



**AN EVALUATION OF THE  
COURT PSYCHIATRIC CLINIC  
OF THE PHILADELPHIA COURT OF  
COMMON PLEAS**

**March 30, 1992**

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*Keilitz, Ingo*

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March 30, 1992

*rec'd 5/5/92*



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This evaluation was conducted by the National Center for State Courts' (NCSC) Institute on Mental Disability and the Law, acting through the NCSC's Northeastern Regional Office, under a contract with the Philadelphia Court of Common Pleas. The views expressed in this report are those of the authors--Ingo Keilitz, Thomas Hafemeister and Patricia Wall--and do not necessarily represent the official policies or positions of the Philadelphia Court of Common Pleas or the NCSC.

# **An Evaluation of the Court Psychiatric Clinic of the Philadelphia Court of Common Pleas**

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# **An Evaluation of the Court Psychiatric Clinic of the Philadelphia Court of Common Pleas**

## ***Executive Summary***

### **Background**

For more than 25 years, Temple University has provided, on a contractual basis, mental health evaluation services to the Philadelphia Court of Common Pleas. The organization of these services, including the work of nine Temple University clinicians (approximately 3.75 full-time equivalents (FTE)) and approximately 7.25 FTE court support staff, is known today as the Court Psychiatric Clinic (Clinic). In 1991, the Clinic responded to approximately 5,000 requests for mental health evaluations by the Trial Division and the Municipal Court of the Philadelphia Court of Common Pleas (Court). The estimated total cost of operating the Clinic in 1991, including the \$600,000 contract with Temple University with the Court, and excluding court personnel benefits and capital expenditures, is approximately \$800,000.

This Executive Summary describes general conclusions and recommendations of an evaluation of the Clinic's organization, management and operation conducted between January 15 and March 31, 1992, by the National Center for State Courts (NCSC). The full report (which follows this summary), and the evaluation upon which it is based, are intended to inform the Court's Trial Division's Administrative Judge, the Office the Executive Administrator, and other divisions, branches and units of the Court in their decisionmaking about present and future mental health examination services of the Court. Recommendations in the full report are referenced by number in parentheses in the general recommendations noted below.

### **Conclusions and Recommendations in Brief**

The central theme of the conclusions and recommendations is that the clinic operates in virtual isolation from the Court's case management and overall administration, and that the key to improvement is integration and coordination of the Clinic's function with those of the Court. Improvements recommended should build upon the responsive and relatively efficient processing of requests for mental health evaluations by the Clinic's staff. As is probably true of most organizations, the problems of the Clinic are problems of the "system," not the people. It is recommended that the Court establish an organization and management structure for the Clinic that ends the virtual isolation from, and ensures the Clinic's full integration with, the administration of the Court. The Court should designate a capable administrator to manage both the clinical and administrative staff and functions of the Clinic. The mission of the Clinic should



be articulated clearly to the Clinic staff, judges and others who work with the Clinic. Further, it is recommended that requests for mental health evaluations be curtailed significantly by elimination of *pro forma*, reflexive requests, especially for pre-sentence and Section 17 evaluations, and that the operation of the Clinic be improved and its services--including consultation, education and training, and research--made more responsive to the needs of the Court. An anticipated reduction in the number of requests for evaluation and a streamlining of the Clinic's operations should lead to a reduction of approximately \$150,000 of the Clinic's yearly operating costs. Finally, because of the Court's long-standing relationship with Temple University, and because of Temple University's expressed willingness to reduce costs and streamline the Clinic's operations, Temple University should be invited to submit a proposal, responsive to the conclusions and recommendations contained in this report, to extend its contract with the Court through fiscal year 1992-1993. The amount of fund requested should not exceed \$450,000.

## **Organization and Management**

The Clinic's mission and purpose, and relationships to the Court's overall administration, are unclear. Though the Clinic has for years produced thousands of evaluation reports in response to requests for mental health evaluations, it has done so without an effective organizational and management structure. The Clinic operates in virtual isolation from the management of the Court. It operates with little or no overall coordination or management. No one appears to be in charge of *both* the clinical and administrative functions of the Clinic and no one is broadly accountable for its performance and the costs of its operations. This lack of organization and management, and isolation from the Court's administration, impedes (if not prohibits) improvements in the efficiency of, effectiveness of, the quality of, and the Court's satisfaction with the Clinic's operations and results.

## **Recommendations**

- **The Court should establish a formal organizational structure for the Clinic that ensures effective direction and management of *both* the clinical and administrative staff of the Clinic, assures the integration of the Clinic with the case-flow procedures, organizational structures, management, policies and procedures of the Court, and provides on-going quality assurance and accountability for the Clinic's operations and performance. The Court should designate a capable administrator to direct and to manage *both* the clinical and administrative staff and functions of the Clinic, including the administration of any contracts between the Court and outside organizations that are relevant to the Clinic's operation. (Recommendation 1)**

- **The mission of the Clinic should be articulated clearly and communicated widely to the Clinic staff, judges and others (e.g., the Sheriff Department, the Defender Association) who work with the Clinic. The mission should not be limited to making reports in response to requests for mental health evaluations but instead should encompass activities that facilitate the Court's adjudicative, investigatory, dispositive, supervisory and administrative functions and responsibilities in cases involving issues of mental disability. To the degree that consultation with judges, attorneys and administrators, training activities and research facilitate these functions and responsibilities, they should be part of the Clinic's mission. (Recommendation 2)**
- **The Court/Clinic should establish specific staffing requirements, job descriptions, and accountability mechanisms for all Clinic staff, including those providing services on a contractual basis. These should be regularly reviewed as part of the on-going management of the Clinic. No mental health professionals should be assigned to evaluate a defendant unless the Clinic determines that the professional's qualifications include: sufficient professional education and sufficient clinical training and experience likely to establish the clinical knowledge required for the evaluations being conducted; and, sufficient forensic knowledge, gained through specialized training or an acceptable substitute, necessary for understanding the relevant legal matters and for satisfying the specific purposes for which the evaluation is being requested. Psychiatric residents and fellows, who do not meet these qualifications, should not be assigned to conduct mental health evaluations except as collaborators with qualified mental health professionals. (Recommendation 3)**
- **Temple University should be invited to submit a proposal, responsive to the recommendations contained in this report, as may be modified by the Court, to extend its contract with the Court through FY 1992-1993. The request for funds should not exceed \$450,000. (Recommendation 4)**
- **To reflect more accurately reflect the functions and composition of the current staff, and to suggest an improved Clinic, the name of the Clinic should be changed to "Court Mental Health Clinic." (Recommendation 22)**

## **Requests for Mental Health Evaluations**

It is likely that a significant proportion of the 5,000 requests for mental health evaluations received by the Clinic in 1991 were *pro forma*, reflexive or unnecessary. Though the number and nature of the requests for mental health evaluations are likely to change as the Clinic's organization and management improve, the number, types, and nature of the requests for mental health evaluation warrant direct scrutiny by the Court and the Clinic.

### **Recommendations**

- **The standard request form, "Request for Presentence Investigation/Mental Health Evaluation," should be revised in ways that discourage *pro forma*, reflexive and unnecessary requests. (Recommendation 5)**
- **Except as may be required or desired if legislation currently pending is passed (see Recommendation 7), requests for mental health evaluations by the Clinic pursuant to Section 17 (35 P.S. § 780-117; Probation Without Verdict) should be curtailed or eliminated altogether. The Court should give serious consideration to assigning to the Investigative Division of the Probation Department the conduct of Section 17 evaluations as part of its presentence investigation, instead of forwarding Section 17 evaluations requests to the Clinic. (Recommendations 6 and 7)**
- **The current practice of requesting pre-sentence mental health evaluations by the Clinic in *almost all* cases in which a pre-sentence investigation is requested should be restricted. Such evaluations should be requested only upon presentations by the parties or Court officials or, alternatively, when the Court directly observes behaviors of the defendant that indicate that the mental condition of the defendant should be considered at sentencing. (Recommendation 8)**
- **Over the course of the next year, Clinic staff regularly should observe the proceedings, and work informally and cooperatively with the judges and court clerks in each of the major court programs (Criminal List/Drug, Section Calendar, Homicide and the Municipal Court), to understand and appreciate the purposes and context in which requests for mental health evaluations arise. The information gained from these observations and interactions with judges and court clerks should be used to improve not only the creation and referral of requests but also the provision of mental health information to the Court. (Recommendation 9)**

## **Operation of the Clinic**

As noted earlier, the Clinic has operated in the absence of an effective organization and management structure. This absence has impeded improvements in the operations of the Clinic.

- **Based in part on this report, the Clinic should develop a manual of policies and procedures governing the important aspects of the delineation, acquisition and provision of mental health evaluations and other services to the Court including, but not limited to, the following: organization, management and operation of the Clinic; services provided by the Clinic including mental health evaluation, consultation, research and training; preparation of case files; scheduling of interviews; conduct of clinical interviews and psychological testing; preparation of reports; reporting mechanisms; and quality assurance procedures. (Recommendation 10)**
- **The facility for word processing and duplication of mental health evaluation reports should be located within the Clinic instead of the Probation Department. (Recommendation 11)**
- **Because judges and clerks (who actually execute the request for mental health evaluations) inappropriately may view presentence investigations and mental health evaluations as one and the same, the Clinic should cease functioning as the intake for *all* requests for presentence investigation. This intake function is more appropriately placed under the aegis of the Investigative Division of the Probation Department. (Recommendation 12)**
- **The preparation and contents of written reports of mental health evaluations should be made to conform to the requirements of relevant statutes, relevant professional standards, and the needs, requirements and preferences of the Court. The Clinic should develop, promulgate, and review and revise regularly written guidelines for and samples of the major types of mental health evaluations requested by the Court. The guidelines and samples should conform to legal and professional standards. The Mental Health Assessment Oversight Committee should advise the Clinic regarding the development of these written guidelines and samples of mental health evaluation reports. (Recommendation 13)**
- **Judges and courtroom clerks should endeavor to prepare the requests for mental health evaluation shortly after the specific time during the proceedings when the order is issued. Alternatively, the courtroom clerk and the Clinic should devise**

**a method whereby the pending order is communicated to the Clinic. (Recommendation 14)**

- To avoid delay in case processing and the excessive costs of transportation and rescheduling mental health evaluations, the Clinic should strive to conduct mental health evaluations of all defendants on the day of their referral to the Clinic. In the order of decreasing potential delays and costs, priority should be given to the scheduling of out-of-county custody cases, custody cases and bail cases. The Clinic should work in cooperation with the Clerk of the Quarter Sessions and the Sheriff Department to identify these cases, as soon as is possible, on the Clinic's schedule. (Recommendation 15)**
- With the advice of the Mental Health Assessment and Oversight Committee, the Clinic should devise a uniform procedure for distribution of mental health evaluation reports. The procedure should comply with applicable statutes and case law governing the transmission of mental health communications and, generally, reflect a common sense appreciation of the context-dependent nature of the communication. (Recommendation 16)**
- The Clinic should develop, as part of its organization and day-to-day management, an on-going mechanism of quality assurance whereby mental health evaluation reports (both oral and written) and other services provided by the Clinic are continuously monitored, reviewed and improved on the basis of their results. (Recommendation 17)**

## **Education and Training**

Professional groups, including the American Bar Association, have articulated desirable levels of education and training for judges, mental health professionals and lawyers on issues of mental disability and the participation of mental health professionals in the criminal justice process.

- Temple University and the Court should ensure that clinicians have sufficient professional education, training and experience, including that required by statute, case law, court rules, and desired by judges in individual cases, for understanding the relevant legal matters and for satisfying the specific purposes for which the mental health evaluation is requested. Judicial, legal and mental health professionals associated with the Clinic should cooperate in promoting, designing and offering basic and advanced programs--both formal and informal--on mental health issues and on the participation of mental health professionals in the judicial**

**process to judges, attorneys, mental health professionals, and to students, including medical residents, fellows and law students. (Recommendation 18)**

### **Linkages With Other Court Programs**

The Court can benefit greatly--in terms of improved quality of services, increased efficiency, continuity, cooperation, and better communication--by linking the Clinic with other programs, units and operations of the Court that deal with cases--both criminal and civil--in which issues of mental health arise.

- **At the direction of the Court, and in cooperation with the appropriate divisions, branches and units of the Court, the Clinic should explore opportunities for coordination with the Medical Branch of the Family Division, Court programs that routinely employ privately-retained mental health professionals to provide mental health expert assistance, and the Mental Health/Mental Retardation Program of the Court responsible for involuntary civil and "criminal" commitment.**



## **1.0 Introduction**

Since 1966, Temple University has provided psychiatric and psychological evaluation services to the Philadelphia Court of Common Pleas (hereinafter "Court") on a contractual basis.<sup>1</sup> The organization of these services, including the work of Temple University's psychiatrists and psychologists, supported by an administrative staff employed by the Court, is known today as the "Court Psychiatric Clinic" (hereinafter "Clinic"). The Clinic provides the judges in the Trial Division and the Municipal Court with psychiatric and psychological diagnostic services upon their request. A total of 4,851 requests for evaluations were received by the Clinic in 1991 in four major categories: (1) evaluations of defendants' competency to stand trial; (2) drug abuse evaluations ("Section 17" evaluations); (3) presentence evaluations; and (4) evaluations of possible involuntary "criminal" commitment. Presentence evaluations constitute between two-thirds and three-quarters of the evaluations requested.

This report describes the results of an evaluation of the organization, management and operation of the Clinic conducted from January 15 to March 31, 1992, by the National Center for State Courts' (NCSC) Institute on Mental Disability and the Law, acting through the NCSC's Northeastern Regional Office. Appendix A describes the methods of the evaluation. Section 2 of this report is a brief description of the background and the events that gave rise to this evaluation. Section 3 describes the current organization of the Clinic including its mission, purpose and current clinical and administrative staff. Beginning with

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<sup>1</sup>Temple University Proposal for Psychiatric Services for Court of Common Pleas (Exhibit A), attached to and made a part of the unapproved Contract between the Court of Common Pleas of the First Judicial District and Temple University, July 1, 1991-June 30, 1992 (hereinafter "1992 Contract"). Temple University's proposal (Exhibit A) is dated April 23, 1991. The Contract is dated and marked as received by the Court on May 28, 1991. As of this writing, the 1992 Contract has been signed by officials of Temple University and is awaiting final approval and signature by the Court. The previous Contract between the Court and Temple University expired June 30, 1991. Except for the staff changes described in later sections of this report, the 1991 Contract is essentially the same in structure and content as the most recent expired contract.



a review of legal authorities, Section 4 summarizes the creation and referral of requests for mental health evaluations. Section 5 describes the operation and the flow of cases and paperwork through the Clinic, beginning with the receipt of the request for mental health evaluations to the distribution of the evaluation report.

Finally, based on the findings discussed in Sections 3-5, Section 6 draws conclusions and makes specific recommendations for the improvement of the organization, management and operation of the Clinic. These conclusions and recommendation are summarized in the Executive Summary at the front of this report. The central theme of the conclusions and recommendations is that the clinic operates in virtual isolation from the Court's case management and overall administration and that the key to improvement is integration and coordination of the Clinic's function with those of the Court.

Toward this end, it is recommended that the Court establish an organization and management structure for the Clinic that ends the virtual isolation from, and ensures the Clinic's full integration with, the administration of the Court. The Court should designate a capable administrator to manage both the clinical and administrative staff and functions of the Clinic. Further, it is recommended that requests for mental health evaluations be curtailed significantly by elimination of *pro forma*, reflexive requests, especially for pre-sentence and Section 17 evaluations, and that the operations of the Clinic be improved and its services made more responsive to the needs of the Court. The anticipated reduction in the number of requests for evaluation and a streamlining of the Clinic's operations should lead to a reduction of approximately \$150,000 of the Clinic's operating costs. Finally, because of the Court's long-standing relationship with Temple University, and because of Temple University's expressed willingness to reduce costs and streamline the Clinic's operations,

Temple University should be invited to submit a proposal, responsive to the conclusions and recommendations contained in this report, to extend its contract with the Court through fiscal year 1992-1993. The amount of fund requested should not exceed \$450,000.



## **2.0 Background**

For more than 25 years, through successive court administrations, Temple University has provided psychiatric and psychological services to the Court. Except for the very early years of the Clinic, Temple's work with the Court was spearheaded by Melvin S. Heller, M.D., then a Clinical Professor of Psychiatry and Director of Temple University's Institute of Law and the Health Sciences, and William H. Traylor, Esq., Professor of Law and Co-Director of the Institute of Law and the Health Sciences. At first, the contract between the Court and the Clinic was administered by the Temple University's School of Law; five or six years ago, for reasons that are not clear, the administration of the contract was moved from the School of Law to the School of Medicine. The recruitment, hiring and oversight of the Clinic's clinical staff (which has remained remarkably stable over the years) were directed by Professors Heller and Traylor relatively independent of the operation of Temple University's law and medical schools, akin to the manner in which a researcher might organize a research project funded by a non-university research grant (while the research staff technically are university personnel, their involvement with the university is minimal).

Over the years, the Clinic attracted medical residents and fellows, and law students, many of whom have continued their work in the justice and mental health systems in Pennsylvania and throughout the country. Some have become prominent in their fields. Reportedly, both Professors Heller and Traylor enjoyed good personal relationships with judges and court administrators which they used effectively for establishing informal networks and gaining ready access to the various programs of the Court. Formal organizational structures and management methods apparently were not much in evidence during their tenure. Major involvement of Professors Heller and Traylor with the Court ended in June

1991 with the expiration of the last formal contract between Temple University and the Court.<sup>2</sup>

In 1990-1991, Burr S. Eichelman, M.D., Ph.D., and Anne C. Hartwig, J.D., Ph.D., were hired by Temple University--Dr. Eichelman as Professor and Chairman of Temple University's Department of Psychiatry and Dr. Hartwig as Professor in Temple University's School of Law. Apparently, Professors Eichelman and Hartwig also joined Professor Traylor as co-directors of Temple University's Institute of Law and Health Sciences; Professor Melvin Heller stepped down as the Director of the Institute. In Temple University's proposal for psychiatric services for FY 1991-1992, Professor Eichelman replaced Dr. Heller as the Clinic Director and, as stated in the proposal, he "assumed direct clinical leadership and oversight responsibilities for the assessment and recommendation tasks of the clinic."<sup>3</sup> Dr. Heller would "remain active in a consultant clinical and teaching role."<sup>4</sup> During its review of Temple University's proposal for 1991-1992, which requested \$600,000 (the same amount as in the previous year), several options for restructuring the contract with Temple University, including a significant reduction in costs, were explored but not concluded by the Court.<sup>5</sup>

In November 1991, Geoff Gallas, D.P.A., was hired by the Court to serve as Executive Director. Shortly after his arrival, Dr. Gallas communicated to Drs. Eichelman and Hartwig the Court's intention to continue to utilize the services of

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<sup>2</sup>Contract between the Court of Common Pleas for the First Judicial District and Temple University, acting through the Institute of Law and Health Sciences, July 1, 1990-June 30, 1991 (hereinafter "1991 Contract").

