. Doe said that he tried various street drugs (including LSD and angel dust) during his high school years but now uses only marijuana once or twice a year. He indicated that during high school he would drink about a six pack a week but reported no difficulties associated with his drinking.

CIRCUMSTANCES OF REFERRAL:

According to Nancy Adams, defense counsel, she requested a screening evaluation of competence to stand trial and criminal responsibility under the provisions of M.G.L. c.123 s. 15(a) after Mr. Doe refused to speak with her. He was seen by Dr. Sam Jones at the Town Court clinic on January 8, 2010. Dr. Jones reported that Mr. Doe declined to speak with him, stating only: "I have rights under the American flag and the Constitution of the United States." Dr. Jones noted that Mr. Doe appeared agitated (suddenly standing and pacing the room) and frightened. Based on this presentation and mother's report of his behavior over the last several years, Dr. Jones concluded that Mr. Doe was suffering from significant mental disorder which would compromise his ability to consult with counsel in any meaningful manner. He recommended further evaluation of competence to stand trial and criminal responsibility under the provisions of s. 15(b).

Ms. Adams said that she advised her client to participate fully in the 15(b) evaluation, but was not certain that he heard or understood this advice, because he did not respond.

COURSE OF HOSPITALIZATION:

On admission to MSH on January 8, Mr. Doe was pleasant and in good behavioral control. Thought content was marked by numerous unrealistic beliefs, such as his insistence that he is a state senator, visiting the hospital to survey the conditions. At first he was reluctant to engage in treatment, declining all medication and group therapies offered. Beginning on January 12, he agreed to a trial of the antipsychotic medication risperidone, initially at a dose of two milligrams a day, and gradually increased to his present dosage of four milligrams a day. He explained to me, "I'm tired of saying no all the time. I'll take whatever they think I should. I just want to get out of here." He has since generally cooperated with ward routine and has participated in all recommended groups on the unit.

Of most concern during this hospitalization has been Mr. Doe's repeated inappropriate sexual statements to women, which are sometimes of a violent nature. For example, during attending psychiatrist Dr. Jackson's initial interview with him, Mr. Doe stated: "Women are always playing mind games with me. I find you attractive. I like to get right to the point. I like women just to offer themselves." When asked whether he had ever forced himself on women, he replied, "I look at women that way. I like to rip off their clothes. It could be a romantic situation.

They take the romance out of it." Mr. Doe emphatically denied any history of rape or other physical assault. When Dr. Jackson asked if he would contract not to hurt any women while on the unit, he replied "Give me your panties and I will."

A relatively serious incident occurred on January 18, when Mr. Doe made sexually provocative statements to a female occupational therapist. When she asked him to stop, he persisted and began walking toward her, backing her into a corner. The staff member had to yell for help from other ward personnel to intervene to end the encounter, which she described as extremely frightening. When asked about this incident, Mr. Doe insisted that the staff person had solicited the contact by “raising her eyebrow” in his direction.

CURRENT MEDICATIONS:

Mr. Doe is prescribed risperidone (4mg) which he has been taking daily.

MENTAL STATUS AND CURRENT LEVEL OF FUNCTIONING:

Mr. Doe is a tall, white male of average build, who appears his chronological age. He was pleasant and cooperative during the interviews. He has long hair which was always uncombed, and he dressed in a casual and. somewhat disheveled fashion during each of our meetings. He established good eye contact and displayed normal movements and mannerisms during the interviews. His speech was generally within normal limits, in rate, tone, and volume. Occasionally when discussing his mother and the people he feels loiter outside his father's office, his speech became louder, he appeared more agitated and he was more difficult to interrupt. Although he displayed some anger at these times, he maintained control and calmed without intervention. He described his mood as "fine" and repeatedly denied any suicidal or homicidal ideation.

Mr. Doe had significant disruption in the form and content of his thought which became increasingly pronounced as each interview progressed. He jumped from subject to subject in ways which had little or no logical connection, and he seemed unaware of this, assuming that I could follow the progression of his discourse at all times. For example, when asked why he thinks he is in the hospital, he replied: "I glow on a screen. That's why the government needs me, they know what I can teach the world. That's why they put me here.” The content of his thought was notable for bizarre delusions revolving primarily around themes of racism, and he frequently expressed paranoid and grandiose beliefs. For example he said, "I’m here in the Northeast because this is where the trouble is. They sent me here to eradicate the agents of the Third Reich.” He acknowledged experiencing auditory hallucinations (i.e., hearing voices) but would not discuss the content of the voices, insisting I already knew since I could read his mind.

Cognitive functioning was relatively intact, with the exception of some moderate disruption in attention and concentration. He was oriented to time, knew who he was and where he was. Short-term memory (as measured by his ability to recall-three words after a five minute delay) was intact. Long-term memory for significant events also appeared unimpaired, as demonstrated by his ability to accurately report details of his personal history (as confirmed by his mother's report). He was, however, able to recall a series of seven digits forwards but only

two digits in backward order, suggesting some acute disruption in concentration. Proverb interpretation showed good ability to engage in abstract reasoning, but his responses were contaminated by intrusions of irrelevant and illogical associations. For example, to the proverb `don't cry over spilled milk' the patient replied, "Stop whining. There's nothing you can do about it. Don't dwell on it or stop whining depending on the personality of the person it's being said to. Some people are more authoritarian. Everyone is different." Based on his use of vocabulary and abstract reasoning abilities, estimated intelligence is at last in the average range. Judgment is markedly impaired by psychotic thinking (for example, Mr. Doe attempted to leave the building without his shoes several times, insisting that walking in the snow wouldn't bother him because "I'm immune to frostbite"). Insight is likewise impaired as he does not associate his life difficulties and behaviors with the fact that he is mentally ill.

