Forensic Populations and the Department of Health and Mental Hygiene

Report to the General Assembly
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Prepared by the Department of Health and Mental Hygiene and the Judiciary

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INTRODUCTION

Across the country, the number of individuals with a major mental illness,[1] substance abuse or alcohol addiction, or with co-occurring mental illness or mental retardation with substance use disorder,[2] who are in criminal justice settings, is higher than it is among the general population. Approximately five percent of the U.S. population has a serious mental illness, compared with approximately 16 percent of the prison or jail population, according to U.S. Department of Justice reports.[3,4] Most researchers agree that 75-80 percent of the defendants entering the criminal justice system have a substance abuse disorder.

Maryland reflects the national trend. Law enforcement, courts, and corrections officials are encountering people with mental illnesses or addictions at increasing rates. This is a population that is often homeless, unemployed, and with multiple medical issues. It is a population that gets caught in the revolving doors between hospitals and the criminal justice system which was neither designed nor equipped to handle the multiple problems presented by the group. It is undisputed that the seriously mentally ill are often vulnerable in a detention or correctional facility, either as the victim of attacks or because they may provoke attacks. If not properly medicated and treated, the symptoms of the illness may be exacerbated. The incarcerated mentally ill offender is frequently unable to earn good time credits or participate in programs available to other detainees or inmates, e.g., work release, and will serve all or most of his/her sentence, only to be released to the community without services. The high recidivism rates compared with populations without mental illness are well documented.

Resources of the Department of Health and Mental Hygiene (Department), the Judiciary, and other criminal justice partners are being taxed, thus necessitating a need to increase and better utilize resources to address this public health and criminal justice crisis. The Judiciary and the Department have a long-standing commitment to better

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[1] The definition of serious mental illness (SMI), as established by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), is "having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and resulted in functional impairment that substantially interfered with or limited one or more major life activities."

[2] An individual with co-occurring disorders (COD) has both a mental illness and a substance use disorder. From a treatment perspective, both disorders are primary. Although the disorders may impact each other, neither are merely symptoms of the other.

[3] U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (2000). *Prison and Jail Inmates at Midyear 2000.* Washington, DC: Beck, A.J. & Karberg, J.C.

[4] U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (1997). Correctional *Populations in the United States 1997.* Washington, DC. These numbers will be updated based on the upcoming BJS report on people with mental illnesses in prisons and jails.

handle the needs of the forensic population. Maryland drug courts have been in existence for over thirteen years, and the Judiciary has established mental health courts and mental health dockets in several jurisdictions. In addition, an Office of Problem-Solving Courts was established within the Administrative Office of the Courts. The Mental Hygiene Administration (MHA) has implemented some diversion programs at the local level. Nevertheless, the Judiciary believes that a major barrier to diversion is the inability, especially for those without insurance, to promptly access health care and other services necessary to maintain the forensic defendant in the community. In addition, stable housing, which includes supervised housing, assisted living, and residential rehabilitation, are critical components of the continuum of care and are in extraordinarily short supply. For example, the average wait for placement in residential rehabilitation program, for a person with mental illness, in Baltimore City is two years, and the average wait for placement in a residential substance abuse program for defendants with co-occurring disorders exceeds four months.

The Judiciary and the Department recognize that there is a need for greater consistency in the Department's approach to the Court-involved person. There is also a need for better coordination between agencies, when a defendant has needs that cross agency boundaries, and for improved communication and cooperation between the Department and the criminal justice system. If we are to move the system forward and achieve mutual goals, there must be cooperation and collaboration, including sharing of expertise and resources, between State agencies and other members of the criminal justice system.

This report's primary recommendation is that an office dedicated solely to forensics[5] be created within the Department. When this report was discussed with the Office of the Courts' Committee on Problem Solving Courts- Mental Health Oversight Committee, the idea of a DHMH Office of Forensic Services was eagerly promoted by the committee members, including the Office of the Public Defender, Office of Parole and Probation, Judicial and court personnel from various jurisdictions, and consumer advocacy organizations. It was the opinion of the non-DHMH participants of the committee that the Department has lacked direction regarding forensics, with separate administrations taking different approaches to the criminal defendant. It was suggested that this office would be responsible for all court-committed individuals, whether committed to MHA, DDA, or ADAA, and would serve as the single point of entry into DHMH. The Office could facilitate the Department's effort to develop a triage system that will provide for a coordinated response from the three administrations. The office would also serve as the liaison to the Judiciary, the Office of Problem-Solving Courts, and other criminal justice partners. The proposed office should be responsible for the development and implementation of policies and regulations involving the criminal

[5] Forensics for purposes of this Report, would include responsibility for adults committed to the Department for evaluation and /or treatment pursuant to competency to stand trial and criminal responsibility statutes, Title 3, Criminal Procedures, Ann. Code of Md, and pursuant to substance and alcohol abuse statutes, Health General §§ 8-505- 8-507, Ann. Code of Md. It will be within the Department's discretion whether juvenile forensics should also be included within this office.

justice system. This will promote coordination within the Department and permit the participants in the criminal justice system to have one identified contact to resolve issues and coordinate change. Such an office would enhance efficiency and increase accountability according to the participants of the Mental Health Oversight Committee. The Department agrees with the goals of a DHMH Office of Forensic Services and is exploring the specific structure and responsibilities. The Judiciary believes that this office or individual must have sufficient authority to enable cross-agency decision making and resource utilization.

