Forensic Services Workgroup – Public Comments

June 23, 2016 – July 12, 2016

June 23, 2016

Comment 1 – Erik Roskes, M.D., DHMH Office of Forensic Services:

From the perspective of DHMH Forensics, there are three concerns that need to be addressed:

1. statutory timeframes are not always consistent with the quality of forensic evaluation work needed to answer the court's question. This can place evaluators in a position of either doing the job quickly or doing it well and doing it completely. When it is done with speed at the expense of quality, sometimes the result is an avoidable admission, tying up a bed that could have been better used in another case, for a more needy patient.

2. There is a misconception that every inmate or detainee with mental illness requires admission to a hospital, and that he or she needs to stay in the hospital for a long period of time.

3. Our system is ill-suited to serve the needs of patients with multiple problems - mental illness, developmental disabilities, cognitive problems, head injuries, etc. Despite our move toward integration, there remains a silo problem not only in our facilities but in our community care sector.

Comment 2 – Erik Roskes, M.D., DHMH Office of Forensic Services:

Bottlenecks:

From a forensic perspective, each decision point is a potential bottleneck: responding to court orders for evaluation, responding to court commitments for admission, courts' timely responding to reevaluations that should end or modify the commitment, courts' acceptance of recommendations for release/discharge (both for competency commitment cases and for NCR commitment cases).

Additionally, in some cases and in some jurisdictions, we have lost sight of the purpose of a commitment as incompetent to stand trial, which is and should be limited to rendering an incompetent defendant competent to proceed with and dispose of his criminal case. Statutory changes have amalgamated a diversion purpose into the competency commitment statute. While diversion is a laudable goal, and is something we should expand and maximize as much as possible, no diversion can be given to a defendant who is incompetent to proceed, until he becomes competent. At that point, his commitment should be lifted in order for the diversion to occur, rather than holding the commitment over the defendant's head as a means of persuading him to accept the diversion. The latter approach at times results in a LOS far longer than needed to discharge the purpose of the commitment, which is to restore competence. This elongated LOS ties up valuable resources that should be made available to more needy patients.

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June 23, 2016 – July 12, 2016

June 24, 2016

Comment 1 – George Kaloroumakis, Wicomico County Department of Corrections:

Addressing the need for a competency evaluation at bond review is a key factor to expedite the process and reduce time in detention centers. Sometimes in the most obvious cases it is not done at that time. PDs at bond review need to know about the individual they are representing.
At the time the eval. is ordered, the new court date should be set within 2 weeks. Comp evals. should be completed expeditiously (& thoroughly) and submitted back to the court for consideration.

We are fortunate, our primary forensic assessor is both thorough and expedient reducing the time we are holding those found not competent.

We routinely monitor the progress of the completed evaluations and ask the judge, PD and SA to expedite the case back for the hearing and they are most cooperative.

Then the waiting game begins for the beds!

All of these measures that require daily follow up should be adopted as SOP so we can fast track those that need hospital intervention. Probably nothing new or that you haven't heard here, but some feedback.

We also have had discussions with our judges about putting those individuals back in a supervised setting in the community on pre-trial, because they have waited so long they are on meds, compliant and stable. Why take up a hospital bed at that point in community intervention is available and effective?

June 26, 2016

Comment 1 – Helen Lann M.D., Beacon Health Options:

• StarTribune - Facing Backlogs. Minnesota Hospitals Develop Housing For Psychiatric Patients Frustrated by chronic bottlenecks in the state mental health system, three of Minnesota's largest hospitals are taking matters into their own hands. Mayo Clinic and Hennepin County Medical Center (HCMC) have cemented plans to develop short-term housing for adults with psychiatric illnesses who may be ready for discharge from the hospital, but need more therapy before returning to their own homes. And in St. Paul, Regions Hospital is exploring plans to develop a 16-bed residential treatment center that will help psychiatric patients after they are discharged from area hospitals.

Comment 2 – Helen Lann M.D., Beacon Health Options:

Bottlenecks: 1) Community Mental Health System volume driven fee for service model makes it difficult to have seriously mentally ill, aggressive, complex needs individuals treated when needed- often not providing urgent care to such individuals when needed- not getting seen soon after discharge from hospitals leading to high readmission rates 2) some individuals getting arrested when picked up by

police rather than taken on EP and involuntarily committed causing backup in jails for individuals who could have been treated in an acute care general hospital, "criminalizing" seriously mentally ill 3) once in State hospital, most (not all) individuals stabilize and no longer meet medical necessity for hospital level care much sooner than actual discharge. Rate limiting steps are waiting for court dates, finishing up forensic evaluations, finding suitable community housing thought to meet judges expectations for conditional release. Lack of readily available housing options and almost no availability of locked step down units without hospital level doctor/nursing where individuals could receive support for transition to community while waiting to go back to court are the biggest causes for bottlenecks.

June 27, 2016

Comment 1 – Captain Michael R. Merican, Maryland Correctional Administrators Association:

Involuntary Commitment process for law enforcement:
There are times when police arrest an individual who suffers from injury or is in mental health crisis. At this point law enforcement is obligated to first seek medical attention at the nearest hospital. Once treatment is provided the offender is taken to the District Court Commissioner of Jail Central Booking as appropriate. In medical instances wherein an offender is admitted to the hospital the police can either "guard" the individual until released or obtain a warrant for the offender to be served at a later date depending upon the severity of the crime of course. What we are finding in the mental health arena is the hospital will make the appropriate assessment and send the offender to jail verses finding a treatment bed. There have been cases when hospitals have written on the discharge sheet encouraging the jail to place the individual on "suicide watch" or return the individual once he/she is released from custody. I have even seen the certification to which hospital the individual should be transferred left blank to be filled in once a bed becomes available meanwhile the offender sits in jail.

Jail Roadblocks:
1. State hospital refuses to accept inmates with coexisting medical problems. Examples include inmates suffering from infection from attempting to remove screws from leg due to hearing voices to such diagnosis of hypertension, diabetes or unable to facilitate blood tests prior to transfer.

2. Court Orders are taking priority over jail commitments (2 doctor signatures, etc) and those in serious need of beds stay in jail longer. Failure of State Hospital to accept and follow the court order in a timely manner.

3. Court ordered competency evaluations issued directly to DHMH result with a quick evaluation of the inmate then a report provided the Judge works well. This is neutralized when a Judge reads the report and issues a commitment order for a competency evaluation then the jail waits for a bed generally to receive the same information. Seems DHMH completes 2 evaluations on the same person.

4. Local inmates with mental health diagnosis who have sex offense charges have "zero" chance of getting a community bed and stay longer in jails. This is also true for dementia or those with "closed head" injuries requiring DHMH care who stay in our jails due to "zero" options.

5. Getting admissions at the State hospitals to answer the phone.

6. The criteria for admission to the State hospital does not seem to involve severity of illness and seems based more so to the type of order.

Solution considerations:
1. Addressing the need for a competency evaluation at bond review

2. At the time evaluation is ordered and completed a time line of 2 weeks (?) should be set for court hearing

3. Supervised setting in community verses jail once offender has been stabilized.

4. Set an admission criteria based upon severity of illness not solely by type of order.

Comment 2 – Cathy Marshall, DHMH-Developmental Disability Administration:

1. When court ordered evaluations have been completed, it may takes weeks or months to secure a court date.

2. After DHMH evaluations are complete, many times the PD or private attorney will request a continuation for independent evaluations.

3. Individuals arrested from other jurisdictions (ie. DC, Delaware) unable to return to their home State and unable to get services in Maryland.

4. Lack of crisis beds.

5. Courts demanding services be put into place by DHMH for individuals who are not eligible for services or funding, either in the BHA system or DDA system.

Comment 3 – Laura Cain, Maryland Disability Law Center:

Global comment: there needs to be the same urgency to get people who do not need hospital level care discharged as there is to get people into a hospital bed. Unfortunately, that is not the case.