ABILITIES RELEVANT TO COMPETENCE TO STAND TRIAL:

Understanding of the charges, verdicts, and potential consequences:

Mr. Doe initially stated that he was charged with "driving the car." He immediately then asked, "Why don't they just send me to Walpole?" Even after I read him the formal charges and told him the range of penalties associated with these charges, he insisted that a likely consequence following a guilty finding would be "incarceration at MCI Cedar Junction." When I began to explain the allegations leading to the charge of malicious destruction of property valued at over $250, (i.e. destroying the fax machine in his father's office), he interrupted and said "The fax machine itself is a crime because violating copyright laws is illegal. Like the Middle East, you know." As noted, Mr. Doe did not know the range of penalties associated with guilty findings on his current charges, and was unable to recall what I had told him just minutes before. He insisted that the Court could sentence him to death or life imprisonment despite having been informed of the maximum 5-year sentence. Mr. Doe understood the potential consequences of being found guilty ("they can put you away") and not guilty ("you go home free"), but refused to discuss the meaning of the not guilty by reason of mental illness plea because he felt that it did not apply to him.

Understanding of the Trial Participants and Process:

Mr. Doe said that the purpose of a trial in general is "to lock someone up but make it look good." When I asked him about the role of the defense attorney, he stated, "They're all in it together she's supposed to be on your side but they're all in it together to shut me up." When I reminded him that he had been assigned an attorney with whom he had in fact met at the time of his arraignment, he responded, "Oh yeah, I remember her. She's in it too." When asked about the role of the prosecuting attorney, he replied with a smile, "He tries to hang you." Upon further questioning, Mr. Doe explained that he was talking figuratively. Mr. Doe described the Judge's role as "making the decision," but could or would not elaborate on this response. He was able to explain that sometimes the decision is made by "a jury of your peers."

Mr. Doe knew that witnesses are required to "swear to tell the truth, the whole truth, and nothing but the truth" prior to testifying, and that they may testify to "what they saw or heard." He

then added, "They will all lie anyway, because they're afraid that the agents will get them, too. They're afraid of what I know."

Mr. Doe said that he had no understanding of the plea bargain process and refused to hear any explanation of this potential option. When asked about possible pleas, he stated that he would plead not guilty and was not willing to discuss other plea options. He stated, “It doesn’t matter how I plead, they’ve stacked the deck against me and paid off the judge and the lawyers.”

Ability to assist counsel in preparing and implementing a defense

Mr. Doe was able to provide me with a logical account of the events leading to his arrest (including his thoughts and feelings during the time of the alleged incident) but only with much structure and redirection. As described above, he had difficulty remaining focused on the topic at hand, speaking more and more about his delusional concerns as the interviews progressed. While he was willing to do his best to provide me with his recollection of events, he insisted that he would not provide this information to an attorney as he had no need of legal representation. Mr. Doe has decided to represent himself because he believes his lawyer was “paid off” by his enemies.

On the other hand, Mr. Doe clearly understood and considered his attorney's advice at the time of the 15(a) evaluation, as demonstrated by his explicit statement that he would participate in the evaluation on the advice of counsel.

Ability to make relevant decisions:

In contrast to his refusal to discuss the plea bargain process in general, he did listen to a possible hypothetical plea bargain (pleading guilty with probation vs. pleading not guilty with the possibility of acquittal or a greater penalty), and immediately responded that he would “be forced” to accept the plea offer. When asked to explain his reasoning he responded by describing how the judge was surely "paid off by my enemies,” so he would be found guilty no matter what evidence was presented at a trial. Similarly, when I asked him if it would be better to opt for a jury trial, he said, “They will get to the jury, too.”

CLINICAL OPINION REGARDING COMPETENCE TO STAND TRIAL:

Based on his clinical history and current presentation, it is my opinion that Mr. Doe suffers from a mental illness, best characterized as schizophrenia, paranoid type. He is currently in an acute stage of this disorder, manifested primarily by significant disturbance in both the form and content of thought. With regard to the former, at times Mr. Doe's verbalizations jump from topic to topic, and he speaks in fragments of thoughts, so that it is difficult for the listener to follow or understand what he is trying to communicate. He manifests unrealistic beliefs (delusions) of a paranoid and at times grandiose nature (believing, for example, that he is being singled out for retribution by various neo-Nazi groups because he is a special governmental agent). In my clinical opinion, current symptoms of this disorder directly and significantly compromise his understanding of the trial process, and his ability to participate

meaningfully and rationally in the preparation and implementation of a defense.

Mr. Doe's responses to questions designed to elicit his factual understanding of the legal system suggested that he does have a basic grasp of the adversarial nature of the trial process. He knew, for example, that defense counsel is supposed to represent him and the prosecuting attorney is not on his side. He understood that the judge decides guilt or innocence and he could explain the role of lay witnesses at trial. However, even those responses were contaminated by paranoid beliefs which are characteristic symptoms of his mental illness. He believes, for example, that all potential witnesses will lie under oath for fear of being associated with him, and thus also becoming targets. Furthermore, I was unable to assess Mr. Doe's factual understanding beyond these rudimentary aspects because he declined to answer some of my questions. However, even if he has a factual understanding, his rational understanding of the proceedings is impaired by his paranoid, irrational thinking.