The second recommendation is the need for additional funding for treatment, services, or other resources for the defendants with mental illness, developmental disability, and/or substance abuse There must be a sufficient number of qualified service providers offering the appropriate level of care and treatment, and there must be adequate funding for the services. This continuum of care includes non-traditional health care services such as a range of housing types from supervised housing, supported housing, assisted living, halfway and recovery houses, to independent living, job training, and employment opportunities.

The Department and the Judiciary firmly believe that defendants who may be safely and appropriately maintained in the community should be diverted from incarceration. Studies support community placement, demonstrating that mentally ill and mentally retarded defendants who are diverted from incarceration to an appropriate level of community-based services have a lower recidivism rate than those who are not diverted. Diversion is best viewed as a continuum with "sequential intercepts," or diversion opportunities, from pre-arrest to sentencing and even post-sentence incarceration. At times, comparatively brief hospitalizations may serve as a least restrictive alternative to incarceration, and may be a helpful means to a community placement. There can be no effective diversion without the range of services, the funding, or the coordination and collaboration we have described. The Judiciary agrees with the MHA and the Committee's Report, filed pursuant to HB 281, 2007 Legislative Session, pertaining to the components of a comprehensive mental health delivery system, and the components necessary for diversion from the criminal justice system. A similar exercise should be performed with regards to services needed to accomplish diversion from arrest or incarceration for individuals with alcohol/substance abuse or developmental disabilities.

This report provides background information collectively on forensic issues within MHA and DDA because of the similarities in the statutes. Separately, it provides background information on forensic issues within ADAA. Finally, the report makes several recommendations for improvement.

DEVELOPMENTAL DISABILITIES ADMINISTRATION
AND
MENTAL HYGIENE ADMINISTRATION

The MHA and the DDA are charged with the responsibility of evaluating defendants for competency to stand trial and criminal responsibility. If the defendant is found to be incompetent to stand trial and dangerous or not criminally responsible due to mental illness or mental retardation, the court may commit the defendant to DHMH for care and treatment. The statute and agreed upon process for evaluations provides that the defendant is first seen by a screener, and then, if necessary, further evaluation is performed at a DHMH facility. A court may find that due to the severity of the mental illness or retardation, the defendant may be endangered by confinement in a correctional setting, and thus may order the Department, at the Department's discretion, to either immediately evaluate the defendant or immediately confine the defendant in a medical facility. The following table (Table 1) shows the number of Court-ordered evaluations for the past seven years.

Table 1
Court Ordered evaluations for competency or criminal responsibility

FY	Pretrial screenings	comp only-facility		responsibility-facility	
	comp and/or responsibility				
2000	1239	293		342	
2001	1199	289		352	
2002	1298	342		393	
2003	1228	594		274	
2004	1144	MHA 344	DDA 13	MHA 373	DDA 13
2005	1206	MHA 345	DDA 29	MHA 337	DDA 11
2006	1334	MHA 406	DDA 57	MHA 342	DDA 26
2007	1399	MHA 421	DDA 52	MHA 362	DDA 17

Data from MHA Office of Forensic Services and DDA.

If the Court finds that the defendant is incompetent to stand trial (IST) and is a danger to self or the person or property of others due to mental disorder or retardation, the Court may order the defendant committed to the Department and transported to the facility the Department designates. If the defendant is committed due to mental retardation, the statute requires that DDA provide the care and treatment the defendant needs. The commitment continues until the Court finds that the defendant is either competent to stand trial, no longer a danger, or that there is not a substantial likelihood that the defendant will become competent to stand trial in the foreseeable future. The following table (Table 2) shows the Department's opinions as to competency to stand trial and the number of defendants opined competent due to treatment (tx). The data does not include the number of defendants actually found to be incompetent to stand trial by

the Court. However, both the Department and the Judiciary believe that the vast majority of defendants opined by the Department as incompetent were found to be incompetent by the Court. In addition, it is agreed that the vast majority of defendants ordered to the hospital for evaluation required hospital level treatment or observation.

Table 2
DHMH opinions in Evaluations for Competency to Stand Trial

FY	# evaluated as IST	# comp due to tx
2000	135	97
2001	93	129
2002	105	129
2003	82	103
2004	MHA 100 DDA 8	138
2005	MHA 80 DDA 22	135
2006	MHA 117 DDA 23	138

Data from MHA's Office of Forensic Services

If the Court finds the defendant *not criminally responsible* (NCR) due to mental retardation, or mental illness, and there is no finding that the individual would not be a danger, as a result of mental disorder or mental retardation, to self or to the person or property of others, if released with or without conditions, the individual is committed to the Department. If the individual is NCR due to mental illness, the law provides that the defendant is committed to the Department for "institutional inpatient care or treatment." If the individual is found NCR due to mental retardation, the "Health Department shall designate a facility for mentally retarded persons for care and treatment of the committed person." Crim Pro § 3-112, Ann. Code of Md. The following chart reflects the number of defendants opined NCR and the percentage of all of the NCR evaluations ordered represented by those opined by the Department as NCR. Data is not available as to actual court findings; however, the Department and Judiciary agree that the Department's recommendation is adopted in most cases.