DHMH

1. Outpatient/Jail evaluators opining defendants "dangerous" without apparent consideration of whether the person could, with appropriate supports, receive treatment to restore competency in the community. In some cases, the evaluator appears uninformed regarding the individual's current community treatment status – e.g., the individual may already be receiving community BH/DDA services when the charge is incurred and may more appropriately be returned to those services (supplemented as needed). In other cases, community services may be readily available but there's no communication with the evaluator. This lack of knowledge/information leads to unnecessary commitments to hospitals.

2. In some cases, following inpatient commitment, there is a failure to regularly re-evaluate individuals committed as IST so that persons may be more promptly returned to court for legal findings on competency, non-restorability or dangerousness. Instead, too frequently, reports to the courts are issued only at the mandatory intervals. As a result, some individuals may be confined longer than is necessary or appropriate.

3. There is tension/conflict between the mission of treatment teams and the purpose of the IST commitment. The treatment goals are designed to ready the person for discharge to the community, which may be relevant in some cases in terms of where the person should receive competency restoration, but is irrelevant to the goal of either restoring to competence or determining the person cannot be restored. This leads to delays in some cases in which the person may be restored to competency to stand trial, or determined not restorable, but this status change is not reported to the Court because he or she is not yet deemed "ready for discharge to the community." This occurs more frequently in cases involving relatively minor crimes, as the assumption is that the case will be dismissed, stet or NP.

4. Once a person found IST is discharged to the community on conditions of release, there are frequently no further attempts to restore competency. Instead, the person is simply re-evaluated every six months until he or she "times out" based on the maximum period for criminal charges. Thus, rather than a timely resolution of criminal charges (either proceeding through the CJS after being restored to competency or having criminal court jurisdiction end upon finding of non-restorability), people remain unnecessarily bound to court-ordered services, reducing the availability of such services for hospital patients and placing the individual at continued risk of violating a condition and being returned to the hospital.

5. The system at Perkins for moving people committed as NCR through "security levels" needs to be reviewed to eliminate unnecessary delays. Patients are transferred back to maximum security for minor infractions. Due to a shortage of psychologists, patients on maximum security – with arguably the greatest need – rarely get individual therapy even though such treatment is identified as necessary to enable the person to progress.

6. Treatment teams at Perkins refuse to assist with discharge planning (securing community services) for NCR patients found "not dangerous with conditions" by a jury. Thus, people entitled to release remain confined for lengthy periods until and unless an outside entity – such as the OPD or MDLC – intervenes and arranges community services. In some cases, the treatment actively sabotages these outside efforts.

7. People on NCR conditional release are returned to the hospital upon an allegation of violation, regardless of how minor or whether there is any clinical need for hospital-based care. It appears that DHMH does not investigate allegations or evaluate clinical need prior to the person's return, and thus fails to prevent unnecessary hospitalizations. Once returned to the hospital, the individual is pressured/persuaded to sign voluntary admission and waive the 10-day violation hearing. Individuals spend weeks or months in the hospital waiting for a hearing to determine whether there was a violation and, if so, whether the person needs inpatient treatment.

8. Treatment teams too often require the most intensive beds in a residential rehabilitation program for IST/NCR patients despite alternative available housing and mobile services being available for the individual upon discharge.

9. Too many social workers are ill-equipped or unmotivated to work through barriers to discharge for IST/NCR patients (e.g., immigration, insurance issues) and allow people to languish for months and sometimes years beyond the time hospital care is clinically indicated. In some cases, applications are sent only to one or two community providers and if the person is rejected, no further action is taken for lengthy periods of time.

10. Community providers are given apparent total discretion to "cherry-pick" individuals ready for discharge. There appears to be little or no CSA or departmental review of decisions by providers to reject applicants, and no pressure (fiscal or otherwise) placed on providers to reverse decisions where there is no valid basis for denying admission to the program. As a result, many individuals remain stuck in state hospitals long after they have been determined to no longer need hospital-based care or confinement.

Courts

1. There have been instances in which a court commits an individual as IST to a state hospital based on a community/jail evaluation but the hospital treatment team quickly discovers the evaluation was erroneous (e.g., the individual was "malingering" or faking MI symptoms to avoid jail). Some courts refuse to immediately schedule a hearing upon receipt of such reports, ensuring that people who are inappropriate for hospital commitment remain confined for weeks or even months, taking up beds and posing an unacceptable safety risk to other patients and hospital staff.

2. There appears to be confusion as to whether the statute authorizes courts to order an in-patient evaluation over DHMH's objection and, further, whether the court is obligated to have the individual "promptly" returned to jail following the completion of the evaluation in instances where the hospital does not "retain" the person. As a practical matter, hospitals are unable to discharge patients who are competent or do not need hospital care until and unless the court approves. The problem is further compounded by the failure of some courts to schedule hearings within the statutory timelines following commitment of an individual for an in-patient evaluation. This is particularly problematic in instances in which the evaluator determines that the individual is competent or does not need in-patient treatment.

3. After a finding of IST, some courts commit defendants to the hospital for a set period of time (usually 90 days for misdemeanors and 6 months to 1 year in other cases), regardless of whether DHMH agrees with the need for hospitalization. In addition, some courts refuse to allow DHMH to discharge individuals to the community until and unless the court approves the community treatment plan. In both instances, judges are substituting their judgment about clinically appropriate treatment for the judgment of clinicians. In both instances, people remain confined, sometimes for lengthy periods, despite their being no clinical need for continued hospitalization. This happens most frequently in "mental health courts" where some judges improperly use judicial authority granted under the IST statute to get defendants the care that the judges believe they need.

4. Some courts refuse to act on evaluation reports opining that the person cannot be restored in order to keep jurisdiction over defendants released to the community on conditions until the mandatory time for dismissal of charges.

5. Courts generally do not question lengthy periods of inpatient confinement to attempt to restore competency to stand trial, but instead allow treatment periods to match mandatory dismissal of charges. This not only results in bed shortages, but gives the appearance that individuals are being punished for alleged crimes for which they will never stand trial.

6. In general, the statutory process governing NCR release of an administrative hearing followed by a court hearing to rule on the ALJs report is too lengthy. The result is that people ready for discharge remain hospitalized simply waiting for this process to play out. The process also creates a bottleneck in instances involving alleged violation of conditional release. By the time a court reviews an ALJ's findings and recommendations, the person may have spent months in the hospital despite either not having committed a violation or not needing hospital level care.

7. Until a recent Court of Appeals decision, at least one court disregarded the NCR statute and conducted de novo evidentiary hearings following an OAH hearing and ordered continued commitment. While that practice will presumably not occur in the future, it raises questions whether other practices may be occurring that result in unnecessary continued confinement of NCR patients.

State's Attorney

1. There are some ASAs who refuse to agree to dismissal of charges of persons who are not going to be restored to competency and insist upon ongoing "court supervision" of conditional release. In one jurisdiction, the ASA advised DHMH that there was no need to conduct further evaluations to determine competency once the person has been released to the community on conditions. It appears that, too often, the ASAs are complicit in using the authority under the IST statute for purposes that having nothing to do with bringing a defendant to trial. The result is that some individuals remain in community services that may no longer be clinically necessary (and thus not available for people waiting to be discharged from a hospital), while putting them at continued risk of minor violations resulting in unnecessary returns to a hospital.

2. Some ASAs reflexively oppose discharge recommendations and, similar to some judges, demand community treatment plans that may not be clinically necessary or appropriate.

OPD

1. Too many public defenders fail to challenge IST/NCR commitments and rulings/inactions by judges that lengthen hospital stays or periods of conditional release.