In my opinion, Mr. Doe is unwilling to consult with counsel in the preparation of a defense at this time, and his decision is based on delusional beliefs. He states unequivocally that he will not accept the services of a legal representative because he believes that the attorney appointed to his case is "in it together" with those conspiring against him. Mr. Doe did indirectly demonstrate some willingness to accept one suggestion made by his attorney by deciding to participate in this evaluation on the advice of counsel. However, the fact that he has consistently refused to talk with Ms. Adams suggests that his cooperation would be extremely limited. Furthermore, he explicitly stated that he would not discuss the details of the alleged offense with her. Even if Mr. Doe were willing to consult with counsel at the present time, his disturbed thought processes would, in my opinion, significantly interfere with meaningful communication. Mr. Doe frequently experiences such disorganization of his thought processes so that he is unable to speak in coherent sentences. It would be difficult for him to convey pertinent information to counsel in the preparation of a defense, and he would not be able to testify with relevance should the matter proceed to trial.

Furthermore, Mr. Doe’s ability to make rational decisions about his case (such as how to plead, whether to accept a pleas bargain, whether to ask for a jury trial) is significantly impaired by his mental illness. Delusional ideas frequently preoccupy his thinking during decision making about such matters, and decisions based on these ideas would have irrational foundations. In addition, his delusional preoccupations sometimes cause him to reason in ways that are not even consistent with his own stated preferences.

Thus, based on the above data, it is my opinion that Mr. Doe’s abilities relative to competence to stand trial are significantly impaired by symptoms of mental illness. Many of the symptoms associated with a schizophrenic disorder respond well to treatment, including psychotropic medications. It is therefore likely that, with treatment, Mr. Doe will show significant improvement and be more willing and able to participate meaningfully with counsel in the preparation of a defense. It is reasonable to expect some response within about a three month period (see following section for additional discussion of prognosis).

CLINICAL OPINION REGARDING NEED FOR CARE AND TREATMENT:

As noted above, in my opinion Mr. Doe suffers from a mental illness, best characterized as schizophrenia, paranoid type. Based on his clinical history, it is likely that Mr. Doe has been living in the community with an untreated, on-going psychotic illness for at least several years. He is currently in an acute stage of this disorder, manifested primarily by significant disturbances in form and content of thought that grossly impair his reality testing, judgment and behavior. In my opinion, and in the opinion of his treatment team, Mr. Doe poses a substantial risk of harm to others at this time due to this mental illness, and thus requires further hospitalization. According to his mother, Mr. Doe's condition has deteriorated markedly over the last several months, and she describes episodes of agitated and threatening outbursts that have increased in frequency and severity during this time. Although he has not physically harmed her to date, his verbal threats are new and frightening to her. His behavior throughout this hospitalization has included not only sexually inappropriate remarks, but also physically menacing behavior which he did not cease upon verbal request. On one occasion, several staff were required to intervene to prevent an assault. Thus, it is the opinion of this evaluator that Mr. Doe would pose a substantial risk of harm to others if not hospitalized.

At the time of writing this report, Mr. Doe had not yet shown any significant response to the prescribed psychiatric medication. Typically, auditory hallucinations and psychotic delusions that have been untreated for long periods of time take weeks or even months to respond to ongoing administration of antipsychotic medication. Although Mr. Doe has cooperated with psychopharmacological intervention while in the hospital, he did so reluctantly and repeatedly stated that he did not find it helpful. It is therefore unlikely that he would voluntarily continue this medication on a outpatient basis. Discontinuation of the medication at this point would likely result in further deterioration in his mental status and an even increased risk for harm toward others.

Thus, should Mr. Doe be adjudicated incompetent to stand trial, I recommend that he be returned to the Massachusetts State Hospital for further care and treatment. A completed petition for commitment under the provisions of M.G.L. c.123, §16(b) is enclosed for this purpose. In addition, if he is committed, the hospital will be pursuing a petition under § 8B for administration of psychotropic medications.

Jane Smith, Ph.D.
Designated Forensic Psychologist

APPENDIX B:

SAMPLE 15b REPORT: CRIMINAL RESPONSIBILITY

CRIMINAL RESPONSIBILITY EVALUATION

NAME: Susan Smith
DATE OF BIRTH: March 2, 1982
EXAMINER: Frank White, Ph.D.
DATE OF REPORT: June 5, 2010

IDENTIFYING INFORMATION:

This is the second State Hospital (SH) admission for Susan Smith, a 28 year old, Caucasian female (DOB 3/12/82). She was admitted to SH on 5/12/10 from the District Court with an order for evaluation of criminal responsibility pursuant to the provisions of M.G.L. c. 123, §15(b). She is charged with Assault and Battery stemming from events which occurred on May 4, 2010. It is alleged that on that date, while a patient at State Hospital, she assaulted a social worker.

LEGAL CRITERIA FOR DETERMINING CRIMINAL RESPONSIBILITY:

In Commonwealth of Massachusetts Courts, a defendant is found not criminally responsible for conduct if, at the time of such conduct, as a result of mental disease or defect, he lacked substantial capacity either to appreciate the criminality [wrongfulness] of his conduct, or to conform his conduct to the requirements of law (*Commonwealth v. McHoul*, 1967).