Table 3

Fiscal Year	Number Opined by DHMH as NCR	Percentage of Evaluations
2000	102	30
2001	112	32
2002	103	26
2003	102	32
2004	MHA 114; DDA 3	30
2005	MHA 91, DDA 0	26
2006	MHA 109; DDA1	32

Data from MHA's Office of Forensic Services

The defendant remains committed to the Department and in a DHMH facility until the Court finds that the individual will not be a danger as a result of mental illness or mental retardation to self or the person or property of others if released. The length of stay for a defendant committed as NCR is significantly longer than for a civil patient. The Court may impose conditions to ensure that the individual would not be a danger in the community based on, or in part, or plans created by the Department. These conditions are set forth in a "Conditional Release Order," and compliance with the Order is monitored by the DHMH Community Forensic Aftercare Program (CFAP). There are presently more than 600 individuals previously found not criminally responsible on conditional release being monitored by CFAP. There are approximately 50 individuals found not competent but not dangerous on pretrial release being monitored by CFAP. These 700 individuals' compliance with court orders is monitored by a staff of three social workers.

The impact of the competency and responsibility statutes is quite significant for both MHA and DDA. For MHA, the volume of cases is much greater than for DDA. The demand on hospital and community resources is huge. Currently, more than 50 percent of the psychiatric beds operated by MHA are occupied by court-ordered individuals. MHA operates seven psychiatric hospitals: Clifton P. Perkins Hospital, in Howard County, Walter P. Carter Center in Baltimore City, Spring Grove Hospital Center in Baltimore County, Springfield Hospital Center in Carroll County, Eastern Shore Hospital in Dorchester County, Upper Shore Community Mental Health Center in Kent County, and the Thomas B. Finan Center in Allegany County. All the facilities, except Upper Shore, serve court involved persons. The percentage of beds occupied by forensic patients has been increasing, mostly because the number of beds operated by MHA has decreased due to budgetary and staffing issues. However, with the increased development of mental health courts, early identification, and diversion from incarceration initiatives, increased demand for evaluation and treatment services for the defendant with mental illness or a developmental disability can be anticipated. Although MHA has made a concerted effort to try to divert some court-ordered defendants by offering the individual a civil admission in exchange for dismissal of the criminal charge, this change of legal status still requires a State-operated bed.

In addition, MHA has expanded resources to serve court involved individuals in the community. The offered services permit diversion from incarceration and hospitalization. Community mental health services are provided by private mental health care providers or local health departments on a fee-for-service basis. MHA, without additional resources, has begun to implement diversion programs in the jails. In addition, MHA funds community mental health services to the uninsured population either leaving jail, prison or hospitals, to serve as a bridge until Medicaid and other entitlement may be obtained. The ability to obtain community services is often a factor in a State's Attorney's decision to prosecute or nolle pross a charge, or a judge's decision as to whether incarceration or commitment to the Department is necessary. Without adequate funding and prompt availability of community services, it is likely even more individuals with mental illness will be incarcerated or court committed to the Department.

The demand on DDA for admission to State residential center (SRC) beds[6] is not as great in numbers as it is on MHA, with only a small percentage of SRC beds occupied by Court-committed people. However the impact of an admission to a State residential center is significant because the beds are not readily available. Over the past 20 years, DDA has downsized State residential centers considerably. In accordance with legislative policy, it is a long standing practice to emphasize services in the community. DDA currently provides services to approximately 22,000 individuals in the community (through a network of community providers) and approximately 350 individuals in State residential centers. DDA continues to discharge individuals from SRC's into appropriate community services as the resources and funding is available. There are currently approximately 40 court involved individuals in SRC beds. DDA maintains four State Residential Centers including the soon to be closed Rosewood Center in Baltimore County; Potomac Center in Washington County, Brandenburg Center in Allegany County, and the Holly Center in Wicomico County. Only 12 percent of the SRC beds are occupied by the forensic population, with the majority residing at the Rosewood Center. However, some of the voluntarily admitted or non-court ordered residents at the Rosewood Center were, at one time, Court-committed defendants whose charges were later dismissed.[7] These individuals may exhibit dangerous or otherwise unacceptable behavior that prevents discharge from the SRC into appropriate community services.

In January 2007, the Department implemented a ban on all admissions to the Rosewood Center due to an unsatisfactory review by the Office of Health Care Quality. As a result, the Department has implemented a policy to appropriately place defendants committed to the Department with mental retardation or who may have mental retardation in a DHMH facility. Defendants have been placed either at the Potomac Center or in a state psychiatric facility when appropriate. This has proven to be very problematic for a number of reasons. The Potomac Center is not designed to be a secure setting, and therefore, may not be appropriate for defendants with serious charges. The individuals with more serious charges have been placed at Perkins Hospital or other MHA facilities. The location of the Potomac Center in Hagerstown makes it difficult for families or legal counsel from the Baltimore metropolitan area to visit. The distance also

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[6] State residential center means a place owned and operated by the State that provides residential services for individuals with mental retardation and who, because of mental retardation, require specialized living arrangements and admits 9 or more individuals with mental retardation. HG §7-101(p), Ann. Code of Md