<sup>3</sup>Temple University Proposal for Psychiatric Services for Court of Common Pleas, Philadelphia, PA, July 1, 1990 to June 30, 1991 (Exhibit A), 1991 Contract *supra* note 2, at 1.

<sup>4</sup>*Id.*

<sup>5</sup>See Letter dated October 18, 1991 from Administrative Judge Nelson A. Diaz to Pennsylvania Supreme Court Justice Ralph Cappy.

Temple University through June 30, 1992, and to explore a restructured contract for mental health services for 1992-1993 in the range of \$350,000 to \$450,000 (a reduction of \$150,000 of the previous contract). This exploration would occur in anticipation of a decrease in the number of requests for mental health evaluations and an overall improvement in the structure, management and operations of the Clinic. This report, and the evaluation upon which it is based, are intended to inform the Court's Trial Division's Administrative Judge, the Office the Executive Administrator, and other divisions and branches and units of the Court in their deliberations and decisionmaking about present and future mental health examination services of the Court.



### **3.0 Current Organization of the Clinic**

#### **3.1 Mission and Purpose**

The mission and purpose of the Clinic appear to be broadly conceived. According to the 1992 Contract between the Court and Temple University, the mission of the Clinic is, in part, to "service the needs of the Criminal Court of the First Judicial District of the Commonwealth of Pennsylvania by performing the necessary professional evaluation and examination of all individuals referred to said Clinic by the Criminal Courts."<sup>6</sup> The services, the results of which are to be documented in appropriate reports, include: (1) one or more individual examinations and interviews of each referred defendant or offender; (2) special psychological testing; (3) review of all clinical and legal materials available on each case; (4) consultation and responses to "special needs" as requested by individual judges and probation officers; (5) diagnosis, prognosis, and recommendations, including history of any organic/medical problems requiring further investigation; (6) other dispositional considerations, including voluntary and involuntary treatment needs and "prospects" with respect to the Mental Health Procedures Act of 1976, as amended; and (7) case follow-up, review and dictation of addendum reports as indicated.<sup>7</sup> This mission and purpose, and list of services to be performed by the Clinic, which appear to have not been systematically examined by the Court or Temple University, appear unchanged in the 1991 Contract and the 1992 Contract. It is not known to what degree this mission, purpose and lists of services have been communicated to, and understood and used by Clinic and Court staff. Notwithstanding any written statements of mission, purpose and services, based on interviews with Clinic and Court staff, it appears that the *de facto* mission of the Clinic simply is to

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<sup>6</sup>1992 Contract, *supra* note 1, at 1.

<sup>7</sup>Exhibit A, *id.*, at 2.



respond to judges' requests for mental health evaluations by oral and written reports.

Temple University's 1992 Contract mentions training services, quality assurance and research.<sup>8</sup> Training includes in-service training for judges, clerks, attorneys, and staff of the Probation Department on topics such as updates on major mental illnesses, clinical aspects of substance abuse, and new developments in criminal forensic psychiatry, as well as mental health law across state jurisdictions. It also includes the training of residents in psychiatry and medical students. While the proposal mentions benefits to be gained by Temple University by these training services, such as the creation of an "environment for training residents in psychiatry and medical students about forensic psychiatric issues" and the provision of a "clinical focus for development of a Philadelphia medical school consortium fellowship-training program," direct benefits to the Court are not explicitly mentioned.<sup>9</sup>

Proposed quality assurance and research includes "work with the Court to assess the utility of the clinic evaluations for the judiciary in '91-'92 and to use this assessment to modify the content of the clinic's assessments so that they have increased utility for the Court."<sup>10</sup>

Except for informal discussions among Drs. Eichelman and Hartwig the Court, and the submission of a grant proposal for a study of presentence evaluations submitted to the National Science Foundation which the Court was asked to review and to support, concerted efforts to organize and manage the Clinic to achieve or fulfill the mission, purpose, services and functions mentioned above were not apparent to the NCSC during its evaluation.

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<sup>8</sup>*Id.*, at 3-4.

<sup>9</sup>*Id.*, at 3.

<sup>10</sup>*Id.*, at p. 4.

## 3.2 Current Staff

### 3.2.1. Personnel

As shown in Table 1, the Clinic currently employs a staff of 14 individuals who are located in the Clinic, including approximately 3.75 full-time equivalent (FTE) clinical staff, provided by Temple University on a contractual basis, and approximately 5.0 FTE administrative staff employed by the Court.<sup>11</sup> The clinical staff includes four part-time psychiatrists (who each work between 11-16 hours per week), four part-time clinical psychologists (who each work 10-27 hours per week), and a psychiatric resident (25 hours per week). The administrative support staff include one full-time supervisor (Ms. Barbara O'Neil) and four full-time administrative clerks.

**Table 1**  
**Clinical and Administrative Staff of the**  
**Court Psychiatric Clinic**

| Personnel                      | Position                           | Hours (Week)  |
|--------------------------------|------------------------------------|---------------|
| <b>Clinical</b>                |                                    |               |
| Burr S. Eichelman, M.D., Ph.D. | Clinic Director                    | --            |
| Sol Barenbaum, Ph.D.           | Clinical Psychologist              | 10            |
| Lawrence Byrne, M.Ed.          | Clinical Psychologist              | 20.5          |
| Joaquin Canals, M.D.           | Psychiatrist                       | 12-16         |
| Jules DeCruz, M.S.             | Clinical Psychologist              | 22            |
| Albert Levitt, M. Ed.          | Clinical Psychologist              | 22.5-27.5     |
| Robert W. Stanton, M.D.        | Psychiatrist                       | 15.5          |
| Richard Saul, M.D.             | Psychiatrist/Clinic Co-Director    | 11-13         |
| Joy Guziec, M.D.               | <u>Psychiatric Resident</u>        | <u>25</u>     |
|                                | Total Clinical                     | 138.5 - 149.5 |
| <b>Administrative</b>          |                                    |               |
| Florence Farinella             | Administrative Technician I        | 40            |
| William Haines                 | Administrative Technician I        | 40            |
| Barbara O'Neil                 | Supervisor                         | 40            |
| Mary Politano                  | Administrative Technician I        | 40            |
| Sherry D. Taborne              | <u>Administrative Technician I</u> | <u>40</u>     |
|                                | Total Administrative               | 160           |

<sup>11</sup>FTE equivalents and hours worked per week are estimates based on reports by Clinic staff and observations by the NCSC. Dr. Eichelman's schedule was unavailable; therefore, his time devoted to the Clinic is not calculated as part of the total FTE. Temple's proposed contract, *supra* note 1, at 1, states that Dr. Eichelman "attends the Clinic on four of the five weekdays."

With the exception of Dr. Eichelman, who replaced Dr. Heller as the Clinic Director, and the psychiatric resident, the clinicians named in Table 1 provide the Court with a vast amount of forensic mental health experience, ranging from eight to 21 years, with the Clinic. With very few staff changes, and through successive court administrations, these clinicians have continued to provide, in a relatively efficient and timely manner, mental health evaluations requested by the Court. Much the same can be said about the administrative staff. Notwithstanding the problems identified in the remainder of the report, the fact that the Clinic has "stayed in business" for as long as it has is a tribute to the hard work and efficiency of the clinical and administrative staff named in Table 1. As is true of most organizations, the problems of the Clinic are problems with the system, not the people. Nothing that the NCSC observed suggested deficiencies with the Clinic staff. To the contrary, improvement should build upon a responsive and relatively efficient processing of requests for mental health evaluations by the Clinic staff.

Not included among the administrative staff listed in Table 1, and not located within the Clinic, are two or three clerk-typists in the Probation Department who, reportedly, spend all or most of their time typing and reproducing Clinic reports. Mr. Frank Snyder, Director of Presentence Investigations of the Adult Probation Department, supervises the administrative staff and functions of the Clinic. His direct supervision of the Clinic's psychiatrists and psychologists, however, seems to be minimal. For the purposes of estimating FTE, the Probation Department staff's contribution to the total FTE of Clinic staff is set at 2.25 FTE, a conservative estimate.

Professors Hartwig, Heller and Traylor, all of whom are mentioned in Temple University's 1992 Contract with the Court,<sup>12</sup> have unclear relationships to

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<sup>12</sup>*Supra* note 1, at 3.

the Clinic. Except for a scheduled interview with Dr. Hartwig, none of these individuals made an appearance in the Clinic during the three site visits to Philadelphia by the NCSC (see Appendix A). Their contributions of time were not calculated as part of the total FTE noted in Table 1.

### **3.2.2 Management**

Both the expired 1991 Contract and the 1992 Contract between the Court and Temple University require the service of a full-time (40 hours per week) "medical director" of the Clinic or, alternatively, two "co-directors," who together would provide full-time service.<sup>13</sup> Further, they require the services of the co-directors of the Temple University's Law and Psychiatry and Dr. Melvin Heller as consultants to the Court on an as needed basis. The administrative oversight, day-to-day management and consultation of the clinical staff that are suggested by these requirements, however, were not in evidence during the NCSC's visits to the Court.

Although the expired 1991 Contract required Temple University to provide the services of a sufficient number of board-approved psychiatrists or licensed psychologists "to professionally and diligently attend to the workload requirements"<sup>14</sup> of the Clinic, no FTE staff requirements were specified in the 1990-1991 contract, nor are such requirements set in the proposed 1991-1992 contract. Clinicians appear to have an implicit understanding regarding their part-time schedule in the Clinic and the relationship of that schedule to the financial arrangement in their contract with Temple University. Apparently, except to the degree that it is specified in Table 1, this understanding regarding the number of hours clinicians work in the Clinic has not been put in writing. During interviews, judges and attorneys complained that clinicians often are not available. In part,

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<sup>13</sup>*Supra* note 1, at 2.

<sup>14</sup>*Supra* note 2, at 2.

their complaints are attributable to their lack of awareness of the overall schedule of the Clinic's psychiatrists and psychologists.<sup>15</sup>

According to the 1992 Contract between the Court and Temple University, the Court is responsible for providing to the Clinic the services of "an administrator and such clerical assistance as shall be deemed qualified and necessary by the President Judge."<sup>16</sup> The administrator is responsible for managing the operations of the Clinic including:

- (1) assurance of proper caseflow;
- (2) coordination of "coverage requirements" of professional and support staff;
- (3) assurance of available adequate facilities and supplies;
- (4) provision of necessary information to concerned parties; and,
- (5) reporting to the President Judge or his designee regarding compliance of Temple University with all the terms of the contract.

The first three of these duties appear to have been ably and successfully managed by the administrative supervisor of the clinic. As discussed in Section 3 and Section 4, the fourth duty, provision of necessary information to concerned parties, is in need of much improvement. Finally, oversight and management of the contract and accountability for compliance with the terms of the contract currently are (and appears to have been for quite some time) nonexistent.

As noted in Table 1, the Clinic currently employs a psychiatric resident. The training and their participation in the work of the Clinic, as noted earlier, has long been a part of the contractual agreement between the Court and Temple University. Currently, the tenure of residents is one month; in the past, it has

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<sup>15</sup> See *infra* Section 5.3, "Scheduling of Interviews."

<sup>16</sup> *Supra* note 1, at 3.

been three months. The current resident's training regimen aptly can be described as "on the job" training and "trial by fire." Shortly after her arrival at the Clinic, she reportedly conducted mental health evaluations and, on at least one occasion, provided live testimony to the Court.

Apparently, there is currently no training program for residents. When asked about the formal orientation and training she received, the current resident stated that her orientation to the Clinic consisted largely of talking with other residents who had completed a residency in the Clinic. Responsibilities for training and supervision of the resident in the Clinic are unclear. Several individuals, including clinicians, attorneys and judges, complained about the residents' lack of preparation prior to their being thrust into the work of the Clinic and the lack of structure of the residency program in the Clinic.

### **3.3 Estimated Operating Costs**

The 1991 costs of operating the Clinic are estimated in Table 2. Not included in these estimates are the costs of administrative staff benefit (fringe) packages, equipment and supplies, and indirect costs (i.e., overhead expenses associated with operating the Clinic and the maintenance of the staff).

**Table 2**  
**Estimated Personnel 1991 Costs of the Court Psychiatric Clinic**

| <b>Item</b>                         | <b>Amount</b>             |
|-------------------------------------|---------------------------|
| Temple Contract (3.75 FTE)          | \$600,000                 |
| Clinic Administration (5.0 FTE)     | 115,221                   |
| Probation Department Administration | <u>75,000<sup>a</sup></u> |
| Total                               | \$790,221                 |

<sup>a</sup>Including approximate time of three full-time clerk typists and Mr. Frank Snyder, Adult Probation Department.

Using the total number of requests for evaluations received by the Clinic in 1991 (4,851) and the approximate personnel cost (\$800,000) to calculate a cost per case, yields a cost per case of approximately \$165 in 1991. Even if one were to double this figure to \$330 per case to account for personnel fringe benefits and indirect expenses, this cost per case still can be considered reasonable if not economical. The fee schedule for forensic mental health examinations in Virginia, for example, provides a range per evaluation from \$200 for evaluations of competency to stand trial to \$400 for presentence evaluations in capital cases. According to an attorney who helped draft the legislation that set the Virginia fee schedule, evaluations of competency to stand trial, which are on the low end of the cost scale, generally take five to six hours to complete, including report preparation.<sup>17</sup>

A look at the costs of operating the Clinic from a somewhat different perspective yields a different picture. A total FTE of 4.0 for *clinical* staff (0.25 FTE higher than that estimated earlier<sup>18</sup>) at a cost to the Court of \$600,000 in contracted services, means that each 1.0 FTE clinician is costing the court \$150,000. Even taking into account Temple University's indirect costs, this is a hefty amount.

Taking both these views of the operating costs of the Clinic into account--one based on a cost per case and the other on FTE costs--and notwithstanding other areas of improvement noted in this report, one is led to the conclusion that the Clinic's clinical staff is a highly productive, well paid group. Assuming a future reduction of the number of requests for mental health evaluations and a streamlining of the Clinic's operations, this conclusion justifies, at least generally, the anticipated reduction in the cost of contracted services to \$450,000.

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<sup>17</sup>Interview with Mr. Larry Fitch, Institute on Law, Psychiatry and Public Policy, University of Virginia, February 26, 1992.

<sup>18</sup>See *supra* Section 3.2.1 "Personnel."

## **4.0 Creation and Referral of Requests for Mental Health Evaluation**

Beginning with a review of legal authorities, this section describes the initial stage of the mental health evaluation process in which the request for evaluation is created and referred to the Clinic. It is in this early stage that many of the problems in the mental health evaluation process can be prevented. Obviously, clearer questions lead to more relevant answers. Generally, a source of frustration for those involved in the process of mental health evaluations are psycholegal questions that are not clearly framed and communicated. Studies of typical requests and orders for mental health information by the NCSC and others suggests that throughout the nation requests for mental health evaluations by the courts are often totally devoid of specific information directing the examination process in a particular case. This can lead to wasted resources, both in the mental health and justice systems, unnecessary evaluations, and irrelevant results.<sup>19</sup>

### **4.1 Review of Legal Authorities**

This section reviews, in brief, the legal authorities for requests for mental health evaluations of competency to stand trial, drug abuse (Section 17 and 18), mental health factors that might be relevant in sentencing, insanity and "criminal" commitment. This review is not intended to be definitive but merely to provide the legal context for descriptions, conclusions and recommendations in the remainder of the report.

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<sup>19</sup> See, for example, Poythress, Otto and Heilbrun, *Pretrial Evaluations for Criminal Courts: Contemporary Models of Service Delivery*, 18 JOURNAL OF MENTAL HEALTH ADMINISTRATION 198-208; G. Melton, L. Weithorn and C. Slobogin, COMMUNITY MENTAL HEALTH CENTERS AND THE COURTS: AN EVALUATION OF COMMUNITY-BASED FORENSIC SERVICES (1985); I. Keilitz, MENTAL HEALTH EXAMINATIONS IN CRIMINAL JUSTICE SETTINGS: ORGANIZATION, ADMINISTRATION AND PROGRAM EVALUATION (1981); and Keilitz, *A Model Process for Forensic Mental Health Screening and Evaluation*, 8 LAW AND HUMAN BEHAVIOR 355-369 (1984).



#### **4.1.1 Competency Evaluations**

Under 50 P.S. § 7402 (1991) (Mental Health Procedures Act), an application for an incompetency examination can be made by the parties or an official at the place where the defendant is detained. The court has discretion to order the examination either upon such application or upon its own motion at any stage in the proceedings, and may do so without a hearing unless the defendant objects. The examination is to be conducted on an outpatient basis unless an inpatient examination is otherwise ordered. At least one psychiatrist must be involved in the examination, with a report subsequently submitted to the court. The court may allow the defendant's psychiatrist and the State's psychiatrist to witness and participate in the examination. The defendant is also entitled to have counsel present at the examination and is not required to answer any questions or perform any tests unless it was the defendant that moved for or agreed to the examination. Nothing said or done by the defendant can be used as evidence in any criminal proceeding on any issue other than the defendant's mental condition. If the defendant objects to the conclusions of the court-appointed psychiatrist, but is unable to afford his or her own expert, the defendant can obtain a psychiatrist with reasonable fees chargeable against the mental health and mental retardation program of the locality.<sup>20</sup>

#### **4.1.2 Section 17 and 18 Evaluations**

Under 35 P.S. § 780-117 (1991) (Probation Without Verdict), no provision is made for a mental health evaluation. It does permit the Court, prior to entering a judgment on a first-time drug offender who is a "drug abuser" and who proves

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<sup>20</sup> Also see 50 P.S. §§ 4407, 4408 (1991) which retains validity applied to persons who are mentally retarded and allows the court to order the exam of a person charged with a crime and released on bail or detained in a penal or correctional institution, and has been used for evaluating incompetency to stand trial (and insanity). However, the courts seem to apply in practice the Mental Health Procedures Act, 50 P.S. § 7402 (1991) discussed above. The Pa. Rules of Criminal Procedure do not address this issue. See J.W. Oler, Jr. PENNSYLVANIA CRIMINAL LAW: DEFENDANTS MENTAL STATE 23-26 (1986).

the fact of such drug abuse to the satisfaction of the Court, to defer sentencing and place the defendant on probation upon such reasonable terms and conditions as the court requires. Upon fulfilling the terms of probation, further proceedings will be dismissed. Judges have relied upon the Clinic's evaluations to reinforce the required proof of drug abuse to the "satisfaction of the Court," as required by statute.