2. Some public defenders fail to advise clients arrested on relatively minor charges the consequences of pleading NCR – indefinite and potentially lengthy confinement in a hospital. Many patients advise that they would have rejected an NCR plea had they been given this information.

Forensic Services Workgroup – Public Comments

June 23, 2016 – July 12, 2016

June 28, 2016

Comment 1 – Lauren Campbell, Montgomery County DOCR/MCCF:

We currently refer inmates to the state mental health hospitals who are either certified or court-ordered to have evaluations. A contract forensic psychologist comes on-site at MCCF to assess the status of inmate competency and at times NCR evaluations per court-order. We communicate with admitting hospitals and fax all requested documents to the hospitals regarding the person's physical and mental health. Upon discharge from the hospital to the Montgomery County Correctional Facility, the hospital sends us discharge documents, on most occasions so that continuity of care can ensue. At times this is accompanied by follow-up clinical updates communicated between hospital and correctional mental health professionals. Inmates who are being released from the Montgomery County Correctional Facility or Detention Center back to the community receive community reentry management coverage (PATH or CRES) to include and provide for psychiatric medications/follow-up psychiatric appointments, housing needs, family/friend support, substance abuse rehabilitation if/as indicated and other services as appropriate. This is especially the case for Montgomery County sentenced inmates. During certain instances, court-ordered inmates are released directly from the hospital to the community, and hospital social workers/case managers facilitate the same. It should be noted that CORPS, a newly created HHS comprehensive case management team, now is beginning to cover select inmates with wrap-around services at both DOCR and DHMH hospital facilities. Please note that a comprehensive discharge plan cannot be made if an inmate is bond-posted or released unexpectedly at court.

Comment 2 – Randall Nero, Maryland Department of Public Safety and Correctional Services:

From DPSCS the primary impacted agency is our Pretrial and Detention facility where there is an order for transfer to a DHMH facility by the court. In these situations we cannot provide the level of needed treatment such as forced medication and must attempt to manage the detainee/patient within the facility.

June 29, 2016

Comment 1 – Paula Langmead, Springfield Hospital Center:

Issue: Patient Flow

Bottleneck:
- Communities not accepting patients back from the State hospitals
- Criminalization of the mentally ill

Patients currently in detention (and on the wait list to get into Springfield) were formerly admitted to the State hospital through the Emergency Rooms. They were formerly driven to the ERs by the police and on Emergency Petitions. As the number of mentally ill increased, police departments could no longer have their officers tied up in the ER all day. The rule of thumb became to arrest all of these cases.

Providers are reluctant to fill up their beds with forensic patients, even though many of these patients have only been arrested for trespassing, loitering, disturbing the peace. Their involvement in the non-therapeutic environment of courts and correctional facilities exacerbates their symptoms and raises their acuity. Community providers are reluctant to take forensic population into their RRP beds since they are more difficult to manage than non-forensic mentally ill.

Remedy: Reversing the criminalization of the mentally ill through:
1. Reduction/elimination of charges
2. Discussion/partnership with ERs to avoid the long wait time for police officers
3. More training to providers of homeless services (shelters, soup kitchens, AA/NA, religious institutions) in order for them to identify early warning signs of the need for stabilization
4. Expansion of ACT Team services by Core Service Agencies to allow timely response to escalating psychiatric emergencies

Issue: Safety and Security of State hospitals

Bottleneck:
• Current salary of Security personnel (designated for non-Forensic State hospitals): $22,700 - $37,200 (20 steps in this process)
• Current salary of Security Attendant (designated for Forensic hospitals): $32,300 - $54,100 (20 steps in this process)

Remedy: Designate State facility as forensic.

Comment 2 – Kathleen Dumais, House of Delegates, District 15:

At the conclusion of the first Workgroup meeting, the members were asked to identify "bottlenecks" to providing proper mental health treatment to individuals certified as incompetent to stand trial and a danger to themselves or others. Based on my discussion with Rob Green, Executive Director of the Montgomery County Correctional Services and several others, here are some of the "bottlenecks" from the perspective of correctional facilities and some providers:

1. Lack of beds – It appears that although there is a "statewide system," each jurisdiction is tied to bed space at specific hospitals. For instance, Montgomery County is tied to bed space at Springfield and other jurisdictions are tied to other specific mental health facilities. Individuals from any jurisdiction should be considered for a statewide bed if one exits. Correctional facilities should not be tied to one hospital by "service region." The service regions that DHMH has currently laid out around the state should be reviewed to assure the best utilization possible. Apparently, this has not been reviewed in a long time.

2. At the first meeting of the Workgroup, a "flow chart" was developed from arrest to an individual's certification as incompetent to stand trial/dangerous to themselves or others. The Workgroup should also develop a "flow chart" for what happens from the point an individual is admitted to a hospital to release.

3. When placing an individual on the list for a bed with Springfield, the correctional facility must first certify that the individual has all appropriate medical testing. For example, - Springfield will not take a person that perhaps has not had a TB Test. However, if the person is mentally ill and incompetent, the likelihood of the correctional facility getting the individual to do so is minuscule. Thus, the physical health of the individual deteriorates due to their compromised mental health and refusal of medical care. Or, Springfield/DHMH may require the correctional facility to perform an x-ray (that Springfield/DHMH view as "non-intrusive") but, in fact, the mental health status of the individual complicates the correctional facilities' ability to deal with the individual's physical health. These are just a few examples of the roadblocks/bottlenecks that prevent prompt and needed mental health treatment. The hospitals (Springfield, Perkins, etc) are clearly in a much better position to treat the individual's physical and mental health issues than the correctional facility.

4. Some counties get beds through threat of contempt proceedings by the Court while other counties wait. For instance, Montgomery County may be next on the list only to be bumped by the more vocal complaints of another jurisdiction. Shouldn't the intake list be managed on first come first serve or the acuity of the individual's needs? The law says all individuals will go without delay, but that is not what is happening. Montgomery County (and others) are forced to manage individuals certified to be in a hospital for lengthy periods of time. The correctional facilities are NOT equipped to do this.

5. Dedicated liaison with local jails. This was a practice that existed in the past that was extremely beneficial to patient flow and process. Basicially, an ombudsman position for mental health beds and returns. If this exists today, it is not effectively being utilized. We can only refer to the history of this process, but when Joan Gillece held this position, that was a very effective conduit of communication and problem resolution.

6. Trust – establish trust between local jails and DHMH that ultimately results in the best treatment possible for those experiencing mental illness.

7. Lack of community beds for the seriously mentally ill population – beds must be available and they must be nibble in placement if we are to ever realize criminal justice deflection and mental health decriminalization.

8. Lack of community supervision programs and pretrial release programs across the state. Enhanced utilization of both community programming and pretrial supervision will allow corrections and local HHS Departments to better keep individuals connected to treatment while awaiting criminal justice outcomes, but also providing for good public safety. A reduction in over utilization of bed space by non-violent offenders will allow for better utilization for those in crisis and posing a threat to public safety.

9. The general Workgroup consensus seemed to be that the system needs new beds. The true need is for additional beds across the spectrum and for a plan that acknowledges that there are people who cannot be safely maintained in the community, and SHOULD NOT be maintained in the jail. There is no question new HOSPITAL beds are needed. The Workgroup conclusion should not be that new beds in the community is the sole or primary solution. Of course, additional beds are needed in the community in addition to new hospital beds. But, the Workgroup should be aware that Montgomery County currently has a waiting list of over 100 people for Residential Rehab beds. There was some suggestion at the meeting last week that, at local levels, the Core Services Agencies need to flow people through the

RRP beds faster, moving them to lover levels of supported housing -- which is important. But, Montgomery County's waiting list of over 100 people for RRP is never going to be eliminated simply through 'improved patient flow' or just more Crisis Beds.