SOURCES OF INFORMATION:

This evaluation is based on:

1. Clinical interviews with Ms. Smith at State Hospital on May 25 and June 5, 2010, lasting a total of 3 hours;
2. Review of current medical chart at State Hospital;
3. Review of records from previous admission to State Hospital in September, 2009;
4. Review of records of admission to County Acute Hospital on April 20, 2008, July 18, 2008, and July 6, 2009;
5. Telephone interview with Mary Jones, LICSW, the alleged victim, on May 22, 2010;
6. Interview with Harry Stone, M.D., Ms. Smith's treating psychiatrist, on May 25, 2010
7. Review of Ms. Smith's criminal record information.
8. Review of the Police report dated May 4, 2010.

9. Review of the 15(a) report completed by Mary Davis, Ph.D. on 5/12/10.
10. Telephone conversation with defense attorney Robert Moore on 5/20/10.

WARNING ON LIMITS OF CONFIDENTIALITY AND PRIVILEGE:

At the beginning of the first interview, I informed Ms. Smith that I am a psychologist and would be evaluating her for the purpose of preparing a report to the court regarding the issue of criminal responsibility as well as her need for treatment, including psychiatric hospitalization. I explained that information she provided and my observations would not be held confidentially but would be included in a written report, which would be sent to the court, and that the court could share it with her lawyer and the prosecuting attorney. I also informed her that I might be called to testify in court. I also explained that her participation in the interview was voluntary, but that I would be submitting a report to the court whether she chose to participate or not. Ms. Smith indicated her understanding of this warning by paraphrasing it ["you're a psychologist and what I tell you is not secret, it is for the judge and the lawyers to see if I can plead insanity and if I need to be in the hospital. I don't have to talk if I don't want to"]. At the beginning of the second interview I repeated this explanation and Ms Smith indicated that she still understood the parameters of the evaluation. In my opinion, she understood the purpose of the evaluation, the limits of confidentiality, and my role.

I provided similar information to the collateral informants with whom I spoke.

CIRCUMSTANCES OF REFERRAL:

Ms. Smith was evaluated at the District Court Clinic on May 20, 2010 by Mary Davis, Ph.D. Dr. Davis described Ms. Smith as

> "in good contact with reality, not endorsing or demonstrating evidence of psychotic thinking. She denied feeling paranoid, was not responding to internal stimuli, and was oriented to time and place. She described feeling anxious, but denied any thoughts or intentions of harming herself. Her affect was labile, as she quickly shifted from a calm demeanor to a angrier, agitated state when discussing her current charges. She expressed anger at the hospital for pressing charges."

Ms. Smith told Dr. Davis that she felt that "I could not control myself" during the alleged offense, but would not elaborate. Dr. Davis recommended further evaluation of the issue of criminal responsibility in an inpatient setting.

RELEVANT HISTORY:

Historical information was obtained from Ms. Smith and corroborated by review of information available in her psychiatric records. The information Ms. Smith provided to me regarding her history was consistent with these records.

Family and developmental history

Ms. Smith is the only child born to her parents, who were not married and never lived together. She was raised for the first four years of her life by her mother, but was removed from her mother's custody by the State when she was four years old due to her mother neglecting her care. Her mother was addicted to crack and often forgot to feed Ms. Smith who was described as "an emaciated, four year old girl, wearing filthy clothes" when she was removed from the home. Permanent custody was awarded to Ms. Smith's maternal grandmother, who raised her through adolescence. Her mother lived with her sporadically, and, until she was 16 years old, she thought that her biological mother was really her sister. She has never met her father. There are no reports of any physical or sexual abuse. However, Ms. Smith did report observing her (biological) mother's boyfriend frequently hit her mother, including once breaking her nose (when Ms. Smith was 12 years old). According to the medical records, Ms. Smith's grandmother (who passed away from cancer five years ago) has reported that Ms. Smith was a difficult child, growing up, often "having tantrums" when she did not get her way.

Educational History

Ms. Smith performed poorly in school, and had to repeat third grade. She was not placed in special education classes, and continued in school until she was 16 (10^{th} grade) when she dropped out. She said that she did not like school, found it boring, and also did not get along well with some of the other students. She was involved in a number of fights with other girls, which resulted in suspensions from school for 1-3 days at a time. None of these fights involved weapons or resulted in any criminal involvement. Ms. Smith reported that she did not have any "boyfriends" in school, but did have sexual relationships with several different boys. At age 16 she became pregnant and dropped out of school. She gave birth to a baby girl whom she gave up for adoption (and has had no contact with since). Ms. Smith reports that she has often regretted this decision, and becomes sad when wondering what happened to her daughter.

Substance Use History

Ms. Smith reported that she drank some beer and wine in high school, but not to excess, and occasionally used marijuana. She said she had never used any other substances. At the age

of 19, she began drinking much more heavily (approximately a six pack of beer per night), becoming intoxicated several nights a week. She was charged with Driving Under the Influence in 2004, and given a suspended sentence after completing an outpatient alcohol treatment program. She has experienced several other periods in which she drank more heavily, and attended detoxification programs twice, once in 2006 and once in 2008 (discussed below in the context of her criminal history).

Employment History

Ms. Smith has a sporadic work history. She has worked for a housekeeping service (cleaning houses), but was fired after frequent fights with some of her co-workers. She explained that she felt her co-workers were slacking off, leaving her to do most of the work, and she didn't like it. She would complain about this, but nothing was done, and eventually she was involved in a fight with one of the other women, bloodying her nose. At that point, she was terminated from the job. This occurred in 2006 and she has not worked steadily since.