House Bill 1467, pending in the Pennsylvania 175th General Assembly, 1991-1992 regular session, would amend Section 17 to require the defendant, for the purposes of proving drug "dependency, not drug abuse," to present the testimony of a "physician trained in the field of drug abuse." Notwithstanding the inconsistencies in the amendment's use of the terms "drug abuse" and "drug dependency," this amendment, if passed, would impose requirements upon defendants, the Court, and the Clinic not in current law (see Appendix B).

However, 35 P.S. § 780-118 (1991) (Disposition in Lieu of Trial or Criminal Punishment) does provide that if a person charged with a nonviolent crime claims to be drug dependent or a drug abuser and requests treatment prior to trial, including civil commitment, the court *shall* appoint a physician trained or experienced in drug dependency or drug abuse to examine "if necessary" and to review the defendant's record and to advise the State, the defendant, and the court in writing of his or her recommendation of whether it would be better for the defendant's treatment and rehabilitation to be prosecuted or have proceedings suspended or withdrawn in order to initiate treatment for drug dependency. The State may also initiate these proceedings.

In addition, after conviction, the defendant can request probation with treatment or civil commitment for treatment in lieu of a sentence. At that point the court *may* appoint a qualified physician to provide a similar recommendation as for a pre-conviction evaluation.

For both reviews, the decision to permit drug dependency treatment in lieu of incarceration is left to the sound discretion of the trial judge.<sup>21</sup>

#### **4.1.3 Presentence Evaluation**

Under Pa. R. Crim. P. 1403 (1989) (Rule 1403, Aids In Imposing Sentence), two vehicles are provided for generating information to assist the judge in sentencing. First, under Rule 1403 (A), the sentencing judge may in his or her discretion order a pre-sentence investigation report, but if he or she does not so order in three specific instances (when incarceration for one year or more is a possible disposition, the defendant is under 21, or for a first-time offender), the judge *must* place on the record the reasons for dispensing with the report. A failure to record these reasons has been held to require re-sentencing.<sup>22</sup>

Second, under Rule 1403 (B), before sentencing and after notice to counsel for both parties, the judge *may* order the defendant to either: a) submit to a "psychiatric" examination (which "may" be conducted at any available clinic, hospital, or institution) for up to 60 days, or b) submit to a "diagnostic" examination (for which the defendant "may" be committed to a state correctional center) for up to 60 days. The commentary to this law recommends (as a matter of sound diagnostic practice) that the 1403 (B) examination not commence until the pre-sentence investigation report (1403 (A)) is completed, suggesting that the 1403 (A) report is the essential prerequisite for the judge's sentence. Furthermore, there is no case law indicating that a judge's sentence has been reversed for failing to state on the record (as required for the pre-sentence investigation) the reasons for not ordering a psychiatric examination. Indeed, the single case addressing whether the court abused its discretion in not ordering a pre-sentence psychiatric evaluation, ruled that the court did not abuse

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<sup>21</sup>Commonwealth v. Kubiak, 379 Pa. Super. 402, 550 A.2d 219, *appeal denied*, 522 Pa. 611, 563 A.2d 496 (1988).

<sup>22</sup>See, e.g., Commonwealth v. Weldon, 287 Pa. Super. 533, 430 A.2d 1180 (1981).

its discretion because the testimony at trial did not convey the impression that the defendant was mentally incompetent (the mere fact that the defendant had been recommended for therapy a year earlier was an insufficient "red flag" to mandate a psychiatric report).<sup>23</sup> No indication was provided that the trial court entered into the record its reasons for not ordering the psychiatric examination.

Nevertheless, 1403 (B) also states that the report of this examination "may be considered the equivalent of a pre-sentence investigation report," leaving open the possibility that the requirement to place in the record the reasons for not ordering the pre-sentence report may also apply to the psychiatric examination. A highly conservative course would be to always make this entry for defendants meeting the criterion noted above to avoid the possibility of reversal. However, this course is perhaps overly cautious in that the failure to state reasons for not ordering a psychiatric exam under Rule 1403 (B) has not been challenged on appeal, would require a considerable amount of wasted paperwork for the great majority of criminal defendants for whom there is no indication that a psychiatric examination is necessary and, for the minority of defendants where there are some such indications, imposing this requirement would create a considerable burden on judges to perform a psychiatric triage with little assistance or insight. The likely result being defendants routinely referred for a psychiatric examination even though neither requested, desired, nor appropriate, delaying the criminal process and wasting valuable court resources.

Although Rule 1403 lists only a series of institutions as the sites for the psychiatric exam, the accompanying commentary states that the exam may also be ordered on an out-patient basis.

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<sup>23</sup>Commonwealth v. Megella, 268 Pa. Super. 316, 408 A.2d 483 (1979).

As an alternative to the Rule 1403 exams, under the Mental Health Procedures Act (50 P.S. §§ 7401, 7405 (1991)) the court *may* defer sentencing and order the defendant to be examined for the presence of mental illness as an aid in the determination of disposition. This action may be taken on the court's initiative, or upon application of any of the parties appearing before the court or any other person acting in the defendant's interest. If the defendant is not currently in detention, the examination is to be conducted on an out-patient basis unless an in-patient examination is ordered pursuant to civil commitment provisions. The nature of this examination or the proper parties to conduct it are not designated (i.e., this examination is not referred to as a "psychiatric" examination, nor are psychiatrists specifically authorized to conduct it). This examination can serve as a predicate to a court order directing involuntary treatment.<sup>24</sup> It has been ruled that these provisions also apply to juveniles 14 years of age or older, whether they are convicted in adult court or adjudicated delinquent in juvenile proceedings.<sup>25</sup>

As a third alternative, if mental retardation is an issue, under 50 P.S. § 4410 (1991) the court *may* defer sentence and order an examination of the defendant for mental disability (limited to mental retardation) to guide the court in reaching its disposition. This action may be taken on the court's initiative or upon the application of one of the parties or another person acting in the defendant's interest. This examination is to take place at a designated facility or by two physicians. Upon receiving the resulting report, the court can commit the defendant in lieu of sentence for a period of time no longer than the maximum sentence for the crime the defendant had been found guilty of.<sup>26</sup>

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<sup>24</sup>50 P.S. § 7406 (1991).

<sup>25</sup>In re McMullins, 315 Pa. Super. 531, 462 A.2d 718 (1983).

<sup>26</sup> Previously when this statute addressed the examination of mentally ill defendants as well, it was ruled that if before the expiration of the maximum period of time for which the defendant is

Finally, if a minor is found to have violated certain specific provisions regarding alcohol abuse, the court may require the minor to be evaluated prior to disposition to determine the extent of the individual's involvement with alcohol, and can subsequently require the minor to successfully complete a program of education, intervention, or counseling approved by the Department of Health, with the costs the responsibility of the minor.<sup>27</sup>

#### **4.1.4 Insanity Evaluations**

Two separate procedures are set out for insanity determinations. First, in conjunction with a hearing on the defendant's competency to stand trial,<sup>28</sup> the court may also hear evidence on whether the defendant was legally insane at the time of the crime charged and make a determination regarding insanity.<sup>29</sup> The report of the examiner that may be appointed by the court to evaluate the defendant's competency to stand trial may also include, at the court's request, an opinion as to the defendant's insanity.<sup>30</sup> As noted in section 4.1.1, *supra*, this examination is to be conducted on an outpatient basis unless an inpatient examination is specifically authorized, and is to be conducted by at least one psychiatrist.<sup>31</sup> In general, the same rules are to apply in making an insanity determination in conjunction with an incompetency hearing as when the insanity issue is addressed in the course of the trial,<sup>32</sup> implying that associated mental

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committed, the defendant is found to be no longer in need of psychiatric treatment, the defendant can be transferred to a penal institution to complete the sentence. *Commonwealth v. Barnes*, 448 Pa. 299, 292 A.2d 348 (1972).

<sup>27</sup>18 Pa.C.S. § 6310.5 (1991).

<sup>28</sup>50 PA. CONS. STAT. ANN. § 7403 (Purdon 1991).

<sup>29</sup>50 PA. CONS. STAT. ANN. § 7404(A) (Purdon 1991).

<sup>30</sup>50 PA. CONS. STAT. ANN. § 7402(E)(4)(iii) (Purdon 1991).

<sup>31</sup>See 50 PA. CONS. STAT. ANN. § 7402(E) (Purdon 1991).

<sup>32</sup> *Id.*

health evaluations would be considered in the same manner in both proceedings.<sup>33</sup>

Second, as part of the criminal trial, the defendant may raise an insanity defense.<sup>34</sup> The burden of proof is placed on the defendant to show by a preponderance of the evidence that the defendant was legally insane at the time of the crime.<sup>35</sup> In the interest of justice, the court may direct that the insanity issue be heard and determined separately from the other issues in the case (i.e., order a bifurcated trial).<sup>36</sup> As developed by Pennsylvania case law, evidence regarding a defendant's sanity may come from several sources, including the defendant's testimony, general testimony regarding the conduct and statements of the defendant at the time of the crime, expert opinion (based on personal observation or hypothetical question),<sup>37</sup> and lay opinion limited to more general expressions of mental capacity and not addressing the ultimate issue of sanity (although this distinction has received varying interpretations).<sup>38</sup>

In the course of the joint incompetency/insanity determination or at trial, "a psychiatrist appointed by the court may be called as a witness."<sup>39</sup> Although the

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<sup>33</sup>*But see* Commonwealth v. Hood, 15 D. & C.3d 73 (Lawrence Co. 1980) (common pleas court held that notwithstanding general rule that at trial burden is on defendant to show insanity by preponderance of the evidence, in course of joint competency and sanity determination the burden is on whoever applied for the determination to meet the clear and convincing evidence standard statutorily applicable to proof of incompetency).

<sup>34</sup>The defendant may raise an insanity defense notwithstanding the court's refusal to grant an insanity acquittal in conjunction with the hearing on the defendant's competency to stand trial. 50 PA. CONS. STAT. ANN. § 7404(A) (Purdon 1991).

<sup>35</sup>18 PA. CONS. STAT. ANN. § 315(a) (Purdon 1991).

<sup>36</sup>50 PA. CONS. STAT. ANN. § 7404(C) (Purdon 1991).

<sup>37</sup>This testimony has been accepted from a psychiatrist, a medical doctor in general practice with some experience with insane persons, and a clinical psychologist with experience with insane persons, but may be rejected from a psychologist of minimal experience. J. WESLEY OLER, PENNSYLVANIA CRIMINAL LAW: DEFENDANT'S MENTAL STATE (1986) at 107.

<sup>38</sup>*Id.* at 103-10.

statutory provision regarding the joint incompetency/insanity determination specifically establishes the role of a court-appointed examiner,<sup>40</sup> the provision regarding the trial determination of insanity does not include similar language. Nevertheless, the statutory language within the trial determination provision allowing for the calling of the court-appointed psychiatrist as witness implies that the court has the same power to order an insanity evaluation during trial as it does during the joint incompetency/insanity determination (as described above).

#### **4.1.5 Criminal Commitment Evaluations**

Under 50 PA. CONS. STAT. ANN. § 7406 (Purdon 1991), if the defendant is found incompetent to stand trial<sup>41</sup> or is acquitted by reason of lack of responsibility,<sup>42</sup> or following an examination of the defendant in aid of sentencing,<sup>43</sup> any interested party (including the court acting through the Commonwealth's attorney) may file a petition for court-ordered involuntary treatment under the general mental health provisions for civil commitment (50 PA. CONS. STAT. ANN. § 7304). The criteria for commitment are set forth in 50 PA. CONS. STAT. ANN. § 7301.<sup>44</sup> In conjunction with this initial commitment proceeding, the only express distinction made for these criminal defendants<sup>45</sup> is

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<sup>39</sup>50 PA. CONS. STAT. ANN. § 7404(B) (Purdon 1991).

<sup>40</sup>50 PA. CONS. STAT. ANN. § 7402 (Purdon 1991).

<sup>41</sup>Under 50 PA. CONS. STAT. ANN. § 7403 (Purdon 1991).

<sup>42</sup>Under 50 PA. CONS. STAT. ANN. § 7404 (Purdon 1991).

<sup>43</sup>Under 50 PA. CONS. STAT. ANN. § 7405 (Purdon 1991).

<sup>44</sup>The person must be shown to be severely mentally disabled and in need of treatment, and to be a clear and present danger to others or to him or herself.

<sup>45</sup>The only other statutory distinctions associated with commitment regard the duration of court-ordered involuntary treatment that is permitted (a maximum of one year allowed for defendants found incompetent to stand trial or acquitted because of a lack of criminal responsibility, while for all other individuals the maximum is 90 days) and the procedures for release following involuntary treatment (for defendants found incompetent to stand trial or acquitted because of a lack of criminal responsibility the court must issue an order of unconditional or conditional release



that it is not necessary to show the required "clear and present danger to others" occurred within the past 30 days if the person has been found incompetent to stand trial or has been acquitted by reason of lack of criminal responsibility,<sup>46</sup> provided an application for examination and treatment is filed within 30 days after the date of such determination or verdict.<sup>47</sup> This express distinction is not made for convicted defendants for whom commitment is proposed in lieu of sentencing. However, to the extent that this exception was created because of difficulty in obtaining recent evidence of the dangerousness of an individual who is incarcerated pending the resolution of his or her criminal charges,<sup>48</sup> it is arguable that the same exception would apply to convicted defendants as well.

The general procedures for civil commitment (50 PA. CONS. STAT. ANN. § 7304) require that the services of an expert in the field of mental health be made available to the individual who is the subject of the proceedings.<sup>49</sup> For those individuals not already "in involuntary treatment," a psychiatric examination (conducted on an outpatient basis by a psychiatrist appointed by the court) may be requested by the individual, the petitioner, or the court.

Independent of this psychiatric examination, a pre-hearing evaluation is not required by statute. However, since inpatient treatment may be required

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following notice to the individual, the county administrator, and the district attorney and a hearing). 50 PA. CONS. STAT. ANN. § 7304(G) (Purdon 1991).

<sup>46</sup>Provided the charge of which the defendant was acquitted arose from conduct involving the infliction or attempt to inflict substantial bodily harm on another.

<sup>47</sup>In such cases, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated.

<sup>48</sup>See, e.g., *In re Watt*, 525 A.2d 421 (Pa. Super. 1987) (lack of recent evidence of actual violent conduct should be viewed in light of the fact that insanity acquittee has been confined to a mental hospital since the crime occurred).

<sup>49</sup>The subject of the hearing has the right to employ a physician, clinical psychologist or other expert in mental health of his or her choice to assist the individual in connection with the hearing and to testify on his or her behalf. If the person cannot afford this expert, the court is to allow a reasonable fee for this purpose. 50 PA. CONS. STAT. ANN. § 7304(D) (Purdon 1991).

only after investigation and "full consideration" of less restrictive alternatives (including consideration of "all available community resources"), it is likely that some form of evaluation must precede any order mandating inpatient treatment.<sup>50</sup> It might be argued that the various mental health evaluations conducted for these defendants as part of their criminal proceedings would provide the necessary inquiry into less restrictive alternatives.<sup>51</sup> However, the very different nature of these earlier evaluations make it relatively unlikely that they would fulfill this requirement.

Alternatively, under the Mental Health & Mental Retardation Act of 1966, applicable only to persons who are mentally retarded,<sup>52</sup> after undergoing a presentence examination for a mental disability due to mental retardation, a convicted defendant may be committed to a "designated facility" in lieu of a criminal sentence.<sup>53</sup> The nature of this examination is discussed in Section 4.1.3, *supra*. Upon receipt of a report based on this examination (conducted by two physicians) that the defendant is so mentally disabled "that it is advisable for his welfare or the protection of the community that he be committed to a facility," commitment may be ordered by the court.<sup>54</sup> No further evaluation prior to commitment is required or mentioned.<sup>55</sup>

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<sup>50</sup>As part of this investigation of treatment alternatives, consideration must be given to the person's relationship to his community and family, his or her employment possibilities, all available community resources, and guardianship services. An order for inpatient treatment must include findings on this issue. 50 PA. CONS. STAT. ANN. § 7304(F) (Purdon 1991).

<sup>51</sup>See *supra* sections 4.1.1, 4.1.2, 4.1.3, and 4.1.4.

<sup>52</sup>See 50 PA. CONS. STAT. ANN. § 7502 (Purdon 1991).

<sup>53</sup>50 PA. CONS. STAT. ANN. § 4410 (Purdon 1991). The defendant cannot be committed for a period longer than the maximum sentence authorized for the crime of which the defendant was adjudged guilty. *Id.*

<sup>54</sup>50 PA. CONS. STAT. ANN. § 4410(c) (Purdon 1991).

<sup>55</sup>Subsequent to commitment, the court may order partial hospitalization or outpatient care following an application to that effect by the director of the facility where the defendant has been placed and if the court determines that such an alternative "would be beneficial to the person so

## 4.2 Types and Frequency of Evaluations

Table 3 summarizes the major types and frequencies of mental health evaluations performed by the Clinic from 1984 through 1991.<sup>56</sup> As noted earlier, the bulk of the work of the Clinic comprises presentence evaluations. In 1991, roughly two-thirds of the evaluations conducted by the Clinic were presentence evaluations; Section 17 evaluations were the next most frequently requested (18.9%) followed by competency evaluations (11.4%), possible commitment evaluations (1.7%) and other evaluations (1.6%), including specific requests for psychological testing, evaluations related to juvenile certification and decertification, drug and alcohol abuse, suitability for employment, insanity and dangerousness. Interestingly, this last category included nine Section 18 evaluations. In 1986 and 1987, the first two complete years during which the Clinic conducted Section 18 evaluations, the Clinic conducted 58 and 93 Section 18 evaluations, respectively.