10. Additional Crisis Beds could be a solution to the larger problem of criminalization if they were created as part of a Deflection/Diversion model that takes place before arrest. When 'flow' is discussed further, it is important to discuss the initial contact with police where officers make a decision to arrest or not. The discussion on 'bottlenecks' in the system needs to consider the bottlenecks that police encounter that lead them to arrest someone. Jail is now viewed as the path of least resistance or the fastest way to get someone some help. The discussion should also focus on pre-arrest options, not just on post arrest events. There was an acknowledgment of the lack of Crisis Services linked with police to allow for pre-arrest diversion/deflection. The national model of "Restoration Centers" is an example of what the State should consider implementing.

11. On Peer Support - There is strong evidence that trained and certified Peer Support networks are beneficial in helping the mentally ill and substance use populations. There are models for Peer run Crisis Residential beds, which should be considered as an element of an overall strategy. The use of Peers as 'system navigators' is also something that is worth considering.

12. Several individuals I spoke with objected to the perspective that "the efficacy of treating people in jail is a matter of opinion" and that "not every person with mental illness needs to be in a hospital." This perspective opens the door to creating hospital-like capacity in the jails, which in my humble opinion, is completely inappropriate. This is essentially another step down the path of criminalizing mental illness, and officially legitimizing the current reality of jails as psychiatric hospitals. While jails may, of necessity, need to address acute issues, creation of long-term psychiatric treatment capacity cannot be sanctioned. Once this door is opened, it will be a long time before we can close it. If, instead, we start with the premise that NOT EVERY PERSON WITH A MENTAL ILLNESS NEEDS TO BE IN JAIL we might begin to address the more fundamental problems of access to care before arrest as well as diversion points along the Sequential Intercept continuum.

As noted in my opening, these comments reflect my discussions with several stakeholders and/or their specific comments and are offered for consideration by the entire Workgroup.

Comment 3 – Kate Farinholt & Jessica Honke, NAMI Maryland:

When someone experiences a psychiatric crisis or acts out as a result of symptoms of their mental illness, often law enforcement are the first-line responders and too often the result is injury to the officer or the individual. These interactions result in an arrest – not because the individual committed a violent crime, but because officers have few alternatives to resolve the situation. The training provided to criminal justice personnel (law enforcement, corrections, and parole and probation) in local jurisdictions, as well as the critical response protocols and crucial partnerships with local behavioral health care providers, are uneven at best, or are totally absent in many areas of the state. Few local jails or state prisons are adequately equipped or funded to appropriately treat serious mental illnesses such as schizophrenia, bipolar disorder or posttraumatic stress disorder (PTSD).

Housing an inmate with a mental illness costs two to three times the average. Insurers do not cover care during incarceration, leaving the county or state to pay the full cost of expensive psychiatric medications and few have the resources to provide psychotherapy or other treatments. Without appropriate treatment, inmates with mental illness are more likely to act out, rack up additional charges and serve far more time than the general jail population. The result is years of cycling through prisons and jails, shelters, and emergency rooms, which is costly for communities, a burden on law enforcement and corrections, and tragic for individuals with mental illness and their families. Most people leave the system worse off and with fewer options for getting needed treatment and services. The cumulative effect has been a substantial cost and growing burden on "default" systems; especially the criminal justice system.

When diversion is not appropriate, there is still a need to address the behavioral health issues that may have led to the criminal behavior. The ability of the court to commit a defendant to treatment is a very important mechanism, however the period in which a defendant is assessed, and if necessary placed in a treatment facility must be immediate. Long waits for treatment tend to increase the severity of a mental illness and consequently the intensity and cost of the services being provided. Currently, Maryland is "warehousing" people in jails and prisons, who could be living safe, meaningful lives in the community if they were receiving effective treatment. This is unacceptable. Additionally, once a defendant has been placed and completed their treatment there is often a gap in care upon re-entry to the community. There is a decided lack of community-based services, especially for forensically engaged individuals, including housing and intensive case management.

In 2013, DLS identified the need to increase bed capacity for forensic patients in their analysis of the FY2014 Maryland Mental Hygiene Administration (MHA) budget. They reported "the department's relationship with the Judiciary is perhaps the key one in immediate initiatives around hospital capacity. The length of stay at the facilities is increasing. The ability to move forensic patients through the psychiatric hospitals more quickly could have a significant impact on bed utilization and thereby change need. Similarly, the emphasis on community-based interventions rather than institutional treatment is the approach that is considered best for the patient and could further depress demand for those beds." Further, DLS recommended, that the "State could work with other facilities to house forensic patients, look to partner with existing hospital systems and/or academic health centers to develop alternative inpatient capacity, and look at alternative financing mechanisms to replace existing State capacity, all while developing community capacity." Yet, three years later the state has not taken "significant" action to address the deficiency in psychiatric bed capacity or community-based interventions.

Based on the DLS analysis, the Maryland General Assembly withheld funds in the 2014 budget and requested that a workgroup be convened by the department that included various stakeholders to review the average wait times for residential placement in State-run psychiatric facilities, as well as for treatment under the 8-507 orders. Further the workgroup was directed to review and report on the availability of staff and services for court-involved individuals, and to report on any recommendations based on an analysis of this data. This report was submitted to the relevant committees on December 12, 2014. According to the workgroup's report, while average wait times were above the standards that would be required, the median wait times were within the expected limits. Thus, the workgroup concluded, "that the data demonstrated that there were not systemic issues with the forensic treatment system, but rather that there were various outlier cases that needed to be examined in order to make smaller improvements." The workgroup also found that, "while § 3-111 evaluations are in line with

statutory guidance, the fact that the median measure for § 3-105 evaluations is 7 days means that half of all of these evaluations are taking place beyond the statutory guidelines." The final report from the workgroup contained seven recommendations, summarized as followed:

• Add 100 beds to the State-supported psychiatric system;
• expedite the building of the forensics database to better capture the information provided in this report;
• develop Managing for Results outcomes to measure the performance of OFS;
• develop a joint behavioral health and criminal justice system for the identification of high utilizers of services of both systems; and
• increase staffing for psychiatric evaluations, especially at Spring Grove Hospital Center, by approximately 10 FTEs.

DLS noted that, "BHA did not comment on what it would cost to implement these recommendations. While they have said that they do not intend to pursue the addition of 100 beds at this time due the fiscal condition of the State, other recommendations, including the increase in staffing for forensic evaluations, could also have a large fiscal impact". To date, NAMI Maryland is unaware that any of the recommendations have been implemented. Our assumption, based on the convening of another forensic workgroup, is that the recommendations have not been implemented or explored further.

We thank you or the opportunity to provide comments on this very difficult and complex issue. Below we have outlined numerous recommendations to improve the forensic psychiatric services system, increase appropriate diversion of individuals from the criminal justice system, and reduce the likelihood an individual cycles in and out of the criminal justice system.

1. The interactions between law enforcement and individuals with mental illnesses can be managed and resolved in a humane and effective manner depending on the service system design, as well as preparation and training. Maryland has taken steps over the last decade to address law enforcements response to people experiencing a behavioral health crisis through Crisis Intervention Team (CIT) programs. CIT programs are built on local partnerships between law enforcement agencies, mental health providers and advocates. The model involves individuals living with mental illnesses and families at all levels of decision-making and planning. CIT programs typically provide 40 hours of skills training for law enforcement on how to better respond to people experiencing a mental health crisis. Unfortunately, in Maryland, the training provided to law enforcement personnel in local jurisdictions, as well as the critical response protocols and crucial partnerships with local behavioral health care providers, are uneven and inadequate at best and totally absent in many areas of the state.