Criminal History

A review of Ms. Smith's criminal record (CORI) reveals that in addition to the DUI charge in 2004 (which was dismissed), she has been arrested three other times. In November, 2005, she was charged with Malicious Destruction of Property, for smashing a neighbor's windshield. Ms. Smith reported that she was angry because the neighbor owed her $50 and would not pay up. She was found guilty of this charge, given probation, and fined. On May 12, 2006 she was charged with Threat to Commit a Crime. In this instance, she verbally threatened to kill her grandmother, who was trying to get her to stop drinking. This charge was dismissed after she completed a 30 day detoxification program. On February 12, 2006 she was arraigned for Assault and Battery on a Police Officer. This charge stemmed from an incident in which she was a passenger in a car that was stopped by the police. When the policeman asked her to get out of the car, she became agitated and punched the officer in the face. At her arraignment she was released on pre-trial surety on condition that she complete a 30 day detoxification program. However, she left the program after 3 weeks, with another client, and the two of them went to a bar to drink. She was returned to court, was eventually convicted of the A&B on the Police Officer and given a two year sentence. She was released after a year, on conditions of parole.

Mental Health History

Ms. Smith's first psychiatric hospitalization occurred on April 20, 2008 (at age 26). Her grandmother, with whom she was living, noticed that Ms. Smith was staying up late at night, playing music loudly, and was becoming more irritable. She would often scream at the neighbors for no apparent reason. At one point, she became extremely agitated, claiming

that there was poison gas in the house, and she disrobed and ran naked through the streets. She was taken to City Hospital Emergency Room, where she was admitted to the acute psychiatry unit. Upon admission, she was described as "manic, hypersexual, speaking rapidly" and reportedly would stay up late at night, singing loudly. She was diagnosed with Bipolar Disorder, most recent episode manic, and treated with Lithium. Over the course of her 10 day hospitalization, her mood improved, although she was still described as "hypomanic" (that is, her mood and energy level were still elevated, but not as severely as in a manic episode).

Ms. Smith returned home to live with her grandmother. Over the next few months there were several incidents in which the police were called because of complaints from neighbors that she was blasting music late at night, disturbing them. On one occasion, when the police told her to turn down the music, she angrily threatened to burn down the neighbor's house. However, the police were able to calm her down without any damage being done. Although her grandmother attempted to get her to take her medication, she refused, and decided to move out of the house, ending up in a homeless shelter. On July 18, 2008 she was again psychiatrically hospitalized at City Hospital. This admission was precipitated by an episode in the shelter in which she accused all the men of wanting to have sex with her, claiming that she was the Virgin Mary, and attempted to light some papers on fire. She remained in the hospital for a month, was diagnosed with Bipolar Disorder with psychotic features, and was treated with Zyprexa (an antipsychotic medication) and Depakote (for mood stabilization). During this hospitalization, she continued to describe paranoid beliefs about the shelter, but her mood stabilized. She was discharged to live with her grandmother.

Ms. Smith lived with her grandmother for approximately 10 months. She saw her outpatient psychiatrist, Dr. Miller, on a monthly basis, and he documented that her acute paranoid and mood symptoms remained in remission. However, in June, 2009, she moved in with a boyfriend and the two of them drank alcohol regularly (she reported that they drank daily). She stopped seeing her psychiatrist, discontinued her medications, and began acting erratically in the community. She stayed up late at night, playing music loudly. When the neighbors complained about the noise, she accused them of wanting to have sex with her. In July, 2009, in the context of a heated argument with a male neighbor, she grabbed a knife and threatened to stab him. Police were called and she was taken to City Hospital where she was admitted on a Section 12. Ms. Smith was again diagnosed with Bipolar Disorder with Psychotic features. She refused to accept any medications, and was committed pursuant to §§7&8 (along with an order for the administration of antipsychotic medications pursuant to §8B) and transferred to State Hospital in September, 2009.

Over the next seven months, her mental status stabilized, and progress notes indicated no evidence of paranoid thinking. However, she would become agitated with minimal provocation (e.g., being told she had to wait to use the shower, or when another patient tried to change the TV channel) and required a quiet room or Ativan (an anti-anxiety medication) to calm down. In April, 2010 the hospital was considering discharging Ms. Smith to independent living. However, she was then involved in an altercation with another patient, and the discharge was put on hold. Shortly thereafter the current alleged offense occurred and Ms. Smith was charged with Assault and Battery.

Ms. Smith reported no history of head injuries nor does she suffer from any medical condition that would be expected to impact on her mental status.

COURSE OF HOSPITALIZATION:

Ms. Smith was admitted to Unit B upon her return from her arraignment on the current charges on May 20, 2010 (the alleged offense took place on Unit A of the hospital). Stephen Ray, M.D., the treating psychiatrist, noted on that date:

> "Ms. Smith is oriented to time and place, and was able to provide coherent answers to my questions. She appeared somewhat anxious, but denied feeling depressed, SI [suicidal ideation], or HI [homicidal ideation]. Although somewhat labile, she did not present with manic symptoms. Reality testing intact, no AH (auditory hallucinations) or delusions. She has a documented history of Bipolar Disorder, which appears to be well controlled with her current medication regimen. Will continue Zyprexa (10 mg, hs) and Depakote (500 mg. b.i.d.)."