Although the total number of evaluations over this eight year period appears to have remained relatively steady, ranging from a low of 4,450 in 1987

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committed." 50 PA. CONS. STAT. ANN. § 4410(d) (Purdon 1991). The court is also authorized to attach such "terms and conditions" as it deems appropriate to these alternative placements. Again the statute is silent regarding whether an evaluation is required or available with this determination. It can probably be expected that the court will rely heavily on the information provided by the facility director and the person committed. Following the expiration of a period of time equal to the maximum sentence authorized for the crime of which the defendant was adjudged guilty, if further care is deemed necessary, the director of the facility where the defendant is placed is instructed to initiate appropriate commitment proceedings as if no crime had been involved, 50 PA. CONS. STAT. ANN. § 4410(c) (Purdon 1991), implying that the evaluations associated with commitment proceedings in general would be required.

<sup>56</sup>Table 3 is based on aggregate data compiled by the Court Psychiatric Clinic. Yearly totals for 1991 and 1990 exceed the actual number of orders received--4,754 and 5,691 respectively--because more than one type of evaluation may have been requested in a single order. Complete breakdowns by type of evaluation before 1989 are not available. Data shown represent orders received by the Clinic; the differences between requests received and evaluations performed are negligible. These data should be used to consider general trends, not to pinpoint precise numbers of evaluations performed.

**Table 3**  
**Mental Health Evaluations by the Court Psychiatrist Clinic**  
**1984-1991**

| Year | Competency |         | Section 17 |          | Presentence |         | Commitment |        | Other |        | Total |
|------|------------|---------|------------|----------|-------------|---------|------------|--------|-------|--------|-------|
| 1991 | 541        | (11.4%) | 897        | (18.9%)  | 3259        | (68.6%) | 79         | (1.7%) | 75    | (1.6%) | 4851  |
| 1990 | 812        | (14.3%) | 723        | (12.7%)  | 4251        | (74.1%) | 71         | (1.3%) | 71    | (1.3%) | 5928  |
| 1989 | -          | -       | 871        | (16.0%)  | -           | -       | -          | -      | -     | -      | 5441  |
| 1988 | -          | -       | 1214       | (23.1%)  | -           | -       | -          | -      | -     | -      | 5250  |
| 1987 | -          | -       | 478        | (10.7%)  | -           | -       | -          | -      | -     | -      | 4450  |
| 1986 | -          | -       | 103        | ( 2.1%)  | -           | -       | -          | -      | -     | -      | 4873  |
| 1985 | -          | -       | 16         | ( 0.03%) | -           | -       | -          | -      | -     | -      | 5371  |
| 1984 | -          | -       | -          |          | -           | -       | -          | -      | -     | -      | 5778  |

to a high of 5,928 in 1990, the mix of types of evaluations appears to have changed over time. For example, in 1986, the number of Section 17 evaluations constituted approximately two percent of the total evaluations performed by the Clinic; by 1991, Section 17 evaluations constituted approximately 20 percent of evaluations.

In years prior to 1984 (the last date noted in Table 3), according to data compiled by Temple University,<sup>57</sup> the number of requests increased dramatically in the 1970s, from 2,255 in fiscal year 1973 to 4,355 in fiscal year 1980, an increase of 193%. Since then, the increase has been less dramatic. Over the nine-year period from fiscal year 1981 through fiscal year 1989, the number of requests averaged 5,173 per year with a low of 4,271 in fiscal year 1987 and a high of 5,826 in fiscal year 1989.

#### **4.3 Sources of Request**

The pattern of requests for mental health evaluations conforms to a general principle of economics and human interactions--a few account for most of what is said and done. In January 1992, a total of 61 judges in the Common

<sup>57</sup>Exhibit A, 1991 Contract, *supra* note 2, at 3.

Pleas Court and the Municipal Court made a total of 493 requests for evaluation. As shown in Table 4, three-quarters of the requests were made by the judges in the Criminal List/Drug Program (57.8%) and the Section Calendar Program (24.9%).<sup>58</sup> With the exception of Judge Stout in the Homicide Program and Judge Papalini in the Criminal List/Drug Program, every judge in the Homicide, Section Calendar, and Criminal List/Drug Programs in January 1992 made at least one request for mental health evaluation. Within each program, however, a handful of judges made two-thirds of the requests originating in that program.

Based on interviews of judges and clinicians, it is quite possible that the source of certain clusters of types of requests can be isolated by major court program, by unit within the program and by individual judge to an even greater degree than is suggested in Table 4. The great bulk of requests for Section 17 evaluations probably originate in the Criminal Lists/Drug program. Further, most of the requests for evaluations are generally made by judges sitting in the tracking, waiver and calendar rooms, and judges who are section leaders in the Section Calendar Program. This type of information about types of evaluations according to specific sources of requests for mental health evaluation within the Court is invaluable for improving the understanding of the need and context of requests for mental health evaluation.

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<sup>58</sup>These data are intended to illustrate general patterns only. January 1992 was selected for sampling simply because it was the last complete month available for review by the NCSC. This month may not be representative, however, because a significant number of newly-appointed judges attended educational conferences and other judges consequently reassigned to different programs.

**Table 4**  
**Request for Mental Health Evaluation in January 1992**  
**by Major Court Program and Judge**

| Program and Judge       | Number     | Percent of Total |
|-------------------------|------------|------------------|
| Criminal List/Drug      |            |                  |
| (1) New                 | 49         | 9.9              |
| (2) Fitzgerald          | 29         | 5.9              |
| (3) Wilson              | 27         | 5.5              |
| (4) Smith               | 26         | 5.3              |
| (5) Lynn                | 25         | 5.1              |
| (6) Quinones            | 22         | 4.5              |
| <u>All Other Judges</u> | <u>107</u> | <u>21.7</u>      |
| Total Program           | 285        | 57.8             |
| Section Calendar        |            |                  |
| (1) Davis               | 25         | 5.1              |
| (2) Lewis               | 19         | 3.9              |
| (3) Guarino             | 12         | 2.4              |
| (4) Jones               | 12         | 2.4              |
| (5) Glazer              | 12         | 2.4              |
| <u>All Other Judges</u> | <u>43</u>  | <u>8.7</u>       |
| Total Program           | 123        | 24.9             |
| Homicide                |            |                  |
| (1) Richette            | 11         | 2.2              |
| (2) Stiles              | 7          | 1.4              |
| (3) O'Keefe             | 4          | 0.8              |
| (4) Latrone             | 4          | 0.8              |
| <u>All Other Judges</u> | <u>14</u>  | <u>2.8</u>       |
| Total Program           | 40         | 8.1              |
| Municipal               |            |                  |
| (1) Margiotti           | 5          | 1.0              |
| (2) Bashoff             | 4          | 0.8              |
| (3) Merriweather        | 4          | 0.8              |
| (4) Cosgrove            | 3          | 0.7              |
| <u>All Other Judges</u> | <u>8</u>   | <u>1.6</u>       |
| Total Program           | 24         | 4.9              |
| Other Programs          | 21         | 4.3              |
| Total Programs          | 493        | 100.0            |



## **5.0 Operation of the Clinic**

Figure 1 is a schematic representation of the operation of the Clinic beginning with the receipt of the request for mental health evaluation and ending with the distribution of the evaluation report. The text of this section generally follows the flow of Figure 1.

### **5.1 Receipt of Court Order**

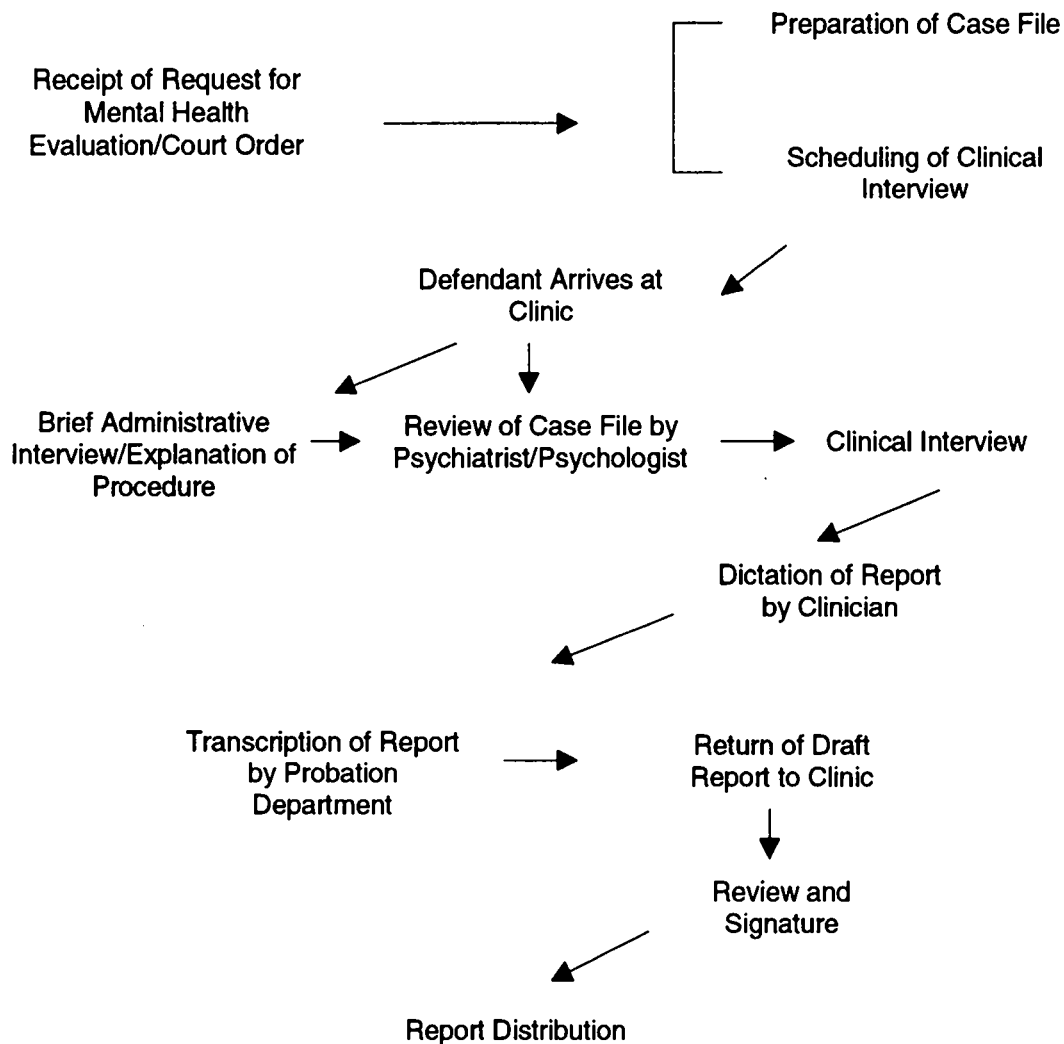
The Clinic's evaluation process is initiated with the receipt of a court order by the Clinic. Court orders for evaluation come in the form of a "Request For Presentence Investigation/Mental Health Evaluation" (see Appendix C). As its name suggests, the form serves to trigger not only mental health evaluations performed by the Clinic but also presentence investigations conducted by the Adult Probation and Parole Department. Most of the orders received by the Clinic are signed by courtroom clerks on behalf of the judges. Several judges admitted that many of the requests for mental health evaluations received by the Clinic may be triggered by judges' oral, *pro forma* instructions to the courtroom clerk to order "presentence-psych" (*both* a presentence investigation and a mental health evaluation), instead of a deliberate request based on a need for specific information related to a defendant's mental condition.

At the time of the writing of this report, and after a number of informal discussions with judges, a number of judges reportedly have become more deliberate and careful in their instructions to the courtroom clerk. One judge stated that he would instruct the courtroom clerk never to order a mental health evaluation, unless he specifically stated that he was ordering a mental health evaluation for a particular purpose.

Court orders/requests for mental health evaluations are delivered directly to the Clinic by a court officer or a sheriff's deputy throughout the day. On rare



**Figure 1**  
**Schematic Representation of the Operation of the Courts**



occasions, the Clinic will receive court orders via mail from police districts, prisons, and courtrooms.

The Clinic will not proceed with a mental health evaluation in the absence of a written court order. A telephone call from a courtroom may alert the Clinic to a forthcoming court order but the Clinic will not proceed until it receives the

formal request even if the defendant has arrived at the Clinic and is prepared to be interviewed.

Ideally, the Clinic ought to receive a request for mental health evaluation shortly after the judge has instructed the courtroom clerk to prepare the court order. In reality, in busy courtrooms, considerable time may pass between the judge's instruction to prepare a court order and the conveyance of that court order to the Clinic. The problem is twofold. First, because of the rapid movement of case processing in some courtrooms, courtroom clerks may not take the time to complete the formal request form until there is time to do so. The Clinic has no way of knowing of the pending evaluation order until it receives the form. Second, once the form is completed, there is no understanding regarding who conveys the request form to the Clinic. Reportedly, court officers, court clerks, other court employee or the sheriff have assumed this duty at some point in time for some cases. This problem is most serious when, in a case of an out-of-county defendant for whom a judge has ordered a mental health evaluation, the request form has not yet been prepared or the completed form has not been conveyed to the Clinic, and the defendant is returned to the Sheriff's cell room and the Sheriff, not knowing that a mental health evaluation has been requested, transports the defendant back to an out of county prison.

## **5.2 Preparation of Case File**

Court orders seldom are accompanied by supporting documentary materials (i.e., the criminal complaint, criminal history). As noted earlier, most requests for evaluations are limited to the evaluation request form and the information it contains. (However, one judge in the Homicide Program has made it a habit to communicate personally with the Clinic before and after the conduct of a mental health evaluation.) Out of a total of 39 requests received on

February 19, 1992, for example, only four requests, all for presentence ("deferred") mental health evaluations, included the criminal complaints.

Upon receipt of a court order, an administrative technician of the Clinic retrieves the criminal history of the defendant from computer files using the "police photo ID" number noted on the evaluation request form. If the criminal history indicates that the defendant has been previously evaluated by the Clinic, the administrative technician will either place copies of past reports in the case file or indicate that such reports are available on microfilm. A complete case file, upon which a clinician bases his or her evaluation of a defendant, typically includes: (a) the original court order (Request For Presentence Investigation/Mental Health Evaluation); (b) a copy of a computer printout indicating the criminal history (including contacts with the Clinic) of the defendant; (c) past examination reports; and (d) a copy of the juvenile record of the defendant, if appropriate.

The Clinic stores approximately 40,000 case files dating back to 1966. Conversion of hard-copy files to microfilm reportedly is ongoing; currently, the Clinic still maintains approximately 20,000 hard-copy case files. Beginning in May 1989, the Clinic began to organize case files according to police photo I.D. number.

### **5.3 Scheduling of Interviews**

Reportedly, between 19 and 27 evaluations are conducted each working day, a range that corresponds roughly to the yearly totals reported over the last few years (see Table 3). Clinicians are scheduled to be in the Clinic between the hours of 9:30 am and 5:00 pm; evaluations are scheduled daily in this time frame. The work of the eight clinicians (3.75 FTE) is distributed unevenly over the 7.5 hour clinical work day (at this writing, no clinicians are regularly

scheduled before 9:30 am or after 5:00 pm). Typically, more clinicians are available in the afternoons than in the mornings.

Generally, scheduling priority is given to those cases--mostly those for Section 17 and competency evaluations--requiring an oral report made to the court the same day of the order (immediately after the evaluation is completed). Typically, requests for such oral reports, followed by written reports, are made by a notation in the "Special Instructions Remarks" box on the referral form; the word "forthwith" frequently is used to request an oral report.

Once scheduled, evaluations of competency to stand trial and possible commitment are conducted, as required by the Mental Health Procedures,<sup>59</sup> by one of the three psychiatrists. All other evaluations are conducted on a "first scheduled, first seen" basis by any available clinician. "Forthwith" evaluations are conducted on a "first in, first out" basis. Generally, defendants in custody are given priority over defendants released on bail. Otherwise, defendants are scheduled for evaluation according to their next "listing date" which is indicated on the referral form.

On any given day, the Clinic will "see" a mix of previously scheduled defendants and "walk-ins" who have been ordered to undergo evaluations on that day. Typically, for various reasons noted below, the Clinic will not evaluate all defendants scheduled on a particular day. The most typical reasons cases are rescheduled include failure of a defendant to appear (in bail cases), the unavailability of the defendant for an evaluation (custody cases), the unavailability of clinicians to conduct the evaluation (referred to as "No Clinical Time" by the Clinic), and the arrival of a court order after the Clinic closes for the day at 5:15 pm.

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<sup>59</sup>See *supra* Section 4.1.

For example, on February 19, 1992, the Clinic received a total of 32 requests for mental health evaluation (excluding requests requiring no immediate mental health evaluation, such as those asking for copies of previously conducted evaluations). The Clinic conducted a total of 25 evaluations on that day, including 14 of the 32 evaluations received on that day and 11 that were previously scheduled. Eighteen of the 32 evaluations received that day were rescheduled for another day. Table 5 summarizes the flow of cases, including cases evaluated and rescheduled, through the Clinic in the entire month of January 1992.

**Table 5**  
**Total Number of Requests Received, Evaluations Conducted,**  
**and Cases Rescheduled by the Court Psychiatric Clinic**  
**January 1992**

|                       | Bail | Custody | Total |
|-----------------------|------|---------|-------|
| Requests              | 251  | 230     | 481   |
| Evaluations Conducted | 238  | 182     | 420   |
| Walk-ins              | 201  | 85      | 286   |
| Previously Scheduled  | 37   | 97      | 134   |
| Rescheduled Cases     | 50   | 145     | 195   |
| Defendant Unavailable | 2    | 72      | 74    |
| No Clinical Time      | 40   | 24      | 64    |
| Other                 | 8    | 49      | 57    |

Ideally, the Clinic should schedule and conduct mental health evaluations on the same day as the defendants' scheduled court appearances. As noted earlier, this is not accomplished in a significant proportion of the cases referred to the Clinic. Rescheduled bail cases constitute a relatively minor inconveniences for the defendants and the Clinic. Defendants on bail who cannot be examined on the date of their court appearance or appointment date

are simply rescheduled to appear at the Clinic on another date. Reportedly, most rescheduled appointments are kept. On the other hand, defendants in custody who are not evaluated by the Clinic on the same date of their court appearance constitute a major problem that has plagued the Clinic and Sheriff Department for years. Defendants in custody for whom mental health evaluations are requested but who, for various reasons, are not seen by the Clinic the day that they make an appearance in the Court, are returned to the prison. They are then rescheduled both by the Clinic and the Sheriff Department for a return visit to the Clinic and transported back to prison at the conclusion of the evaluation. The costs of rescheduling and transportation are particularly high for out-of-county defendants.