[7] Pursuant to Crim Pro 3-106 (d), if the Court finds a defendant not competent to stand trial and not likely to become competent in the foreseeable future, and is a danger to self or the person or property of another because of mental retardation, the court may order the defendant be confined a resident in a DDA facility for 21 days, for the initiation of civil admission proceedings under §7-503 of Health General, Ann. Code of Md. The admission process, as set forth in Health General §7-502 et. seq, Ann. Code of Md., requires a finding by the Secretary of DHMH and the Office of Administrative Hearings, that

1. the individual has mental retardation,
2. needs residential services for the individual's adequate habilitation,
3. and there is no less restrictive setting in which the needed services can be provided that is available to the individual or will be available to the individual within a reasonable time after the hearing.

presents problems for transitioning individuals from various jurisdictions (i.e. Anne Arundel, Montgomery and Prince George's County and Baltimore City) back to the community. Even more troubling to the Judiciary and defense counsel is the Department's decision to place some defendants with mental retardation, and no active symptoms of mental illness or not otherwise needing inpatient psychiatric level of care, in State psychiatric hospitals. While the Judiciary appreciates the Department's problem with Rosewood, in the opinion of the Judiciary, the use of State psychiatric hospitals for the individual with mental retardation is both legally and clinically questionable and is unacceptable.

Although relatively few individuals in SRC's are court committed, the individuals do require specialized services that are different from the "average" SRC resident and present problems when allocating the few community dollars available. According to DDA, there are clinical and behavioral differences between the forensic population and the non-Court involved residents of the SRC's. The Court-involved SRC residents tend to be higher functioning than non-Court involved residents. The average forensic resident has mild to moderate mental retardation, and most non-Court involved residents have moderate to severe mental retardation. Elopement is rare among non-Court involved residents, but escape is a risk for forensic residents. It is interesting to note that some of the forensic residents were on the DDA waiting list for services before becoming involved with the criminal justice system.

Language in the competency and criminal responsibility (NCR) statutory schemes, as well as the statute and rules governing pretrial detention, give trial courts considerable authority to direct placement to DDA. The NCR commitment statute provides that if a defendant is found NCR due to mental retardation, "the Health Department shall designate a facility for mentally retarded individuals for care and treatment of the committed person". Criminal Procedure Article §3-112. According to Sec. 3-106(b) (2), after a finding of IST, "if a Court commits the defendant because of mental retardation, the Health Department shall require the Developmental Disabilities Administration to provide the care or treatment that the defendant needs". Due process precludes the continued jail detention of a person found by a judge to be incompetent to stand trial.[8] Thus, absent the ability to implement a community-based service plan for those individuals found incompetent or not criminally responsible who would not pose a danger in the community if certain specified services were in place, the Court is left with no option but to commit to the Department for residential care, defendants who would pose a risk to self or others in the community. DDA, because of limited resources, and a long waiting list, is inhibited in its ability to develop community-based service plans in a timely manner.

[8] Crim Pro §3-106, Ann. Code of Md, provides a defendant found by the Court to be incompetent due to mental retardation and because of mental retardation a danger to self or the person or property of another may be committed to DHMH for placement in a facility that DHMH designates, and that DDA is required to provide care or treatment that the defendant needs.

Some defendants found to be incompetent and dangerous due to mental retardation do not meet the definition of mental retardation[9] used for the purpose of "civil" admission to a residential center or for eligibility for services, e.g., Asperger's syndrome, or traumatic brain injury. Nonetheless, DDA must plan for these defendants, including funding and arranging services and monitoring the provision of those services. This subgroup of forensic individuals also creates a quandary for DDA when the Court finds that a defendant is not restorable and commits to the Department for civil admission. If an Administrative Law Judge later finds that the defendant is not eligible for admission because he/she does not meet the admission criteria, including the definition of "mentally retarded", there is no legal authority to retain the defendant. In addition, some of the defendants are eligible for "Support Services only" from the DDA which prohibits DDA from offering residential services to them. Many of these defendants are homeless, without family, and unable to care for themselves without assistance.

In the opinion of the Judiciary, DDA must accept from the onset that this type of defendant is in the custody of DHMH, by virtue of the Court commitment, and is the responsibility of DDA. DDA is required to initiate prompt planning and implement appropriate community services. DDA must be able to expeditiously access funding for individualized services to cover the needs of these defendants "who fall between the cracks."

[9] The DDA uses the AAIDD (formerly AAMR) definition of mental retardation. That definition is in its 10th incarnation and was last updated in 2002. The definition is as follows:
"Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18.
Five Assumptions Essential to the Application of the Definition:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors.
3. Within an individual, limitations often coexist with strengths.
4. An important purpose of describing limitations is to develop a profile of needed supports.
5. With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation generally will improve."

Table 4

DDA Administration	REPORTING PERIOD			
	Aug-07	Sep-07	Oct-07	Nov-07
Total served in DDA system	22,173	22,415	22,271	22,257
Total SRC population	335	336	336	335
SRC Average Daily Population	336	335	335	334
Forensic SRC Admissions	4	2	1	2
Non-forensic SRC Admissions	0	0	1	0
Forensic SRC Population	38	39	39	37
Non-forensic SRC Population	297	278	298	298
Number of people on Waiting List	16,415	16,607	16,788	17,091

DDA's State Stat information.