Since her return to the hospital, Ms. Smith has been described as "at baseline" with no significant symptoms noted. Although she had not been involved in any physical altercations with staff or other patients during this evaluation period, on several occasions she became angry and loud when she was not able to leave the unit. (While on Unit A she had been granted grounds privileges, but these had been revoked following the alleged offense.) At such times, staff was able to direct her to return to her room without incident.

CURRENT MEDICATIONS:

Ms. Smith has been prescribed Zyprexa (10 mg, hs), an antipsychotic medication, and Depakote (500 mg. b.i.d.), for mood stabilization. She has been agreeable to taking these medications on a daily basis.

MENTAL STATUS AND CURRENT LEVEL OF FUNCTIONING:

Ms. Smith is a 28 year old woman who looks approximately her stated age. She was dressed appropriately with good hygiene. At several points, she got up from her seat to pace, but was then able to return to complete the interview. Her speech was slightly accelerated, particularly when a sensitive topic (such as the alleged offense) was raised, but she was able to communicate in a coherent manner.

Her cognitive functioning (attention, memory, concentration, abstract reasoning) was uneven. She was able to remember 3 simple words after a 5 minute delay and her memory for recent and remote events appeared intact. She experienced some difficulty interpreting proverbs, for example, stating that she did not know what was meant by "people who live in glass houses should not throw stones" or "every cloud has a silver lining." However, she responded to the proverb, "don't cry over spilled milk" by saying, "that means, don't worry your head about little things that go wrong, it's not worth it." For the most part, she was able to attend to the questions asked and concentrate on the issue at hand. However, on occasions, as she became more anxious, she became momentarily distracted and asked for the question to be repeated, at which time she responded appropriately. Based on her history as well as her level of vocabulary, it appears that she is likely of below average intelligence, but there were no indications to suggest significant intellectual limitations.

Ms. Smith reported no current or previous experiences of hallucinations (hearing or seeing things that are not there). She acknowledged that in the past she has experienced delusions (rigidly held false beliefs that are impervious to reason) such as believing that she was the Virgin Mary or that people were plotting against her. She indicated that she does not entertain these thoughts currently. However, she stated that she feels that her treatment team (psychiatrist, social worker, and nurse) is unfairly keeping her in the hospital, blaming her for an incident which she claims was really the fault of another patient (discussed below). She described her mood as "fine" and stated that she does not feel depressed or elated. Her observed mood was one of slight irritability, but, other than her pacing when stressed, she did not display unusual movements or excessive energy. She reported that her appetite and energy level are "okay" and that she typically sleeps about 6 hours a night, without waking in the middle. She denied any suicidal or assaultive thoughts or intentions.

Ms. Smith is currently prescribed Zyprexa (10 mg. a day) and Depakote (1000 mg. a day) and she reports that she takes the medications daily (this is confirmed by the hospital record). She recognized that she has a mental disorder ("I'm Bipolar"), and that the

medications help keep her calm. She also acknowledged a history of alcohol abuse, but stated that she has not had anything to drink in almost a year (since she has been in the hospital). She also stated that she drank heavily with her boyfriend, but she is no longer involved with him.

OFFICIAL VERSION OF THE ALLEGED OFFENSE:

Sgt. Michael Strahan of the City Police wrote in a report dated May 4, 2010 that police received a complaint from Mary Jones (a social worker at State Hospital) that she had been assaulted on that day by patient Susan Smith and she wanted to press charges. Ms. Jones gave a statement in which she stated that she and Dr. Stone, a psychiatrist, had told Ms. Smith earlier in the day that she would be remaining at the hospital for at least a few more months. Later that day, when Ms. Jones was walking by the dayroom, Ms. Smith jumped her from behind, threw her to the ground, and began punching her in the face. Several other staff responded, pulling Ms. Smith away. Officer Strahan noticed that Ms. Jones had a "black eye and abrasions about her face, with visible stitches on her chin."

Information From State Hospital Records:

I reviewed the progress notes for the period before and after the alleged offense. According to these notes, Ms. Smith had been described over the month prior to the alleged offense as psychiatrically stable. For example, her treating psychiatrist, Dr. Stone, noted on April 28, 2010: "mood stable, no evidence of paranoid symptoms" and a nursing note by Gail Small, R.N. on April 30, 2008 stated "Ms. Smith is following ward routine and interacting well with nursing staff." The progress notes, though, describe an incident on April 15, 2010 in which Ms. Smith and another female patient were involved in an altercation. According to these notes, the other patient had been newly admitted and was described as "intrusive, with poor boundaries, having to be told repeatedly not to enter other patient's rooms." On April 15, this patient entered Ms. Smith's room and attempted to remove a book from the room. When Ms. Smith returned to her room, she told the other patient to put it back and leave. When the patient refused, Ms. Smith grabbed the book, slapped the patient about the head and shoulders, and punched her in the stomach. Staff intervened and spoke with both patients. According to a note by Mary Jones, LICSW, "Ms. Smith stated that patient… had made her angry by trying to take her book and so she hit her to 'teach her not to do it again.' Ms Smith was not remorseful and stated that patient … was to blame for coming into her room and taking her book."

On May 3, 2010, the following was documented by Dr. Stone: "Treatment team meeting today regarding disposition of Ms. Smith. Based on her recent incident with patient…, and

her history of conflicts with neighbors when she was living in the community, discharge plans are being placed on hold. Treatment will focus on helping Ms. Smith deal with frustrations from other patients, without resorting to violence."

A note entered by Mary Jones, LICSW on May 4, 2010 p.m. states: "Dr. Stone and I spoke with Susan Smith about the treatment team's decision to delay her discharge and focus on anger management. She reacted angrily, stating that we were not being fair and that it was really patient X's fault for coming into her room. She turned to Dr. Stone and told him that it was really up to him and he could discharge her if he really wanted to. I agreed to come back tomorrow to discuss this further with her."

Information from Mary Jones, LICSW:

On May 22, 2010, I spoke by phone with Ms. Jones, the alleged victim. She informed me that she had not returned to work since the alleged assault, and is waiting for her face to completely heal. She reported that she has been Ms. Smith's social worker since Ms. Smith was admitted to State Hospital in September. She described Ms. Smith as "manic and paranoid" when first admitted to the hospital, but stated that she had improved considerably over the past 6 months. She also stated that she and Ms. Smith usually have a good relationship, although Ms. Smith can get "testy" at times when she does not get what she wants (like having to wait to go outside, for example). She confirmed that earlier on the day of the alleged assault, she and Dr. Stone had informed Ms. Smith of the decision to delay her discharge. This meeting took place in Dr. Stone's office on the unit and Ms. Smith was angry, but appeared to be in control. I asked if Ms. Smith had appeared agitated or made any other statements, to which Ms. Jones responded that she only told Dr. Stone that he could discharge her, but made this statement as a plea, not as a threat.

Information from Harry Stone, M.D.

On May 25, I spoke with Dr. Stone, Ms. Smith's treating psychiatrist. He confirmed that Ms. Smith had shown improvement over the course of her hospitalization but would sometimes become annoyed and frustrated if she did not get her own way. Staff were typically able to intervene before the situation escalated. He confirmed that the treatment team had decided to delay Ms. Smith's discharge due to the incident with the other patient; he stated that although the other patient had provoked the incident, in light of Ms. Smith's history he thought that it was important to work with her on developing better management strategies for dealing with such frustrations. He stated that he realized that she was angry with him when she left his office on May 4, and seemed to be agreeable to Ms. Jones' offer to talk with her more about it the next day. He noted no change in her mental status in the

days prior to the alleged assault. He also stated that the hospital neither encourages nor dissuades staff from pressing charges in such a situation, and the decision was up to Ms. Jones.

Dr. Stone also reported that after the incident, he ordered Ms. Smith to be restrained, and she went to the restraint room without incident. She remained in restraints for an hour, and was then released since she had calmed down. He asked her at that time why she had assaulted Ms. Jones, and she said "I was just pissed." She also stated, "I figured I'd have to do some time in restraints, but I'm okay now." Since that time, there have been no other incidents with Ms. Smith, although she is monitored more closely.

DEFENDANT'S VERSION OF ALLEGED OFFENSE:

Ms. Smith expressed frustration at being charged with Assault and Battery, claiming that "she [Ms. Jones] is making a big deal of it, so she can go on IA [Industrial Accident leave] and collect money." She acknowledged that she did hit Ms. Jones, but claimed that her injuries were not that severe. Ms. Smith was asked about the preceding incident with patient X, at which point she became animated and said, "that bitch came into my room, she was trying to take the book I was reading, I just needed to show her that she can't do that, I didn't really hurt her." She stated that this had happened a couple weeks earlier than the alleged offense and she thought that it was over and done with. She stated that she was looking forward to leaving the hospital and having more freedom, and was surprised and angry when she was told that she could not leave.

Ms. Smith was asked to describe her perspective of the meeting with Dr. Stone and Ms. Jones. She stated that Dr. Stone did most of the talking, telling her that the treatment team decided that she couldn't leave because of what happened. She was angry, but controlled herself and told him that she knew that since he was the psychiatrist it was up to him, and he could discharge her. He told her that he did not think she was ready for the community, at which point Ms. Jones offered to follow up with her the next day. She described herself as feeling angry and frustrated at that time. I asked if she had any thoughts of harming either Dr. Stone or Ms. Jones at that time and she responded, "well, I thought of picking up one of the books in his office and throwing it at him, but I figured then he'd just put me in restraints, so I just left." She was also asked if she was particularly angry with Ms. Jones at that point, which she denied.

Ms. Smith reported that she went back to her room and felt frustrated. She wanted to go outside to the yard, but it was not yard time, so she just went into the TV room to watch a show. She did not remember what she was watching. A while later, she noticed Ms. Jones

walking by to leave the unit, and "I just became angry, thinking, how come she can leave and I can't?" She stated that she could not really describe her thoughts at that time, but felt frustrated and needed to "take it out on someone." She denied maintaining any paranoid thoughts about Ms. Jones (that is, she did not think that Ms. Jones had deliberately delayed her discharge or even thinking that she was the person primarily responsible). She reported that she had planned to just knock Ms. Jones down, but once she fell to the ground, "I became enraged, and kept hitting her." When asked to explain this further, she stated, "when I get that angry, it's hard to stop." She remembers someone pulling her off of Ms. Jones, and stated that she did not resist at that point, and agreed to go to restraints. While in restraints, she realized that she was in trouble, but did not think that Ms. Jones was hurt that badly.

Ms. Smith did not describe any distorted beliefs about Ms. Jones and did not claim that she thought the behavior was justified, stating that she knew she would get in trouble, but did not think they would press criminal charges against her. She stated, "they were going to keep me in the hospital anyway, so what if I had to spend a few hours in restraints?" She was asked if she thought that she would have attacked Ms. Jones if there were other staff around at that time, to which she responded, "no, because I knew they could stop me, but I saw that she was not looking at me, so I figured I could knock her down before she knew what hit her."