The successes of CIT programs are well documented, as well as valuable, and often lead to life-saving outcomes for law enforcement, and reduce and prevent officer injury. CIT trained law enforcement officers also use less lethal force and are better at ensuring a safe outcome for the individual and third parties. CIT officers report that because of better coordination with mental health crisis services, they are able to efficiently transfer individuals in crisis to behavioral health care and get back on the beat. Further, CIT programs have also served as a springboard for broader collaboration between the criminal justice and behavioral health systems. Many people who come into contact with a CIT officer have had a history of cycling through emergency rooms, homeless shelters and jails. This cycle of crisis is very expensive. CIT programs reduce arrests of individuals with mental illness in crisis, and improve the

chances that an individual needing mental health care will get care rather than go to jail. Over the long term, these individuals spend more time in the community, rather than in jail or the hospital, saving taxpayer money and even adding to the tax base.

However, it's important to keep in mind that CIT is not just a training program. While one outcome of creating a best practice CIT program is training for law enforcement, training is not the only goal. It's very important to go through the entire process of building partnerships with local law enforcement agencies and behavioral health providers, as well as ensuring community participation to map out the problems and solutions in each community. The International Chiefs of Police (IACP), the Bureau of Justice Assistance (BJA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) released a publication that outlines the scope of the problem, identifies factors that have contributed to current challenges and describes innovative policies, programs and practices that have emerged in the last 10-20 years to provide a foundation from which to begin these conversations and programs (see the Building Safer Communities: Improving Police Response to Persons with Mental Illness document).

2. Statewide implementation of the Sequential Intercept Model. The "Sequential Intercept Model" is a comprehensive approach emphasizing interventions at whatever stage of the criminal justice process a person is, whether pre-arrest, post-arrest, during incarceration, or upon re-entry into the community. It requires all relevant systems (criminal justice, mental health, substance abuse, consumers and families and others) to work together to design and implement strategies to reduce imprisonment and improve treatment and rehabilitation. Interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support.

3. Developing procedures to reduce inappropriate referrals and provide competence restoration services in the community (for select, appropriate defendants) will reduce delays and expenses while better stewarding inpatient resources and better respecting defendants' liberties. Inpatient services that remain should be better standardized across hospitals. Washington State, like Maryland, currently relies solely on inpatient hospitalization for all incompetent defendants, even though such intensive service is necessary for only some of them. A report was released in 2014 to assess and make recommendations to address issues in Washington's mental health forensics system. The Washington report may provide insight on how to reform Maryland's current system. Maryland may also want to consider this type of evaluation. The report can be found at here.

4. Establish statewide stabilization centers; such as:
- New York: https://www.omh.ny.gov/omhweb/facilities/ropc/consumers/forensic.html
- Missouri: http://dmh.mo.gov/mpc/

Further, Maryland established a Behavioral Health Crisis Response System (BHCRS) in 2002. Yet, fourteen years later the system has not been fully implemented statewide. Yet, the need for crisis services continues to grow and the geographical imbalance of resources in terms of those communities receiving crisis services and those that are not—particularly in Southern Maryland, the Mid and Lower Shore and Western Maryland, still persists. As noted in the fiscal and policy note for HB682, the Behavioral Health Administration (BHA) fully acknowledges that "crisis services in each jurisdiction vary considerably, and none of the jurisdictions offer the entire continuum of services. Crisis services in most jurisdictions are not available 24 hours a day and 7 days a week.

A mental health crisis can be an extremely frightening and difficult experience for both the person in crisis and those around them. We know this because we receive dozens of calls every week from individuals with mental illnesses and their families who are in crisis. Loved ones and caregivers are often ill-equipped to handle these situations and need the advice and support of professionals. Further, delays in treatment can increase the severity and duration of the individual's distress, but also as a crisis escalates, options for interventions may narrow and become more costly.

All too frequently, law enforcement is called to respond to behavioral health crises as the only rapid and 24/7 response, and they often lack the training and experience to effectively handle the situation. Conversely, behavioral health crisis teams DO have the training and know-how to help resolve a behavioral health emergency; if they are available. Access to early intervention also stabilizes crises more quickly and at the lowest level of care appropriate. When individuals have access to timely and effective services, they and their families have the opportunity to lead full and productive lives, paying taxes, contributing to society.

Maryland must establish a fully operational BHCRS. Otherwise, high utilization of costly treatment in emergency rooms; high rates of incarceration in jails and prisons; high rates of unemployment and lost productivity will continue. Apart from the clear financial costs to our systems, there are also human costs: loss of hope, damage to families and relationships, lost productivity, and suicide.

5. Maryland can look to other states, such as Texas to learn more about successful jail diversion programs (Jail Diversion Program: Multnomah County, Texas: Mental Health Jail Diversion Project Report). Further, several states have developed successful step-down residential facilities who no longer meet the level of need for hospitalization, but who remain in state custody.

6. Ensure that Maryland has mental health and substance use treatment courts, as well as veteran treatment courts, in every county, to provide effective alternatives to sentencing. Mental health courts can serve a significant role to address the disproportionate number of individuals with mental illness in the justice system. Like drug courts and other "problem-solving courts," after which they are modeled, mental health courts move beyond the criminal court's traditional focus on case processing to address the root causes of behaviors that bring people before the court. They work to improve outcomes for all parties, including individuals charged with crimes, victims, and communities. (Resource to learn more about mental health courts can be found here and information for policy makers can be found here)

7. Work with local jurisdictions directly to implement the National Initiative, SteppingUp, to help advance counties' efforts to reduce the number of adults with mental and co-occurring substance use disorders in jails. Across the nation, many counties are investing huge sums of money to house people with mental illness in jails, with little return for the community in terms of public safety or treatment for people who need it most. Stepping Up, a national initiative provides an opportunity for counties in our state to obtain support in addressing this problem. This initiative has the support of a powerful coalition of national organizations, including NAMI, and challenges counties and local communities to work together on solutions that fit the local community. The goal is to help counties use money wisely, make behavioral health services available and implement programs that keep low-level offenders with mental illness out of jails. Calvert, Harford, Montgomery and Prince George's County have all passed resolutions to convene teams of decision makers and diverse stakeholders to develop and action plan to reduce the

number of individuals with mental illness in their local jails. NAMI has provided guidance on how to start the initiative. Maryland should work to ensure that every local jurisdiction in Maryland has not only passed a resolution, but developed and begun to implement an action plan.

Comment 4 – Chief Judge John Morrissey, Judge Sheila Tillerson Adams and Judge Michael Whalen:

"Significant "bottlenecks" exist in the screening and evaluation of incompetence by DHMH, after an individual has been determined incompetent and ordered admitted to the DHMH, the lack of appropriate less restrictive alternatives for stabilized individuals and the lack of options for community placement. These "bottlenecks" are the direct result of a lack of resources, including both staff and "bed" space, at both the front and the back ends of the current mental health system."

July 5, 2016

Comment 1 – Laura Cain, Maryland Disability Law Center:

Questions and issues asked at the June 30th meeting:

Should evaluations be done in the emergency department or jail?

If a person is arrested and appears to the officers to be in psychiatric crisis, the individual should be taken to an emergency department for evaluation for inpatient admission. More importantly, people in psychiatric crisis who are believed to have committed a minor criminal offense should not be arrested but should be diverted to crisis services or taken to an emergency department for evaluation. Emergency departments should utilize diversion services where appropriate.

What data elements should DHMH be collecting, especially with regard to measuring outcomes?

Persons committed for competency evaluation, by facility and court:

•Length of time to admittance at hospital following court order for inpatient evaluation

•Length of time to complete evaluations where no extension requested by DHMH; number found competent & not competent

•If evaluator opines not competent, percentage of persons also opined dangerous due to mental disorder or intellectual disability

•Number and diagnosis of persons opined not restorable during initial evaluation

•Number of requests for extensions, reasons for request, number of requests granted or denied by courts, number of individuals opined competent prior to being returned to court for competency hearing; length of commitment

•Length of time from completion of evaluation to receipt by court of report

•Length of time from providing court with report until competency hearing takes place, broken down by opinion of competent or incompetent

Persons committed inpatient for treatment to restore competency, by facility and court:

•Number of persons initially committed and ordered to continuing commitment where court made findings of incompetent and/or dangerous contrary to opinion of evaluator and whether independent evaluator testimony/report offered by SA or OPD

•Length of commitment of persons subsequently found competent to stand trial

•Length of commitment of persons subsequently found not restorable by category of mandatory dismissal of criminal charges (less than 3 years, 3 years, 5 years)

•Number of persons ordered to continuing commitment as IST, restorable and dangerous reaching the mandatory dismissal, by category (>3, 3, 5)

•Number of reports sent to court with change of status (competent, not restorable, not dangerous) other than 6-month status reports or for required annual hearing

•Length of time between notice to court of change of status and hearing

•Number of individuals opined competent, not restorable, or not dangerous, returned by court to hospital for development (or further development) of discharge plan

•Number of individuals opined by DHMH not restorable on conditional release and length of continuing conditional release following report of not restorable

•Length of conditional releases by category of mandatory dismissal of charges

Persons committed following NCR plea, by facility and court:

•Length of commitment

•Time to discharge following treatment team's initial recommendation for discharge

•Number of persons granted conditional release but remaining in hospital waiting for required community services, length of ongoing hospitalization

•Barriers to discharge

•Number of persons granted conditional release via jury trial; time to discharge following order for conditional release

NCR status individuals discharged on conditions of release:

•Number of persons returned to hospital for alleged violation of condition(s) of release; type of violation

•Number of persons returned to hospital for a violation, but do not need inpatient care
•Number of persons returned for alleged violation agreeing to voluntary admission; length of voluntary hospital admission

•Time from admission to OAH hearing

•Time from OAH report and recommendation to court order

•Number of persons found to have violated but found not to need hospital commitment

•Number of cases in which exceptions filed by state's attorney and outcome

•Time from admission to release

•Number of hearings to extend periods of conditional release, reasons for request, and outcomes

•Number of persons whose total length on conditional release exceeds five years

With regard to 'Returns to Court':

If the statute is unclear with regard to returning to court, do we want to clarify the meaning in statue?

Yes. We should also clarify whether a court has authority to order person confined in a hospital for an evaluation or whether the Department retains discretion to conduct the evaluation in jail

Should we be tracking the 30 day requirements for setting hearings?

Yes. We should also consider shortening the timeframe. A person should not be confined inpatient up to a month following a determination by the Department that he or she is competent, not dangerous, and/or not restorable

Comment 2 – Erik Roskes, DHMH Office of Forensic Services:

In the last 8 months of FY15, there were 47 hospital warrants requested by CFAP, or just under 6 per month

In FY16 through the first 11 months, there were 78 hospital warrants requested by CFAP, or just over 7 per month

It is not clear if this is a meaningful trend, as the month-to-month numbers vary widely, from as few as 3 in a month up to a high of 11 in a month. We will be tracking this to try to identify trends, but it likely will take several years of organized data collection to be able to do any meaningful analysis.

Comment 3 – Paula Langmead, Springfield Hospital Center:

With regard to 'Return to Court': There are specific cases that have not been able to get back to Court in a timely manner. There are times when a patient is returned to court and the Hospital is expecting discharge, only to have the patient returned. Reasons vary from attorneys seeking delays, the refusal of the court to accept the discharge plan, or the court stating that patient may not be discharged until further notice. Specific examples will be provided to the Work-group on Thursday. Currently there are about 13 patients who are clinically stable and ready for release, and whose criminal commitment has been lifted, but who have not yet been accepted by community providers.

Comment 4 – Paula Langmead, Springfield Hospital Center:

With regard to 'What can the hospitals do':
1-Develop a better relationship with the court system. A good example of this is Judge Eugene Wolfe of Montgomery County. He called after receiving word of the 'census crises'. He said that he understood and would be patient and he had some ideas of how to make things more efficient. He called for a meeting in the Law Library and rolled out his idea. He has called for another meeting in 30 days to see the preliminary data of how the proposal worked. The Judge wants to cut down on any delays in getting the patients back to court.

2-Better data collection for our consumers. Dr. Erik Roskes has developed and is refining a data system to monitor the system as a whole. The additional data elements to be tracked are:
- Original court commitment date/Date admitted
- 1st court date/Rescheduled court dates
- Total length of stay following notifications to the court of an opinion that a defendant previously adjudicated as incompetent is now, in the opinion of the evaluator, competent to proceed.

In regard to patients returning to hospitals due to violation allegations: In FY'15, 16 patients at SHC were returned due to allegations that they had violated the terms of their conditional release, and in FY'16 12 such patients were returned to SHC for the same reason.

Comment 5 – Lauren Grimes, On Our Own of Maryland:

So much of what has been discussed in the first 2 meetings comes back to the need for expanded community crisis services. More and better connected ACT teams, 24 hour stabilization centers, peer respites etc. These represent many of the solutions we are looking for. Robust after care plans ordered by judges wouldn't be a problem if the services were there. We would be able to divert individuals with petty offenses away from hospitalization and incarceration if we had more robust crisis services. I highly suggest we spend time discussing this next meeting.

Forensic Services Workgroup – Public Comments

June 23, 2016 – July 12, 2016

July 7, 2016

Comment 1 – Erik Roskes, M.D., DHMH Office of Forensic Services:

A question was raised in the July 7 Workgroup meeting about the basis for who goes to Clifton T Perkins Hospital (CTP) versus a regional hospital, and how people move between levels of security, i.e. between CTP and a regional hospital.

The first distinction is the charge level. Defendants charged with serious crimes go to CTP, while those charged with less serious crimes go to a regional hospital. Each of the four regional hospitals has an assigned portion of the state, by county. There are exceptions that can be made in a variety of directions, but that's the general principle. (Examples of exceptions include elderly or frail defendants charged with serious crimes, or defendants who are deaf or profoundly hearing impaired.)

People are often transferred from CTP to a regional, and have been for many years. This often happens after a period of time at CTP during which the individual has stabilized. Sometimes this is done to demonstrate to community providers that the patient may be safely managed in a less secure hospital. After a detailed review by the CTP forensic review board, that person may be placed on the "regional transfer list", and at some point is transferred to a regional facility. Lately, this occurs most often when CTP absolutely needs a bed in which to admit and doesn't have anyone they can discharge.

Transferring people from a regional hospital to CTP generally occurs in situations where the patient has demonstrated that he or she is too difficult for the regional hospital to manage. This occurs a few times per year. There is a requirement for an administrative hearing (H-G 10-807).

July 10, 2016

Comment 1 – Clarissa Netter, Consumer Advocate:

Make recommendation that 1/3 or more upcoming vacant beds be utilized for newly not competent to stand trail consumers; create an orientation committee to include: clinician, social worker, residential staff, and peer support specialist.

Comment 2 – Clarissa Netter, Consumer Advocate:

Create a policy that would require ALL forensic after-care plans to include the following State of Maryland funded, peer-run/led programs that promote recovery and wellness, for the forensic consumers who re-enter or are in the community: Completion of a Wellness Recovery Action Plan (WRAP), introduction to a Wellness & Recovery Center and/or Recovery Community Center of their choice, Completion of a psychiatric Advance Directive; and for the provider of services to complete training with the Anti-Stigma Project of On Our Own of Maryland to reduce stigma and become educated on culturally sensitive & diversity issues.