In the worst case scenario, an out-of-county defendant not seen by the Clinic on the date of his or her court appearance is first transported back to Graterford Prison (where out-of-county prisoners are temporarily housed awaiting court appearances) and subsequently returned to his or her "home" institution in the western part of the state because Graterford had reached its bed capacity for "transfers." In order to evaluate this out-of-county defendant, the Clinic requests transportation of the defendant from the western part of the state to Philadelphia solely for the purpose of an one-hour evaluation. To exacerbate the problem of rescheduled custody cases further, on any given day, when the Sheriff Department's transportation capacity reaches its limits, defendants requiring transportation to the Court solely for the purpose of mental health evaluation are "bumped" to make room for defendants who are scheduled for court appearances.

#### **5.4 Arrival and Administrative Interview of the Defendant**

Defendants scheduled to be interviewed who are on bail typically arrive at the Clinic unescorted. If they cannot be evaluated immediately upon their arrival,

they are asked by Clinic staff to wait in the hall outside of the Clinic until they are called.

Defendants in custody are either in the Court for the sole purpose of a mental health evaluation or are also scheduled for a Court appearance. The former are transported from one of the prisons by the Sheriff's Department and temporarily housed in the Sheriff's cell block on the 7th floor of City Hall. When the Clinic notifies the Sheriff's Department, the defendant is handcuffed and escorted to the Clinic's secured cell room (see below). Defendants in custody are taken to the Sheriff's cell block immediately following their court appearance. If they have been ordered to be evaluated by the Clinic, they are transported from the Sheriff's cell block to the Clinic's cell room for evaluation.

Once a defendant arrives at the Clinic for evaluation, and approximately at the same time that an administrative technician prepares the case file (if the arrival of the order coincides with that of the defendant), an administrative technician confers with the defendant briefly to verify personal data (i.e., name and address) and to explain to the defendant that he or she is scheduled to be interviewed by a psychiatrist or psychologist pursuant to a particular proceeding (i.e., Section 17, presentence evaluation, competency).

## **5.5 Conduct of Clinical Interview**

On any given day, upon arrival at the Clinic, a clinician will check the daily schedule, and receive assignment to a particular case. As noted earlier, psychiatrist are assigned to competency and possible commitment cases. Otherwise, cases are assigned in the order that they are scheduled.

Once a case is assigned, the clinician will review the case file. Typically, this review is relatively brief and involves no more than a reading of the information in the file, unless the request form indicates special instructions or unusual circumstances. Reportedly, clinicians rarely confer with the judge or the

attorney who initiated the request, or each other, before conducting mental health evaluations.

The clinical interview, conducted by one of the Clinic's psychiatrists or psychologists, is the mainstay of the evaluation process. Some psychological testing reportedly supplements the clinical interview in approximately half of the presentence evaluations and almost all "complicated" cases. Collection of corroborating evidence, interviews of family members and witnesses, follow-up evaluation by another clinician, and staff conferences are rarely conducted. Reportedly, such inquiries were conducted in the past but were discontinued as the number of requests for evaluations increased.

Defendants released on bail are typically interviewed in one of the clinicians' offices in the Clinic. Defendants in custody are interviewed in one of several interview rooms in the secure area adjacent to the Clinic referred to as the "Clinic's Cell Room." The "mental health holding area," which includes a secure cell room (with the capacity to hold 10 to 15 defendants and prisoners awaiting mental health evaluations), five interview rooms, and an anteroom, is staffed by three Sheriff's deputies. Staff of the Clinic, the Sheriff Department, and several judges have voiced concerns about security problems in this holding area due to structural peculiarities. For example, when an individual must be transported to or from the Sheriff's cell block, or taken to the restroom, two of the three deputies are required for the transport, leaving only one deputy to secure the mental health cell room area, including the five interview rooms. Reportedly, some of the security problems have been alleviated but others remain.

The interviews, which typically last no more than one hour--but may take longer in complex cases or cases requiring special arrangements (e.g., those requiring a language interpreter)--begin with the clinician introducing himself or herself to the defendant, explaining the purpose of the evaluation, and disclosing



that the information gained in the interview will be shared with the judge.

Thereafter, semi-structured interviews are conducted to address the question posed, or believed to be posed, on the referral form. Several of the clinicians use a variety of checklists that they use both to structure and organize the interview and to record the responses of the defendant. An example of such a checklist is attached to this report as Appendix D. Only rarely does the clinician confer with the judge or attorneys before initiating, or during, the evaluation.

## **5.6 Preparation and Content of Evaluation of Report**

### **5.6.1 Preparation**

Upon completion of the clinical interview, the clinician will begin preparation of the report of the results of the interview. If a "forthwith" oral report was requested (usually only in Section 17 and competency matters), the clinician will telephone the courtroom to communicate his or her recommendations. The oral communication typically is made to a court official other than the judge, unless the order specified otherwise. A defense attorney stated that he preferred that clinicians make oral reports of the evaluation known to a court official, rather than the judge, to preclude *ex parte* communications between the judge and the clinician. Usually, the oral report is very brief, indicating only the major recommendation made by the clinician. For example, in the case of a Section 17 evaluation, the clinician may simply state that the defendant qualifies for probation without verdict and should be treated on an outpatient, rather than inpatient, basis.

Almost without exception, reports of evaluations are dictated on audiotapes on the day the evaluation is conducted. The following morning, tapes of the dictations are delivered to the Probation Department's typing pool at 121 North Broad Street, where the dictation is transcribed. Draft written reports are returned to the Clinic for review and corrections the day following receipt of

the dictation. After the report is corrected and signed by the clinician, the report is once again returned to the Probation Department for duplication.

Reportedly, under ideal circumstances, the evaluation process, from receipt of the request to the preparation and duplication of the evaluation report, can be accomplished in four or five days. For example, a clinician may conduct and dictate his or her evaluation report on a Monday, the dictated report is transmitted to the Probation Department's typing pool on Tuesday morning and returned to the Clinic in written form on Wednesday; on Thursday, the clinician reviews the draft report, makes the necessary corrections and signs the report; by Thursday afternoon, or Friday morning, the written report is ready for distribution.

### **5.6.2 Content**

To ascertain both the general content and format of mental health evaluation reports produced by the Clinic, the NCSC randomly selected and reviewed a sample of 100 reports written in 1991, including 26 reports of competency evaluations, 20 presentence evaluations, 25 Section 17 evaluations, and 29 evaluations of possible "criminal" commitment. As shown in Table 6, with the exception of text describing the evaluation procedures and techniques used by the clinicians in presentence and Section 17 evaluations, almost all the reports in the sample contained at least *some* information about: (1) the general purpose of the evaluation; (2) a history or background of the defendant/prisoner; (3) the procedures and techniques used in the evaluation; (4) the clinical findings or opinions; (5) the general basis of the opinion or reasoning of the clinician; and (6) specific recommendations.

Reports averaged between two to three pages in length and ranged from a low of 0.75 page to 4.33 pages. Section 17 evaluation reports were prepared most expeditiously in an average of 2.42 days; presentence evaluations took the

longest time to prepare (an average of 11.25 days). Only one report was typed after the listing date noted on the evaluation request form (see Appendix C).

**Table 6**  
**General Content Characteristics of a Sample of Reports of Mental Health Evaluations**  
**Conducted by the Court Psychiatric Clinic in 1991**

| <b>Characteristics</b>          | <b>Categories</b>            |                               |                              |                              |
|---------------------------------|------------------------------|-------------------------------|------------------------------|------------------------------|
|                                 | <b>Competency<br/>(N=26)</b> | <b>Presentence<br/>(N=20)</b> | <b>Section 17<br/>(N=25)</b> | <b>Commitment<br/>(N=29)</b> |
| Purpose of Evaluation           | 25(100%)                     | 2( 10%)                       | 25(100%)                     | 29(100%)                     |
| History/Background              | 26(100%)                     | 19( 95%)                      | 25(100%)                     | 29(100%)                     |
| Procedures/Techniques           | 26(100%)                     | 15( 75%)                      | 12( 48%)                     | 23( 93%)                     |
| Clinical Findings/Opinions      | 25( 96%)                     | 19( 95%)                      | 25(100%)                     | 29(100%)                     |
| Reasoning/Basis of Opinion      | 26(100%)                     | 20(100%)                      | 25(100%)                     | 29(100%)                     |
| Recommendations                 | 25( 96%)                     | 19( 95%)                      | 25(100%)                     | 29(100%)                     |
| Mean Length (pages)             | 2.25(1.33-4.33)              | 2.66(0.75-4.0)                | 2.0(1.33-3.5)                | 2.0(1.25-3.33)               |
| Mean Preparation Time<br>(days) | 7.04                         | 11.25                         | 2.42                         | 8.40                         |

All reports were covered by a standard facesheet (see Appendix E) that identified a defendant's name, police photo identification number, birth date and place, ethnicity, religion, sex, marital status, occupation, education, charges and, if available, plea and disposition. Other information elicited by the facesheet (and actually provided in all the reports in the sample) included: (1) the name of the judge or trial commissioner requesting the evaluation; (2) the dates on which the evaluation was ordered, received, typed, and submitted; (3) the general reason for the evaluation (i.e., competency, possible commitment, Section 17, presentence or other); (4) charges, plea and disposition; (5) the name of the evaluator; (6) the dates of any prior evaluations; and (7) the next listing date. Entries in the two remaining categories of information on the standard facesheet--diagnostic formulation and summary and recommendations--refer the reader to the text of the attached full report.

Beginning with a standard, "boilerplate" headings for the defendant's name and age, the date of the examination and other identifying information (see Appendix E), the texts of the reports themselves generally were organized under the following subheadings: sources of information, defendant's account of the offense, the defendant's recent life situation, background information, medical and psychiatric history, drug and alcohol history, past arrest record, psychological assessment, mental status and recommendations. As noted in Table 6, the texts of all reports of competency, Section 17, and possible commitment evaluations contained information about the purpose or reason of the evaluation. Typically, such information was contained under the subheading "Identifying Information" in a single sentence such as: "This is an evaluation being done pursuant to the (date) request of Judge (name of judge) to determine competency to stand trial on charges (listing of charges)." Interestingly, only two out of the twenty reports of presentence evaluations included such information under the subheading "Identifying Information."

Information about the defendant's background, including recent life situation, medical and psychiatric history, drug and alcohol history, and past arrest history, were indicated in all but one of the 100 reports sampled. The exception is a report of a defendant who refused to participate in the mental health evaluation.

At least some mention of the methods used by the clinician in the evaluation (e.g., interview, psychological testing), was made in almost all of the competency and possible commitment evaluations and three-quarters of the presentence evaluations; however, only approximately half of the Section 17 evaluations contained such information. Quotations of the defendant's actual responses to interview questions were noted in approximately one-third of the sampled reports. Typically, a brief summary statement suggested the general

type of interview questions and the conclusions drawn from the responses. ("Her social judgment as indicated by responses to social judgment questions is adequate.")

All except two of the sampled reports included the clinicians' findings or opinions regarding the defendants' mental conditions. In one, a report of a presentence evaluation, the defendant refused to participate in the evaluation. In the other, a competency evaluation, the clinician deferred diagnosis until the defendant's juvenile record could be reviewed and further psychological testing could be performed. In this case, the clinician stated that he was "unable to determine if this young man would benefit from rehabilitation as a juvenile." All reports contained at least a cursory statement regarding the general mental status of the defendant. In almost all the reports indicating the presence of mental illness, mental retardation or drug abuse, the diagnoses were formulated in terms of the diagnostic criteria of the American Psychiatric Association's *Diagnostic and Statistical Manual III-Revised (DSM-III-R)*. All except one of the reports of the 29 commitment evaluations, for example, included a *DSM-III-R* diagnosis (e.g., Axis II-Schizoid Personality Disorder). Generally, the *DSM-III-R* criteria reflect a consensus of evolving knowledge in psychiatry. The purpose of *DSM-III-R* is to provide clear description of diagnostic categories in order to enable clinicians to diagnose, communicate about, study and treat various mental disorders. Use of the criteria is purported to enhance agreement among clinicians.

Reportedly, the use of the *DSM-III-R* criteria by the Clinic was introduced by Dr. Burr Eichelman within the last two years and has met with some resistance from the clinicians. The rationale for its introduction and the basis for the clinicians' resistance to it were not clearly articulated in the interviews of the clinicians. Among the reasons for the introduction of the *DSM-III-R* criteria

mentioned by the interviewees, however, was the creation of a more rigorous base for future research.

What seems quite clear is that judges generally are unfamiliar with the *DSM-III-R* criteria formulations and, absent an interpretation of the *DSM-III-R* diagnoses in non-technical terms, they gain little useful information from such diagnoses. None of several judges interviewed, for example, knew the meaning of the "axis" scheme used in the *DSM-III-R* classification system.

Ideally, written reports of evaluations should describe the reasoning or the factual and judgmental bases of the examiner's findings and opinions.<sup>60</sup> As noted in Table 6, all but one of the reports in which the defendant refused to participate in the evaluation contained at least a cursory statement of the reasoning or the factual or judgmental bases of the clinician's findings or opinions.

Except in one case in which the defendant refused to participate and another in which the clinician deferred judgment, specific recommendations were contained in all of the sample reports, most typically under the subheading "Recommendations" at the end of the report. Among the 26 competency evaluation reports sampled, clinicians recommended that the defendant be found competent in 17 cases; incompetent in 8 cases; and judgment was deferred in one case. Several reports addressed the question of a defendant's competency at the sentencing stage. The recommendation in one report of a competency evaluation noted that the defendant would be capable of

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<sup>60</sup> See, for example, *Guidelines for Involuntary Civil Commitment*, 10 MENTAL AND PHYSICAL DISABILITY LAW REPORTER 456 (1986); ("Written reports should contain . . . a brief description of the procedures, techniques, and factual basis of the examiner's findings and opinions."); American Bar Association ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS 109 (1989) (Standard 7-3.7, "Preparation and Contents of Written Reports of Mental Evaluations," states in part that contents of written reports should ordinarily "identify the sources of information and present the factual basis for the evaluator's clinical findings and opinions.").

understanding the sentencing procedures "if an interpreter translates into Hungarian."

Interestingly, all of the reports of *presentence* evaluations (not competency evaluations), except one in which the defendant refused to participate, contained recommendations that the defendants were either capable or incapable of participating in the sentencing procedures. Apparently, clinicians ordinarily consider requests for presentence evaluations, at least in part, as a threshold determination of competency to proceed rather than primarily as an aid in sentencing.

In all except one of the reports of Section 17 evaluations, the examiners determined and specifically stated that the defendant met the criteria for treatment. A typical recommendation stated that the defendant would "benefit from detoxification and treatment." In the one report that does not specifically state that the defendant would benefit from treatment, and presumably qualify for probation without verdict, the examiner simply stated that the defendant was capable of participating in the sentencing procedure. Although this recommendation is somewhat vague, it could easily be interpreted to mean that the defendant, in the opinion of the examiner, qualifies for probation without verdict.

Finally, of the 29 reports of commitment evaluations, 14 contained recommendations that the defendant be committed (e.g., for 30 days at the Hahnemann Psychiatric Unit of the Philadelphia Prison) and 15 recommended that the defendant not be committed (e.g., the defendant is capable of standing trial and there are no psychiatric indications for treatment).

A total of 12 different clinicians, including all four of the psychiatrists, all four of the psychologists named in Table 1, and four residents, prepared the 100 reports in the sample. In general accord with statutory requirements and stated

policies of the Clinic, all of the possible commitment evaluations and all but two of the competency evaluations were conducted by psychiatrists. All but five of the Section 17 evaluations and five of the presentence evaluations were conducted by psychologists.

### **5.6.3 Perceived Utility of the Reports**

Late in 1991, to gauge the perceived usefulness of the Clinic's reports, the Office of the Executive Administrator sent a questionnaire to eight judges asking them to rate the various types of evaluation reports prepared by the Clinic. All six of the judges who responded to the questionnaire rated the evaluation reports as either "satisfactory" or "very helpful." One judge noted, however, that the presentence evaluations "all sound familiar," a sentiment echoed by most of the judges interviewed by the NCSC. Other shortcomings of the reports noted by interviewees included their overall "boilerplate" provisions, their lack of meaningful information with regard to treatment options, and their use of diagnostic formulations (e.g., *DSM-III-R* criteria) that are of little use. With regard to the latter criticism, one judge noted that most defendants in her courtroom can be fairly described as lacking in intelligence, undereducated, impulsive, lacking in acceptable personal goals, and either angry or apathetic. She averred that "it does not advance the issue to conclude 80% of the reports with a diagnosis of mixed personality disorder which covers most or all [of the defendants that appear before me]."

## **5.7 Report Distribution**

For reasons that are not clear, the method of distribution of reports depends upon the type of evaluation conducted. Following the duplication of the reports by the Probation Department, reports of presentence and Section 17 evaluations are sent via messenger to the mail room in City Hall, where another messenger delivers copies of the report to the judge who ordered the evaluation.



The judge, in turn, distributes the copies to the defendant's attorney the district attorney, and the prison.

Reports of evaluations of competency and possible commitments are returned, after their duplication, to the Clinic. The Clinic distributes a copy of the report each to the judge and the prison by messenger. Copies for the district attorney and the attorney of the Defender's Association are placed in a mail box in the Clinic. If the defendant is represented by a private attorney, a copy of the report is mailed to the attorney.

## **5.8 Other Clinic Functions**

In addition to the evaluation process outlined above, which constitutes the bulk of the Clinic's work, the administrative staff attends to two clerical matters not directly related to the evaluation process described in the previous sections.

### **5.8.1. Presentence Investigation Intake**

Notwithstanding the "note to the clerk" on the evaluation request form (see Appendix C), which indicates that requests for presentence investigations are to be sent to the Probation Department's Investigation Division, *all* requests for presentence investigations are submitted to the Clinic whether they include a request for mental health evaluation or not. However, as noted earlier, in almost all cases in which a presentence investigation is requested, a mental health evaluation is requested as well. On February 19, 1992, in only three of the 29 cases in which a presentence investigation was requested did the judges fail to order a mental health evaluation. One judge reported that requests for both presentence investigation and mental health evaluation are made on a *pro forma*, routine basis by the judge or the courtroom clerk (a practice that may be prompted by the form of the Request for Presentence Investigation/Mental Health Evaluation itself).