CLINICAL OPINION REGARDING CRIMINAL RESPONSIBILITY:

Ms. Smith has a long, documented history of a mental illness, with a diagnosis of Bipolar Disorder. During periods of acute exacerbation, she has experiences of elevated mood, and distortions of reality, including paranoid thinking. She was committed to State Psychiatric Hospital for treatment at the time of the alleged offense and had been there for approximately six months. The sources of information are consistent in establishing that Ms. Smith's mental status had improved over the course of her hospitalization and that she had not been manifesting acute symptoms of her disorder in the weeks prior to the alleged offense, nor on the day of the alleged offense. . Indeed, she had shown significant enough improvement to the point that she had been considered for discharge. The discharge was delayed because she assaulted another patient (about 2 weeks prior to the alleged offense). However, all accounts of that incident, including Ms. Smith's, indicate that the assault did not occur in the context of acute symptoms, but rather in reaction to the other patient intruding into Ms. Smith's room and taking her property.

Regarding the specific alleged offense, neither Ms. Smith, nor any of the other sources of information (clinical treatment team members) indicate that she was experiencing acute symptoms at that time. She did not have any distorted perceptions of reality, but acted out of

reality-based anger and frustration. She acknowledges now, and close in time to the alleged offense (when speaking with Dr. Stone while in restraints), that she knew that it was wrong to assault Ms. Jones. For example, she told Dr. Stone, just shortly afterwards, "I was just pissed… "I figured I'd have to do some time in restraints, but I'm okay now." She clearly stated to this evaluator that she knew she could get in trouble, just did not expect someone to press criminal charges. She did not report any distorted beliefs to suggest that she thought the behavior was justified. Thus, based on all the data, it does not appear that Ms. Smith's ability to appreciate the wrongfulness of assaulting Ms. Jones was impaired.

Regarding her capacity to conform her conduct, the data do not indicate that she was experiencing acute symptoms of a mental illness that may have impaired her ability to control her behavior. Although she has been diagnosed with Bipolar Disorder which, in an acute phase (and, particularly when accompanied by psychotic features) can impact an individual's ability to exert controls over her behavior, the data available do not indicate that she was experiencing such symptoms at, or near, the time of the alleged offense. She has clearly stated that she acted out of anger. She did say that once she knocked Ms. Smith down she became "enraged" and that "when I get that angry, it's hard to stop." Although this suggests that she experienced herself as having limited control once she began the alleged assault, as noted above, any impairments in control were not attributable to a mental illness, but rather to feelings of anger provoked by a realistic frustration (not being allowed to leave the hospital). Furthermore, based on her own account, at the time she initiated the alleged assault, she made conscious choices about her behavior, and considered the consequences (she was aware that no other staff were around, and that the nurse was not looking her way). Thus, the available data do not suggest that her ability to control her behavior was substantially impaired by symptoms of mental illness.

CLINICAL OPINION REGARDING NEED FOR CARE AND TREATMENT

Based on all the available data, it is the evaluator's clinical opinion, and the opinion of Mr. Smith's treatment team, that she suffers from Bipolar Disorder. During acute phases of her illness, Ms. Smith experiences a high energy level, mood swings, grandiosity (e.g., at one point claiming that she was the Virgin Mary), and paranoid delusions (irrational fears that others are trying to harm her). However, at present she appears to have returned to a baseline level of functioning, with intact reality testing, and a stable mood. She has been cooperative with her medication regimen and acknowledges that the medications help keep her stable.

Ms. Smith does not have a history of engaging in self-injurious behaviors and does not report any current suicidal thoughts or intentions. She does have a history of both

threatening others and engaging in assaultive behaviors. These behaviors have occurred both during acute phases of her mental illness, as well as during periods when she has been more psychiatrically stable (including both the current alleged offense and a previous assault on another patient several weeks earlier). During periods of psychiatric instability, her risk is significantly increased, as she distorts reality, becomes paranoid, and has engaged in more serious acts of violence (including assaulting a neighbor with a knife, and attempting to set fire in a shelter). Furthermore, she has a history of alcohol abuse, which is also a risk factor for violence. As noted, at present she is psychiatrically stable, is taking her medications, and has not been drinking alcohol (as she has been committed to the hospital for approximately the last 10 months).

Thus, it is the opinion of this evaluator, as well as the treatment team at State Hospital, that Ms. Smith is currently psychiatrically stable, and does not currently pose a substantial risk of harm to herself or others due to mental illness, and thus does not meet criteria for continued psychiatric hospitalization. She does have a history of assaultiveness associated with both substance use, as well as poor anger control. The risk of harming others is exacerbated when she is not psychiatrically stable, coupled with substance abuse. This risk can be mitigated if she continues to obtain psychiatric treatment and refrains from substance abuse, which she is more likely to do if there are external consequences. If she were to be held in jail pending resolution of the current charges, she could manage in that setting as long as she received her medications and was monitored by mental health staff. If she is released to the community, she can continue to obtain psychiatric treatment at Community Center. She has also agreed to attend AA sessions. On June 4, 2010 I contacted Dr. Davis at the court clinic to apprise her of these recommendations.

Respectfully submitted,

Frank White, Ph.D.
Designated Forensic Psychologist