In addition to cost to DDA, when considering the overall cost of providing service to the mentally retarded forensic population, one must factor in the cost to society, if no services are provided. The expenses of arrest, processing, incarceration, adjudication, criminal justice costs associated with prosecution, defense, trial and the predictable re-arrest are considerable, in addition to the trauma and expenses incurred by victims. In some instances, special housing within the detention center or prison must be arranged. The effects of prison socialization for this developmentally disabled population and its potential for increasing antisocial behaviors and addiction should also be considered.

ALCOHOL AND DRUG ABUSE ADMINISTRATION

Most researchers agree that approximately 75-80 percent of the defendants entering the criminal justice system have a substance use disorder. This statistic holds true for the forensic population as well, and is reflected in those defendants described as having a co-occurring mental illness or mental retardation and a substance use disorder. In order to effectively treat this co-morbidity, evidence-based practices call for integrated treatment addressing both conditions. Research also demonstrates that the longer an individual remains in treatment, the greater the chance of maintaining sobriety. There is no doubt that treatment produces positive outcomes and that if the defendant is able to be successfully engaged in treatment, the long term gains are far more beneficial and cost-effective than the expense of incarceration.

The Maryland Judiciary has a long history of efforts to implement programs that will divert individuals from incarceration, who can be safely supervised and treated in the community. DHMH and the Judiciary agree that in order to fashion sentences that meet sentencing goals of punishment, deterrence, and rehabilitation, and to further diversion strategies, the Courts must have ready access to an appropriate level and type of treatment services, including residential treatment and integrated residential and community-based treatment for co-occurring disorders. Without treatment, the defendant with a history of alcohol or substance abuse is likely to continue cycling through the criminal justice system, emergency departments, and social service agencies. The current system of substance abuse care does not allow ready access because of allocation of limited resources. The ADAA's ability to provide services is limited by its budget which is insufficient to purchase the treatment slots needed to meet the demand. ADAA cannot create treatment slots without increased budget allocations commensurate with the service costs.

Criminal defendants may be referred for assessment of, and placement for, substance abuse treatment in several ways. Offices of Parole and Probation have the capacity to either perform or to refer probationers for substance abuse evaluation and treatment. In addition, some jurisdictions have assessors, funded by the local substance abuse agency or the Health Department, that work with the Court. Local jurisdictions have latitude as to what services it will buy with State and local funding. Thus, some jurisdictions have elected to purchase residential treatment slots. Drug Courts in some counties and the Baltimore City Felony Drug Initiative are able to access a limited number of substance abuse beds for defendants participating in those programs. Therefore, there are a number of portals through which defendants may enter drug treatment programs.

It is the opinion of the Judiciary, this is an incredibly confusing and difficult "system" to negotiate, where one must first determine what type of bed, if any, may be available the soonest e.g. a a local bed or a state funded bed. Furthermore, each of the described portals has inherent problems. Many defendants are not appropriate for probation, either because of the nature of the crime, the length of the criminal history, or history of prior violations of probation. It takes time to go through the probation process of evaluation and placement, and the Court loses control over the process. The judge simply delegates the task of obtaining treatment to the local Parole and Probation office and doesn't know the result, unless and until, the violation of probation occurs. In addition, outpatient treatment through Probation is primarily viable for low level offenders whom the judge believes can be adequately served in an outpatient setting. Unfortunately, research demonstrates that 50 percent of probationers violate the order of probation. With regards to Drug Courts, many defendants are not eligible for specialized court, where those courts exist. Regardless of the portal one enters, the local beds, where they exist, are quickly filled and remain filled. Suffice it to say that the demand for substance abuse treatment grossly exceeds the availability. Without the alternative of treatment, incarceration may be imposed. And while incarceration may temporarily

remove the offender from the community, it usually does not benefit society in the long term.

There is only one statutory provision, Health General § 8-505 et. seq, available to the Judiciary to *order* ADAA to evaluate a defendant, recommend the level of care needed, and to promptly place in the recommended program The statutes underwent a major revision in the late 1980's and were again revised in 2005. Both revisions resulted from long discussion and debate between the Department, the Judiciary, and other criminal justice partners. Compromises were made and procedures for implementation, including draft forms, were developed by a workgroup consisting of the Director of ADAA, District and Circuit Court judges, Parole and Probation, the Office of the Public Defender, and the Office of the State's Attorney. The Administrative Office of the Courts and the Conference of Circuit Court Judges approved the protocols and forms. Health General §8-505 authorizes the Court to order the ADAA to evaluate a consenting defendant to determine whether, by reason of drug or alcohol abuse, the defendant is in need of and may benefit from treatment. The report, which must be submitted within seven days, must include the level of treatment recommended, the recommended placement, and the estimated date of admission. The ADAA-approved assessor[10] determines amenability for treatment, the level of care needed as determined by the American Society of Addiction Medicine criteria, and the program which should provide the treatment. If placement is recommended, pursuant to HG 8-507, the judge may then commit the defendant to ADAA for placement in the recommended program. The law requires ADAA to "facilitate the prompt treatment" of the committed defendant. The definition of "prompt treatment" is the subject of debate between the Judiciary and ADAA. However, because of the delays in placement and other difficulties in using this law, it is generally reserved for defendants who the judge believes requires residential treatment, and but for the opportunity to receive the necessary treatment, would receive a jail or prison sentence. It is used primarily for defendants with a history of convictions, probation violations, and treatment failures.

In FY 2007, there were 1,357 evaluations ordered pursuant to HG 8-505. A total of 888, or 65 percent, were from three jurisdictions: Anne Arundel County, Baltimore City, and Baltimore County.

[10] Not all substance abuse assessors are approved by ADAA to conduct § HG 8-505 evaluations

Table 5

8-505 EVALUATIONS	
Jurisdiction	**Total**
Allegany	1
Anne Arundel	247
Baltimore City	**496
Baltimore County	145
Calvert	8
Caroline	29
Carroll	41
Cecil	19
Charles	21
Dorchester	6
Frederick	55
Harford	36
Howard	16
Kent	7
Montgomery	74
Prince George's	81
Queen Anne's	40
Somerset	4
St. Mary's	6
Talbot	11
Washington	3
Wicomico	11
TOTAL	1357

Data Source: ADAA
**Data Source: Baltimore Substance Abuse Systems, Inc.(BSAS)

According to ADAA, in FY 2007, there were 522 commitments for drug treatment pursuant to HG 8-507. Four hundred one (401) individuals were admitted to treatment. One hundred forty-two (142), or 35 percent, were admitted to Level III.3 (long-term residential). Two hundred thirty (230), or 57 percent, were admitted to Level III.5 (therapeutic community). Ninety-two percent of all admissions were accounted for by these two levels of care. Below is a chart showing the statewide distribution of HG 8-507 commitments.

As previously mentioned, the majority of Orders are from Baltimore City, Baltimore County, and Anne Arundel County. One would expect the larger urban jurisdictions to be the more frequent users of the statute. With regard to Montgomery County, judges report that they are able to access their own local services without resorting to the use of HG §8-507, which they find to be slow and frustrating.

Table 6

8-507 COMMITMENTS	
Jurisdiction	**Total**
Anne Arundel	128
Baltimore City	394,**
Baltimore County	50
Calvert	2
Caroline	27
Carroll	29
Cecil	5
Charles	5
Dorchester	6
Frederick	30
Harford	10
Howard	9
Kent	6
Montgomery	10
Prince George's	29
Queen Anne's	10
St. Mary's	3
Talbot	4
Washington	1
Wicomico	3
TOTAL	522

**Data Source: BSAS, Inc.

Baltimore City is only one jurisdiction, but its numbers require specific attention. As seen in the chart below, the number of 8-507 placements since 2001 has increased over 1000 percent. Although not as dramatic, other jurisdictions have also seen an increase in the use of this statute. It has become clear that this statute is used by the judiciary when there is insufficient access to treatment in the jurisdiction. When a jurisdiction has insufficient resources for this population, the judiciary relies on the statutory requirement for admission.

Table 7

Baltimore City § 8-507 Commitments

2001	35 Orders
2002	59 Orders
2003	44 Orders
2004	54 Orders
2005	120 Orders
2006	248 Orders
2007	394 Orders**

**Data Source: BSAS, Inc.

Unlike MHA and DDA which operate facilities, ADAA does not operate substance abuse programs. ADAA funds jurisdictions to operate substance abuse treatment programs. ADAA distributes over 90 percent of its funding to local jurisdictions to operate substance abuse programs and/or purchase treatment services from private providers. Less than 10 percent of ADAA funding is actually retained by ADAA for direct contracting with providers, and almost all is allocated for residential

treatment for individuals committed under HG §8-507. With this model of grant disbursement, the local jurisdictions may contribute funding to the purchase of substance abuse services, which expands treatment availability. Based on their local jurisdictional plan that defines local funding priorities, some jurisdictions have designated ADAA and local funds to provide services for the HG §8-507 defendants committed by their respective courts. The ADAA retains the oversight and coordination of statewide placements into residential treatment Admissions for statewide beds are orchestrated through an ADAA Criminal Justice Services unit.

In the opinion of the Judiciary, the multiple funding streams for substance abuse treatment are confusing, and there are jurisdictional differences in the availability of treatment. If a defendant is committed to the Department for residential treatment under HG 8-507, the treatment may be paid for by the county or the State, depending upon whether the county has allocated funds for the service or whether a county slot is available. If a county-budgeted residential slot is not available, the individual may receive services in a slot paid for by the State. This is especially true for individuals requiring co-occurring services. Thus, the door through which one enters, as well as the jurisdiction of residency, may have an effect on how quickly one may obtain services, especially residential care.

The following chart shows the percentage of admissions from all criminal justice sources. As shown below, almost half of all funded treatment slots are used to serve those involved with the criminal justice system.

Table 8
All levels of care

2007 ADMISSIONS			
	Funded		
County	CJ	Non-CJ	Percentage of CJ
Allegany	292	951	23.5%
Anne Arundel	1,746	1,699	50.7%
Baltimore County	1,254	1,875	40.1%
Baltimore City	5,352	7,137	42.9%
Calvert	1,101	451	70.9%
Caroline	172	47	78.5%
Carroll	367	664	35.6%
Cecil	424	109	79.5%
Charles	777	452	63.2%
Dorchester	232	131	63.9%
Frederick	617	1,296	32.3%
Garrett	155	114	57.6%
Harford	208	306	40.5%
Howard	194	115	62.8%
Kent	230	581	28.4%
Montgomery	1,107	2,066	34.9%
Prince George's	584	752	43.7%
Queen Anne's	219	85	72.0%
Somerset	182	169	51.9%
St. Mary's	337	585	36.6%
Talbot	232	76	75.3%
Washington	823	288	74.1%
Wicomico	670	185	78.4%
Worcester	472	853	35.6%
Statewide	492	867	36.2%
TOTAL	18,239	21,854	45.5%

Source: ADAA

The need for long-term residential treatment is only partially reflected in the number of commitments for treatment pursuant to HG §8-507. Resources for this population are limited by ADAA's budget allocation. The consequence of the allocation policy is the wait for admission incurred by the defendant. The following chart shows the wait time for those with and without a co-occurring substance abuse and mental health disorder. In both circumstances, admission is delayed due to insufficient funding for treatment slots and the resulting scarcity of co-occurring treatment slots. The ADAA is aware of the statutory requirement of prompt placement. However, DHMH maintains that any definition of prompt placement must be considered within the context of ADAA's budget allocation. DHMH further opines that through its oversight and coordination functions, the ADAA streamlines the admission process so resources are used in the most effective and timely way.

The Judiciary maintains that inclusion of the word "prompt" in the statute clearly and unambiguously emphasizes the legislative intent to have placement available without delay. In addition, the Judiciary does not share ADAA's perspective on the efficacy of its oversight and coordination. Although, the HG §§ 8-505- 507 statute is the only tool

currently available to the Judiciary to effectuate this type of treatment with any certainty,[11] it is the opinion of the Judiciary that many judges are reluctant to use the law because of the lack of clarity in the estimated admission date, the burden that falls on the Court to obtain information regarding the placement, and inconsistency in obtaining progress reports and discharge plans in many jurisdictions.[12]

The statute provides for the commitment of the defendant to the Department. In the Judiciary's opinion, ADAA has delegated oversight duties to local jurisdictions and is reluctant to hold providers accountable. This is the source of great tension between the Judiciary and ADAA. In 2006, it became necessary for members of the Judiciary to meet with then-Secretary McCann about the chronic problems with ADAA's implementation of the statute. It is the Judiciary's understanding that an agreement was reached and Secretary McCann directed ADAA to place committed defendants within 90 days. It is ADAA's understanding that Secretary McCann stated that if a defendant had not been placed within 90 days, he would look at using other resources, including taking resources from jurisdictions and making them available for judicial placements. Utilizing either interpretation, the Judiciary believes the Department has failed to deliver and implement the requirements of the statute in a timely manner. The Judiciary believes the delays are inordinate and are a disincentive to treatment. This problem is particularly serious for those defendants assessed to require residential treatment who suffer from mental illness as well as a substance use disorder.

Table 9
Non-Co-Occurring HG § 8-507's
Hargrove District Courthouse, Baltimore City

	Average Wait/Days	Shortest/Days	Longest/Days
May 2007	23.2	14	41
June	22.8	13	35
July	18.8	16	24
August	32	15	63

Table 10
Co-Occurring HG § 8-507's
Hargrove District Courthouse, Baltimore City

	Average Wait/Days	Shortest/Days	Longest/Days
May 2007	94.2	83	103
June	73	21	104
July	106	104	108
August	107.5	106	109

[11] Upon occasion, the Division of Parole and Probation may be able to arrange residential treatment for a probationer, but the judge may not directly order this type of treatment, and the judge does not know when, or if, the defendant will be admitted.

[12] In 2006, the Judiciary supported proposed legislation that amended the Health General Article, requiring the ADAA to prepare and be bound by the contents of the required discharge plan presently in COMAR. The ADAA opposed the proposed legislation, and it failed to pass.

This data, derived from the Office of the Public Defender, highlights the wait times for defendants at the Hargrove District Court in Baltimore City for patients involved in the HG § 8-507 process committed to ADAA and awaiting placement in the program that ADAA's agent recommended. Not only are mentally ill defendants held longer than other defendants, but the Department of Public Safety and Correctional Services is paying to house, feed, and provide medication for a defendant, whom the judge is willing to place in a treatment program. The Judiciary believes that the fiscal implications of this problem should be strictly scrutinized.

CONCLUSIONS

The criminal justice system offers few treatment alternatives to incarceration. The demand on the Department for services for the court involved person is substantial. However, there is no evidence that the demand on resources is inappropriate. All the studies show that if there are resources available, then treatment works and diversion from inpatient care and incarceration are possible. There needs to be sufficient services available to address the needs of the criminal defendant with mental illness, developmental disability and/or substance abuse addiction. By having services readily available in the community, there may be the opportunity for diversion. Diversion may include diversion from a costly inpatient hospitalization, a residential substance abuse treatment, or incarceration. In addition, there needs to be a more coordinated system of care for individuals with serious mental illness and substance use disorder. Currently there are three administrations, MHA, DDA and ADAA, with three varying levels of involvement with the criminal justice system. It is not uncommon for the Defendant to require the services of two or even three administrations. Coordination between administrations and coordination with the other participants of the criminal justice system is necessary to better utilize scarce resources. Coordination among the agencies when developing integrated services for individuals in the criminal justice system is necessary to improve outcomes and better utilize resources.

RECOMMENDATIONS

1. Creation of a DHMH Office of Forensic Services. It is the opinion of the Judiciary and members of the Office of the Courts' Committee on Problem Solving Courts- Mental Health Oversight Committee, that an adequately funded and staffed office within the Department be developed with the responsibility of overseeing the compliance with the various statutes, authorizing the commitment of criminal defendants by the Courts, developing consistent policies and practices, and coordinating the overlapping services required by the forensic population would provide the clear lines of authority necessary for accountability, reduce the time involved in obtaining community placement and services, and increase overall efficiency. Currently, the three separate agencies, with three separate directors, three separate lines of authority, and three separate budgets are

mandated to provide evaluations, treatment, and planning for Court-committed individuals. There are overlapping needs, and a duty to be responsive to the Court. A single office would foster open communication and the level of collaboration needed to truly fulfill the mission of the Department as it relates to the Court-committed population. The Department agrees with the goals set forth for a DHMH Office of Forensic Services, and is exploring the specific structure and responsibilities. In addition, specific initiatives DHMH is examining include:

a. Standardize evaluation process. A single office would foster the ability to have one gate of entry into being evaluated and served by the Department. Defendants would be seen as a forensically involved individual, and not necessarily, as an ADAA forensic person or MHA forensic person. By combining the expertise and facilitating access to the resources of each administration, a more comprehensive evaluation and diversion plan may be formulated. The administrations have in fact initiated discussions on how to implement a standardized process, utilizing the data banks, a joint assessment process, plan implementation, and a mechanism for evaluation of the effectiveness of the process.

b. Development of data banks and sharing of data banks, as permitted by state and federal confidentiality statutes, to facilitate diversion activities. MHA has implemented DataLink in Baltimore City which permits the identification of detained defendants who have received mental health services from the Public Mental Health System. MHA seeks to expand the program to other jurisdictions as funding permits. ADAA has set up its SMART data bank in Baltimore City. Access to all treatment histories by the new Office or the evaluators in the jails, would facilitate the development of service plans.

c. Improved response/communication to the Judiciary by the administrations is necessary. A single person or office may foster better communication with the Judiciary and other participants of the criminal justice system.

2. Increased funding and development of services. As stated throughout this report, the key to successful diversion is the availability of and access to services. Many criminal defendants lack insurance for services. Many may be eligible for entitlements, but there will be a delay in obtaining eligibility. It is difficult for the police to exercise their discretion in appropriate cases to divert the individual from the criminal justice system if the individual does not have immediate access to hospitalization or a suitable alternative placement. Currently, there are an insufficient number of community psychiatric beds, resulting in overly stringent application of the standards for involuntary commitment and delays in emergency rooms while waiting for a public bed. There has been no increase in the number of community psychiatric beds in the past 10 years, while beds have increased for many somatic illnesses. Likewise, the Judiciary is of the opinion that the funding

for drug and alcohol programs for Court-committed defendants is insufficient, and the number of high quality residential programs providing integrated treatment for co-occurring disorders must be dramatically increased.

3. Improved compliance with statutory requirements and oversight of programs assigned responsibility to provide court ordered services. ADAA is responsible for implementation of HG §8-505 et seq. This responsibility includes oversight of the contractual service providers and promptly sanctioning noncompliance. Providers are required to submit regular and complete progress reports and to develop viable discharge plans. ADAA should recognize the community program's responsibility to ADAA and the court- to provide court requested information regarding compliance with the conditions of the order, and be prepared to sanction providers for failure to comply with ADAA contractual requirements. At a minimum, ADAA must insure that the State is receiving the services for which it has paid.

    a. ADAA is mandated to facilitate prompt treatment, which in no event should take longer than 90 days.

4. Implementation of a forensic training curriculum under the auspices of the proposed DHMH Office of Forensic Services which specifically addresses the various commitment statutes and the expectations of the Court. It would be useful for all criminal justice partners to participate in the training. Well-trained judges, State's Attorneys, defense counsel, probation agents, psychiatrists, psychologists, social workers, substance abuse assessors and counselors would not only improve and expedite service delivery to the forensic population and defendants committed for substance abuse evaluation and treatment, but would also improve everyone's compliance with the law. The training would provide a vehicle for discussion of issues of mutual interest, areas of agreement and disagreement, and practical considerations in addressing the needs of the shared population. This joint endeavor would, hopefully, foster a better understanding of different perspectives and would assist in identifying gaps in the service delivery system, and encourage problem solving and the development of creative ways to enhance diversion opportunities.

5. Promulgation of forensic regulations should be developed by DHMH, with the opportunity for comment by the criminal justice partners before publication. Present regulations in effect for DHMH should be reviewed and revised, if necessary, to specifically address the Court-committed population. Regulations could be used as the vehicle to develop a cohesive, comprehensive DHMH approach to forensics. The Judiciary also seeks that ADAA's regulations should clarify that the statutory mandate of prompt placement must be carried out according to the legislative intent. At a minimum, the agreement of the former Secretary to place within 90 days should be incorporated into the ADAA regulations.