### **5.8.2 Processing Criminal Commitment Orders**

The second clerical function, which is separate from the management of the evaluation process, and a function that occupies one administrative technician (referred to as the "Commitment Clerk") on a full-time basis, is the processing of involuntary "criminal" commitment orders. This processing requires a considerable amount of paperwork. It takes a torturous path that requires numerous signatures and check-offs, and usually consumes no less than five days and sometimes weeks, despite the fact that no disputes need to be resolved, judicial authority has already been established, and no review by a psychiatrist or psychologist is required. The typical steps in the processing of commitment orders are as follows:

- (1) a courtroom clerk or sheriff's deputy delivers a commitment order (referred to as a "short form") to the Clinic;
- (2) the Commitment Clerk (an administrative technician) makes copies of the "short form" for the attorneys and the hospital or center where the defendant is to be committed:
- (3) the clerk then prepares a formal petition for involuntary treatment "via" the criminal justice system. Ms. Barbara O'Neil, Supervisor of the Clinic, signs the forms as the petitioner; (Two forms are used. One is used for a petition for up to 30 days treatment under Section 402 B of the Mental Health Procedures Act of 1976 when a person has been found incompetent to stand trial but is not severely mentally disabled. The other form is used pursuant to a petition for involuntary treatment pursuant to Sections 401 and 405 of the Mental Health Procedures Act of 1976.);
- (4) when necessary, the clerk will confer by telephone with the district attorney and/or the judge who ordered the commitment to clarify entries made in the commitment order (In one set of commitment forms reviewed by the

evaluator, the commitment order on the "short form" cited the incorrect sections of the Mental Health Procedures Act, an oversight that was corrected in the forms completed by the Clinic after consultations with the judge and the district attorney.);

(5) the clerk hand-carries the forms to the "First Filing," where the case is assigned a number which, apparently, is required to process the order;

(6) the clerk prepares a brief cover memorandum for the set of forms, including the original court order, the completed forms, and the reports of the supporting evaluations, requesting that the judge who first ordered the commitment sign both the first and last pages of the commitment forms and return the entire set to the Clinic;

(7) once the judge returns the package, the clerk makes five copies of the package for distribution;

(8) one copy each is distributed to the district attorney and the defense attorney, and three copies to the Clerk of the Court Sessions (Room 668);

(9) upon receipt of the commitment forms, the Clerk of the Quarter Sessions makes up a transportation order for the Sheriff and the designated institution (referred to as the "blue form") and calls the Clinic's Commitment Clerk when the order has been completed; and, finally,

(10) the clerk gives the Sheriff the transportation order and package of forms or she sends the information directly to the institution depending upon whether the case is a "new commitment" or a recommitment (i.e., the respondent/defendant is already residing in the institution where he or she has been admitted).

## **6.0 Linkages With Other Court Programs And Units**

The Court may benefit greatly--in terms of improved quality of services, increased efficiency, cooperation, continuity and better communication--by linking the Clinic and its staff with other programs, units, and operations of the Court that deal with cases--both criminal and civil--in which issues of mental health arise.<sup>61</sup> Although these programs and units are not the primary focus of this report, three are reviewed in this section to provide the context for several conclusions and recommendations regarding the Clinic's possible linkages with these programs and units in the next section.

### **6.1 The Medical Branch of the Family Division**

The Medical Branch of the Family Court Division currently provides services that include psychological evaluations, family counselling, mediation and supervised parental visitation. Reduced to their essential elements, the services provided by the Medical Branch are much like those provided by the Clinic, i.e., a process conducted by mental health professionals, at the direction of justice authorities, for the purposes of delineating, acquiring and providing information or services that are useful for adjudication, disposition or case management. For example, in 1991 the Medical Branch reportedly conducted 3,782 evaluations of juveniles. These psychological evaluations were performed by six or seven psychologists in very much the same way that the Clinic evaluates adult criminal defendants. Obviously, there may be some benefits to

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<sup>61</sup>Generally speaking, a trial court may provide the following types of mental health services or functions: (a) bail risk determinations focusing on the mental status of defendants; (b) indigent defense evaluations; (c) other pretrial mental health "screening" (e.g., competency to confess or waive counsel); (d) determinations of "criminal competency" or "civil" capacity; (e) criminal responsibility; and (f) presentence or post-conviction mental health evaluations to assist the court in sentencing. Special courts of limited jurisdiction (probate, family, juvenile, and mental health) may have exclusive jurisdiction involving (a) involuntary civil commitment determinations; (c) guardianship investigations and evaluations; (c) determinations of civil competency; and (d) mental health evaluations and family matters. See Keilitz and Roesch, *Improving Justice and Mental Health Systems Interactions: In Search of a New Paradigm* 16 LAW AND HUMAN BEHAVIOR 5-26 (1992).

the Court in exploring coordination, consolidation, integration and other linkages between the Medical Branch and the Clinic.<sup>62</sup>

## **6.2 Mental Health Expert Assistance in Insanity Cases**

Except as may be necessary to resolve threshold issues of competency, the Clinic rarely renders mental health assistance to the Court in insanity cases. Reportedly, in cases in the Homicide Program, if an attorney seeks mental health expert assistance pursuant to an insanity defense, he or she petitions the Homicide Program calendar judge, who may authorize court funds (Class 200 funds) for the attorney to employ a psychiatrist or psychologist. Typically, attorneys do not limit the mental health expert's assistance to the issue of insanity but may employ the expert to assist the defense with regard to a number of issues including competency to stand trial, amenability for treatment by the juvenile court, diminished capacity, determinations related to the "guilty but mentally ill" verdict (GBMI), self-defense, voluntary manslaughter, and voluntary/involuntary intoxication. In capital cases, the Court may also authorize funds to employ a mental health expert in assisting the defense at the sentencing stage.

## **6.3. Involuntary Civil Commitment Proceedings**

Two judges of the Court of Common Pleas hear involuntary civil commitment cases pursuant to the Mental Health Procedures Act of 1976. Commitment hearings, and apparently any mental health examinations of respondents, occur in various hospitals in Philadelphia, the County Prison, Norristown State Hospital, and the Embreeville Center in Chester County. The Clinic has no involvement with the respondents, the judges, the proceedings or the processing of involuntary civil commitment cases.

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<sup>62</sup>Information about the Medical Branch was provided by Mr. Leonard Hacking who is preparing a background report of the Medical Branch for the Office of the Executive Administrator.

## **7.0 Conclusions And Recommendations**

Many, if not most, of the conclusions and recommendations for the improvement of the organization, management and operation of the Clinic in this final section relate to the Clinic's lack of coordination and integration with and virtual isolation from the Court's case management and overall administration. As is probably true of most organizations, the problems of the Clinic are problems of the system, not the people. The Clinic's current staff has worked assiduously to conduct and report mental health evaluations requested by the Court in an expeditious and timely manner. Improvements recommended in this report should build upon a relatively responsive and efficient processing of requests for mental health evaluations by the Clinic staff.

Integration of the Clinic with the Court is the key to the improvement of the Clinic's organization, management and operation, as well as to increased satisfaction among judges, other court personnel, and attorneys with the Clinic's services.<sup>63</sup> An apt analogy to describe the Clinic--one already used by the NCSC in conversations with the Clinic and the Court during the course of this evaluation--is that of a black box. The box has a slit on one side into which the Court deposits requests for mental health evaluations and a slit on the opposite side through which the Clinic slips completed reports of mental health evaluations. Those outside of the black box do not see inside the box, and those inside do not see outside. No means exists for those inside and those outside the box to communicate with each other.

The conclusions and the 22 recommendations that follow are grouped under only a few thematic subheadings intended to facilitate review, modifications and implementation of the recommendations. Some are practical

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<sup>63</sup>This general recommendation has been advanced for other jurisdictions. See Keilitz, *Mental Health Services to the Courts: A System Isolated from Judicial Administration*, in R. Rosner and R. Harmon (Eds.) CRIMINAL COURT CONSULTATION 29-43 (1989).

and focused on the present, others are future-oriented. References to the previous sections, especially Section 3, 4 and 5, which provide the factual bases for the conclusions and recommendations, are noted in parentheses following the recommendations. Other sources of information are noted in the commentaries accompanying the recommendations.<sup>64</sup>

## **7.1 Organization and Management of the Clinic**

With very few staff changes, and through successive court administrations, the Clinic has continued to provide, in a relatively efficient and timely manner, mental health evaluations requested by the Court. Notwithstanding the problems identified in this report, the fact that the Clinic has "stayed in business" for as long as it has is a tribute to the hard work and efficiency of the clinical and administrative staff named in Section 3.2, Table 1, *supra*. However, the Clinic operates with little or no coordination or management. No one appears to be in charge of *both* the clinical and administrative functions of the Clinic and no one is broadly accountable for its performance and the costs of its operations.

While the Clinic's clinical and administrative staff appear to get along together quite well, except for informal conversations, clinicians work relatively independently and only rarely discuss the Clinic's operations with the administrative staff. The clinicians appeared to be largely ignorant of the administrative aspects of the Clinic; administrative staff make few demands on clinicians. On one occasion, during which the NCSC staff was discussing the Clinic's filing system with one of the Clinic's administrative technicians, a psychiatrist who has worked in the Clinic for over ten years remarked that he had never, until this instance, concerned himself with the manner in which written evaluation reports were filed. This may seem like a trivial example, but it serves

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<sup>64</sup> See Appendix A, *infra*, for a discussion, including of limitations, of the evaluation methods.

to illustrate deficiencies in the overall organization and management of the Clinic--both internal and external to the "black box."

### **Recommendation 1. Organizational Structure and Management**

- (a) The Court should establish a formal organizational structure for the Clinic that ensures effective direction and management of *both* the clinical and administrative staff of the Clinic, assures the integration of the Clinic with the case-flow procedures, organizational structures, management, policies and procedures of the Court, and provides on-going quality assurance and accountability for the Clinic's operations and performance.**
- (b) The Court should designate a capable administrator to direct and to manage *both* the clinical and administrative staff and functions of the Clinic, including the administration of any contracts between the Court and outside organizations that are relevant to the Clinic's operation. (Sections 3.2 and 3.3)**

The Clinic's mission and its relationships to the Court's overall administration are poorly understood. Organizations are cultures with shared beliefs, values, goals and schemes by which people make sense of events and actions of the organization. A mission refers to an organization's aim, purpose, goals and fundamental responsibilities--what it does and does not do and where it is headed. Every organization is headed somewhere, but few articulate that direction clearly. The stated purpose and list of services of the Clinic in the various contracts between the Court and Temple University, whatever their shortcomings, have not been widely communicated and reviewed. Those inside and outside the Clinic are unclear about the functions and the responsibilities of the Clinic's staff beyond responding to requests for mental health evaluation.

To what degree should Clinic staff proactively influence judges regarding requirements and needs for requests for various types of mental health evaluations? Should the Clinic conduct training programs for Court personnel? Should the Clinic provide educational opportunities for residents, fellows and



other students of psychiatry, psychology, law and related fields? To what degree should the Clinic proactively reach out to judges and administrators and try to improve the Court's case processing and administration of *all* cases involving issues of mental disability? These are important questions that need to be addressed. To the degree that mission-driven court organizations and units are more successful than those that are not so guided, and there seems to be at least some suggestions that they are,<sup>65</sup> the Court and the Clinic could benefit greatly by making explicit the Clinic's mission and purpose.

## **Recommendation 2. Mission**

- (a) The mission of the Clinic should be articulated clearly and communicated widely to the Clinic staff, judges and others (e.g., the Sheriff Department, the Defender Association) who work with the Clinic. The mission should not be limited to making reports in response to requests for mental health evaluations but instead encompass activities that facilitate the Court's adjudicative, investigatory, dispositive, supervisory and administrative functions and responsibilities in cases involving issues of mental disability. To the degree that consultation with judges, attorneys and administrators, training activities and research facilitate these functions and responsibilities, they should be part of the Clinic's mission.**
- (b) Over the next six months, the Mental Health Assessment Oversight Committee should be available to assist the Court and the Clinic to develop a mission statement for the Clinic.**
- (c) A statement of mission, once drafted and reviewed, should drive the operation and future plans, including contracts and proposals, related to the Clinic. (Section 3.1)**

Except for the 5.0 FTE court administrative support staff, the Clinic staff is loosely organized. Lines of communications, authority, affiliations and loyalties are defined by history and individual preferences. Who does what, when, where and why seems unrelated to any mission, purpose, or policies of the Clinic and the Court.

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<sup>65</sup> See Keilitz and Roesch, *supra* note 61, at 15-16.

### **Recommendation 3. Staffing Requirements**

- (a) The Court/Clinic should establish specific staffing requirements, job descriptions, and accountability mechanisms for all Clinic staff, including those providing services on a contractual basis. These should be regularly reviewed as part of the on-going management of the Clinic.**
- (b) No mental health professionals should be assigned to evaluate a defendant unless the Clinic determines that the professional's qualifications include:**
  - (i) sufficient professional education and clinical training and experience likely to establish the clinical knowledge required for the evaluation being conducted; and,**
  - (ii) sufficient forensic knowledge, gained through specialized training or an acceptable substitute therefor, necessary for understanding the relevant legal matters and for satisfying the specific purposes for which the evaluation is being requested. Psychiatric residents and fellows, who do not meet these qualifications, should not be assigned to conduct mental health evaluations and give court testimony except as collaborators with qualified mental health professionals. (Section 3.2)**

As discussed in Section 3.3 and noted in Table 2, *supra*, the estimated total personnel costs, including \$600,000 of contractual services provided by Temple University, is approximately \$800,000. While these costs are not low, given the current caseload of the Clinic, they are not unreasonable. Anticipated reductions in the number of mental health evaluations in the future and a general streamlining of the Clinic's operations consistent with the recommendations in this report give support to the reasonableness of the Court's intended reduction of the costs of contractual services from \$600,000 to \$450,000 per year.

Demonstrating good faith, and in keeping with its long-standing relationship with the Court, Temple University has provided the Court with the clinical staff to conduct requested mental health evaluations *without* an approved

contract since July 1, 1991. Although there has been a change in the leadership of Temple University's team, the new leaders have expertise and experience that appears no less formidable than that of their predecessors. Further, Drs. Eichelman and Hartwig have expressed a willingness to cut costs and streamline the operations of the Clinic. There appears to be some friction between Dr. Eichelman and the rest of current clinical staff, but it has not decreased the productivity of the Clinic. At this writing there appears to be no reason not to continue the contractual relationship between Temple University and the Court.

#### **Recommendation 4. Contractual Services**

- (a) Temple University should be invited to submit a proposal, responsive to the recommendations contained in this report, as may be modified by the Court, to extend its contract with the Court through FY 1992-1993. The request for funds should not exceed \$450,000.**
- (b) In the event that Temple University is unwilling or unable to submit a proposal deemed acceptable to the Court, the Court should consider other alternatives including securing the services of a private contractor other than Temple University and hiring mental health experts as employees of the Court on a part-time or full-time basis. (Sections 2.0 and 3.3)**

In addition to being responsive to the conclusions and recommendations in this report, Temple University's proposal should contain: (a) a detailed narrative that describes the proposed services; (b) the purposes, goals and objectives toward which those services will be directed; (c) the methods and procedures for delineating evaluation requests, conducting the evaluations, preparing reports of evaluations, and assuring the accuracy, utility and overall quality of the evaluation reports; (d) training and research activities and, importantly, their anticipated benefits to the Court; (e) proposed clinical staff, including residents, fellows and students, and their responsibilities and duties; (f) procedures and mechanisms that will be used to ensure that all tasks, duties and

functions, are performed on time and at the highest level of quality; and (g) a detailed budget (including personnel, benefits, and indirect costs) and budget narrative.

## **7.2 Requests for Mental Health Evaluations**

Ideally, the Clinic conducts only those mental health evaluations that are required by law and, absent legal requirements, those that are needed or desired by the Court. It is highly likely that a significant proportion of the approximately 5,000 requests for mental health evaluations received by the Clinic in 1991 were *pro forma*, reflexive or unnecessary. The Clinic probably does much that is not required, needed or desired, and fails to do much that it probably should. This issue needs to be addressed. It will be addressed, in part, by attention to the first four recommendations, especially if their implementation puts an end to the Clinic's virtual isolation from the Court's administration. However, this issue should also be addressed directly by an examination of the number, types and nature of the requests for mental health evaluations.

### **Recommendation 5. Evaluation Request Form**

**The standard request form, "Request for Presentence Investigation/Mental Health Evaluation," should be revised in ways that discourage *pro forma*, reflexive and unnecessary requests. (Section 5.1; Appendix C)**

### **Recommendation 6. Curtailment of Section 17 Evaluations**

**Except as may be required or desired if legislation currently pending is passed (see Recommendation 7), requests for mental health evaluations by the Clinic pursuant to Section 17 (35 P.S. § 780-117; Probation Without Verdict) should be curtailed or eliminated altogether. The Court should give serious consideration to assigning to the Investigative Division of the Probation Department the conduct of Section 17 evaluations as part of its presentence investigation, instead of forwarding Section 17 evaluations requests to the Clinic. (Sections 4.1.2, and 4.2 and 4.3)**

As discussed in Section 4.1.2, *supra*, House Bill 1467, which is moving rapidly through the Pennsylvania General Assembly with broad sponsorship, would impose requirements upon defendants, the Court and the Clinic not in current law. For the purposes of proving drug dependency, it would require a defendant to present the testimony of a physician trained in the field of drug abuse. Because psychologists have performed the great bulk of Section 17 evaluations in the past, if House Bill 1467 is enacted into law, the Court and the Clinic would need to alter the way Section 17 evaluations are conducted. At the very least, assuming that the Clinic's psychiatrists would qualify as physicians "trained in the field of drug abuse," Clinic psychiatrists would need to conduct all Section 17 evaluations. In any event, the Court and the Clinic should plan and anticipate the enactment of House Bill 1467.

Standard 2.3 of the *Trial Court Performance Standards*<sup>66</sup> require that a trial court not only make its own personnel aware of changes, such as those prompted by impending legislation, but also notifies court users to such changes to the extent practicable. Further, Standard 4.5 requires trial courts to recognize and to respond appropriately to new conditions or emergent events and adjust their operations as necessary.<sup>67</sup>

#### **Recommendation 7: Responsiveness to New Legislation**

**The Court and the Clinic should make plans for the conduct of Section 17 evaluations in the event that House Bill 1467 is enacted into law. Alternatively, the Court should explore other options available to defendants and the Court for presenting the testimony of a physician trained in the field of drug abuse for the purposes of proving his or her drug dependency. (Sections 4.1.2; Appendix B)**

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<sup>66</sup>Commission on Trial Court Performance Standards, TRIAL COURT PERFORMANCE STANDARDS 12-13 (1990).

