A New Pretrial Screening Program

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Pretrial evaluations of competency to stand trial and responsibility at the time of the crime are important forensic issues that necessitate the involvement of mental health professionals. It has been estimated there are one million such forensic mental health screenings, classifications, and evaluations in the United States each year.[1] In many jurisdictions, in order to obtain such evaluations, defendants are committed to a designated state hospital where they remain for 7 to 30 days or more, depending on various circumstances.[2] In some jurisdictions, defendants are examined as outpatients at the local jail, community mental health center, or court clinic, and only those in need of hospitalization or further evaluation are committed.[3] Many of the laws regarding such evaluations are imprecise and may cause confusion.[3]

Since, in recent years, a substantial majority of defendants committed by the courts for pretrial evaluations have been found both competent to stand trial and responsible at the time of the crime, there has been concern about unnecessary hospitalization. In repeated studies only 25 to 35 percent of those evaluated have been found incompetent and even less have been held not responsible.[4] Cooke and others have reported the reasons given for requesting competency evaluations.[5,6,7,8,9,10,11] They cover a multitude of sins, from a means to delay the trial to a free psychiatric exam that might furnish information for an insanity plea. Prosecutors and judges sometimes request competency evaluations for "undesirables (alcoholics, vagrants) for whom no other criminal disposition appears appropriate."[5] At other times, the evaluations may be used as a means to obtain treatment for a noncommittable defendant or may serve as a last effort for those charged with serious crimes for whom there is no reasonable defense. One attorney with a large criminal practice raised the issue of competency for several clients because he wanted to delay their trials until he returned from his European vacation![12]

In Maryland, many defendants with histories of hospitalization have been referred for competency exams primarily to obtain treatment. Unfortunately for these patients, most have been returned to the court as competent and responsible and have received little or no treatment. Obviously,

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few have received what they needed, and the system has been overloaded. In Maryland in 1978, almost 2,000 individuals were hospitalized on court orders for competency or responsibility examinations. The vast majority of these individuals (70 to 85 percent) were found to be competent and responsible and were returned to the courts for trial.[13] All individuals who entered pleas of "incompetent to stand trial" or "not guilty by reason of insanity" were hospitalized at one of the regional state hospitals.[14] Defendants who were not considered dangerous (that is, those whose offense was not a violent one) were sent to one of the four regional hospitals, but males whose crime involved serious acting-out behavior were hospitalized at Clifton T. Perkins Hospital Center, the maximum security hospital for the state. Since the latter facility accepts only males, violent females were sent to regional hospitals.

In 1974, the maximum security hospital had become so overcrowded that severely disturbed defendants were held for weeks in local jails with minimal or no psychiatric care. Although Maryland law allowed outpatient evaluations for nondangerous incompetents, this was rarely done, and many hospital beds were occupied by those who didn't need to be there, resulting in even longer waiting lists.[14]

To deal with this problem, in 1975 the Supreme Bench Medical Office* recommended the establishment of a procedure requiring that all but the most obviously psychotic individuals be "screened" before they could be committed on court order for a competency or responsibility examination.[15] This screening program was to be used only by the Supreme Bench.[16] The screen was established with a large mesh or low threshold. If there was the slightest doubt as to competency or responsibility, hospitalization was recommended. As the seriousness of the crime—and therefore the consequences of a guilty finding—increased, the threshold went even lower. Of course, an evaluation for responsibility could be requested only by counsel. The screener would recommend this to counsel where indicated.

The Supreme Bench experiment was successful in preventing the unnecessary hospitalization of four out of five defendants. It became clear that most of those screened out had been referred for the questionable reasons discussed by Cooke and others; in some cases, referrals had been attempted by counsel to obtain psychiatric help for the defendant.[11]

Two problems were encountered that had to be resolved in order to continue this screening program. First, many defense attorneys believed they had to subpoena the screening psychiatrists when their pretrial evaluation of "not competent" was followed by a hospital assessment of "competent" at the time of the trial. It seemed legally necessary to have on record the fact that a screened incompetent had now responded to treatment and become competent. The law is not comfortable with changing status. The screening psychiatrists resolved this by changing their opinion to "possibly not competent" and informing the attorney that this opinion resulted from a superficial examination and had little probative value. The judges supported

this position and forcefully discouraged subpoenaing of screening staff in order to preserve their time for evaluations.

The other potential problem that had to be considered involved what to do if a defendant's attorney insisted that his or her client be evaluated as an inpatient after the screener had reported the defendant as competent. The screening psychiatrists recommended to the court that if the attorney had substantial evidence, such as an independent evaluation that supported incompetency or insanity, then the court should order further evaluation at the hospital. (This has rarely happened.)

While the Supreme Bench screening program was effective in reducing the overload of felony cases, the regional hospitals, which evaluated most of the misdemeanor cases referred from the district (police) courts, were complaining about an ever-increasing number of court-committed patients. A review of Maryland statistics for 1977 showed that 1,780 individuals were hospitalized for evaluation for competency or responsibility. Approximately 65 to 85 percent of those individuals were eventually deemed to be competent and responsible by the various state mental hospitals. This tremendous false-positive was of major concern to the Maryland Department of Health and Mental Hygiene ("the Department"). The same problem was occurring in other states (for example, Massachusetts, Connecticut, Tennessee) some of which were reporting success with screening programs. The Department began to investigate these programs and develop one of its own, which we will now examine in some detail.[17]

Method

Maryland (23 counties and the City of Baltimore) has a highly diverse population of 4,216,446.[18] A large portion of the population resides in Metropolitan Baltimore and in Montgomery and Prince George's Counties adjacent to Washington, DC. The western section of the state consists of hilly farmland, mountains, and mining country, while the southern tidewater and eastern ocean areas are basically flat farmlands.

The Department's plan was to establish screening teams in each of the state's 23 counties and the City of Baltimore. At first, it was thought the county health department would be the appropriate source of professional help. Another suggestion was to use trained jail personnel to administer the 22-question Competency Screening Test (CST).[19] This latter idea was rejected when the authors of this article, who were also consultants to the state program, reported poor results with CST at the Supreme Bench Medical Office; they believed only trained mental health professionals should do the evaluations.[20] The health department concept did not seem feasible in most jurisdictions because of limited personnel, limited working hours, bureaucratic red tape, and the problems inherent in coordinating the efforts of two or more social welfare (for example, health, mental hygiene, court and jail) systems.

The Department decided to develop a program for the district courts—

municipal or police station courts—since the regional state hospitals were dealing with such large numbers of defendants from these courts of limited jurisdiction. (Subsequently, this program was expanded to include all circuit courts.) It became apparent that not only was there waste of expensive hospital services, but also the courts, particularly the district ones, were not being adequately served. Judges were aware that many of the individuals who came before them "the morning after" an alcoholic bout or a domestic dispute were not necessarily incompetent, particularly after a few days of sobering up or settling down, but were in need of some type of professional service. What the judges really wanted under such circumstances was some professional help in finding a solution to a psychosocial crisis.[21] (In fact, the authors have come to view the district courts of Maryland as "the psychosocial emergency room of the community.") As others have reported, these defendants represent a marginal group in society.[22,23]

The consensus of those involved in developing the program was that it was imperative to have local professionals examine defendants. This meant that innovation was required to "tailor" programs to meet the needs of the individual communities. The general concept was that where possible screening would be done by a local team consisting of a psychiatrist or psychologist and a psychiatric social worker, who would perform a screening evaluation and, in certain cases, make recommendations for disposition. To attract the most competent people, team members would be offered good remuneration ($100 for a competency evaluation and an additional $35 for a responsibility evaluation) and flexibility as to where and, to some extent, when they had to see the defendants.

As the program evolved, three different models were developed. One model was a direct grant to the City of Baltimore, which was developed because of the large volume of cases seen there (four to six defendants per day). The second model, now used in eight counties, was a grant to local health departments to operate and administer the program. These health departments are responsible for contracting with the professionals who are either full-time health department staff or private practitioners. In the remaining 13 counties, psychiatrists or psychologists who are in private practice provide evaluations.

In operating these three models in Maryland, the program employs thirteen psychiatrists, eight PhD clinical psychologists, and seven MSW psychiatric social workers. Great care is taken in selection of personnel and audit of their reports to protect against criticism or bias, prosecutor identification, and so forth.

Defendants must be evaluated within 48 hours of their arrests, and a report must be furnished to the court in writing and verbally, where time is of the essence. The Department has been able to obtain the services of top professionals, thanks largely to the cooperation of the courts, which have rarely summoned evaluators for testimony. Since the inception of the program in 1979, only six subpoenas have been issued. In four cases, after discussion with the judges and the attorneys by the administrative team, the

subpoenas were quashed; in two cases, the evaluators had to testify.

For the district courts, a very important and well-received part of the screening program is the "alternative treatment recommendations." Program planners believe this concept is unique to Maryland and responsive to the court's true needs. These recommendations center on the issue of what social or mental health program can best serve the defendant so he or she may avoid further contact with the criminal justice system. This can represent either an alternative to trial or, after trial, an alternative to incarceration. The screening psychiatrist/psychologist may opt to bring in a social worker to examine treatment needs with him or her and the defendant to provide a viable treatment plan. Whether or not a social worker's services are used, the evaluator must submit alternative treatment recommendations for everyone who is deemed "competent" or "possibly not competent" but not so dangerous as to require hospitalization (that is, outpatient treatment of incompetents).[14,24]

The following case vignettes illustrate some of the options available in these alternative recommendations to the district court:

The evaluation team suggests that the prosecutor consider a stet of the "disturbing the peace" charge against this chronic schizophrenic so that his mother can take him to the community mental health center clinic for his Prolixin, which he previously refused to take. The defendant has agreed to this plan as an alternative to being hospitalized or awaiting a trial.

This chronic alcoholic is willing to try the local "quarter-way program" for the second time. The representative will be available in court.

Mr. and Mrs. Jones, who have both been seen for psychiatric evaluation, have agreed to marriage counseling at Catholic Charities. The team suggests that the court delay the hearing on Mr. Jones's assault charges for 60 days to see if the couple follows through.

The evaluations include screening for responsibility as well as competency even if counsel has not entered an insanity plea. When an evaluator believes the defendant may be eligible for an insanity plea, his report recommends that counsel consider entering such a plea. (This is a decision only available to defense counsel.)

Since the circuit court is more formal that the district court, there is less leeway at the pretrial level and evaluation reports do not include any alternative treatment recommendations.

Results

At its inception in 1979, the Department's screening program was confined to Baltimore—whose numbers and complexities presented the state's greatest challenge. Since 1981, 22 of 23 counties have been included. It is anticipated that the twenty third county will be added to the program during fiscal 1984.

The administrative superstructure is minimal, consisting mostly of part-time personnel. The superintendent of the Clifton T. Perkins Hospital

Center is the director of the program and accepts this responsibility along with his regular duties. The major operations are overseen by the Coordinating Team. The director of the Coordinating Team is the Chief Medical Officer of the Supreme Bench of Baltimore; he and his medical administrator, who serves as administrator, handle the Coordinating Team's major tasks of arranging contracts and consulting with evaluators. These responsibilities represent less than 10 percent of their time. There is a part-time social worker (three days per week) who serve as a coordinator between the program and the state hospitals, and a part-time secretary. Communication among the members of the Coordinating Team and with the evaluators is maintained by telephone and letter, with an occasional meeting. The program was organized in this fashion to prevent the establishment of yet another expensive bureaucratic superstructure to operate a program quite capable of functioning adequately with simple telephonic communication. This, of course, requires the easy availability of people who are knowledgeable about the entire program and various facilities within the state. Much of this is accomplished by the administrator (the medical administrator of the Supreme Bench), who is always available by telephone, 24 hours a day. He is backed by the director of the Coordinating Team and the social worker; they, in turn, are backed by the director of the program. Consequently, no one feels isolated, and there is no need for bureaucratic delays while waiting to make a decision.

Fortunately, at the time the program was formulated, the Medical Service of the Supreme Bench of Baltimore had enjoyed respect and recognition from both the judiciary and the mental health systems in the state for well over fifty years. This, coupled with its basic interest in the program, allowed the members of the Coordinating Team to gain the cooperation of both the executive and judicial branches of the government.

None of this would have been possible without the complete cooperation of the Chief Judge of the Court of Appeals, who is also the Chief Judge for the entire court system, and the Chief Judge of the District Court system. Their leadership encouraged the cooperation of all of the judges (and their clerks) in the circuit and district courts. This fact cannot be overemphasized, as the success of such a program requires the total cooperation of both the mental hygiene system and the judicial system. The mental hygiene system was encouraged to cooperate when it realized that admissions would be reduced.

Another very important factor was the announcement by the Department of Health and Mental Hygiene that it would close all regional forensic beds with the establishment, in 1984, of an additional 80-bed facility at the Clifton T. Perkins Hospital Center. This gave each county greater reason to assist in developing the screening program since without it sheriffs would be required to transport defendants long distances from their homes, increasing their expense. With the screening system, the unnecessary hospitalizations would be prevented.

The actual fiscal 1982 funding for this program was as follows:

Staff	$ 51,046
Direct Services	142,208
Total	$193,254

In the 1982 fiscal year, 1,139 patients were screened at a total cost of $193,254 or approximately $170 per case. Table 1 shows the results of the competency screenings. As expected, about 66.3 percent were found to be competent and required no hospitalization; most of the 31.5 percent considered possibly not competent were hospitalized. (A few who had previously established outpatient treatment contacts were returned to that status.) "Failed to keep appointment" usually referred to patients who were so ill that they had to be committed via emergency evaluation and commitment certificates with a later request by the court to the hospital for a competency and/or responsibility examination.

Table 1. Pretrial Screening Program, Fiscal '82: Competency Findings

	Percent	Number
Competent	66.3	755
Possibly Not Competent	31.5	359
Failed to Keep Appointment	2.2	25
Total	100	1,139

Table 2 furnishes a breakdown by sex, which reflects the expected lower arrest rate of females but also shows a disporportionately high finding of "possibly not competent" for arrested females.

Table 2. Pretrial Screening Program, Fiscal '82: Breakdown by Sex

		Percentage of Total Screened	Number
Competent	Male	56.9	649
	Female	9.4	106
Possibly not competent	Male	21.7	247
	Female	9.8	112

The savings in dollars shown in Table 3—to say nothing of wasted services—was as expected: over 60 percent of the cost of hospitalization was saved. An additional fact frequently overlooked when screening out the competent is that, by avoiding hospitalization, they do not receive the stigmatized label of "mentally ill." It is frequently easier to obtain a job with a criminal record than with a psychiatric record.

That most evaluations for competency (and responsibility) come from the larger urban areas is clear from Table 4, which shows that almost 90 percent of the fiscal 1982 cases were from metropolitan areas. Steadman's finding that many counties had no insanity pleas filed in several years highlights this urban-rural disparity.[25]

Table 3. Pretrial Screening Program, Fiscal '82: Cost Benefits

For 1,139 Patients		
Average cost of hospitalization	$91/day	
Average stay in hospital	7 days	
Cost if no screening program		
1,139 × $91 × 7		$725,543
Cost of 1,139 screenings		$270,696
Total savings		$454,847

Table 4. Pretrial Screening Program, Fiscal '82: Geographic Distribution

Metropolitan Areas	Percent	Number
Baltimore City	70.8	807
Prince George's County (Metropolitan DC)	7.4	84
Metropolitan Baltimore Counties (Baltimore County & Anne Arundel County)	11.7	134
All other counties	10.1	114
Total	100.0	1,139

Discussion

The development of pretrial screening programs that can be done quickly on an outpatient basis not only has prevented unnecessary hospitalization but also has protected the defendant. The challenge is to develop a high-quality system that is not and will not become costly. A statewide system with centralized accounting, and so forth, can also offer opportunities for quality control. Carefully selected and adequately paid screeners require minimal supervisory staff.

The cooperation of the courts can be difficult if the judges are accustomed to sending everyone to the hospital. Therefore, something must be offered to replace this "out of sight—out of mind" position. Educating judges about the possible damage of hospitalization is not sufficient. However, guaranteed quick evaluations, coupled with alternatives that judges might use for those who are competent, represent a very satisfying option. After all, disposition is the area of greatest concern to judges, and they never have received much help with this from the hospital. Support from the judges' superiors is also quite helpful. When all of this is put together, a useful program of pretrial screening, such as that developed in Maryland, can be established. The selection and training of staff are crucial; the criteria used and methods of communication are also important. The results presented for the screening program in Maryland are far from complete: further studies are needed on such issues as the comparative evaluation of the performance of the evaluators from each county, with special attention given to understanding and correcting any disparities that may be found.

Petrila found many disparities between hospitals in Missouri.[26] While comparison with his findings may be a useful check for reliability, it does not touch on the validity of the examiners' results, which represents another area to be studied. Of further interest is a breakdown by offense and diagnosis, and a comparison between our results and those reported by others.[22,23]

Summary

Pretrial screening of defendants for competency to stand trial and responsibility at the time of the crime reduces unnecessary hospitalization. It can be developed on a statewide basis at little cost, resulting in great savings. Such programs should be established in every state.

*As of January 1, 1983 the name of our court was changed from the Supreme Bench of Baltimore to the Circuit Court for the City of Baltimore.

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10. Roesch, note 4 supra, p 49
11. Geller JL and Lister ED: The process of criminal commitment for pretrial psychiatric examination: an evaluation. Am J Psychiatry 135:1:53-60, 1978
12. Personal communication, Conti N, Medical Administrator, Supreme Bench of Baltimore, Baltimore, MD
13. Estimates based on figures supplied by the Md Dept of Health and Mental Hygiene
14. MD. Health-Gen. CODE ANN §12-103 to 106 (July 1982)
15. The Supreme Bench Medical Office is one of the older outpatient forensic evaluative services in the nation. It was established in 1920 by John Oliver, MD and was headed for over 36 years by the late Manfred Guttmacher, MD. Dr. Jonas R. Rappeport has been Chief Medical Officer since 1967.
16. The Supreme Bench of Baltimore City is in the 8th Judicial Circuit in Maryland. It is the court of general jurisdiction or felony court. It is the oldest circuit court in Maryland and the highest of the trial courts in Baltimore. As a circuit court, it handles major offenses; the district courts, located in each police district, handle misdemeanors.
17. Roesch, note 4 supra, p 206
18. U.S. Bureau of the Census, Census of Population (1980), Washington, D.C., 1980
19. McGarry AL et al: Competency to stand trial and mental illness. Washington, D.C.: U.S. Government Printing Office, 1973
20. Unpublished data resulting from two years' experience at pretrial screening at the Supreme Bench Medical Office
21. Personal communication from several of the judges of the district courts

22. Roesch R et al: Evaluating fitness to stand trial. Int J of Psychiatry & Law, Vol 4, 1981, pp 145-157
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