Forensic Services Workgroup – Public Comments

June 23, 2016 – July 12, 2016

July 11, 2016

Comment 1 – Captain Michael R. Merican, Maryland Correctional Administrators Association:

Jail Recommendations: First we must understand there is a significant difference between jails and prisons when addressing this issue from a jail perspective. Jails are not designed for this target population and we have limited personnel to deal with mentally ill folks from a clinical perspective, absent the obvious of segregation and mixing persons who are sentenced verses pretrial. Understandably sick people do not need to be in jails or prison environments. Now I will move on to recommendations based upon our work group discussions:

1. Interaction prior to or in lieu of arrest is critical towards effective population management. This will require increased community services which I might add are virtually non-existent in some locations. Support and assistance to include the need of increased local practitioners, housing and aid to our local hospitals. Also community providers should not be permitted to arbitrarily refuse to accept forensic patients if this process is going to work.

2. Persons under certification or court order evaluation should not be accepted or held in the confines of a jail regardless of any other recommendations.

3. Expanding the Inpatient/Outpatient forensic evaluation process is a good opportunity for bottleneck reduction. We must be cautious not to become over reliable on Tele-Health as my personal experience finds there still remains a significant need for "one-on-one" physical communication between the client and clinician. Providing Tele-Health in all jails will assist in maximization for expediting evaluations but there needs to be an individual on the other end to do the assessment. There will be a need for increased numbers of evaluators to maintain timeliness and effectiveness.

4. There must be a standardization for patient acceptance. A Judicial order must be followed but also remember there are some folks languishing in our jails who are considerably more in need of treatment than those being directed by the courts.

5. Centralizing DHMH Forensic process is a must. Jail inmates should not be discriminated by jurisdiction for service. There should be a single point of contact, single point of admission and a structured discharge and transfer policy. Courts/Jails/DHMH should be conversing weekly regarding the status of persons within their respective custody, and any decisions for extensions or return to jail.

6. In today's day and age of technology there is absolutely no excuse why data collection and sharing from an interoperability standpoint is not occurring within our disciplines. The DPSCS and the Courts have spent a significant amount of resources toward this subject and it needs to become a priority of the Governor's Office.

7. Medication over Objection Issue... Jails and Prisons have found themselves to be the mental institutions within their respective jurisdictions. However unfortunate the use of medication over objection cannot apply as we are a jail and not a hospital. Many of us do not even have the appropriate clinician available if it were an option. There comes a time with certain inmates/patients for the need of physical restraint to prevent harm to themselves or others. Providing the course of conduct is to

continue maintaining these folks in a jail or prison environment then certain conditions should apply to humane medication over physical restraint. Jails would proffer a more appropriate hospital setting is most optimal over medication within the confines of our jails and prisons.

8. Privatization Issue....Jails outsource many operational disciplines to include inmate medical and mental health programs. If the State cannot afford additional beds from a budgetary perspective then perhaps privatization of some or all DHMH disciplines may be a viable solution. I am really not familiar with all the processes for such a transition but no doubt some laws may need to be changed and fee for service issues worked out. I am sure I have missed a few other obstacles toward this effort

Comment 2 – Laura Cain, Maryland Disability Law Center:

Preventive Diversion

1. Fully fund a coordinated and comprehensive crisis services system that is available 24/7, including recommendations made by the BH Advisory Council (per legislation).
2. Work with police departments across the state to develop crisis intervention teams (CIT) to divert people from arrest to supports/services including, if necessary, hospital-based care. At a minimum, work with police departments statewide to develop appropriate behavioral health training for officers and to encourage oversight of police actions – e.g., monitor number of arrests on low-level charges of persons exhibiting BH needs and develop plans to divert people to ERs and crisis services instead.
3. Fund and implement ER diversion programs to reduce inpatient admissions and connect people to appropriate community-based services. Individuals who frequent ERs and are either evaluated and released or admitted for a few days and released (in either case are NOT getting connected to community services) are at high risk of getting picked up by police and ending up in the CJS.
4. Provide funding for intensive initial and ongoing engagement of individuals who have histories of disconnecting (voluntarily or involuntarily) with services. This is a critical missing piece that unfortunately leads to unnecessary arrests and hospitalization, as well as leading many to call for increased coercion and restriction on liberties.
5. Substantially expand housing first model and other proven/promising permanent housing models that do not make housing contingent on treatment.
6. Support and fund peer-operated crisis houses for individuals who do not need medical care.
7. Continue to develop and fund innovate programs for treatment of early-onset psychosis. Recognize that studies repeatedly show that a substantial number of people do not respond to medications and/or have better long-term outcomes not using medications and support alternative approaches to supporting people (e.g., Open Dialogue).

Initial Competency Evaluations

1. In 2012, the Department's consultant documented inappropriate commitments for competency evaluations that resulted in defendants with no clinical need for hospital-based evaluations being court-ordered to a state hospital. The consultant also documented delays resulting in defendants being held beyond the 7-day evaluation period (excluding cases in which the Department requested an extension). He noted that there were varying statutory interpretations regarding whether the Department has "discretion to determine where to

conduct court-ordered forensic evaluations, including whether and how long to confine defendants for those evaluations." He recommended that, if the Department lacked this authority, the statute should be amended. The Department should immediately collect and review data to determine if the problems observed by its consultant are still occurring at Spring Grove (and whether they are occurring at other facilities statewide). If so, there should be further discussion on whether the statute needs to be amended. At a minimum, there should be consideration of specifying a very short time frame for the current statutory requirement that defendants be "promptly returned to court" at completion of the evaluation.

2. Not all individuals found CST following an evaluation should be returned to/remain in jail. Collect and review data to determine whether persons arrested on non-violent offenses are inappropriately held in jail awaiting trial and, if so, work to increase releases to the community (RORs).
3. Improve communication between evaluator and Department at the time of competency evaluations to ensure that evaluator is provided with available community service options (which in some instances are already in place for the individual) to decrease number of people opined dangerous for lack community services. Assign a point person at the Department responsible for connecting people to community services to avoid unnecessary hospital commitments.
4. Related to #3, the Department should review all evaluations to ensure that evaluators are not improperly applying an overly broad" dangerous" standard, i.e., basing opinion on factors unrelated to risk to public safety.
5. The OPD should implement policies on appealing court findings on competency, restorability and dangerousness.

Treatment to Restore Competency to Stand Trial

1. It is essential that the statute be amended to provide maximum treatment periods based on clinical research, i.e., not correlated to the mandatory dismissal of charges. Confining people or keeping them under conditional release orders up to the mandatory dismissal periods of 3 or 5 years, violates civil rights, is contrary to good clinical practice, and wastes precious resources.

Research exploring rates of competency restoration consistently demonstrates that 80-90% of defendants committed to a hospital for competency attainment treatment are restored to competency within 6 months, with a majority restored within 90 days. For example, a study conducted in Washington found that 77.7% were restored within 90 days, with an additional 19.12% restored between 91-180 days. The remaining defendants treated for more than 180 days (3.31%) had average lengths of stay in the hospital of 231 days. Accordingly, twenty states have statutory treatment limits of the lesser of the maximum sentence of the charged crime or 12 months, with an additional three states having a maximum ranging from 15-18 months. Many of these states have short initial confinement periods (45-90 days), with the possibility of additional short periods of treatment orders following a hearing up to the maximum. The National Judicial College's Best Practices Model similarly limits treatment to attempt to restore competency to stand trial of defendants charged with a felony to a maximum of one year, with the initial period limited to 120 days and the possibility of granting 60-day extensions up to a total of 365 days. For those charged with a misdemeanor, the maximum restoration period is the lesser of 120 days or the maximum sentence for the charged offense. In all cases, the person may be restored or determined not restorable earlier than the end of the commitment period.

Recommendations:

- Amend the statute to adopt either the time frames under the National Judicial College's Best Practices Model or those of another state with similar provisions -- short initial treatment period with the possibility of one or two additional short extensions, up to a maximum of the lesser of the maximum sentence for the charged offense or twelve months.
- Persons charged with misdemeanor charges (e.g., trespassing) should not be committed inpatient for restoration treatment (though they could be referred for civil commitment, if appropriate). There should also be a review of defendants charged with 2nd degree assault involving physical contact that does not result in injury (or charges of attempted assaults), and classifying those defendants as ineligible for competency commitment but eligible for civil commitment if appropriate).
    - Given the low likelihood of defendants with significant cognitive impairments being restored to competency (estimated to be approximately 30%), consider precluding competency restoration attempts except in cases where the person is charged with a crime of serious violence, consistent with the greater state interest in bringing the person to trial.
    - The Department should immediately devise a policy for all state hospitals setting clinically appropriate periods for treatment that track the literature. The policy should provide clear guidance on determining whether there is a "substantial likelihood of restoring the person in the foreseeable future."
    - The Department should conduct a clinical review of all persons committed to a state hospital or under conditional release for longer than six months and identify those who, pursuant to policy, are not substantially likely to be restored in the foreseeable future. Reports on those identified as not restorable should be immediately forwarded to the courts. The Department should continue review of commitments at 90-day intervals.
    - The Department must ensure that treatment teams understand that the purpose of commitment is to attempt to restore competency to stand trial so that treatment goals are limited and consistent with that purpose.

2. The aftercare plan provision in the IST statute is sometimes (often?) being used to get persons arrested on minor offenses the community services that the judge believes are beneficial. This takes time to set-up and prolongs – in some cases significantly - inpatient LOS. Because these orders are frequently extended up through the mandatory dismissal of charges period, resources that may no longer be necessary for the individual unavailable to others. These practices are inconsistent with the purpose of restricting people's liberties for a period of time to attempt to restore competency to stand trial, and interfere with the Department's ability and responsibility to properly allocate limited resources according to clinical need.

Recommendations:

- If the evaluator determines that there is a substantial likelihood that person may be restored to competency in the foreseeable future but there is no clinical need for hospital-based care, the court must make these findings in the absence of any contrary expert evidence introduced.
- If the Department determines that there is a clinical need for supervised residential placement, the Department shall secure such placement within a short, specified

timeframe. If the person is not yet Medicaid-eligible, the Department should fund the community treatment until eligibility issues are resolved.
- Aftercare care plans submitted to the court should focus on services needed for competency attainment. The absence of beneficial supports, e.g., housing or benefits, should not delay discharge. Instead, the Department should assign a case manager to the individual to help secure additional supports or benefits as needed after the person is discharged.
- The Department and defense counsel must challenge court orders continuing inpatient commitments due to the absence of services demanded by the court but not clinically necessary.

3. There should be system-wide training on:
   - The narrow purpose of the IST statute;
   - Best or evidence-based practices and standards on treatment to restore competency to stand trial;
   - Appropriate limits on attempts to restore competency consistent with the literature;
   - The unique needs of persons with TBI

NCR

1. The Department should review the flow at Perkins to identify and reduce bottlenecks within that facility.
2. The Department must ensure that non-pharmaceutical treatment, such as trauma treatment and individual therapy, is available on a timely basis.
3. There should be a time limit on keeping people under NCR status, e.g., the average length of time served for persons convicted and sentenced for the same crime. If the person remains hospitalized at the end of that period, the commitment should convert to civil. The period could be shorter in instances where the person is discharged and completes the period for conditional release.
4. Individuals who prove eligibility for release on conditions at a jury hearing must have the support and active participation of their treatment team in securing needed community resources.
5. Conditional release plans should not include restrictions that are not applicable to the individual. Although this has improved in recent years, there are still plans that include blanket prohibitions, e.g., no consumption of alcohol for individuals who do not have a history of abusing alcohol or drugs.
6. The system for addressing alleged violations of conditions of release needs to be reviewed and reformed. Possible fixes include:
   - Absent an emergency, the Department should conduct an investigation and arrange for a psychiatric evaluation of the person to determine whether hospital-based care is clinically necessary. If hospitalization is not clinically indicated, the person should remain in the community and any appropriate additional or alternative supports and services should be secured. If the person does need hospital care and agrees to voluntary admission, the hospital should control the discharge in instances where the alleged violation is minor.
   - The Department should not request extensions of conditional release for individuals who have complied with conditions for the entire term.
   - All persons working with individuals on conditional release must be intensively trained on behaviors related to trauma to minimize reporting of violations that are trauma-based and

can be rectified through support that is trauma-informed. For example, if a person misses appointments, rather than simply reporting this as a violation, understand that it may be based on fear related to prior traumatic events and work with the person to develop solutions.

7. Based on comments made by both inpatient and outpatient treatment providers, it appears that Maryland is not providing quality programming for forensic patients. It is not enough to add hospital staff or incentivize providers to admit forensic patients into their program. If staff are ill-equipped to serve this population, we are setting people up for failure (both staff and forensic patients). The Department should identify and implement best practices and allocate the resources necessary to allow state hospitals and community providers to attract qualified staff.
8. Also based on the comments, it appears that there are evaluations incorrectly concluding that the person is NCR, leading to commitments of persons whose actions are not due to a mental disorder or intellectual disability. There have been longstanding complaints from hospital staff that people exhibiting "criminal behavior" that is not subject to psychiatric treatment are causing significant problems and placing staff and patients at risk of harm. The Department should conduct a review and provide training for evaluators.
9. The solution to the bottleneck problem is not to simply open "step-down" units on the hospital grounds. "Parking" people on a non-medical unit for often lengthy waits would ease the current pressure being applied by the judiciary, but would also remove the pressure to improve the flow from hospital to the community. However, if this is a recommendation the Department intends to adopt, it is critical that the step-down placements be clinically necessary and time limited.
10. Expand community services; develop and expand specialized programming (e.g., TBI); develop protocols for matching individuals with providers; review provider rejections for appropriateness and have authority to override rejections.

July 12

Comment 1 – Paula Langmead, Springfield Hospital Center:

Issue: Immigration Issues Immigration/documentation Issues have become an obstacle to discharging a patient back to their community.

Immigration from terror stricken territories have high incidences of PTSD and other traumas. These necessitate additional mental health services in State Hospitals which prolong their integration into the community. Cultural diversities, complicated by language barriers, necessitate increased education for staff to be able to effectively treat and communicate with this population. There are more than a dozen patients currently at our hospital that are known to have documentation/immigration issues that impact their ability to be discharged and aftercare planning. Immigration/documentation issues become obstacles in moving patients back into the communities from our hospital in a timely manner. Patients enter the state hospital system from the detention centers in many cases without their documents because they are lost or they cannot be located. These documents include green cards (permanent resident cards), passports, birth certificates, and certificate of naturalization paperwork. The entire process of reacquiring these documents is tremendously time consuming as well as costly. In many cases, our patients do not know their "Alien Number, or A Number as it is also known. The first step then becomes to get the Alien Number, which necessitates arranging an Info Pass appointment in

Baltimore which the patient must be able to attend. After getting the A Number, an application to replace the missing documents must be completed and mailed. Typically after several weeks staff are sent back an appointment date for a Biometrix Appointment in Baltimore City, again which the patient must attend, in which they are photographed and fingerprinted. Subsequently it takes 6-9 months or longer, on average for the documents to arrive, even when expedited.

There are no providers willing to take patients that are green card holders, even after going through the lengthy process of acquiring a green card. This is due to the fact that although many green card holders are eligible for Medical Assistance, they are usually not eligible for an income such as SSI/SSDI which becomes a "deal-breaker" for most all providers as far as accepting them into RRP.

Comment 2 – Paula Langmead, Springfield Hospital Center:

Issue: Safety and Security of State Hospital

The number of forensic admissions to the hospital has increased from 32% in FY 2007 to 92% in FY 2016. The complexities of dealing with this challenging forensics population indicates that changes need to take place to improve the safety and security of the facility. These include a critical need to upgrade security infrastructure and to increase staff salaries in order to recruit clinicians capable of delivering the necessary level of care for these forensically ill individuals.