<sup>67</sup>*Id.* at 34.

## **Recommendation 8. Presentence Evaluation Requests**

**The current practice of requesting pre-sentence mental health evaluations by the Clinic in *almost all* cases in which a pre-sentence investigation is requested should be restricted. Such evaluations should be requested only upon presentations by the parties or Court officials or, alternatively, when direct observations of behaviors of the defendant by the Court indicate that the mental condition of the defendant should be considered at sentencing. (Sections 4.1.3, 4.2, and 4.3)**

In addition to the above recommendations that (if accepted and implemented by the Court) are likely to have an immediate effect on the number of requests that are required, needed, or desired, the Clinic should take measures to improve the creation and referral of requests for mental health evaluations. As noted in Section 4, *supra*, it is in the early stages of the evaluation process that many problems can be averted. What the Clinic does and how it does it depends greatly upon how the mental health issues facing the Court are initially defined. A source of frustration for those involved in the process of mental health evaluations are questions that are not clearly framed and communicated. Based on interviews with judges and administrators, and observations by the NCSC, it seems unlikely (except in unusual circumstances) that judges and court clerks have the time to craft specific psycholegal questions in individual cases and communicate those questions orally or in writing to the Clinic. Clinic staff must come out of their "black box" and learn about the context in which requests are created and thereby improve the manner in which the requests are created and referred to the Clinic.

## **Recommendation 9. Creation and Referral of Requests for Evaluation**

- (a) Over the course of the next year, Clinic staff should regularly observe the proceedings, and work informally and cooperatively with the judges and court clerks in each of the major court programs (Criminal List/Drug, Section Calendar, Homicide and the Municipal Court), to understand and**

**appreciate the purposes and context in which requests for mental health evaluations arise.**

- (b) The information gained from these observations and interactions with judges and court clerks should be used to improve not only the creation and referral of requests but also the provision of mental health information to the Court. (Section 4.3)**

### **7.3 Operation of the Clinic**

As has been mentioned several times throughout this report, the Clinic has operated in the absence of an effective organization and management structure. This has impeded improvements in the operations of the Clinic. The recommendations that appear below are relatively straightforward and flow, generally, from the description of the operation of the Clinic in Section 5, *supra*.

#### **Recommendation 10. Policies and Procedures Manual**

**Based in part on this report, the Clinic should develop a manual of policies and procedures governing the important aspects of the delineation, acquisition and provision of mental health evaluations and other services to the Court including, but not limited to, the following: the organization and management and operation of the Clinic; the services provided by the Clinic including mental health evaluation, consultation, research and training; preparation of case files; scheduling of interviews; the conduct of clinical interviews and psychological testing; the preparation of reports; reporting mechanisms; and quality assurance procedures. (Section 5.0)**

#### **Recommendation 11. Word Processing and Duplication of Reports**

**The capacity for word processing and duplication of mental health evaluation reports should be located within the Clinic instead of the Probation Department. (Section 5.6.1)**

#### **Recommendation 12. Elimination of Presentence Investigation Intake Function**

**Because judges and clerks (who actually execute the request for mental health evaluations) may inappropriately view presentence investigations and mental health evaluations as one-and-the-same, the Clinic should cease functioning as the**

**intake for *all* requests for presentence investigation. This intake function is more appropriately placed under the aegis of the Investigative Division of the Probation Department. (Section 5.8.1)**

Generally speaking, although several judges and attorneys expressed relatively mild criticism of the evaluation reports received by them, the preparation and contents of the written reports of mental health evaluations conducted by the Clinic appear to meet at least the *minimum* requirements for case processing. That is, the preparation and contents of the reports apparently seldom have delayed case processing or failed to meet procedural requirements that have led to untoward consequences such as mistrials and reversals. Nonetheless, the written evaluation reports should, as recommended by the American Bar Association, the American Psychiatric Association, the American Psychological Association and other professional groups, ordinarily identify the specific matters referred for evaluations; describe the procedures, tasks and techniques used by the evaluator; state the evaluator's clinical findings and opinions on each matter referred for evaluation and indicate specifically, those questions, if any, that could not be answered; identify the sources of information and present the factual basis for the evaluator's clinical findings and opinions; and, present the reasoning by which the evaluator utilizes the information to reach the clinical findings and opinions.

The *provision* component of the mental health evaluation process includes three essential steps: the actual preparation of the communication between the Clinic and the Court, the communication itself, and the exchange of information about the consequences of that communication. These are important steps in the examination process that have not received the attention that they deserve. Clinic personnel are relatively uninformed about how the Court reviews and uses evaluation reports. For example, precisely why, when



and how an oral ("forthwith") report is required, needed and desired should be clarified.

### **Recommendation 13. Preparation and Contents of Reports**

- (a) The preparation and contents of written reports of mental health evaluations should be made to conform to the requirements of relevant statutes, relevant professional standards and the needs, requirements and preferences of the Court.**
- (b) The Clinic should develop, promulgate, and regularly review and revise written guidelines for and samples of the major types of mental health evaluations requested by the Court. The guidelines and samples should conform to legal and professional standards. The Mental Health Assessment Oversight Committee should advise the Clinic regarding the development of these written guidelines and samples of mental health evaluation reports. (Section 5.6)**

As noted in the Section 5.1, *supra*, ideally, the Clinic receives requests for mental health evaluations shortly after the Court has requested them. In reality, considerable time may pass between a judge's instruction to prepare a court order and the conveyance of that order to the Clinic. Courtroom clerks may not take the time to complete the formal request until there is time to do so. Once the form is completed, there is no understanding regarding who conveys the request to the Clinic. Of course, the Clinic has no way of knowing of the pending evaluation order until it receives the form.

### **Recommendation 14. Transmission of Court Orders**

**Judges and courtroom clerks should endeavor to prepare the requests for mental health evaluation shortly after the specific time during the proceedings when the order is issued. Alternatively, the courtroom clerk and the Clinic should devise a method whereby the pending order is communicated to the Clinic. (Sections 5.1 and 5.3)**

Again, ideally, the Clinic schedules and conducts mental health evaluations on the same day as the defendant's scheduled court appearance or, in bail cases, the defendant's scheduled appointment at the Clinic. This is not accomplished in a significant proportion of the cases referred to the Clinic. Rescheduled bail cases constitute a relatively minor inconvenience for the defendants and the Clinic. On the other hand, defendants in custody who are not evaluated by the Clinic on the same date of their court appearance constitute a major problem. Defendants in custody for whom mental health evaluations are requested but who, for various reasons, are not seen by the Clinic the day they make an appearance in the Court, are returned to the prisons and then must be rescheduled for a return visit to the Clinic. The costs of rescheduling and transportation are great.

Clinicians are scheduled to be in the Clinic between the hours of 9:30 am and 5:00 pm. Evaluations are scheduled daily in this time frame. Assuming that it is either impossible or unreasonable to schedule court events to accommodate the schedule of clinicians, the schedule of clinicians should be adjusted to accommodate the flow of cases into the Clinic.

#### **Recommendation 15. Scheduling Priorities**

- (a) To avoid delay in case processing and the excessive costs of transportation and rescheduling mental health evaluations, the Clinic should strive to conduct mental health evaluations of all defendants on the day of their referral to the Clinic. In the order of decreasing potential delays and costs, priority should be given to the scheduling of out-of-county custody cases, custody cases and bail cases. The Clinic should work in cooperation with the Clerk of the Quarter Sessions and the Sheriff Department to identify these cases, as soon as is possible, on the Clinic's schedule.**
- (b) Clinical resources should be adjusted, as much as possible, to the daily flow of requests for mental health evaluations into the Clinic. The schedule of clinicians should be extended into the morning hours to accommodate scheduled and**

**rescheduled bail cases and into the evening hours to accommodate, especially, out-of-county custody cases. (Section 5.3)**

Who receives what information, when, and how are questions that should not be left to be answered by administrative staff. As noted in Section 5.7, *supra*, for reasons that are not clear, the method of distribution of reports depends upon the type of evaluation conducted.

#### **Recommendation. 16. Distribution of Reports**

**With the advice of the Mental Health Assessment and Oversight Committee, the Clinic should devise a uniform procedure for distribution of mental health evaluation reports. The procedure should comply with applicable statutes and case law governing the transmission of mental health communications and, generally, reflect a common sense appreciation of the context-dependent nature of the communication. (Section 5.7)**

As noted in several places in this report, there is currently no mechanism for follow-up and feedback after mental health evaluations are completed by the Clinic (i.e., no way to get into the "black box"). Except for anecdotal accounts, the Clinic is relatively uninformed about how (and even if) the Court uses evaluation reports. There is no mechanism to ensure that the consequences of the mental health evaluation reports are known and have an effect on the improvement of the delineation, acquisition and provision of future mental health evaluations. The consequences of the mental health evaluation process should govern the conduct of the process in a deliberate, planned and continuous manner. As has been discussed in the professional literature,<sup>68</sup> the most effective regulation of the flow of information and feedback regarding mental health evaluations is that initiated proactively by forensic mental health officials-- first on an individual, informal basis and then, perhaps, on an agency-wide basis.

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<sup>68</sup> See, *supra* note 19.

Regulation, program monitoring and program evaluation by external sources seems less likely to offer substantive and practical guidance.

#### **Recommendation 17. Quality Assurance**

**The Clinic should develop, as part of its organization and day-to-day management, an on-going mechanism of quality assurance whereby mental health evaluation reports (both oral and written) and other services provided by the Clinic are continuously monitored, reviewed and improved on the basis of their results. (Section 5.6.3)**

#### **7.4 Education and Training**

Both judges and Clinic staff have expressed the need for and desire to participate in education and training programs. Professional groups, including the American Bar Association,<sup>69</sup> have articulated desirable levels of education and training for judges, mental health and mental retardation professionals and lawyers on issues of mental disability and the participation by mental health professionals in the criminal justice process. Education and training programs should not be limited to formal educational conferences but include, as may be deemed desirable by the Court and Clinic, small group meetings, individual consultations, video conferences, newsletters, and other types of education and training that are likely to be well-received and successful.

#### **Recommendation 18. Interdisciplinary Cooperation in Education and Training**

- (a) Temple University and the Court should ensure that clinicians have sufficient professional education, clinical training and experience, including that which may be required by statute, case law, court rules, and that which may be needed or desired by individual judges in individual cases, for understanding the relevant legal matters and for satisfying the specific purposes for which the mental health evaluation is requested.**

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<sup>69</sup>American Bar Association, ABA CRIMINAL JUSTICE MENTAL HEALTH STANDARDS, 18-22 (1989).

- (b) Judicial, legal and mental health professionals associated with the Clinic should cooperate in promoting, designing and offering basic and advanced programs--both formal and informal--on mental health issues and on the participation of mental health professionals in the judicial process to judges, attorneys, mental health professionals, and to students including medical residents, fellows and law students. (Sections 3.1 and 3.3)**

## **7.5 Linkages With Other Court Programs and Units**

The services provided to the Court by mental health professionals can be broadly defined as all the activities conducted by those professionals, at the direction of Court authorities, for the purposes of delineating, acquiring, and providing information about the mental condition of defendants and offenders that is useful in judicial decisionmaking and case management. Defined in this manner, the services provided by mental health professionals--by various financial and organizational arrangements--to the various divisions, programs and units of the Court are more similar than they are different. As noted in Section 6, *supra*, the Court may benefit greatly--in terms of improved quality of services--by linking the Clinic and its staff with other programs, units and operations of the Court that deal with cases--both criminal and civil--in which issues of mental health arise. The Medical Branch of the Family Division, the mental health expert assistance provided by privately retained mental health experts in homicide cases, and involuntary civil commitment proceedings are but three examples of Court programs and proceedings that could benefit from some type of linkage with the Clinic. Most certainly there are others (e.g., guardianship evaluations).

The following recommendations are meant to be illustrative of the type of actions the Court might take to link the Clinic with other Court programs, units and proceedings in which issues of mental health arises.

#### **Recommendation 19. Use of Medical Branch Personnel by Clinic**

**At the direction of the Court, and in cooperation with the Medical Branch of the Family Court Division, the Clinic should develop a procedure whereby mental health professionals in the Medical Branch are available to conduct mental health evaluations for the Clinic, and Clinic professionals are made available to the Medical Branch. (Section 6.1)**

#### **Recommendation 20. Insanity Evaluations**

- (a) With the advice of the Mental Health Assessment Oversight Committee, the Court should explore the use of the Clinic to provide mental health evaluations of defendants as a prerequisite to its approval of funds provided to defense attorneys to employ privately retained psychiatrists or psychologists. Such preliminary examinations by the Clinic, which may be limited, for example, to the question of the presence of a serious mental illness (the threshold question of an insanity defense), may assist the Court in controlling the costs of privately retained mental health experts and potentially serve as a quality control of those experts.**
- (b) Alternatively, the Court should explore the possibility of the Clinic developing and maintaining a list of qualified privately retained mental health professionals who are willing and able to conduct insanity evaluations at the request and direction of the Court and appointed defense attorneys. (Section 6.2)**

#### **Recommendation 21. Involuntary Commitment**

- (a) In conjunction with the Mental Health Assessment Oversight Committee, the Clinic should establish a procedure whereby orders for involuntary "criminal" commitment of criminal defendants are processed by the Clinic in a single day.**
- (b) In conjunction with the Mental Health Assessment Oversight Committee, the Clinic should establish an alternative to Clinic administrative personnel serving as the petitioner in all "criminal" commitments.**

- (c) In conjunction with activities suggested by paragraph (a) and (b), above, Clinic personnel should become familiar with the involuntary commitment process—both civil and "criminal"—and develop working relationships with the judges and mental health professionals involved in those proceedings. (Section 6.3)**

## **7.6 Miscellaneous**

Names and titles provide information and create impressions. At the least, the name of the Clinic should convey its functions, responsibilities and staff composition. Names and titles also contain potentially powerful symbols that reinforce values and concepts behind change. Consistent with these notions, and the recommendations for improvement of the Clinic in the remainder of this report, the Court should consider changing the name of the Clinic.

### **Recommendation 22. Court Mental Health Clinic**

**To reflect more accurately the functions and composition of the Clinic's current staff, and to suggest an improved Clinic, the name of the Clinic should be changed to "Court Mental Health Clinic."**

## **Appendix A. Evaluation Methods**



The National Center for State Courts (NCSC) conducted the evaluation upon which this report is based between January 15, and March 30, 1992, the date this report was submitted to the Philadelphia Court of Common Pleas. Dr. Ingo Keilitz, the Director of the NCSC's Institute on Mental Disability and the Law, and/or Ms. Patricia Wall, Research Associate, visited the Court on four separate dates over the course of the evaluation: February 19-21; March 5-6; March 12-13; and March 16-18, 1992.

Evaluation methods included: (1) reviews of relevant statutes, case law, and background materials (e.g., periodic reports of the Court, correspondence, contracts and proposals); (2) review and analysis of aggregate data on mental health evaluation requests made available by the Court Psychiatric Clinic and the Probation Department; (3) sampling, collection, review and analysis of a sample of approximately 100 mental health evaluation reports conducted by the Clinic, in 1991; (4) telephone, face-to-face, and group interviews of the individuals named below; and (5) direct observation of as many clinical, judicial, and administrative procedures relevant to the Court Psychiatric Clinic as time permitted.

Because this evaluation is a "snapshot" of the Clinic, one may differ from other "snapshots" taken at different times and from broader perspectives, the conclusions and recommendations should not be taken as research conclusions or empirically proven statements of fact. Rather, they are NCSC's suggestions, based upon a variety of information sources and points of view including: ideas generated by the NCSC during the course of the evaluation; discussions and specific suggestions made by people who were interviewed; and conclusions and points of view drawn from the NCSC's past work and the professional literature relevant to this evaluation. It is impossible to sort out the influences of these various sources in any recommendation, or to report accurately how

extensively any person or group would agree with any single recommendation. The purpose of presenting conclusions and recommendations is to highlight certain problems and areas of improvement and to alert the court to possible solutions. Although it is easy to identify a problem, the NCSC does not pretend to hold "the answer." A more realistic expectation is to present "an answer," however modest and tentative, as a stimulus and practical starting point for improvement.

## **Interviews**

This report is based, in part, on interviews conducted with the individuals listed below conducted during the period January 15, 1992 and March 31, 1992. Interviews included both telephone and personal interviews, designated (P), conducted on an individual or group basis.

Robert Armstrong, Captain, Sheriff Department. [3/6 (P)]

Lawrence C. Bryne, M.Ed., Psychologist, Court Psychiatric Clinic, (215) 686-4292. [2/19 (P)]

William Carroll, Captain, Enforcement Division, Sheriff Department. [3/6 (P)]

Hon. Pamela Pryor Cohen, Court of Common Pleas, 1st Judicial District of Pennsylvania, 212 One East Penn Square, Philadelphia, PA 19107, (215) 686-3735. [3/6 (P); 3/17 (P)]

Jules DeCruz, M.S., Psychologist, Court Psychiatric Clinic, (215) 686-4292. [2/19 (P); 2/20 (P); 3/17 (P)]

Hon. Nelson A. Diaz, Administrative Judge. [3/17 (P)]

Burr S. Eichelman, M.D, Ph.D., Professor and Chairman, Temple University Health Sciences Center, School of Medicine, Department of Psychiatry, Philadelphia, PA 19140, (215) 221-3364. [2/19 (P); 3/5 (P); 3/27]

Geoff Gallas, D.P.A., Executive Administrator, 1st Judicial District of Pennsylvania, Office of the Executive Administrator, 364 City Hall, Philadelphia, PA 19107, (215) 686-2525. [2/19 (P); 3/17 (P); 3/18 (P)]

Joy Guziec, M.D., Resident, Temple University Health Sciences Center, School of Medicine. [2/20 (P)]

Florence Farinella, Administrative Technician, Court Psychiatric Clinic, (215) 686-4292. [2/19 (P)]

Leonard Hacking, Office of the Executive Administrator, 1st Judicial District of Pennsylvania, Office of the Executive Administrator, 364 City Hall, Philadelphia, PA 19107, (215) 686-3775 (3776). [2/13; 2/19 (P); 2/20 (P); 2/21 (P); 3/5 (P); 3/6 (P); 3/17 (P); 3/18 (P)]

Bill Haines, Administrative Technician, Court Psychiatric Clinic, (215) 686-4292 [2/19 (P)]

Anne Hartwig, J.D, Ph.D., Temple University. [3/5 (P)]

David C. Lawrence, Deputy Court Administrator, Philadelphia Court of Common Pleas. [2/19 (P); 3/6 (P); 3/19 (P)]

Ned J. Levine, Esq., Defender Association of Philadelphia, 121 North Broad Street (8th Floor), Philadelphia, PA, 19107, (215) 568-3190. [2/19 (P); 3/5 (P)]

Albert Levitt, M.Ed., Psychologist, Court Psychiatric Clinic, (215) 686-4292. [2/19 (P); 2/20 (P)]

Hon. William J. Manfredi. [3/17 (P)]

Hon. Arnold New. [3/6 (P); 3/17 (P)]

Barbara O'Neil, Supervisor, Court Psychiatric Clinic (215) 686-4292. [2/6; 2/13; 2/19 (P); 2/20 (P); 2/21 (P); 3/5 (P); 3/6 (P); 3/17 (P); 3/18 (P)]

Frank Snyder, Director of Presentence Investigations, Adult Probation Department, 121 N. Broad Street (8th Floor), (215) 686-9568 (9561). [2/13; 2/19 (P); 3/5 (P); 3/18 (P)]

Richard Sol, M.D., Psychiatrist, Court Psychiatric Clinic. (215) 686-4292. [2/19 (P)]

Robert Stanton, M.D., Psychiatrist, Court Psychiatric Clinic. (215) 686-4292. [2/19 (P)]

Sherry D. Taborne, Administrative Technician, Court Psychiatric Clinic, (215) 686-4289. [2/21 (P)]

Hon. Carolyn Engel Temin. [3/18 (P)]

## **Mental Health Assessments Oversight Committee**

The following individuals serve on the Mental Health Assessments Oversight Committee which was created by the Office of the Executive Court Administrator to oversee and advise the NCSC. The Committee met on February 21 and March 19, 1992 (dates following members' names indicate their presence at the scheduled meetings).

Dr. Geoff Gallas, Executive Administrator, 1st Judicial District (2/21/92)  
Hon. Carolyn Engel Temin (2/21/92)  
Hon. Thomas Watkins (2/21/92)  
Hon. Pamela Cohen (2/21/92; 3/17/92)  
Hon. Arnold New (3/17/92)  
Hon. James Fitzgerald (3/17/92)  
Hon. Legrome Davis (2/21/92; 3/17/92)  
Mr. Jim Stewart C.P.O., Adult Probation (2/21/92; 3/17/92)  
Mr. Ned Levine Esq., Defender's Association of Philadelphia (3/17/92)  
Ms. Patricia Yusem, Esq., District Attorney's Office (2/21/92; 3/17/92)  
Mr. Len Hacking, Senior Staff Advisor, OECA, 1st Judicial District  
(2/21/92; 3/17/92)

## **Appendix B. House Bill 1467**

1ST DOCUMENT of Level 1 printed in FULL format.

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175TH GENERAL ASSEMBLY -- 1991-92 REGULAR SESSION

HOUSE BILL 1467

1991 PA H.B. 1467

ATE-INTRO: MAY 15, 1991

AST-ACTION: MARCH 24, 1992

YNOPSIS: Amends the Controlled Substance, Drug, Device and Cosmetic Act; further provides for probation without verdict and for certain dispositions.

STATUS:  
5/15/91 INTRODUCED. To HOUSE Committee on JUDICIARY.  
1/13/91 From HOUSE Committee on JUDICIARY as amended.  
2/10/91 In HOUSE. Read second time.  
1/29/92 In HOUSE. Read third time and amended. Passed HOUSE. \*\*\*\*\*To SENATE.  
2/04/92 To SENATE Committee on JUDICIARY.  
3/24/92 From SENATE Committee on JUDICIARY.

UBJECT: LAW AND JUSTICE, CORRECTIONS, Probation and Parole, CRIMINAL LAW, controlled Substances & Drug Paraphernalia, Criminal Procedure and investigations

PONSOR: O'Brien et al

1ST DOCUMENT of Level 1 printed in FULL format.

THE STATE OF PENNSYLVANIA  
BILL TEXT  
STATENET

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PENNSYLVANIA 175TH GENERAL ASSEMBLY -- 1991-92 REGULAR SESSION

HOUSE BILL 1467

PRIOR PRINTER'S NOS. 1683, 2730

PRINTER'S NO. 3016

THE GENERAL ASSEMBLY OF PENNSYLVANIA  
HOUSE BILL SESSION OF  
NO.1467 1991

AS AMENDED ON THIRD CONSIDERATION, HOUSE OF REPRESENTATIVES, JANUARY  
29, 1992

1991 PA H.B. 1467

VERSION: Amended

DATE-INTRO: May 15, 1991

SYNOPSIS:

AN ACT

Amending the act of April 14, 1972 (P.L.233, No.64), entitled "An act relating to the manufacture, sale and possession of controlled substances, other drugs, devices and cosmetics; conferring powers on the courts and the secretary and Department of Health, and a newly created Pennsylvania Drug, Device and Cosmetic Board; establishing schedules of controlled substances; providing penalties;; requiring registration of persons engaged in the drug trade and for the revocation or suspension of certain licenses and registrations; and repealing an act," further providing for probation without verdict and for certain dispositions.

NOTICE:

> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A>  
> Text within these symbols is deleted <D>

TEXT: The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Sections 17 and 18 of the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act, amended October 26, 1972 (P.L.1048, No.263), are amended to read:

Section 17. Probation Without Verdict. -- [D> A person may be entitled to probation without verdict under the following circumstances: <D]

[D> (1) A person who has not previously been convicted of an offense under this act or under a similar act of the United States, or any other state, is eligible for probation without verdict if he pleads nolo contendere or guilty, or is found guilty of, any nonviolent offense under this act. The court may, without entering a judgment, and with the consent of such person, defer

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1991 PA H.B. 1467

urther proceedings and place him on probation for a specific time period not to exceed the maximum for the offense upon such reasonable terms and conditions as t may require. <D]

[D> Probation without verdict shall not be available to any person who is charged with violating clause (30) of subsection (a) of section 13 of this act and who is not himself a drug abuser and who does not prove the fact of such drug abuse to the satisfaction of the court. <D] [A> EXCEPT AS PROVIDED IN LAUSE (1) OF THIS SUBSECTION, THE COURT MAY PLACE A PERSON ON PROBATION WITHOUT ERDICT IF THE PERSON PLEADS NOLO CONTENDERE OR GUILTY TO <A] [D> , or is found uilty of, <D] [A> ANY NONVIOLENT OFFENSE UNDER THIS ACT AND THE PERSON PROVES E IS DRUG DEPENDENT. FOR THE PURPOSES OF PROVING DRUG DEPENDENCY, THE PERSON UST PRESENT THE TESTIMONY OF A PHYSICIAN TRAINED IN THE FIELD OF DRUG ABUSE. HE TERM OF PROBATION SHALL BE FOR A SPECIFIC TIME PERIOD NOT TO EXCEED THE AXIMUM FOR THE OFFENSE UPON SUCH REASONABLE TERMS AND CONDITIONS AS THE COURT AY REQUIRE. THE FOLLOWING SHALL APPLY: <A]

[A> (1) THE FOLLOWING PERSONS SHALL BE INELIGIBLE FOR PROBATION WITHOUT ERDICT: <A]

[A> (I) ANY PERSON WHO HAS PREVIOUSLY BEEN CONVICTED OF AN OFFENSE UNDER THIS CT OR SIMILAR ACT OF THE UNITED STATES OR ANY OTHER STATE. <A]

[A> (II) ANY PERSON WHO HAS BEEN CONVICTED OF A MISDEMEANOR OR FELONY IN THIS OMMONWEALTH OR AN EQUIVALENT CRIME UNDER THE LAWS OF ANY OTHER STATE. <A]

[A> (III) ANY PERSON WHO HAS BEEN PLACED ON ACCELERATED REHABILITATIVE ISPOSITION WHERE THE PERSON WAS CHARGED WITH A VIOLATION OF THIS ACT OR THE OMMISSION OF A MISDEMEANOR OR FELONY IN THIS COMMONWEALTH. <A]

[A> (IV) ANY PERSON WHO IS CHARGED WITH, OR HAS PLEADED GUILTY OR NOLO NTENDERE TO, MULTIPLE OFFENSES WHICH ARE BASED ON SEPARATE CONDUCT OR ARISE OM SEPARATE CRIMINAL EPISODES SUCH THAT THOSE <A] [D> cases <D] [A> OFFENSES ULD BE TRIED SEPARATELY IN ACCORDANCE WITH 18 PA.C.S. SECTION 110 (RELATING TO IEN PROSECUTION BARRED BY FORMER PROSECUTION FOR DIFFERENT OFFENSE), <A]

[A> (V) ANY PERSON WHO IS A DANGEROUS JUVENILE OFFENDER UNDER 42 PA.C.S. CTION 6302 (RELATING TO DEFINITIONS) OR WHO WAS ADJUDICATED DELINQUENT FOR ONDUCT WHICH WOULD CONSTITUTE A VIOLATION OF CLAUSE (30) OR (37) OF SUBSECTION a) OF SECTION 13 OF THIS ACT. <A]

[A> (VI) ANY PERSON WHO WAS CHARGED WITH VIOLATING CLAUSE (14), (30) OR (37) SUBSECTION (A) OF SECTION 13 OF THIS ACT. <A]

(2) Upon violation of a term or condition of probations, the court may enter judgment and proceed as in any criminal case, or may continue the probation thout verdict.

(3) Upon fulfillment of the terms and conditions of probation, the court all discharge such person and dismiss the proceedings against him. Discharge d dismissal shall be without adjudication of guilt and shall not constitute a nviction for any purpose whatever, including the penalties imposed for second subsequent convictions: Provided, That probation without verdict shall be ailable to any person only once: And further provided, That notwithstanding y other provision of this act, the prosecuting attorney or the court, and

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1991 PA H.B. 1467

he council shall keep a list of those persons placed on probation without verdict, which list may only be used to determine the eligibility of persons for probation without verdict and the names on such lists may be used for no other purpose whatsoever.

Section 18. Disposition in Lieu of Trial or Criminal Punishment. -- (a) If a person charged with a nonviolent crime claims to be drug dependent or a drug abuser and prior to trial he requests appropriate treatment, including but not limited to, admission or commitment under the Mental Health and Mental Retardation Act of 1966 in lieu of criminal prosecution, a physician experienced or trained in the field of drug dependency or drug abuse shall be appointed by the court to examine, if necessary, and to review the accused's record and advise the government attorney, the accused and the court in writing setting forth that for the treatment and rehabilitation of the accused it would be preferable for the criminal charges to be held in abeyance or withdrawn in order to institute treatment for drug dependence, or for the criminal charges to be prosecuted. The government attorney shall exercise his discretion whether or not to accept the physician's recommendation.

(b) In the event that [D] he [D] [A] THE GOVERNMENT ATTORNEY [A] does not accept the physician's recommendation [D] he shall state in writing and furnish the defendant a copy of his decision and the reasons therefor [D] [A] , THE PERSON CHARGED SHALL NOT BE ELIGIBLE FOR RELIEF UNDER THIS SECTION [A].

(c) If the government attorney accepts the physician's advice to hold in abeyance, he shall arrange for a hearing before the appropriate court to hold in abeyance the criminal prosecution. The court, upon its approval, shall proceed to make appropriate arrangements for treatment.

(d) The government attorney, upon his own application, may institute proceedings for appropriate treatment, including but not limited to, commitment pursuant to the Mental Health and Mental Retardation Act of 1966.

(e) A criminal charge may be held in abeyance pursuant to this section for no longer than the lesser of either (i) the appropriate statute of limitations or (i) the maximum term that could be imposed for the offense charged. At the expiration of such period, the criminal charge shall be automatically dismissed. A criminal charge may not be prosecuted except by order of court so long as the medical director of the treatment facility certifies that the accused is cooperating in a prescribed treatment program and is benefiting from treatment.

[D] (f) If, after conviction, the defendant requests probation with treatment in lieu of civil commitment for treatment in lieu of criminal punishment, the court may appoint a qualified physician to advise the court in writing whether it would be preferable for the purposes of treatment and rehabilitation for him to receive a suspended sentence and probation on the condition that he undergo education and treatment for drug abuse and drug dependency, or to be committed pursuant to the Mental Health and Mental Retardation Act of 1966 for treatment in lieu of criminal punishment, or to receive criminal incarceration. A copy of the physician's report shall be furnished the court, the defendant and the government attorney. The court shall exercise its discretion whether to accept the physician's advice. [D]

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1991 PA H.B. 1467

(g) Disposition in lieu of trial as provided in this section shall be available to any person only once.

Section 2. This act shall take effect in 60 days.

PONSOR:

INTRODUCED BY O'BRIEN, CALTAGIRONE, NOYE, DEMPSEY, MAIALE, ULIANA, BELARDI, GRUPPO, DeLUCA, CLARK, J. TAYLOR, KENNEY, REINARD, HAGARTY, SCHEETZ, RAYMOND, BUSH, GLADECK, BARLEY, ARMSTRONG, MELIO, SAURMAN, ARGALL, HECKLER, NYCE, LEH, ALLEN, VROON, PERZEL, KOSINSKI, STISH, CIVERA, M. N. WRIGHT, FARGO, NAHILL, SERAFINI, D. W. SNYDER, FAIRCHILD, JOHNSON, NICKOL, STABACK, CLYMER, HAYDEN, BUNT, BATTISTO, FARMER, TOMLINSON, RIEGER, ADOLPH, FREIND, KRUSZEWSKI, GALLEN, KING, MCHUGH, TRELLO, MCGEEHAN, BUTKOVITZ, DENT, DONATUCCI, PICCOLA, MICOZZIE, FOX, GERLACH, KASUNIC, BILLOW, GEIST AND RICHARDSON, MAY 15, 1991

**Appendix C. Request For Presentence Investigation/  
Mental Health Evaluation**



## **Appendix D. Sample Clinical Interview Checklist**

1st  
2nd  
3rd  
4th  
5th

Interview Date: \_\_\_\_\_

Judge: \_\_\_\_\_

Date of Request: \_\_\_\_\_

\_\_\_\_\_  
Presentence

IDENTIFYING INFORMATION:

Age:

Race:

Name:

D.O.B.:

Alias:

Religion:

Address

Informed:

Sources of Information:

BACKGROUND HISTORY:

Intact Family

Still

Left at Age:

Parents left Subj. was:

Still w/M

Left age:

No. of sisters:

brothers:

Subj. is:

MARITAL HISTORY:

EDUCATION:

WORK HISTORY:

SERVICE:

ARMY

NAVY

MARINES

From

Type of Discharge

PHYSICAL & MENTAL HEALTH HISTORY:

Physical:

Neurological:

Suicidal:

Psychiatric:

Alcohol:

Drugs:

Treatment:

RECENT LIFE CIRCUMSTANCES:

SUBJECT'S VERSION:

Previous Record

MENTAL STATUS:

Approach:

Physical Appearance:

Date:

Orientation:

MEMORY:

Long

Short

Affect: 1

Judgment: 2

Abstract: 3

Proverbs:

---

1

2

3

PSYCHOLOGICAL TEST RESULTS:

PSYCHOLOGICAL ASSESSMENT:

RECOMMENDATIONS:

## **Appendix E. Standard Evaluation Report Facesheet**



|  |  |           |   |                                |  |     |
|--|--|-----------|---|--------------------------------|--|-----|
| <b>MENTAL HEALTH EVALUATION</b>                                    |  |           | <b>COURT OF COMMON PLEAS</b><br><b>TRIAL DIVISION</b><br><b>ADULT PROBATION AND PAROLE DEPARTMENT</b> |                                |  |     |
| <b>IDENTIFYING<br/>DATA</b>  | Name:<br>AKA :   |           |   | Phila. Photo #                 | Date Evaluated                                     |     |
|  | Age  | Birthdate | Birthplace  | Ethnic Group                   | Religion   | Sex |
|  | Marital Status   |           | Occupation  |                                | Education  |     |
| <b>PSYCHIATRIC<br/>EVALUATION<br/>ORDERED<br/>BY</b>               | Judge:   |           |   | Date Ordered                   | Date Received                                      |     |
|  | Trial Commissioner:  |           |   |                                |  |     |
| <b>REASON FOR<br/>EVALUATION</b>                                   | <input type="checkbox"/> Competency  |           | <input type="checkbox"/> Sect. 17   | <input type="checkbox"/> Other | <input type="checkbox"/> Presentence<br>Evaluation |     |
|  | <input type="checkbox"/> Possible Commit                                       |           | <input type="checkbox"/> Sect. 18   |                                |  |     |
| <b>PRESENT<br/>OFFENSE</b>   | Charges  |           |   | Plea                           | Disposition  |     |
|  |  |           |   |                                |  |     |
|  |  |           |   |                                |  |     |
|  |  |           |   |                                |  |     |
| <b>EVALUATION<br/>PREPARED ON</b>                                  | By   |           | Submitted   | Typed                          | Listing Date                                       |     |
|  | <input type="checkbox"/> Psychiatrist<br><input type="checkbox"/> Psychologist |           |   |                                |  |     |
| Date(s) of Prior Evaluations:                                      |  |           |   |                                |  |     |
| <b>DIAGNOSTIC FORMULATION AND SUMMARY</b><br><br>PLEASE SEE REPORT |  |           |   |                                |  |     |
| <b>RECOMMENDATIONS</b><br><br>PLEASE SEE REPORT                    |  |           |   |                                |  |     |

ONFIDENTIAL            ☐ PRISON COPY                      ☐ JUDGES COPY  
 ONFIDENTIAL            ☐ DISTRICT ATTORNEY                      ☐ DEFENSE ATTORNEY

COURT OF COMMON PLEAS  
ADULT PROBATION AND PAROLE DEPARTMENT  
121 NORTH BROAD STREET  
PHILADELPHIA, PENNSYLVANIA 19107

EDWARD J. BLAKE  
President Judge

DAVID C. LAWRENCE  
Chief Deputy Court  
Administrator

NELSON A. DIAZ  
Administrative Judge

JAMES E. STEWART, JR.  
Chief Probation Officer

MENTAL HEALTH EVALUATION

DEFENDANT'S NAME:

DEFENDANT'S AGE:

DATE EXAMINED:

IDENTIFYING INFORMATION: