MENTAL HEALTH PROCEDURES

PREPARED BY:
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District Court of Maryland
2014

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BALTIMORE CITY MENTAL HEALTH COURT

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Section 1.1

Mission and Background

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MISSION

The Mental Health Court for Baltimore City will strive to humanely and effectively address the needs of individuals with mental disorders who enter Baltimore's criminal justice system. The court is committed to focusing resources, training and expertise on the unique needs of these individuals. All participating agencies have agreed to collaborate for the purpose of improving outcomes for this special population while increasing public safety. Most importantly, the court and partner agencies will make every effort to encourage the involvement of the individuals in all aspects of the process.

BACKGROUND

Increasingly large numbers of mentally ill people are entering the criminal justice system each year. The criminalization of people with mental illness is a growing social problem, which is a burden to both the criminal justice system and the public mental health system. It is estimated that 16% of the incarcerated population suffer from a serious mental illness, and at least 75% of those have a co-occurring substance abuse problem. The traditional approach to processing criminal cases often creates a barrier that prevents the court from identifying and responding to the unique needs of the mentally ill offender. These offenders frequently spend unnecessary time in jail, and, lacking access to mental health treatment services on release, tend to be re-arrested and cycle through the system over and over again. The needs of the community are not addressed, the costs to the taxpayer escalate, and the defendant continues to have the same problems and associated risks as before.

In Baltimore City, the mentally ill offender population is quite large and the problems are extreme. All of the agencies touched by this group recognized the need to take action to change the course, and every agency, without exception, committed time, energy and services to develop a plan that would address the particular needs of our jurisdiction.

In 2002, the Mental Health Court began by consolidating on one docket all cases in which a competency evaluation was ordered. There were approximately 250 of these cases each year. Previously, the cases were scattered among nine different criminal courts and multiple judges, prosecutors and defense attorneys. This consolidation allowed for case processing by a dedicated team of individuals trained in mental health law who follow the cases throughout the process. The Office of the Public Defender and the Office of the State's Attorney agreed to provide resources to the court. This partnership laid the groundwork for an expanding mental health court docket. All involved agencies identified the need to design and commit to a coordinated effort based on collaboration with recognition of the individual responsibility of each agency.

FAST (Forensic Alternative Services Team) staff, which is composed of masters' level licensed clinicians, plays a key role. They assist with the identification, assessment, planning, and in some cases, monitoring of the defendants. The Department of Parole and Probation and Pretrial Detention and Services have each dedicated one agent to

work with the Mental Health Court. FAST staff assists these individuals by providing clinical guidance as needed. The Baltimore City Police Department has also participated in the effort by agreeing to expedite the execution of any warrants that are issued.

Section 1.2

Procedures

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OBJECTIVES

The Baltimore City Mental Health Court program represents an effort to develop a collaborative relationship between two systems that have not worked closely together in the past—the criminal justice system and the public mental health system. With these two systems working in concert, the program hopes to achieve the following outcomes:

- Early identification
- Expedited case processing
- Diversion from incarceration when appropriate
- Improved public safety
- Reduced recidivism
- Improved access to public mental health treatment services.

CRITERIA FOR MENTAL HEALTH COURT

- Baltimore City resident
- At least 18 years old
- Diagnosed with Axis I serious mental illness and/or trauma related disorder
- Eligible for public mental health services
- Agrees to comply with program requirements
- Charged with a misdemeanor or felony within the jurisdiction of the District Court, with the exception of a domestic violence related offense
- Has never been convicted of a crime of violence: abduction; arson in the first degree; burglary in the first, second or third degree; carjacking and armed carjacking; escape; kidnapping; manslaughter, except involuntary manslaughter; maiming; mayhem; murder; rape; robbery; robbery with a dangerous or deadly weapon; sexual offense in the first or second degree; use of a handgun in the commission of a felony or other crime of violence; an attempt to commit any of the aforesaid offenses; assault in the first degree; and assault with intent to murder, assault with intent to rape, assault with intent to rob, and assault with intent to commit a sexual offense in the first or second degree
- No detainers or pending cases unless it is determined that the pending cases will not interfere with treatment

As the program evolves and after much team discussion, it is clear that certain exceptions to the criteria have proven to be desirable in order to foster inclusion. Exceptions have been made in the areas of residency, eligibility for the public mental health system, and diagnostic criteria. Since these exceptions are so case specific, it would not be beneficial or practical to attempt to reflect the exceptions in the listed criteria.

From time to time, the residency requirement has been relaxed in order to allow otherwise eligible individuals who reside in counties in close proximity to Baltimore City to participate, as long as the participant is able to attend court hearings and meet with the monitor. In addition, some flexibility has been exercised with regard to the eligibility

for the public mental health system. On occasion, veterans and defendants with private insurance have been accepted into the MHC when an appropriate plan could be developed. The eligibility criteria that has been the primary subject of debate is the requirement of an Axis I mental disorder or a trauma related disorder. The MHC handles all cases in which a judge orders a competency or criminal responsibility evaluation, and some of these evaluations are ordered as a result of the defendant's cognitive limitations. The listed criteria are not applicable to those cases entering the court through the competency or criminal responsibility track. However, when certain severely cognitively limited individuals are found to be competent, it may be appropriate to offer the individual the opportunity to participate in the MHC program. Due to the multi-faceted aspects of the issue, we have found the best approach is to decide on a case-by-case basis, if the otherwise eligible defendant could potentially benefit from the program and if a viable plan can be developed.

HOW MANY?

Many of the cases in Mental Health Court involve competency and/or criminal responsibility issues. In FY 2011, the court heard approximately 340 cases. Competency evaluations were ordered in 128 cases, and 11 cases involved pleas of not criminally responsible. In addition, 102 voluntary defendants entered the program last year.

CASES INVOLVING COMPETENCE

When the question of competency is raised in any criminal court and a Baltimore City District Court judge orders a competency or criminal responsibility evaluation, the case is transferred to the MHC docket. The MHC handles the cases as mandated by statute, and special hearings are held (e.g., competency hearings, bail hearings, revocation of bail or recognizance hearings). Treatment may be required to restore competence, and status conferences are conducted on a regular basis in order to insure that defendants are not held in the hospital or DDA forensic center beyond the time that level of care is required for restoration or safe release to the community. In addition, the MHC carefully monitors the likelihood that the defendant will be restored in the foreseeable future, the maximum time in custody consistent with the pending charge (s), as well as the State's ability to prosecute.

Defendants Opined To Be Competent

The court procedure for case processing remains relatively straight forward, with the ability for expedited scheduling and other quick response when there is a need. However, the responsibility for planning and monitoring has become somewhat complicated over the years.

If FAST determines that the defendant opined to be competent, either after screening or evaluation, meets the legal and clinical criteria for MHC and appropriate community services are available, the case is handled like any other MHC referral. When it is

agreed that the defendant is to be offered the opportunity to participate in the MHC program, the Public Defender will consult with their client to be sure the defendant understands his/her options and the program requirements and agrees to comply with the rules. If the defendant is interested in taking part in the MHC, the Public Defender will go over the MHC Agreement, and the defendant will sign. A copy of the agreement will be made part of the court file. If the defendant does not want to participate in MHC or is not eligible to participate, the case returns to the regular criminal docket. Certain matters can be handled that day in MHC, such as *nol prosses*, dismissals, and prayers for jury trials.

For those defendants found by the court to be competent, a treatment plan with recommendations is presented to the Mental Health Court judge. With the exception of screening reports and reports indicating a change in clinical status, all other evaluation reports, treatments plans, aftercare plans, and status or progress reports, will be submitted to FAST, the court, counsel, and the MHC coordinator, at least three business days prior to the hearing.

The agency with the responsibility for preparing the recommended plan depends on a number of factors, including where the evaluation was performed or restoration treatment was provided. If the Circuit Court for Baltimore City Medical Services Division, hereinafter CCMSD, screener opines that a mentally ill defendant is competent, the CCMSD social worker will develop the plan. For defendants evaluated in the hospital or the SETT Unit or committed for treatment and restored to competency, the treatment team will prepare and submit an aftercare plan. Some mentally ill defendants may be eligible for monitoring by FAST. In those cases, FAST will conduct a psychosocial evaluation before deciding whether or not to accept the defendant for monitoring.

When the Department believes that there has been a change in the defendant's clinical status from incompetent to competent or incompetent and dangerous to incompetent and not dangerous, a new report and plan will be submitted and the matter will be promptly scheduled for hearing on modification of the commitment. If the Department determines that the defendant remains incompetent, but is not likely to be restored in the foreseeable future, upon notification, the matter will also be promptly scheduled. All reports containing a new opinion or change in the defendant's status will be submitted to the court at least two weeks prior to any scheduled hearing or status conference. Timely receipt of the reports will reduce delays and postponements of scheduled cases and will expedite processing of other cases that may have to be advanced.

Hospitalized Defendants Opined To Be Incompetent But Not Dangerous

In the case of a defendant who remains incompetent but who is no longer believed to be dangerous or a defendant who is evaluated in the hospital or the SETT Unit and opined incompetent but not dangerous, the Community Forensic Aftercare Program (CFAP) will review the hospital's aftercare plan to determine if CFAP is willing and able to monitor

the defendant in the community, if the court finds the defendant to be incompetent but not dangerous with services in the community.

Defendants Opined To Be Incompetent But Not Dangerous After An Outpatient Competency Evaluation

Outpatient evaluations can be difficult to manage for a variety of reasons, including problems scheduling the evaluation, missed appointments, delays in completion, and the quality of the community plan. Yet, there are many benefits to the outpatient evaluation in appropriate cases, where safety is not an issue, and there is confidence that the appointment will be kept.

Since the court date is determined at the time of scheduling and only the judge can agree to postpone the matter, prompt docketing is not an issue. Presumably, a defendant opined incompetent but not dangerous is, in fact, not dangerous as long as certain services are in place or conditions met. The recommended service/treatment plan will be submitted to the court with the examiner's opinion. The clerk will insure that a copy of the submitted material is provided to FAST and the Mental Health PTS agent, in the event the court, after hearing, finds the defendant to be incompetent but not dangerous.

Determining who is responsible for developing the plan depends on where the evaluation was performed. The CCMSD District Court social worker will develop the plans for the defendants opined by the CCMSD screener to be IST-ND by reason of mental disorder and will recommend the necessary range of services clinically required for safety and monitoring in the community. If the defendant was evaluated at SGH, hospital staff will create the service plan, and DDA will develop the service plan when a DDA evaluator performs the outpatient examination.

If FAST plans to assume monitoring responsibility, FAST will conduct a psycho-social assessment of the defendant and determine if any clinical revisions of the recommended plan would enhance the defendant's chance of success and positive monitoring in the MHC. If the defendant is opined to be incompetent as a result of mental retardation, DDA will insure that all reports and recommendations required by the court are provided at least three business days prior to the hearing. The Mental Health PTS agent will monitor the cases of those defendants found by the court to be IST-ND as a result of mental retardation, as well as the cases of those defendants found to be IST-ND as a result of mental disorder that FAST declines.

HOW ARE REFERRALS MADE?

Referrals are accepted from any source and are made to FAST (410) 878-8328. FAST staff will screen for eligibility. If the defendant meets the criteria for Mental Health Court, the Public Defender will promptly discuss the program with the defendant to determine whether the defendant wants to participate. If so, the case will then be presented to the State's Attorney for approval. If all parties agree, FAST staff will then arrange with the

Mental Health Court clerk to transfer the case to the Mental Health Court docket. In **exceptional** cases, if all parties do not agree to the defendant entering the Mental Health Court, the parties may present the matter to the MHC judge for discussion and a final decision.

PRETRIAL DIVERSION

Some defendants may be released to the community on a pre-trial basis with supervision by Pretrial Services and/or monitoring by FAST. If, after consultation with the Public Defender, the defendant agrees to participate in the Mental Health Court program, a plan will be developed incorporating conditions for release. The plan will include psychiatric treatment, substance abuse treatment and, if indicated, housing and case management.

FAST will arrange with the Mental Health Court clerk to issue a writ for the defendant and transfer the case to MHC on the next business day. The judge will then conduct a hearing on reconsideration of bail and will determine whether to approve the proposed release. There may be some cases in which FAST staff has a plan in place at the time of the original bail review. If so, the bail review judge may elect to consider the proposal for release at that time.

There are some defendants with minor charges, such a disorderly conduct, and little criminal history, who meet FAST criteria and who do not require the structure of MHC. FAST may monitor those defendants without MHC involvement.

MAY A DEFENDANT OPT OUT OF THE PROGRAM?

Yes, the program is voluntary. Any defendant may elect to opt out of the program. If this occurs, the case will be handled as any other criminal case.

MENTAL HEALTH COURT PROCEDURE

If the defendant is approved for the program and agrees to participate, the defendant, in most cases, will proceed on an agreed statement of facts. The sentencing will be postponed to give the defendant an opportunity to demonstrate compliance with the treatment plan. During the interim, either FAST or the Mental Health PTS agent will supervise the defendant. In some cases where the defendant seems to be stable and the plan is in place, the defendant will be placed on probation either to FAST or the Mental Health probation agent. The plan will be incorporated into the Probation Order in the form of special conditions. If the Mental Health PTS agent supervises the defendant, the conditions will be part of the Order for Recognizance. Periodic review hearings will be scheduled at interims suggested by the supervising agent. Although in most cases the defendant agrees to either plead guilty or proceed on an agreed statement of facts in order to be eligible for the program, there may be some cases in which the State decides to offer a stet with conditions or a nol pros upon successful completion. The terms of the treatment plan are conditions of the stet or the release.

The defendant stipulates to facts, and the stipulation is entered in the event of non-compliance. In this way, the State does not have the concern of lost witnesses or other prosecutorial problems that could result from the delay. The case will either be monitored by FAST or supervised by the Mental Health PTS agent until the stet or nol pros is entered.

HOW ARE VIOLATIONS HANDLED?

One of the advantages of the specialized management of the case is the ability to respond quickly. FAST will be available to assist the Mental Health PTS agent and the Mental Health Probation agent by providing clinical guidance if the problem can be addressed through the mental health system. If this avenue is not appropriate or not feasible, the agent will prepare a report and bring the report directly to the judge who will determine whether to issue a warrant or a summons. If a warrant is issued it will be marked **MENTAL HEALTH COURT/DEFENDANT TO BE BROUGHT BEFORE ISSUING JUDGE IMMEDIATELY UPON AREST.** The warrant will be given directly to the police liaison who will make arrangements for the prompt execution of the warrant. If there are any other special instructions, such as bring the defendant directly to court or let the judge know when the defendant has been apprehended, the instructions will be noted on the warrant and discussed with the police liaison. The MHC coordinator or MHC clerk will facilitate the timely handling of any violations.

Section 1.3

Criteria for Supervision

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CRITERIA FOR FAST SUPERVISION

1) Adult.

2) Baltimore City resident.

3) Major mental illness, e.g. bipolar disorder (manic depressive disorder), major depressive disorder, schizophrenia, schizoaffective disorder.

4) Disorders associated with trauma.

5) Relatively minor offenses.

6) No history of arrests or convictions for violent crimes e.g. murder, manslaughter, serious assaults or repeated assaults, rape, or other sex offenses.

7) Agrees to treatment.

8) Defendants most appropriate for FAST supervision:

- Primary issue is psychiatric disorder as opposed to substance abuse.
- Unstable with a history of noncompliance with outpatient treatment.
- Unsuccessful with traditional probation due to psychiatric symptoms.
- Special needs that would best be monitored by a clinician.

PROCEDURE FOR REFERRAL TO FAST

Contact FAST by telephone and arrange for an assessment.

FAST will determine whether the defendant is appropriate for either FAST supervision or for supervision by the Mental Health probation agent or PTS agent.

FAST will report to the court on the results of the assessment.

If the defendant is appropriate for supervision either by FAST or the Mental Health Probation or PTS agent, FAST will present a treatment plan for consideration by the judge.

JUDGES DO NOT HAVE THE AUTHORITY TO ORDER FAST TO ACCEPT THE MONITORING OF A SPECIFIC DEFENDANT.

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CRITERIA FOR MENTAL HEALTH PROBATION AGENT AND FOR MENTAL HEALTH PRETRIAL AGENT

1) Adult.

2) Baltimore City resident. (Some exceptions are made if the defendant can keep appointments and attend court hearings).

3) Major mental illness, e.g., bipolar disorder (manic-depressive disorder), major depressive disorder, schizophrenia, schizoaffective disorder.

4) Disorders associated with trauma.

5) Psychiatrically stable.

6) Relatively compliant with treatment.

7) Agrees to participation in Mental Health Court.

PROCEDURE FOR REFERRAL TO MENTAL HEALTH PROBATION AGENT

Contact FAST to arrange for assessment.

FAST will determine whether the defendant is appropriate for supervision by the Mental Health probation agent/ PTS agent and, if so, will offer a treatment plan to the agent.

FAST will be available to consult with the agent if decompensation occurs or if the treatment plan needs modification.

JUDGES DO NOT HAVE THE AUTHORITY TO ORDER THE MENTAL HEALTH PROBATION AGENT TO ACCEPT THE MONITORING OF A SPECIFIC DEFENDANT.

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Section 1.4

Roles of Team Members

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Role of Probation and Pretrial Service Agents With a Mental Health Caseload

By Evelyn Mays

Introduction

As the mentally ill population grows in Baltimore City and seriously mentally ill people are entering the criminal justice system in vast numbers, mental health cases for probation agents continue to increase. The Division of Parole and Probation and the division of PTS agreed to collaborate with the MHC by assigning an agent exclusively to MHC, for the purpose of improving outcomes for this special population while increasing public safety.

DPSCS's vision for handling the case of mentally ill offenders works in conjunction with the mission of the Mental Health Court (MHC). Where the MHC will strive to humanely and effectively address the needs of individuals with mental disorders who enter Baltimore's criminal justice system – DPSCS will be known for dealing with tough issues, demonstrating evidence-based practices, and bringing about successful change.

According to an article written by Skeem and Petrila:

> The courts by necessity depend on others, including social services, treatment providers, and probation officers to implement the mandate to participate in treatment. One particularly promising strategy is the development of specialty caseloads for probationers with mental illness. Probation officers with specialty caseloads play a central role in monitoring and enforcing the conditions of probation, including the mandate to participate in treatment. Thus, these officers combine two functions: they seek to assure public safety (the traditional probation officer role), but also attempt to assure the rehabilitation of the probationer (a therapeutic role). Supervising this population is time consuming for a probation officer. Mental health caseloads are considered in need of intensive supervision, with appropriate caseload caps. The Probation Officer must exert sustained effort to implement both the general conditions and special conditions that mandate treatment. Reduced mental health caseloads provide officers with the time to develop and implement difficult social service referrals, handle crisis, and intensively supervise these high-risk individuals. Specialty officers use a graduated or problem solving approach to non-compliance before pursuing revocation as absolutely the last resort. [1]

The Mental Health Court probation officer works specifically with referrals from Mental Health Court. Larger caseloads necessarily limit officers' resources for supervising and meeting the needs of this population.

[1]Skeem, J. &Petrila, J., (2004). Problem-Solving Supervision: Specialty Probation for individuals with Mental Illness, *Court Review*, 40 (3-4), 9.

Procedures and Strategies for Supervising the Mentally Ill Offender

Caseloads

A. A Mental Health agent's caseload should be no more than 30 total cases and should consist of mental health cases only.
B. Special conditions must be related to receiving mental health treatment.

Assessment and Risks

A. Cases should be assessed as intensive for the first six months of receiving the case and establishing mental health treatment.
B. Cases should be reassessed to intermediate when there has been 6 months of successful compliance. If compliance has not been successful, then classification should remain at intensive.
C. Mental health cases should not be assessed or transferred to standard or kiosk unless an evaluation indicates that psychiatric treatment is no longer needed or a mental illness did not exist. The court should be notified of such indications or recommendations via Informative Report.
D. Risk factors for the mentally ill population include, but are not limited to: past and current failure to comply with medications, failure to keep treatment appointments and poor attendance, need for mental health services, homelessness, history of felony arrests and arrests related to the probationer's mental health and/or substance abuse.

Contacts

A. Intensive cases should have at least 2 contacts per month, with at least one face-to-face contact.
B. Intermediate cases should be bi-monthly and face-to-face.
C. Home visits should include behavioral observations by family members, behavioral and house-rule compliance at assisted-living homes, recovery homes or shelters.
D. Community collaterals are in-person visits to hospitals, day programs, clinics, and any other community-based program related to the probationer's case.
E. Agents should use motivational interviewing to encourage compliance.
F. Other contacts can be by telephone.
G. Contacts should be entered in CNS per policy. At this time, the PTS agent relies primarily on hand written notes.

Intervention

A. Agents should attend and participate in clinical treatment team meetings as often as possible and encourage the defendant's compliance with treatment through motivational interviewing.
B. Agents should contact Baltimore Crisis Response or law enforcement officers

immediately, if the defendant poses a threat of harm to himself or others.

C. Agents should document any hospitalizations, emergency petitions, incarcerations or any events that interfered with mental health treatment. Agents should attempt to collect a copy of discharge instructions from hospitals to ensure that the probationer is following discharge recommendations.
D. Agents should inform the defendant's treatment team of any recommendations that resulted from events that interfered with treatment.

Dual-Diagnosis

A. Dual diagnosis is having both a mental illness and substance abuse problem that usually occur together.
B. Dual diagnosis is also referred to as: dually diagnosed, co-occurring disorders, co-morbid disorders, co-morbidity, concurrent disorders, and multiple disorders.
C. Agents should attempt to refer the probationer to programs that will address both the substance abuse and mental illness.
D. Agents should indicate urinalyses results in CNS if the program is doing the collecting, otherwise, agents should collect urinalysis per policy.

Consents

A. Agents must have a signed Release of Information or Consent before sharing or obtaining information per HIPAA and other confidentiality laws.

Verifications

A. Probation agents should collect DNA per policy.
B. Agents should verify compliance in writing, by fax, by email, or by phone from therapist, psychiatrist, counselors, social workers, or other related clinicians.
C. Verified information should be documented, according to agency policy and should include:

    1. Attendance – required frequency of attendance and compliance. Verify that all individual and group and any other required appointments or sessions have been kept.
    2. Medications – name and dosage of medications, observe that medications have been filled by observing medications bottles, verify that appointments with psychiatrist have been kept for medication management, verify that appointments have been kept for medication injections.

Violations

A. Violation Reports related to treatment non-compliance should be prepared and submitted after the agent has made at least 1 attempt with the defendant's clinical team psychiatrist, therapist, counselors, social workers, or other related clinicians) to develop a treatment plan that will improve the defendant's treatment

compliance.

B. A Violation Report should be submitted no later than 2 days after learning of the defendant's failure to comply with a treatment plan.
C. Other reports should be handled according to policy.

Transferring Cases

A. Probation agents should not transfer cases without written verification of treatment compliance.
B. Verifications must not be more than 30 days old. Cases should not be transferred if there is verification of non-compliance or an attempt at intervention.

Failure to Report

A. Agents should refer the defendant to local transportation services or, if eligible, to case management services that will assist the defendant with transportation and other daily living skills.
B. If the defendant fails to report due to cognitive limitations or mental disorder, then the agents should make an attempt to contact the mental health clinicians to assist with alternate contact arrangements. Agents should document the mental health related reason for failing to report.
C. If the clinicians have determined that the defendant has the ability to report to the Office, then the defendant must report as directed. If the defendant does not report, the agents will submit a Violation Report.

Ability to Pay Fees

A. If a defendant has a mental impairment and receives Social Security or Social Security disability income, or public assistance, then testing fees should be waived.
B. Agents should inform the court of the defendant's inability to pay supervision fees and other court costs and request further instructions from the court, if the court has not already waived the fees.
C. Probation agents should attempt to set up a payment plan, if restitution is required, and inform the court of failure to pay per policy.

Mental Health Court

The probation and pretrial agents assigned to the Mental Health Court follow all of the above duties along with the following:

A. Reports

1. Status Update Reports – submitted to Mental Health Court 2 days prior to Mental Health Court hearings. These reports include all compliance, verification, non-compliance, progress, new arrests, and any other information needed by the Mental Health Court team.

2. Warrants or Summons – hand delivered within 24 hours of violation notification to The Mental Health Court judge (exceptions made with the consensus of the Mental Health Court team).

B. Meetings

1. Morning Mental Health Court Review Meetings at least twice per week and as often as required.

2. Afternoon Mental Health Court Progress/Review Hearings at least twice per week and as often as required.

3. Mental Health Court Meetings monthly and as often as required.

4. Treatment Team Meetings with therapists, psychiatrists, case managers, counselors, and any other related clinician monthly or as often as required.

5. Supervision of cases that have 8-507 Commitments and are assigned to Mental Health Court. Agent will make program visits. Obtain reports from BSAS or DHMH and submit Status Update Reports when required.

C. Other Mental Health Court Involvement

1. Participation with Mental Health Court graduations.

2. Participations/Attendance in other Mental Health Court or outside mental health related trainings, lectures, conferences, and meetings.

3. Networking and collaborating with other Mental Health Court related agencies or programs.

4. Assistance with client referrals when necessary and with Mental Health Court approval.

Mental Health Court Pretrial Services Agent

Like the MHC probation agent, the MHC Pretrial Services (PTS) agent is integral to the operation and success of the program. There are some MHC participants who are on recognizance or bail and who are supervised by PTS pending trial. These defendants generally do not meet the criteria for FAST monitoring. In addition, CFAP no longer monitors defendants who are evaluated in the community and found by the court to be incompetent to stand trial but not dangerous with services. The MHC PTS agent supervises those defendants. The conditions of release, including the treatment plan, should be incorporated into the Order for Recognizance or Order for Conditional Bail, so the agent has a clear understanding of the court's expectations. If no Order of Recognizance or Order for Conditional Bail is available, the conditions are listed on the trial summary.

There are some areas where the policies and practices of PTS differ from those of the Division of Parole and Probation. The PTS protocols for requesting rescission for failure to report and urinalysis are described below. **PTS does not charge supervision fees. Since the defendants monitored by PTS have not been adjudicated, PTS has no mechanism for collecting restitution or fines.**

Failure to Report

The pretrial release case agent will attempt to make two contacts with a client prior to filing a rescission order for failure to report. The agent will first attempt to contact the client by telephone with the contact information provided. If that attempt is unsuccessful, the agent will then send a compliance letter to the address provided. A rescind order is to be filed within five (5) days of non-compliance on any client that has been non-compliant with the conditions of pretrial release.

Urinalysis

The Pretrial Release Services Program will conduct urinalysis, as often as deemed necessary, unless specifically stipulated by the Mental Health Court pretrial release conditions. If the Pretrial Release Services Program is unable to conduct the appropriate urinalysis that the court wants, then arrangements will be made with the Division of Parole and Probation to assist in collection.

Forensic Alternative Services Team (FAST)

"The Forensic Alternative Services Team is a program that operates under the auspices of the Medical Services Division of the Circuit Court of Maryland for Baltimore City. The program is grant funded through Baltimore Mental Health Systems, Inc., the core service agency for Baltimore City, and has been in existence since approximately 1990. Staffing includes six licensed clinicians who are located in the Baltimore jails and in two of the three District Court locations in the City " [2]

FAST was initially designed as a diversion program for non-violent offenders. "The program diverts defendants at the booking/bail review phase, at accelerated trial dates, and at existing trial dates. Occasionally, the team is asked to consider a sentence modification to divert defendants sentenced to the Division of Corrections, which could be considered post sentence diversion. As with most diversion programs, FAST prefers the defendant's participation in the diversion agreement to be voluntary. A level of coercion on the part of the court to "convince" the defendant to accept the conditions of release may occur under certain circumstances. To determine program eligibility, the clinician conducts a psychosocial evaluation, during which the clinician balances individual defendant's characteristics with the program criteria and community safety risks. If the defendant is accepted, an individualized treatment plan is created and offered to the defendant at the designated hearing. With the court's approval, the defendant is placed under court order to comply with the terms of the treatment plan." [3]

In a role that complements the program's initial mission, FAST staff currently works directly with the Baltimore City Mental Health Court. The MHC is a post arrest diversion opportunity. FAST has been a key partner of the Mental Health Court since the court's inception and has collaborated with the other partners in designing the MHC program. The role of FAST in the MHC is multi-faceted and essential to the successful operation of the court. A FAST clinician serves as MHC clinical coordinator and, from time to time, other FAST clinicians monitor MHC defendants.

All MHC referrals go through FAST. A FAST clinician conducts a psychosocial assessment and determines eligibility, legal and clinical, for the MHC. If, after consultation with his/her attorney, the defendant elects to participate in the MHC, a comprehensive treatment plan is developed for submission to the court. "The clinician who presents the original treatment plan to the court will usually be the monitor of the defendant's compliance with release conditions. The clinician typically meets with the defendant and receives written and telephone documentation from the community

[2] Roskes, R., Cooksey, C., Lipford, S., Dlugacz, H., Tambree, J. (2005). The Criminal Justice System and Offenders Placed in an Out Patient Setting. Scott, C. (Ed.), in Handbook of Correctional Mental Health, pps 239-240. Washington, DC: American Psychiatric Press.

[3] Ibid.

mental health treatment provider. The clinician also provides support to the community provider by making home visits, encouraging compliance, and helping to adjust the plan when needed. If the defendant does not adhere to the terms of his or her agreement, FAST personnel respond quickly, and the sentencing judge is notified. Depending on the stage at which the defendant was diverted to community treatment, the responses by FAST can include an upgrade in the level of mental health or substance abuse treatment, a request for a bail revocation, or a recommendation for program revocation." [4]

In addition to the roles of screener/gatekeeper, monitor, and planner, FAST staff is available, as needed, to provide clinical guidance to other MHC monitors, the MHC probation agent and PTS agent. FAST staff attends all MHC sessions, case conferences/reviews "morning meetings", and team meetings and provides invaluable insight and assistance that advance the team's ability to quickly address problems that arise.

[4] Ibid. p.240.

Section 1.5

Violation of Court Order

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Violation of Court Order

Any violations of probation or pretrial supervision are to be presented directly to the Mental Health Court (MHC) judge. If the judge decides to issue a warrant, the request will be made to the MHC clerk, who will immediately prepare the warrant.

The warrant will require that the defendant be held without bail and presented immediately to the MHC judge or the duty judge, if the MHC judge is not available. If the defendant can be picked up during business hours, the police may bring him/her directly to the judge. The judge will recall the warrant and set the bail. This method of handling the violation expedites the process and eliminates the need for the arresting officer to go the Central Booking and Intake Facility.

The police liaison is contacted to assist with arranging service of the warrant. The probation agent, Pretrial Services agent, or FAST staff will facilitate getting the warrant to the police liaison and providing information on where the defendant is likely to be found.

EVERY EFFORT SHOULD BE MADE TO RESPOND TO PROBLEMS IMMEDIATELY.

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Section 1.6

Goodwill STEP Procedures

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Procedures for Referral to Goodwill Step Division

Many participants in the Mental Health Court can benefit from vocational training and workforce development services. In order to increase the opportunities to expeditiously obtain those services, the Mental Health Court and Goodwill have established the following procedures:

1) Referrals will be made by fax, mail, email or in person to Goodwill's STEP division located at 2211 Maryland Avenue, Baltimore, Maryland 21218 phone: (410) 625-1877 fax: (410)625-2891; email: NSalmon@goodwillches.org.

2) The contact person is Natasha LeVons-Salmon (Program Coordinator), phone (410) 625-1877 ext. 109. Natasha LeVons-Salmon and Evera Rutledge-Smith (Rehabilitation Counselor) will monitor the referrals submitted to STEP.

3) The court, Public Defender, FAST, the State's Attorney, a probation officer, or a PTS agent may make referrals from the Mental Health Court.

4) The referral will be made when the defendant, the defendant's counselor, and the monitor believe that the defendant is ready to begin preparing for employment or reemployment on a part-time or full-time basis.

5) STEP personnel will assume responsibility for: referrals to Division of Rehabilitation Services (DORS) in order to determine eligibility for services, to obtain funding for STEP and Goodwill programs, and to gain access to services that would contribute to successful completion of the Mental Health Court and maintaining employment.

6) If STEP is not the best fit for the person referred or if other Goodwill programs can better help the individual to become and remain employed, STEP staff will seek to engage the other Goodwill divisions that may be more suitable. Other Goodwill divisions that will be made available include SEETTS program for former offenders, GenesisJobs, Waverly Family Center, and the Goodwill Redwood Street Career Center, which includes occupational training programs.

7) A monitoring form will be developed to keep the court apprised of the status of the referral and the defendant's compliance and progress. This form may be submitted by e-mail.

STEP
A Division of Goodwill Industries of the Chesapeake, Inc.
2211 Maryland Avenue
Baltimore, MD 21218
410-625-1877
410-625-2891 – Fax

MENTAL HEALTH COURT MONITORING FORM

Client Name _____

Date Referred _____

Referral Source _____

Monitor Program __ Pre-Trial __ Probation __ FAST __ CFAP

Monitor Name _____

STEP's Employment Specialist_____

Status of Service:

__Awaiting Intake
__Vocational Assessment Completed
__Pre-Employment Service (PRP)
__Human Services Training
__Job Development
__Attained Employment
__On-the-Job Coaching
__Extended Employment Support
__Case Closed, Date Closed _____

Comments:

_____

_____

_____

_____

Submitted By: _____ Date: _____

Section 1.7

Mental Health Court Contacts

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MENTAL HEALTH COURT CONTACTS

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***Requests from courts for evaluation of competency to stand trial or criminal responsibility and/or dangerousness are to go to Archie Wallace, Pre-Trial Evaluation Services.**

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Section 1.8

Forms

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Copies of the forms listed below have been placed in the manual binders and may be obtained from the CourtNet forms index using the links below. *

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MARYLAND JUDICIARY

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

_____ Address

_____ City, State, Zip Telephone

COMPETENCY STATUS REPORT

(To be completed by Forensic Coordinator or designee.)

Conference Date: _____

Hospital/Residential Center: _____

Form completed by: _____

Date of initial confinement, if known _____ Date of Incompetency Finding: _____

1. It is the opinion of the Department that the Defendant/Patient is
   - ☐ competent.
   - ☐ incompetent.
   - ☐ dangerous by reason of ☐ a mental disorder ☐ mental retardation.
   - ☐ not dangerous by reason of ☐ a mental disorder ☐ mental retardation.

   Basis for above opinion: _____

2. If it is the opinion of the Department that the Defendant is incompetent and dangerous due to ☐ a mental disorder ☐ mental retardation, is there a substantial likelihood that the Defendant will be restored in the foreseeable future? ☐ Yes ☐ No
   a) If yes, when is restoration anticipated?
      - ☐ Within 30 days
      - ☐ Within 90 days
      - ☐ Within 6 months
      - ☐ Within 12 months
      - ☐ Over 12 months

   b) If not restorable, does the Defendant meet the criteria for civil commitment or admission pursuant to Title 7 to a Developmental Disabilities Administration facility? ☐ Yes ☐ No

   Basis for opinion for 2(a) and 2(b): _____

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Case Number .....

3. If the Department believes that the Defendant is now competent or remains incompetent but would not be dangerous by reason of mental disorder or mental retardation with certain supportive services in the community, what is the recommended aftercare plan?

LIVING ARRANGEMENT ☐ With Relative ☐ Independent ☐ Supportive Housing

Referrals made to: ..... Date: .....

Will reside with: .....

Address: .....

Will be available on .....

MENTAL HEALTH TREATMENT Name of program: .....

Will begin on .....

SUBSTANCE ABUSE TREATMENT Name of program: .....

Will begin on .....

FINANCES

☐ Public Assistance (MA, AFDC, Pharmacy assistance, Food stamps)
Will receive on .....

☐ SSI Will receive on .....

☐ SSDI Will receive on .....

☐ Representative payee .....

EDUCATIONAL OR VOCATIONAL TRAINING Where? .....

Will begin on: .....

CASE MANAGEMENT OR SERVICE COORDINATION services to be provided by:

.....

Will begin on .....

Case manager met with Counselor and Defendant on .....

4. What services are clinically most appropriate to
(a) maintain the Defendant safely in the community? .....

.....

.....

(b) maintain competency or restore competency? .....

.....

.....

If the Defendant is incompetent due to mental retardation, has the DDA eligibility determination been completed? ☐ Yes ☐ No

If yes, determination is ☐ Eligible ☐ Not eligible

If not eligible, why? .....

.....

.....

Case Number _____

REQUEST FOR COURT INTERVENTION

☐ On and off grounds privileges

☐ Postpone due to: _____

☐ Schedule for hearing on competency

When will the plan be ready for implementation? Within:

☐ 30 days ☐ 90 days ☐ 6 months ☐ 12 months

Is the Defendant cooperating with the discharge plan? ☐ Yes ☐ No

5. Has referral been made to CSA?

When? _____

a. To whom? _____
Name

_____
Address

b. Was CSA involved in aftercare planning? ☐ Yes ☐ No

c. If not, why not? _____

d. If so, what assistance will the CSA provide for discharge? _____

CONTACTS WITH DEFENDANT'S COMMUNITY AGENCY/SUPERVISOR/MONITORING AGENT

(Pretrial Services or Probation Agents, Case Manager, Community Service Coordinator)

Name of agent/monitor: _____

Agency: _____

Telephone communication on: _____

Meeting on: _____

Plan reviewed on: _____

_____
Date

_____
Forensic Coordinator/Designee

_____
Printed Name

_____
Address

_____
City, State, Zip

_____
Telephone

_____
Fax

_____
E-mail

CC-DC-MH-001 (Rev. 8/2014) Page 3 of 3 **Reset**

DISTRICT COURT OF MARYLAND FOR _____ (City/County)

Located at _____ (Court Address) Case No. _____

STATE OF MARYLAND vs. _____ (Defendant)

_____ (Address)

_____ (City, State, Zip)

MENTAL HEALTH COURT REFERRAL FORM FOR FAST SCREENING

(TO BE COMPLETED BY REFERRAL SOURCE)

Date of Referral _____

Name _____ Agency _____

Telephone _____ Fax _____ E-mail _____

Reason for Referral _____

Check all that apply:

- ☐ Competency
- ☐ Medication Referral
- ☐ Service Plan
- ☐ Transfer to Mental Health Court
- ☐ Assess for Mental Health Probation Agent
- ☐ Assess for Mental Health Pretrial Agent

Agency _____

DEFENDANT INFORMATION

SID No. _____ Court Date _____

DOB _____

Lives with _____

Telephone _____ Additional Telephone _____

In custody _____ In community _____

TO BE COMPLETED BY FAST

Accepted by FAST ☐ Yes ☐ No Explain _____

Accepted into Mental Health Court ☐ Yes ☐ No Explain _____

Appropriate for MH Probation Agent ☐ Yes ☐ No Explain _____

Appropriate for MH PTS Agent ☐ Yes ☐ No Explain _____

OUTCOME OF REFERRAL

Mental Health Pretrial Supervision _____ Meds Provided _____

Comp Eval _____ FAST Supervision _____ Plans Arranged _____

Transferred to MH _____ Mental Health Probation Supervision _____

Defendant Refused Participation _____

Copy of completed form sent to referral source _____

When _____

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Reset

☐ **CIRCUIT COURT** ☐ **DISTRICT COURT OF MARYLAND FOR** _____
City/County

Located at _____ Case No. _____
Court Address

STATE OF MARYLAND vs. _____
Defendant

_____
SID No.

Scheduled Review Date: _____

MENTAL HEALTH / SUBSTANCE ABUSE STATUS UPDATE FORM

Please check the appropriate options below & return at least 2 days prior to the scheduled review/trial date to Court designee.

Reporting Agency: ☐ FAST ☐ Pretrial ☐ Parole & Probation ☐ CFAP ☐ DDA
☐ Other: _____

Monitoring Status: ☐ Pretrial ☐ Probation ☐ Incompetent to stand trial, not dangerous
☐ Committed to MDH

Reporting Compliance: ☐ Good ☐ Fair ☐ Poor
Date(s) of Missed Appointment(s): _____

Treatment:

Housing
Resides w/Provider as required ☐ Yes ☐ No
Concerns: _____
Provider: _____

Mental Health
Overall compliance ☐ Good ☐ Fair ☐ Poor
Date(s) of Missed Appointment(s): _____
Concerns: _____
Problem w/Meds ☐ Yes ☐ No

Substance Abuse
Overall compliance ☐ Good ☐ Fair ☐ Poor
Date(s) of Missed Appointment(s): _____
Positive Toxicology Screen(s) ☐ Yes ☐ No
Date(s) of Positive Results: _____
Concerns: _____

Next Hearing Date: ☐ 2 Weeks ☐ 4 Weeks ☐ 6 Weeks ☐ 8 Weeks ☐ Other: _____

Issues to be addressed at hearing: _____

_____

_____

_____ _____
Date Signature

CC-DC-MH-005 (Rev. 07/2017)

MARYLAND JUDICIARY

☐ **CIRCUIT COURT** ☐ **DISTRICT COURT OF MARYLAND FOR** _____
City/County

Located at _____ Case No. _____
Court Address

COURT STATUS / ANNUAL REPORT
INCOMPETENT TO STAND TRIAL AND NOT DANGEROUS IN COMMUNITY

Defendant's Name: _____ Case No: _____

SID No.: _____ Date of Conference / Hearing: _____

Court: _____ Date of Report: _____

Judge: _____ Form Completed by: _____

Date Released to Community: _____ Date of Incompetency Finding: _____

Pending Charges: _____

If this is an Annual Report or if the opinions expressed below represent a change in the Defendant's status, please attach a full report to this completed form. ☐ Report Attached.

Status in community since last report: _____

Has the Defendant's clinical status changed? ☐ Yes ☐ No

If it is the opinion of the Department that there has been a change in the Defendant's clinical status or if this is an annual report, has a reevaluation been completed? ☐ Yes ☐ No

If not, when will reevaluation be complete? _____

Compliance with conditions listed in Order of Release: ☐ Good ☐ Fair ☐ Poor

With living arrangement: _____

With mental health treatment: _____

With substance abuse treatment: _____

With abstinence from drugs and alcohol: _____

With vocational or educational services: _____

With avoiding contact with victim: _____

Other conditions: _____

Has individual required inpatient hospitalization or admission to DDA facility since last report? ☐ Yes ☐ No

Has there been any indication that clinical status has changed regarding competency? ☐ Yes ☐ No

If so, has reevaluation been completed? ☐ Yes ☐ No

Has there been any indication that Defendant can no longer remain in community without being a danger to self or the person or property of others due to mental disorder or mental retardation? ☐ Yes ☐ No

Other relevant information/concerns or explanation of answers: _____

Name of Monitor: _____

Telephone No: _____

Address: _____

MARYLAND JUDICIARY ☐ **CIRCUIT COURT** ☐ **DISTRICT COURT OF MARYLAND FOR** _____
City/County

Located at _____ Case No. _____
Court Address

STATE OF MARYLAND vs. _____ _____
Defendant DOB

_____
Address

_____
City, State, Zip Telephone

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, DOB _____, authorize
Print Name

☐ Court ☐ Pretrial agent ☐ My defense attorneys

☐ Court clinical staff ☐ Probation agent ☐ Other _____

to obtain my protected health information ("PHI")/confidential clinic/hospitalization/clinician/service provider records regarding previous treatment received and/or treatment I am currently receiving from:

_____
Name and Address of Agency of Provider

_____.

Specific records requested:

- ☐ Social history (personal, family, and legal history).
- ☐ Treatment plans.
- ☐ Progress notes (current and past treatment progress, lack of progress, or change in condition).
- ☐ Psychiatric assessment (report by psychiatrist including psychiatric history, current functioning, medical history, mental status examination, and diagnostic formulation).
- ☐ Psychological assessment (report by psychologist including psychological history, current functioning, medical history, mental status examination, and diagnostic formulation).
- ☐ Discharge summary (recap of hospital/clinical course and recommendations for follow up).
- ☐ Aftercare plan (information on problems requiring hospitalization, medications, diagnoses, and treatment recommendations for continuing care).
- ☐ Medical assessment (physical exam, medical history, and treatment recommendations).
- ☐ Immunizations.
- ☐ Diagnostic results (most recent labs, which could include HIV test results, blood alcohol levels, and illicit substance abuse levels).
- ☐ School records (including GED programs).
- ☐ Court records (Evaluations for Competency and/or Criminal Responsibility, Pre-sentence Investigations, Psychiatric Evaluations, Charging documents, Regional Hospital aftercare plans, Developmental Disabilities Administration Forensic Center aftercare plans).
- ☐ Other: _____

I consent to the release of the records requested, records developed by the health care/treatment provider, and records the provider received from another health care provider, unless otherwise prohibited by the other provider.

The purpose of obtaining the requested records and any re-disclosure deemed necessary is to develop and implement an appropriate mental health, substance abuse, and social service treatment plan, as well as to monitor the plan and make adjustments when needed.

I understand that any records relating to treatment of an alcohol or substance abuse problem are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and my medical records, including mental health records, are protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as Maryland's Confidentiality of Medical Records Act (Md. Code Ann., Health-Gen. §§ 4-301 through 4-309), and cannot be disclosed without my written consent unless otherwise provided for in the law.

I understand that persons and organizations I authorize to receive and/or use my PHI are not subject to the federal or State health information privacy laws, and that they may further disclose my PHI, and thus, my PHI may no longer be protected by the health information privacy laws.

I understand that my health care and payment for my health care will not be affected if I do not sign this form for requested use and disclosure of information.

I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this authorization is valid for the duration of the Court's supervision/monitoring period in the above-captioned case.

I have had full opportunity to read and consider the contents of this Consent to Disclose Protected Health Information and I confirm that the contents are consistent with my intent.

Name	Date
Witness	Date

IN THE DISTRICT COURT OF MARYLAND FOR BALTIMORE CITY

STATE OF MARYLAND	**CASE NO.:**
VS.	
	SID #:

MENTAL HEALTH COURT AGREEMENT

What is the Baltimore City Mental Health Court?

The Baltimore City Mental Health Court is a special part of the Baltimore City District Court. It is a court-supervised program for Baltimore City District Court defendants who have serious mental health issues, who need treatment and other services, and who choose to participate in the court program instead of having their case proceed in the regular court process.

What do I have to do?

A treatment plan will be prepared for you based on an assessment of your needs for mental health treatment, substance abuse treatment, developmental disability services, case management, housing and other needs. Read the treatment plan with your lawyer and with anyone else you wish to consult. In order to participate in the court, you need to comply with the treatment plan and with all terms and conditions of your probation or pre-trial release. While you are participating in MHC, the judge, the Mental Health Court Team, probation or pretrial agent, or a clinician from the FAST program will monitor your participation and progress in treatment.

How long will I be involved in the Mental Health Court?

The length of time is dependent on your charges, plea agreement, compliance with the treatment plan and your progress in treatment.

This agreement between _____, the State's Attorney, and the court is intended to secure the participation of the Defendant in the Mental Health Court (MHC) program. In consideration for the opportunity to participate in the MHC program, I agree to the following conditions.

1) I agree to:
   i) Waive the right to a jury trial
   ii) Waive the right to a speedy trial
   iii) Comply with the terms and conditions of the treatment plan and/or the conditions of the Order of Probation or the Order of Pretrial Release, if I am placed on probation or pretrial release supervision.

2) I understand I must be found to have committed the offense charged; to be in violation of probation; or I must agree to the facts that would establish my guilt. If the State has agreed to enter a nol pros upon my successful completion of the program or the judge has agreed to offer probation before judgment, the guilty verdict/plea will be stricken at that time.

3) I agree to sign all authorizations for release of information as requested, and as is necessary to coordinate treatment and any other needed services and monitor compliance. If I withdraw from the program, my consent to release information is also withdrawn.

4) I understand that a meeting is held with the judge, the State's Attorney, my court monitor and other MHC staff before the afternoon docket of the Mental Health Court. At the meeting, my progress with the services and compliance with the court order may be discussed. I understand that my attorney will be present to represent my interests.

5) I agree that if I am required to live in a particular type of housing or in a particular housing facility, I must do so, and I must follow all my housing provider's rules.

6) I agree to take all medications as prescribed and to submit to periodic blood tests, if necessary, to determine the presence and levels of the medication. If I have complaints about my medication I must tell my psychiatrist. If I continue to have complaints about my medications, and feel that my psychiatrist is not responding to my concerns, I will contact my court monitor and/or my attorney.

7) I agree to participate in all evaluations requested by my treatment providers to assess my treatment needs.

8) I understand if I do not comply with MHC requirements and the conditions of probation or pretrial release, or if my treatment needs change, my treatment plan may be adjusted including:
   i) Increase drug/alcohol testing

ii) Refer to another treatment or service provider
iii) Increase reporting for supervision

9) I agree that if I fail to comply with the conditions of probation or pretrial, release, the court may impose, but is not limited to the following sanctions: increased drug/alcohol testing; curfew; community service; house arrest; increased progress hearings; extension of probation or supervision length; incarceration; and termination from the MHC program.

10) I understand that I am entitled to notice and opportunity for hearing prior to imposition of sanctions by the court.

11) I understand that the MHC program, is voluntary, and I may opt out or withdraw at any time, unless I entered into a plea agreement incorporating my consent to enter and complete the MHC program. If I withdraw from the program, I understand that my case will be handled in the traditional criminal process.

12) I agree that the length of any suspended sentence and the length of probation or supervision will reflect my success in treatment; compliance with program conditions; recommended continuing care; criminal record; and threat to public safety.

I have read this entire Agreement and discussed it with my lawyer. I understand what is expected of me, what will happen if I do not follow the rules and what I must do to stay in Mental Health Court. I freely and voluntarily agree to follow the provisions in this Agreement. I request to be accepted in the Baltimore City Mental Health Court and I promise to follow all the rules, terms and conditions of the program.

_____ _____
Defendant Date

_____ _____
Defense Counsel Date

_____ _____
Assistant State's Attorney Date

_____ _____
Judge Date

DISTRICT COURT OF MARYLAND

YOU ARE ORDERED TO REPORT TO
PRETRIAL RELEASE SERVICES PROGRAM

ON _____/_____/_____ AT 8:30 A.M.

JOHN R. HARGROVE, SR., DISTRICT COURT
700 EAST PATAPSCO AVENUE
BALTIMORE, MD 21225
SUITE 1198

PLEASE BRING:

PHOTO ID
PROOF OF INCOME
PROOF OF ENROLLMENT IN SCHOOL OR TREATMENT

_____ _____
Day of Week Reporting Date

I understand that the Court has placed me under the supervision of the Pretrial Release Services Program, and failure to report or to comply with the release conditions will result in revocation of my recognizance or bail.

_____ _____
Defendant's Signature Date

ORDERED BY _____
Judge

SPECIAL CONDITIONS

☐ Defendant shall regularly participate in drug/alcohol treatment as directed.

☐ Defendant shall participate in psychiatric treatment as directed and shall take any medication as prescribed.

☐ Other: _____

L01-013 (9/2012)

Reset

REFERRAL CHECKLIST FOR COMMUNITY PROVIDERS

A. Psychiatric History

1. Psychiatric diagnosis (according to self-report or psychiatric records).
2. Psychiatric medications while incarcerated (name, dose, and schedule)
3. Pre-Incarceration Psychiatric Medications (according to self-report or psychiatric records)
4. Outpatient mental health provider and contact information (court social worker will check with BMHS to determine the mental health services received in order to obtain records and, if necessary, to terminate the current services)
5. Other record of treatments

B. Substance Abuse (is the referral for both substance abuse and mental health treatment)

1. Drug abuse history (drug, onset of abuse, duration of abuse)
2. Treatment history (date, duration, completed the program?)

C. Medical

1. Medical conditions (record of physical performed at jail/prison)
2. Medications for somatic conditions
3. Primary care physician and contact information

A. Legal

1. Name/Contact info for Court SW
2. Name/Contact info for Probation Officer or PTS Agent
3. Results of Competency Assessment
4. Court Order including:
   i. Rehabilitative compliance requirement
   ii. Psychiatric Treatment compliance requirement
   iii. Medication compliance requirement
   iv. Drug screening and treatment requirement (frequency of drug testing, if stipulated)
   v. Legal History

E. Resources:

1. Health Insurance (Medical Assistance, Medicare, PAC, private insurance)
2. For Medical Assistance: Medical MCO
3. Housing situation: Homeless? Other needs
4. Income (employment, SSI, SSDI, none)
5. Identification (social security card, birth certificate, ID)

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CHAPTER 2

COMPETENCY

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Section 2.1

Competency Guidelines

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INTRODUCTION

The requirement that an individual be competent in order to stand trial has a long history in English law and is a constitutional mandate. Trial and conviction of a person while legally incompetent violates the due process clause of the Fourteenth Amendment of the U.S. Constitution, *Pate v. Robinson,* 383 U.S.375, 86 S. Ct. 836, 15 L.Ed.2d 815 (1966), *Medina v. California,* 505 U.S. 437, 439, 112 S. Ct. 2574, 120 LEd, 2d at 359 (1992). Competency is not fixed, and a trial judge must be alert to changes before and during trial that would render a defendant unable to meet competency standards*, Drope v. Missouri*, 420 U.S.162, 181, 95 S.Ct. 896, 43 L.Ed.2d 103 (1975).

A person accused of a crime is presumed to be competent*. Ware v. State*, 360 Md. 650, 703, 759 A.2d 764, 792 (2000). However, once the issue of competency is properly raised, the General Assembly places the duty to determine competency on the trial court, in order to insure that the requirements of due process are met. *Roberts v. State,* 361 Md. 346, 363-64, 761 A.2d. 885, 895 (2000).

The number of competency evaluations ordered has increased significantly over the years from an estimated 25,000 [1] in 1973 to an estimated 60,000[2] in 2011. In Maryland, 1404 competency and criminal responsibility evaluations were performed in 2011. According to the Department, with rare exception, the defendants found to be IST-D and committed to the Department's state psychiatric hospitals and state forensic centers were severely impaired and required in patient care. These numbers are a reflection of the significant number of individuals with a mental illness or intellectual disability entering the criminal justice system.

It is an emerging best practice to have a competency court or competency docket to handle the cases after the question of competency to stand trial is raised. A number of advantages to having this specialized court or docket have been identified, including enhanced accuracy, efficiency and cost effectiveness for the criminal justice and behavioral health systems. The accuracy of competency referrals as well as outcomes can significantly improve when specially trained judges, attorneys, probation and pretrial agents, social workers, and DHMH forensic coordinators work together on a regular basis. "Such collaboration is likely to result in the best outcome for the criminal justice system—meaning, the outcome most likely to protect the public safety, decrease system costs, and increase the quality of life for the mentally ill defendant so as to prevent the individual from recidivating."[3] The experience in Maryland where these specialized dockets are in place is consistent with the conclusions reached by the contributors to the *Best Practices Model.*

In the 2006 Joint Chairmen's Operating Budget, the legislature requested the judiciary and the Department to submit a Joint Report on the Needs of the Forensic Population.

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[1] McGarry AL: Competency to Stand Trial and Mental Illness. Washington, DC: National Institute of Mental Health, 1973.
[2] National Judicial College, Mental Competency- Best Practices Model (2011). (p.1) Retrieved 2/12/12 from http//www.competency@judges.org.
[3] Ibid. (pp. 39-40)

After a great deal of thought, discussion, and negotiation, we were able to reach sufficient consensus to produce and submit the report. One of the major recommendations agreed upon by the Secretary of DHMH was the creation of the DHMH Office of Forensic Services. This Office is empowered to speak for the Secretary on forensic matters and to serve as liaison to the judiciary. In the liaison capacity, the Director is the designated contact person for resolution of problems and concerns judges may have with the competency and criminal responsibility procedures as well as the HG 8-505 commitments. Whenever a decision about which agency has responsibility for a given defendant or which facility will admit the defendant and when the admission will occur, are all matters in need of immediate attention and solution for the judge faced with the problem. The Director of the DHMH Office of Forensic Services is the judiciary's problem solver.

INDEX

COMPETENCY GUIDELINES

5) What happens to the information once it is submitted?
6) Is the written statement admissible at the hearing or review of commitment?
7) May the victim/victim's representative attend hearings involving the defendant?

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COMPETENCY GUIDELINES

I. Substantive Standards for Incompetency to Stand Trial

1) What is the legal definition of IST?

Incompetent to stand trial means not able to: 1) to understand the nature or object of the proceeding; or 2) to assist in one's defense. Md. Code Ann. CP § 3-101 (f); *Rozzell v. State*, 5 Md. App.167, 245 A.2d 917 (1968), *cert denied*, 252 Md. 732 (1969); *Hill v. State*. 35 Md. App. 98, 369 A.2d 98 (1977); *Peaks v. State,* 419 Md. 239, 251 (2011).

2) What is the requisite understanding and ability to assist counsel?

The defendant must have a rational as well as factual understanding of the *proceedings and sufficient present ability to consult with his/her attorney with a* reasonable degree of rational understanding. At a minimum, the defendant must be sufficiently coherent to provide his/her attorney with information necessary or relevant to constructing a defense. *Dusky v. United States,* 362 US 402, 80 S. Ct. 788, 4 L.Ed. 2d. 824 (1960); *Raithel v. State,* 280 Md. 291, 372 A.2d 1069 (1977); *Gregg v. State*, 377 Md. 515, 527 (2003).

3) Do conditions such as physical disabilities or amnesia render a defendant incompetent to stand trial?

The issue is one of mental competence, either mental disorder or mental retardation, and does not encompass physical illness or disability, inability to attend court, or other reasons, which may require a continuance. *Colbert v. State,* 18 Md. App. 167, 245 A.2d 726, *cert denied*, 269Md. 756 (1973).

Amnesia, by itself, as to the events of the crime charged, does not justify a finding of incompetence. *Morrow v. State*, 293 Md. 247, 443 A. 2d 108 (1982); *Evans v. State*, 322 Md. 24, 585 A.2d 204 (1991).

4) What is the difference between competency to stand trial and competency to waive the right to counsel or a jury trial?

The standard for competence to waive rights is the same as the standard for competence to stand trial. *Godinez v. Moran*, 509 U.S. 389, 113 S.Ct. 2680, 125 L.Ed. 2d 321 (1993); *Thanos v. State*, 332 Md. 511, 632 A.2d 768 (1993).

II. Initiating the Incompetent to Stand Trial Proceedings

1) Who may raise the question of competency to stand trial?

The court's duty to determine the competency of a defendant is triggered by an allegation by a defendant or defense counsel or upon the court's *sua sponte* decision that the defendant appears to be incompetent. Competency may be raised by defense counsel, even over the objection of the defendant, or by the prosecutor. Md. Code Ann. CP § 3-104 (a); *Langworthy v. State*, 46 Md. App. 116, 416 A.2d 1287, *cert. denied*, 288 Md. 798 (1980), *cert. denied*, 450 U.S. 960 (1981); *Thanos v. State*, 330 Md. 77, 85, 622 A.2d 727, 730 (1993); *Peaks v. State*, 419 Md. 239 (2011); *Wood v. State*, 436 Md. 276, 81 A.3rd 427 (2013).

2) When is a *sua sponte* inquiry by the court required?

If the court finds from the evidence and/or its observation of the defendant's behavior in court that there is a "bona fide doubt" that the defendant is incompetent, a competency inquiry is required.

Mere eccentric behavior does not require a *sua sponte* inquiry by the court, especially if the issue of competence is not otherwise presented to the court or apparent from other evidence. *Gregg v. State,* 33 Md. 515, 528 (2003); *Peaks v. State*, 419 Md. 239, 253 (2011).

3) When may the issue of competency be raised?

The issue may be raised in a criminal case before or during a trial or during a violation of probation proceeding. Md. Code Ann. CP § 3-104(a).

4) How is the question of competency to stand trial raised?

The issue of competency to stand trial is raised if it is alleged in any fashion, and no plea or motion is required. Md. Code Ann. CP §3-104(a). However, the allegation of competency must be "sufficient" to alert the trial judge to its duty to determine whether the defendant is competent to stand trial. *Kennedy v. State*, No. 51 Sept. Term 2013, Decided 2/21/2014.

III. Competency Examination

1) When is a competency examination ordered?

After giving the defendant an opportunity to be heard, the court finds good cause to order the Health Department to examine the defendant to determine whether the defendant is incompetent to stand trial. Md. Code Ann. CP § 3-105.

2) Is the court required to order a competency examination?

While an expert opinion from a psychiatrist can be very useful and is usually recommended, such testimony is not necessarily required before the court may make a determination of competency beyond a reasonable doubt. *Hill v. State,* 35 Md. App. 98, 369 A.2d 98 (1977); *Bean v. Dept. of Health and Mental Hygiene, 406 Md. 419, 437,* 959 A.2d. 778, *(2008).* Observation of a defendant in the courtroom can be critical and dispositive evidence on the issue of competence to stand trial. *Gregg v. State*, 377 Md. 515, 547, 833 A.2d 1040,1059 (2003). See also *Muhammad v. State*, 177 Md.App. 188, 266, 268, 934 A.2d 1059, 1105, 1106 (2007).

3) How long does it take to complete a competency examination and receive a report?

The defendant is entitled to have the report within seven (7) days after the court orders the examination. Upon a finding of good cause, the court may extend the time. Md. Code Ann. CP §3-105(d) (2). After much discussion and negotiation among the judiciary, the Department, and criminal justice partners, a system for prompt "screening" by the Community Forensic Screening Program was put in place. The program began in Baltimore in 1979 and was expanded to all jurisdictions by 1984. At present it is used in many, but not all, jurisdictions. A screening is a brief examination performed either in custody or outpatient, if the defendant has been released on recognizance or bail. The "screening" is completed within seven (7) days, and the opinion is either competent or "possibly not competent". In the latter case, the screener requests additional time for an evaluation in an inpatient setting. *Lewis v. State,* 79 Md. App. 1, 13, 555 A.2d 509, *cert. denied*, 316 Md. 549, 560 A.2d 118 (1989).

In addition to the opinion, when the Community Screening Program was developed, it was agreed that brief treatment recommendations would be included with the report, if the screener opines that the defendant is competent but has a mental illness. Over the years, in many jurisdictions, the recommendations for treatment have become more and more cursory and have disappeared entirely in some counties. The Department currently will include brief treatment recommendations for mentally ill defendants opined to be competent "if necessary to ensure the defendant remains competent to stand trial." (See Addendum for Order for Competency Examination CC-DC-CR 108A)

4) What is a "definitive evaluation"?

In recent years, the Department has implemented a process for "definitive competency and criminal responsibility evaluations" for some types of cases in some jurisdictions. The "definitive evaluation" consists of a complete evaluation as opposed to a screening. The defendant opined incompetent and dangerous is not admitted to the hospital until the court makes that finding and enters the Order for Commitment. The statute makes no distinction between "screenings" and "definitive evaluations", and the "definitive" competency evaluation must also be completed within seven (7) days. (See Appendix for a list of those jurisdictions where "definitive"" evaluations are conducted). The "definitive evaluation" model is not used in cases in which the defendant is charged with "Perkins level" crimes[4] and in many cases in which the defendant is deemed to have an intellectual disability (mental retardation) rather than primarily a mental disorder.

It is incumbent upon the judge and the attorneys to insure that the case is scheduled properly, and that the competency hearing is scheduled for no more than seven (7) business days after the Order for Competency Evaluation is entered. If a request for extension of time is submitted, and the court finds good cause exists for granting the request, the case can be re-scheduled accordingly. Close attention to the statutory time line is particularly important in jurisdictions where "definitive" evaluations are performed, since defendants opined incompetent are not admitted into the hospital until the court makes a finding of incompetent. The court has an interest, and, perhaps, a duty to move incompetent detainees from the detention center to a treatment setting as soon as possible.

5) Where does the competency examination take place?

The court **shall set and may change** the conditions under which the examination is to be made**.** Md. Code Ann. CP §3-105 (a) 2. The Order for Competency Evaluation sets out the judge's options in deciding where the examination will take place, as well as the dates for return of the defendant to court.

a) The judge may release the defendant on recognizance or bail and order an outpatient evaluation. Outpatient evaluations can be difficult to manage, for a variety of reasons, including problems scheduling the evaluation, missed appointments, delays in completion, and the quality of the community plan. Those concerns aside, there are many benefits to the outpatient evaluation in appropriate cases, where safety is not an issue, and there is confidence that the appointment will be kept. Since some likely incompetent defendants may have difficulty getting to the evaluation on time, a family member or friend may be willing to assist in insuring that the defendant appears when ordered to do so. Md. Code Ann. CP § 3-105 (b).
(Some MHA facilities utilize what they call "presumptive outpatient evaluations" in order to avoid an inpatient hospitalization when the community screener opines "possibly not competent" and recommends further evaluation in an inpatient setting. These evaluations are used for defendants in custody, and, therefore, are not outpatient. They

[4] "Perkins level charges" are: Child abduction; first degree arson; assault with a firearm; carjacking; kidnapping; murder in the first and second degree; rape; robbery with a dangerous weapon; first degree sexual offense and any attempt to commit any of the listed crimes.

are also conducted in direct contravention of the statute, since the defendant is seen in the hospital and returned to the detention center instead of to court after the evaluation. In many cases, the court is under the impression that the defendant is being evaluated and treated in the hospital until the hearing date, when, in fact, the defendant remains in the detention center.)

b) The vast majority of competency evaluations occur while the defendant is in custody. If the defendant is incarcerated, the judge has a number of options for the location of the examination, depending upon the severity of the illness and/or the risk incarceration poses to the defendant.

1) If the court believes that special housing within the correctional facility is required to protect the defendant's health and safety, the court may order that the defendant be placed in a medical or other " isolated and secure" unit. Md. Code Ann. CP § 3-105 (c).

2) If the court finds that the defendant's mental condition is so severe that he/she would be endangered by incarceration in a detention center, the court may order the Health Department to make alternative arrangements. The Health Department may use its discretion to either conduct the evaluation immediately or to confine the defendant, pending examination in a medical facility. Historically, the Health Department has not been able to conduct immediate evaluations, so the "at risk" defendant is generally placed in either a state psychiatric hospital or forensic center for evaluation. Md. Code Ann. CP § 3-105(c).

Since the judge is responsible for setting the conditions under which the examination is to be conducted, the Commitment for Competency Examination (CC –DC-CR 107) includes check off boxes for each option.

6) What constitutes good cause to extend the time for the examination?

Typically, a legitimate basis of good cause is to allow for additional time to more fully evaluate the defendant in an inpatient setting. A thirty (30) day extension is usually a more than adequate amount of time; however, the judge may wish to grant a shorter time depending on the circumstances.

7) How long will it take to obtain a bed for the defendant if the judge grants the extension?

The Department has expressed confidence that "definitive evaluations" can be completed within the 7 days without the need for an extension. Therefore, the extension/bed delay issue may only be a potential problem for those cases in which a "screening" rather than a "definitive evaluation" is performed.

DHMH has agreed to arrange for a bed in no more than 3 days. The Department further agreed that the forensic screener will include a line in the report which provides

that in the opinion of the examiner, the defendant will not be a risk in the detention center until an inpatient bed is obtained, if, in fact, that is the opinion of the screener.

It is important for the court and defense counsel to closely monitor the time frame for the admission in order to insure that the "possibly incompetent" defendant is promptly placed in an appropriate treatment facility. The obligation under Md. Code Ann.CP 3-105 (a) (2) that "the court shall set and may change the conditions under which the examination is to be made" helps to assure the procedural due process required in a given case. See, *Pate v. Robinson*, 383 US 375, 385-386(1966) and its progeny. The court's ability to set the date of admission along with tailoring the length of extended evaluation and other procedures for a particular case may further not only fair adjudication of an often fluid competency issue, but also may promote appropriate treatment, expedited restoration and least restrictive placement.

If the judge believes that the defendant is at risk in the detention center pending admission to an inpatient facility and the Department is not making sufficiently prompt arrangements for a bed, the judge can exercise the statutory authority to set the conditions for examination pursuant to Md. Code Ann. CP § 3-105 (c) (2) (i).

8) What does the report of the competency evaluation contain?

At a minimum, the report should include an opinion on competency and the basis for the opinion. If the examiner opines that the defendant is incompetent, the report should state, in a complete supplementary opinion, whether the defendant would be a danger to self or the person or property of another because of mental disorder or mental retardation, if released. Md. Code Ann. CP § 3-105 (d) (3).

If an addendum to the Order for Competency Examination (See, CC-DC-CR 108A) requesting a treatment plan is submitted, the Department has agreed to include a recommended plan of services. When the evaluation is performed in the hospital or SETT Unit, the defendant/patient is entitled to an aftercare plan. (See Chapter 6.2)

9) Who may give an opinion on competency?

An opinion on competency must be made by a psychiatrist or licensed psychologist. *Colbert v. State,* 18 Md. App. 632, 642, 308 A.2d 726, 732, *cert. denied*, 269 Md. 756 (1973).

There is also legal foundation for allowing licensed clinical social workers to provide an opinion on competency; however, the Department does not currently utilize clinical social workers for this purpose. Md. Health Occupations Code Ann. § 19-101 (m)(4) (2014)

10) Where does the defendant go after the competency examination?

Unless the Department retains the defendant, the defendant is returned to the court. Md. Code Ann. § 3-105 (c) (2) (ii). The court must be attentive to the scheduling to

insure that the issue of competency is decided promptly and that incompetent defendants who require hospital level care receive that care and that competent defendants do not take up hospital beds.

IV. Procedure

1) What happens when competency is raised?

The court **shall** determine, on evidence presented on the record, whether the defendant is competent to stand trial. If the issue arises during the course of a jury trial, the mandatory determination takes place out of the presence of the jury. Md. Code Ann. CP § 3-104 (a); *Jones v. State*, 280 Md. 282, 372 A. 2d 1064 (1977); *Hill v. State* 35 Md. App. 98, 369 A 2d 98 (1977).

2) What happens to the criminal charges before, during, and after the competency proceeding?

The trial stops until the defendant is found competent or the charges are dismissed or otherwise terminated. In *Hill v. State*, the court stated that when the trial judge is unable to find the accused is competent, "the trial is not commenced, or if commenced must be suspended or a mistrial declared as the ends of justice in a particular case may require." *Hill v. State*, 35 Md. App. 98, at 107.
However, if the defendant is found to be incompetent, defense counsel may make any legal objection to the prosecution that may be determined fairly before trial and without the personal participation of the defendant. Md. Code Ann. CP § 3-106 (d).

3) What happens to the right to a speedy trial?

Any delay resulting from the evaluation or commitment of an incompetent defendant is not chargeable to the State for speedy trial purposes. *Langworthy v.State*, 46 Md. App. 116, 416 A. 2d 1287, *cert. denied*, 288 Md. 738 (1980), *cert denied*, 450 U.S. 960, 101 S. Ct. 1419, 67 L. Ed. 2d 384 (1981).

4) Is the court ordered competency report admissible without live testimony from the examiner?

Due process does not require that the reporting experts be personally present at the competency hearing. The report constitutes "evidence presented on the record". Any party that wants to question him/her on the record must subpoena the examiner. *Sangster v. State*, 312 Md. 560, 541 .2d. 637 (1988); *Peaks v. State*, 419 Md. 239, 254-56 (2011).

5) Is a formal competency hearing required?

The determination of the court does not have to be in the form of a formal hearing. A judge with no jury present is not "required to use any magic words to designate as a separate hearing the presentation to him of testimony and evidence for his determination of the competency of the accused to stand trial." *Roberts v. State,* 361 Md. at 368, 761 A.2d at 897, *Peaks v. State*, 419 Md. 239, 18 A.3d. 917 (2011).

6) What is the burden of proof?

The court must find beyond a reasonable doubt that the defendant is competent to stand trial. *Strawderman v. State*, 4 Md. App. 689, 244 A. 2d 888 (1967), (*cert denied)*, 252 Md. 733 (1969). *Jolley v. State*, 282 Md. 353, 384 A.2d 91 (1978).

All doubts and ambiguities are resolved in favor of incompetency. *Langworthy v.State*, 46 Md. App. 116, 416 A.2d 1287, *cert denied*, 280 Md. 738 (1980), *cert. denied* 450 U.S. 960, 101 S.Ct. 419, 67 L.Ed. 2d 384 (1981).

7) Are statements made during the course of the examination admissible to establish guilt?

Any statement made by the defendant during the examination is not admissible to prove the commission of a criminal offense or to enhance the sentence. Nor is a report prepared as a result of an examination admissible to prove the commission of the offense or to enhance the sentence, with the exception of use for the purpose of impeaching the defendant's testimony. Md. Code Ann. CP §§ 3-105 (4)-(5).

8) May the defendant challenge the IST finding?

The defendant may challenge the finding by means of habeas corpus. Md. Code Ann. CP §3-105 (c)(3).

9) May the defendant appeal the finding of IST?

Pursuant to the collateral order doctrine, the finding of IST is appealable. *Jolley v. State,* 282 Md. 353, 357, 384 A.2d 91 (1978), *Adams v. State,* 204 Md. App. 418, 41 A.3d 572 (2012).

V. Transportation

1) Which agency is responsible for transportation from the detention center to the hospital or forensic center for evaluation?

The local detention center is generally responsible for transportation prior to commitment as IST-D. After the commitment, it is up to the hospital or forensic center to transport to court.

There are some exceptions to this general rule. Clifton T. Perkins Hospital Center and the DDA SETT Unit prefer to use their Transportation Units to transport defendants to court for hearings after examination and after commitment as IST-D.

VI. Finding of Incompetent to Stand Trial

1) What happens after the defendant is found to be IST-D?

If the court finds that because of mental disorder or mental retardation the incompetent defendant is a danger to self or the person or property of another, the court may commit the defendant to the DHMH facility **designated by the Department**. DDA shall provide the care and treatment the defendant needs, if the defendant is found IST-D because of mental retardation. Md. Code Ann. CP § 3-106 (b).

2) When the court finds the defendant IST-D, where does the defendant go?

The Department determines the facility and should include the name of the facility in the report, if the defendant is opined IST-D. Obviously, the designation of the facility should be accomplished prior to submission of the report. If, for some reason, the name of the facility is omitted from the report and the Department remains undecided, contact the Director of DHMH Office of Forensic Services for a decision.

The state psychiatric hospitals tend to utilize a regional catchment area, so, with the exception of “Perkins level charges”, for defendants found IST-D because of mental disorder, the Department will usually designate the regional hospital for the jurisdiction. In addition, if the defendant was evaluated in either a state psychiatric hospital or a DDA forensic center, the defendant generally returns to that facility.

3) When is the IST-D defendant admitted?

The defendant should be immediately transported to the designated DHMH facility and admitted.

4) What happens when the defendant is found to be IST-ND?

Except in a capital case, the court may set bail or release the defendant on recognizance. Md. Code Ann. CP § 3-106 (a).

Typically, the IST-ND defendant is released on recognizance with conditions that incorporate the terms of the treatment plan or any restoration services. However, if the court decides to set a bail, the conditions could be incorporated as well.
(See, CC-DC-CR 059, 132, 128)

5) How is the IST-ND defendant monitored in the community?

In most cases, the defendant will be found not dangerous due to their mental disorder or mental retardation provided he/she complies with a recommended treatment regimen. Therefore, monitoring compliance and the need for any changes is generally important for the defendant's well-being and for public safety reasons.

If the competency evaluation was performed in a hospital or forensic center, and if CFAP determines that the plan can be monitored in the community, CFAP has agreed to monitor those defendants. If the evaluation is performed on an out- patient basis, those jurisdictions that have Pretrial Services could utilize that agency for monitoring/supervision. Other jurisdictions will have to be creative and develop relationships with the service providers, so that any needed information is accessible. As long as the case remains open, the court retains jurisdiction and must, at a minimum, conduct the mandatory annual hearing.

6) Who performs the evaluation and prepares the report for the annual hearing for defendants found IST-ND?

The statute specifically provides that the requirement for the mandatory annual hearing applies whether or not the defendant is confined. However, we can only assume that the Department has the responsibility for the re-evaluation and report for defendants found to be IST-ND.

When the competency statute was amended, CFAP was monitoring the IST-ND defendants and would facilitate the arrangements for the new evaluation as well submitting the Annual Hearing Report for IST-ND Defendants in the Community. (See CC-DC/MH 8) Recently, the Department has limited the role of CFAP with the IST defendants. Therefore, as a backup, it is suggested that a new competency evaluation be ordered for the Annual Hearing, if the judge feels an evaluation is necessary. Since the Department is statutorily required to conduct court ordered competency evaluations, the Department must determine where the evaluation will take place, and insure timely submission of the evaluation report.

VII. Judicial Review/Monitoring

1) How does the court determine whether there has been a change in the defendant's status or whether it is likely that the defendant will become competent in the foreseeable future?

Whether or not the defendant is confined, the court may hold a discretionary status conference or a hearing on the record at intervals the court deems appropriate. Typically, the status conferences or hearings are held at least every six months, in order to insure that the defendant is not kept in an IST status any longer than required by law and that hospitalized defendants are released to the community as soon as that level of care is no longer needed. Md. Code Ann. CP §§ 3-106 (c) (2), (f) (1) (ii).

2) When is a hearing on the record required?

The court must hold an annual hearing and must hold a hearing within 30 days if the State or defense files a motion setting forth new facts or circumstances. Likewise, a hearing must be held within 30 days of the Department submitting a report stating a new opinion or new and relevant facts or circumstances. Md. Code Ann. §§ 3-106 (c) (1), (f) (1).

3) When does the Department submit reports to the court?

In addition to submitting a report for status hearings/conferences and for the annual hearing, DHMH is required to report to the court every six months and whenever the Department's opinion is that the defendant is no longer incompetent, is no longer dangerous due to mental disorder or mental retardation, or is not restorable. Md. Code Ann. CP § 3-108 (a) (1).

4) What information is in the report?

A full evaluation report is submitted for the annual hearing and whenever the report states a change in the defendant's clinical status. One significant feature of the amended competency statute is the requirement that the Department develop a discharge/continuing care plan and include the plan in a supplemental report if stating the opinion that the defendant is competent or no longer dangerous and services are needed to maintain the defendant safely in the community, to maintain competency, or to restore competency. If it is the opinion of the Department that the defendant is not likely to become competent in the foreseeable future, the report will also indicate whether the Department believes that the defendant meets the criteria for commitment pursuant to CP § 3-106 (d). In addition, for defendants committed to a DDA facility, the report will state whether the defendant is eligible for DDA services and whether the services needed could be provided in a less restrictive setting. Md. Code Ann. CP §§ 3-108 (2)-(5), (See, CC-DC-MH-001, 008)

VIII. Duration of IST-D and IST-ND Commitments

1) How long does a competency commitment last?

The court may commit the defendant until the court finds that:

a) The defendant is no longer incompetent.
b) The defendant is no longer a danger because of mental disorder or mental retardation.
c) There is not a substantial likelihood that the defendant will be restored to competency within the foreseeable future, or
d) The charges are dismissed pursuant to Md. Code Ann. CP § 3-107.

2) When are the charges subject to dismissal pursuant to CP § 3-107?

In 2006, the competency statute was amended to comply with *Jackson v. Indiana,* 406 U.S. 715 (1972), which held that "A person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future."

The dismissal provisions of the statute apply **whether or not the defendant is confined (IST-D or IST-ND**), and, unless the State successfully petitions for extension, dismissal is mandated:

a) After the expiration of 10 years when charged with a capital offense
b) After the lesser of 5 years or the maximum sentence for the most serious crime charged, when charged with a felony or statutory crime of violence
c) After the lesser of 3 years or the maximum sentence for the most serious offense charged, when charged with anything not covered in a. and b.

3) What constitutes extraordinary cause to extend the time limits?

"Extraordinary cause" is not defined in the competency statute, but the Court of Appeals has in the past referred to it as cause that is beyond the ordinary or commonplace, limited to the rarest of circumstances. Recently, the Court of Appeals stated "neither the seriousness of the charge nor the dangerousness or restorability of the individual is solely determinative." *State v. Ray,* 410 Md. 389, 419-420 (2009).

4) What action may the court take if the IST defendant is not likely to become competent in the foreseeable future?

When the court finds that the defendant committed due to mental disorder is not restorable, there is no longer justification for continuing court jurisdiction. If the court finds that the defendant meets the following standards (which are the same standards as those for civil admission), the court may involuntarily commit the IST-D defendant to the state psychiatric hospital if the court finds by clear and convincing evidence that:

a) the defendant has a mental disorder;
b) inpatient care is necessary for the defendant;
c) the defendant presents a danger to the life or safety of self or others;
d) the defendant is unable or unwilling to be voluntarily committed to a medical facility; **and**
e) there is no less restrictive form of intervention that is consistent with the welfare and safety of the defendant. Md. Code Ann. CP § 3-106 (d) (1)

When the defendant is incompetent to stand trial due to mental retardation the court shall order the confinement of the defendant for 21 days as a resident in a

Developmental Disabilities Administration facility for the initiation of admission proceedings pursuant to Health General Article § 7-503 if the court finds that the defendant, because of mental retardation, is a danger to self or others. Md. Code Ann. CP § 3-106 (d) (2).

5) What is the standard of proof?

The State must prove that the incompetent defendant meets commitment standards by clear and convincing evidence.

6) How long does the court's civil commitment/confinement last?

The provisions of Title 10 of the Health-General Article apply to the continued retention of defendants committed because of mental disorder and the provisions of Title 7 of the Health-General Article apply to defendants ordered confined in a DDA facility.

The individual committed to a psychiatric hospital can be released at any time the hospital believes the individual no longer meets the criteria for retention, or is willing to be a voluntary patient. If the individual is still involuntarily committed after 5 months, an administrative hearing must be convened before the individual is committed for 6 months.

An individual committed to DDA must have a hearing within 21 days on a DDA admission. If DDA finds the individual does not meet the admission criteria, the individual may be released to the community.

7) Under what circumstances may the State re-institute the charges after a dismissal without prejudice?

The State may re–indict a defendant after a CP § 3-107 dismissal without a showing that the defendant has become competent. However, a dismissal of charges under § 3-107 creates a rebuttable presumption that there is no substantial likelihood that the individual will become competent in the foreseeable future, and the defendant may not be held in IST commitment unless the State overcomes the presumption. Otherwise, the court shall initiate civil commitment proceedings in accordance with CP § 3-106 (d). *State of Maryland v. John Wesley Ray,* 429 Md. 566, 57 A.3d 444 (2012).

IX. Notification of Dismissal

1) Who must the court notify prior to dismissal of the charges?

The court must notify the State's Attorney and a victim/ representative who has requested notification pursuant to HG 3-123 and provide them an opportunity to be

heard. In addition, the court must report the dismissal to CJIS. Md. Code Ann. Crim. Proc. 3-107 (c).

X. Public Access

1) What contents of the court file are not subject to public access?

Public access is automatically denied for case records that consist of a medical or psychological report or record from a hospital, physician, psychiatrist, or other professional health care provider containing medical/psychological information about an individual or a case record that contains information concerning the consultation, examination, or treatment of a developmentally disabled person. Maryland Rule 16-1006 (h), Maryland Code Ann. Heath General Article § 7-1003.

In addition, Code, Correctional Services Article § 6-112 prohibits public access to the contents of a Presentence Investigation conducted by the Department of Parole and Probation.

2) How should the confidential records be stored?

There is no requirement that a separate file be maintained for confidential information. However, it is advisable to at least maintain the records together, in order to avoid any problems if public access is requested.

XI. Victim's Rights

1) What rights does a victim have when a defendant is found IST?

When draft amendments to the competency statute were being developed, the victims' rights representative who participated was quite active in advocating for a full range of rights for his constituency. A victim has a number of rights to be informed of certain actions and proceedings involving the IST defendant. These rights are predicated on the victim/representative filing a request pursuant to CP 3-123 (c).

2) Who has the responsibility to inform the victim or their rights?

The State's Attorney must inform the victim/representative of their rights.

3) What are the notification responsibilities of the Health Department?

Once the Department has been advised of the victim/representative's request for notification, the Department must notify the victim/ representative in writing when:

a. the Health Department receives a court order to evaluate the defendant.
b. the Health Department receives a court order committing the

defendant.
c. a hearing involving the defendant is scheduled.
d. the Health Department receives notice of a petition or hearing for release.
e. the Health Department receives a court order for conditional release or discharge from commitment.
f. the ALJ recommends release.
g. the defendant is absent without authorization.
h. a hospital warrant has been issued, or a defendant charged with a statutory crime of violence has been charged with violation of probation.

4) May the victim submit information and requests to the court and the Health Department?

With the exception of a competency or criminal responsibility hearing, the victim/representative may submit a written or oral statement about the crime, its consequences, any contacts after the crime from the defendant, as well as a request that the defendant be prohibited from future contact with the victim or the victim's family as a condition of release, to the court and to the ALJ who is conducting a hearing or review relating to the defendant. Md. Code Ann. CP § 3-123 (e)(2).

In addition, a written or oral statement containing relevant information and /or a request for no contact from the defendant may be submitted to the State's Attorney and the facility where the defendant is committed. Md. Code Ann. CP § 3-123 (e)(1).

5) What happens to the information once it is submitted?

The law requires the recipient to consider the information and/or request and to delete the victim/representative's contact information from any document before the document is shown to the defendant. The Health Department must maintain the statement/request separate from the defendant's medical record at the commitment facility. Md. Code Ann. CP § 3-123 (f).

6) Is the written statement admissible at a hearing or review of the commitment?

At least 30 days prior to the hearing or review, the Health Department must inform the defendant of the intent to use the victim's written factual statement and must send the defendant a copy of the statement. Unless the defendant sends written notification of his/her objection to the admissibility at least 20 days prior to the hearing, to the Health Department, State's Attorney, court, and Office of Administrative Hearings, the objection is waived. If the defendant provides the required notice, the Health Department must inform the victim/representative that the statement is inadmissible, but he/she may attend the hearing and testify. Md. Code Ann. CP § 3-123 (2).

7) May the victim/victim's representative attend hearings involving the defendant?

If the requisite notice has been filed, the victim may attend hearings. However, in administrative hearings, at the request of the defendant, the ALJ may exclude the victim/representative from expert testimony, if the ALJ finds that the information is highly sensitive to the defendant and not relevant to the issues of release or violation. Md. Code Ann. CP § 3-123.

Section 2.2

Competency Highlights and Tips

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COMPETENCY HIGHLIGHTS AND TIPS

Who

May be raised by State, defense, or judge

When

Any time, including violation of probation

Degree of Proof

The court must determine beyond a reasonable doubt that the defendant is competent

Test for Competency

The accused must be able to understand the nature and object of the proceedings and to assist in defense.

Competency Examination

- Must have a hearing to determine whether competency examination should be ordered.
- Defendant must be present, represented, and given an opportunity to be heard. The PD will provide representation unless private counsel has been retained.
- Judge must present reasons for ordering the evaluation
- Insure Order for Competency Examination is complete
  Reasons specified by judge
  - Full names of S/A and PD or private counsel
  - Judge determines conditions of confinement
    (a) General population
    (b) Medical wing or other secure setting
    (c) Medical facility determined by Department
- Defendant is held without bail unless judge specifies otherwise
- 7 days for report unless extended for good cause. Most frequent legitimate reason for extension is to further evaluate the defendant in an in-patient setting.
- Schedule defendant to be returned to court in seven (7) (business) days *(Mondays H5 and Thursdays H2)*
- Report of outpatient examination is also due within (7) days unless extended for good cause
- *FAST should be requested to interview the defendant before ordering the evaluation, if possible*

Finding of Competent

- Judge sets bail or releases on recognizance
  - o May include treatment plan as conditions of release
  - o Specify monitoring/supervising agency on the order
- Defendant enters NCR plea
  - o Obtain written plea
  - o Prepare Order for Competency and Criminal Responsibility Evaluation
  - o If the defendant came from a psychiatric hospital or forensic evaluation unit, the defendant will return to that facility for the NCR evaluation
  - o If the defendant came from the detention center, schedule screening/evaluation
  - o 60 days are allowed for the criminal responsibility evaluation

EVALUATOR GIVES AN OPINION. THE JUDGE MAKES A FINDING.

Reports to the Court

- Facility reports to the court every 6 months from the date of commitment as IST-D and whenever DHMH opines that:
  - o Defendant is no longer IST
  - o Defendant is no longer dangerous to self or the person or property of others because of mental disorder or mental retardation
  - o There is not a substantial likelihood that the defendant will become competent in the foreseeable future
- DHMH must provide a supplemental report with plan for services to facilitate the defendant remaining competent or not dangerous if:
  - o Opinion is that the defendant is no longer IST or no longer IST-D (b/c of MD or MR); and
  - o Services are necessary to maintain the defendant safely in the community, to maintain competency, or to restore competency
- If appropriate, the plan shall include recommended
  - o Mental health treatment, including providers of care
  - o Vocational, rehabilitative, or support services
  - o Housing
  - o Case management services
  - o Alcohol or substance abuse treatment
  - o Other clinical services
- If report recommends community placement, it must include
  - o Location of placement
  - o Names and addresses of providers
  - o Statement that the provider is willing, able, and available to serve the defendant, and
  - o If available, the date of placement or service

o If the plan in the supplemental report is for a defendant committed to a DDA residential center, the report shall state whether:

  - the defendant meets the criteria for commitment under CP § 3-106(d)
  - the services could be provided in a less restrictive setting
  - the defendant is eligible for services pursuant to HG § 7-404
- If the opinion is that there is not a substantial likelihood that the defendant will become competent in the foreseeable future, the report must state whether the defendant meets the criteria for commitment under CP § 3-106(d).

Status Conference

- Discretionary
- Intervals to be determined by the judge
- Record not required
- Presence of defendant not required
- Any change in status or conditions requires a hearing with the defendant

Review Hearing

- Mandatory at least annually
- From the date of release if IST-ND and date of commitment if IST-D
- Within 30 days of motion by State or defense setting forth new circumstances
- Within 30 days of report from DHMH stating facts, opinions, or circumstances not previously presented

Possible Outcomes of Review Hearing

- Defendant found to be competent to stand trial
- Defendant found to be IST-D
- Defendant found to be IST-ND with conditions
- Defendant found to be IST-D and not restorable
  - Court determines whether the defendant meets the criteria for civil commitment by clear and convincing evidence
    i. Has a mental disorder
    ii. Needs inpatient care or treatment
    iii. Presents a danger to the life or safety of the individual or others
    iv. Unable or unwilling to be voluntarily admitted
    v. No available less restrictive form of intervention that is consistent with the health or safety of the individual
  - If so, commit to DHMH or
  - If the defendant presents a danger to self or others because of mental retardation, order the defendant confined for 21 days in a DDA facility for initiation of admission proceedings

Dismissal of Charges

Unless the State petitions for extension, the court shall dismiss charge

- 10 years if capital offense
- Lesser of 5 years or maximum sentence if felony or crime of violence
- Lesser of 3 years or maximum sentence, if other offense

DIFFERENCES BETWEEN COMPETENCY AND CRIMINAL RESPONSIBILITY

COMPETENCY

- Standard
  - 0 Unable to understand the proceedings **or**
  - 0 Unable to assist in defense
- Deals with condition at time of trial
- May be raised by:
  - 0 Court
  - 0 Defense or defendant
- May be raised at any time including violation of probation
- No plea or motion required
- Proceedings stop until defendant attains competency or charges are dismissed
- 7 days for evaluation
- Return to court after evaluation

CRIMINAL RESPONSIBILITY

- Standard
  - 0 Unable to appreciate criminality of conduct **or**
  - 0 Unable to conform behavior to requirements of the law
- Condition at time of offense
- May only be raised by the defendant
- Plea filed at time allowed for initial pleadings unless court, for good cause, allows more time
- Written plea filed by defendant or defense counsel
- Case continues after completion
- NCR plea is not permissible in violation of probation proceedings
- 60 days for evaluation
- Return to detention center/prison after evaluation (unless defendant is on bail or recognizance)

MAY NOT FILE NOT CRIMINALLY RESPONSIBLE PLEA IN DISTRICT COURT IF THE DEFENDANT IS CHARGED WITH A FELONY

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Section 2.3

Procedure for Judge

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JUDGE'S PROCEDURE FOR COMMITMENT FOR COMPETENCY EVALUATION [4]

(Criminal Procedure Article Section 3-104 et. seq.)

HEARING

1) Competency may be raised by the judge, State, or defense any time **before final verdict in a criminal case or a violation of probation proceeding.**

2) If the issue of competency is raised, a **hearing must be held and the defendant provided an opportunity to be heard** before deciding whether or not to order an evaluation. Insure that the Office of the Public Defender represents the defendant unless the defendant has retained private counsel, and that the Office of the State's Attorney is present.

FAST should be contacted for guidance and to involve that agency in the planning for the defendant. However, if FAST staff is not available, do not postpone the bail review. The State's Attorney and Public Defender have given their assurances that they will be responsive.

3) Record the names of the State's Attorney and Public Defender in the court file and on the order. Insure that the order is fully completed.

4) If a competency evaluation is ordered, the judge must make findings of fact to support a finding of good cause to believe the defendant may be incompetent. The facts upon which the Order for Competency Evaluation is based should be recorded on the order.

OUTPATIENT OR IN-CUSTODY

1) The competency evaluation may be ordered on an outpatient or in-custody basis. Usually, the judge orders that the defendant be confined for evaluation and sets "no bail" pending evaluation. (See Procedure For Outpatient Evaluation Section 2.4)

2) If an in-custody evaluation is ordered, the defendant should be held without bail. It is, of course, the judge's prerogative to set a bail, but if the bail is posted and the defendant released prior to completion of the evaluation, it may be difficult to avoid re-scheduling and the delay in case processing that would result.

[4] Procedures applicable only to Baltimore City are in italics.

CONDITIONS OF CONFINEMENT

1) The statute requires that the judge determine the conditions of confinement. If you feel that the defendant would be **vulnerable** in the general jail population, designate medical wing or other secure setting. Unless you are confident that local detention center staff will be attentive to all provisions of the order, it may be advisable to contact the appropriate detention center personnel to inform them of the special housing condition. *In Baltimore City, if you order that the defendant be housed in a medical wing or other secure setting, the clerk must fax a copy of the order to BCDC Central Records to insure compliance.*

2) If you find that, because of the apparent severity of the mental disorder or mental retardation, the defendant in custody would be **endangered by confinement** in the jail, you may order DHMH, in its discretion, to either immediately conduct the examination or to confine the defendant in a medical facility.

3) Typically, DHMH will opt for authorizing the immediate hospitalization for evaluation. Contact the Director of **DHMH Office of Forensic Services**[5] to facilitate the admission or, if the Department chooses, the immediate evaluation*. Request that FAST contact the forensic coordinator and ask that the defendant be admitted immediately. In the event of problems with that approach, the court should contact the Director of DHMH Office of Forensic Services to intervene and resolve the issue. If the defendant is in jail, the BCDC Transportation Unit will take the defendant to the hospital. If the defendant is in the courtroom, and you feel that the defendant is too vulnerable to be confined, the BPD will provide the transportation. If a responsible family member is available and the defendant is compliant, you may wish to allow the family to transport.*

TIME FOR EVALUATION

1) The law requires that the report of the evaluation be completed within 7 days unless the judge extends the time for good cause. It is important that the judge insure that the matter is scheduled for hearing right after the date the report is due. *The Mental Health Court (MHC) clerk will obtain an evaluation date ("to be seen") and a "to be returned" date from the Medical Services Division of the Circuit Court, Community Forensic Screening Program.*

2) The defendant is to be returned to **court not to jail** upon completion of the evaluation.

3) In those jurisdictions where "definitive evaluations" are performed, the defendant will usually not be admitted into the hospital for the evaluation. The admission will probably not occur until the competency hearing is held, and the judge finds the defendant IST-D.

[5] The DHMH Office of Forensic Services serves as liaison between the Judiciary and the Department and, among other things, acts as a "problem solver."

REQUEST FOR EXTENSION OF TIME TO COMPLETE EVALUATION

1) If the screener is of the opinion that the defendant is "possibly not competent," further evaluation in a hospital will be recommended. On the "to be returned" date, a request for extension to allow for the further evaluation will be submitted by the screener. The request will contain good cause for the extension (usually "in order to further evaluate in an inpatient setting"), the date of admission, which will be within 2 business days, and the name of the DHMH facility. In addition, the request will include verification from the screener that the defendant will not be endangered by confinement in the jail until the admission date.

2) The judge may authorize the extension without hearing. However, the State's Attorney and Public Defender should be notified of the request and the action taken by the judge. *The MHC clerk will submit the request and an order with the requisite information for the judge's consideration.*

3) The Order for Extension must be fully completed including the date of admission, the name of the admitting facility, and the trial date. Include the Addendum to the Order for Competency Examination regarding submission of discharge plan (See forms CC-DC-CR 108 sample, and CC-DC-CR 108A).

REPORT SUBMITTED ON "TO BE RETURNED" DATE OPINING THE DEFENDANT COMPETENT TO STAND TRIAL

1) The screener or the forensic coordinator will fax the report to the *MHC* clerk who will insure that the court file and report are included on the MHC docket. Copies of the report will be provided to the judge, *FAST*, the State's Attorney and the Public Defender. *All evaluative material will be maintained in the confidential section of the court file.*

2) *FAST will assess for Mental Health Court and follow the referral process if the defendant meets the criteria.*

3) *If the defendant is eligible for Mental Health Court and agrees to participate, the case remains in MHC. If the defendant is not eligible or does not wish to participate, schedule for trial in the District of origin on the original trial date or the closest available date to the original. If the original trial date has passed, schedule as soon as possible and, in no event, beyond 30 days.*

4) The competency hearing will be held, and if the judge finds the defendant competent, the bail will be reconsidered.

5) The judge should note the finding and bail on the bottom of the pretrial docket so that any other judge who may follow can easily see the ruling. This also helps the court clerk know what entry to make.

REPORT SUBMITTED INDICATING THAT EXAMINER BELIEVES DEFENDANT IS INCOMPETENT

1) The report shall be sent to *MHC* clerk, the judge, State's Attorney, defense attorney, *FAST and the MHC coordinator.*

2) If the report is submitted before the scheduled trial date, the matter will be scheduled for the competency hearing only.

JUDGE FINDS THE DEFENDANT INCOMPETENT AND DANGEROUS DUE TO MENTAL DISORDER OR MENTAL RETARDATION

1) If, after a competency hearing, the judge finds the defendant to be IST-D, the court commits the defendant to DHMH and orders the defendant to be transported to a facility the DHMH designates. The designated facility should be named in the report.

2) The court **may** schedule a status conference or status hearing to be convened at intervals the judge deems appropriate.

3) The court **must** schedule an annual review hearing to be convened within 12 months of the date of the Commitment Order. DHMH has requested that the annual hearing date be scheduled at the time of the finding and commitment, so the Department is on notice of the time line. Scheduling the date at this time also helps the court and the parties.

4) DHMH **shall** submit the Annual Report and any Status Report containing a change in the defendant's clinical status at least **two weeks** prior to the scheduled hearing/conference. A Status Report containing no change in the clinical status shall be submitted at least **3 business days** before the Status Conference/Hearing. The report will address, among other things, the following: competency, dangerousness and restorability, and an appropriate discharge plan. (See CC-DC-MH-001, CC-DC-MH-008)

5) For the Annual Hearing or a Status Hearing, the facility's forensic coordinator will be summonsed. A writ to the facility should be issued for the defendant. For a status conference, the defendant's presence is not necessary.

6) DHMH may, at any time, submit a report to the court advising of a change in status (e.g., defendant now competent, no longer a danger, or will not become competent in the foreseeable future). The court **must schedule a hearing within 30 days** of receipt of the report.

JUDGE FINDS THE DEFENDANT INCOMPETENT BUT NOT DANGEROUS DUE TO MENTAL DISORDER OR MENTAL RETARDATION

1) The judge shall rescind the commitment to DHMH and may release the defendant on conditional bail or recognizance. (See Forms CC-DC-CR-059, 132, 128)

2) Prior to the hearing, the DHMH should have submitted a report listing the services necessary to maintain the defendant safely in the community and to restore competency. Such services may include:

a. Mental health treatment, including providers of care.
b. Vocational, rehabilitative or support services.
c. Housing.
d. Case management services.
e. Alcohol or substance abuse treatment.
f. Other clinical services.

3) If community placement is recommended, the report should include:

a. Location of placement
b. Names and addresses of recommended provider/s
c. Statement indicating whether the service provider is willing and able to serve the defendant.
d. If available, date of placement and/or appointments for service/s for the defendant.

4) If the defendant is coming from a DHMH facility, the proposed conditions should be submitted by the hospital or DDA forensic residential center to the Community Forensic Aftercare Program (CFAP) for review prior to the hearing.

5) If the defendant is coming from the local detention center or the community, CFAP will not monitor the defendant's compliance with the court order in the community. In those jurisdictions with a PTS agency, that agency can provide the monitoring services.

6) If CFAP or another agency agrees to monitor, and the defendant is released with conditions, a release order must be prepared. (CC-DC-CR-059, 132, 128)

7) The release order shall contain the date and time of the required Annual Hearing.

STATE ELECTS TO NOL PROS OR OFFER A STET

1) In some cases, the hospital or residential center may be prepared to civilly commit or admit the defendant, or the defendant may be willing and able to enter into a voluntary admission agreement. When there are no victim issues or public safety concerns, the State may choose to accept the alternative of civil commitment or voluntary admission or admission to a residential center and nol pros or offer a stet.

2) Immediately upon the defendant's admission to the hospital, the forensic coordinator should discuss with the State any cases where these alternatives may be

appropriate. This decision should be made early so the success of civil commitment or admission will be more likely.

Section 2.4

Procedure for Clerk

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PROCEDURE FOR CLERK WHEN JUDGE ORDERS COMPETENCY EVALUATION

(Criminal Procedure Section 3-104 et. seq.)

IN-CUSTODY EVALUATION

1) When the competency evaluation is going to be performed while the defendant is in custody, the judge must determine the conditions of confinement. The procedure for scheduling depends on where the defendant will be held i.e. detention center, hospital or DDA residential center.

a) Detention center (general population or special housing)- Contact the Community Forensic Screener for the jurisdiction to obtain the date of the evaluation and the date of return (See Chapter 11.2 for list of screeners with contact information). The date of return must be within 7 days.

b) State hospital or DDA SETT Unit- It has been the practice to contact the forensic coordinator for the MHA facility or the DDA Director of Court Involved Services in the case of the DDA SETT Unit to arrange for immediate admission (See Chapter 11 for Contacts). Alert the judge to any problems with scheduling, so the judge can intervene as necessary. If there is any difficulty in obtaining an admission date, the court should contact the Director of the **DHMH Office of Forensic Services** to facilitate the expedited admission.

2) Include on the Order for Competency Examination, the date of the evaluation and the date (within 7 days unless extended by the judge) the defendant is to be returned to court. If the defendant held in the detention center for the evaluation, insure that a "to be returned" date is on the "jail work" and that the Commitment for Examination As To Competency To Stand Trial is attached. (CC-DC-CR-107)

3) Try to insure that the judge completes the order, including the reason(s) for the evaluation, the names of attorneys and conditions of confinement.

4) If the judge orders that the defendant be confined in the medical unit or other isolated and secure unit, *fax a copy of the order to BCDC Central Records (410-545-8118).* In jurisdictions other than Baltimore City, follow whatever procedure is in place to alert the detention center of special circumstances.

5) If the judge wants a treatment plan to be developed and included with the report of the competency evaluation, in the event the defendant is opined competent and in need of services, include the addendum to the Order for Competency Examination. (See CC-DC-CR 108A)

6) Fax a copy of the Order for Competency Evaluation and statement of probable cause to the community forensic screener/ evaluator, *FAST court coordinator, and MHC clerk*, or the forensic coordinator, depending on the location of the evaluation. The order should include all available identifying information: name, birth date, address, SID number, and case number.

7) Schedule for competency hearing on the "to be returned" date *on the closest Monday (H5) or Thursday (H2), Hargrove Building. Flag file for MHC clerk and send immediately to Hargrove.*

8) All reports from the community evaluator or the facility shall be sent to the *MHC* clerk, who will insure that the State's Attorney, Public Defender, and judge receive a copy.

OUTPATIENT EVALUATION

This type of evaluation is very difficult to coordinate and should only be used if there is a responsible party to insure that the defendant keeps the appointment.

1) Contact the *CCMD* community evaluator to determine date of evaluation and date of return. Date of return must be within 7 days. If the judge is reasonably confident the defendant is incompetent and/or there is a need to complete the evaluation quickly, the judge may wish to request the hospital to conduct the evaluation. For hospital outpatient evaluations, contact the forensic coordinator to assist in making the arrangements and obtaining a date and time for the evaluation. (CC-DC-CR-106)

2) The defendant will be given a summons with the appointment date. The date will be within 7 days, unless the judge agrees to an extension.

3) *The defendant will also be given a summons to appear at the Hargrove Courthouse in Part 2 (Thursday) or Part 5 (Monday) for the competency hearing.*

4) *The court file will be immediately sent to the Hargrove Courthouse, attention MHC clerk. If further evaluation is needed after screening, the evaluation will be scheduled to take place at Spring Grove Hospital Center. The appointment should be arranged by the CCMD and provided to the defendant at the conclusion of the screening. In the event the CCMD does not obtain the appointment, the court clerk should contact the Spring Grove forensic coordinator, (410) 402-7765, for the date and time.*

5) *The trial date will be scheduled for the closest day to the original date in either H2 or H5.*

6) If the defendant does not appear for either the screening or the evaluation and there is no valid reason presented, the judge will issue a bench warrant. *The Hargrove Police Liaison will expedite the execution of the warrant. If the defendant is picked up during business hours, the defendant will be presented to the Mental Health Court judge, if that judge is available. Otherwise the defendant will be brought before the judge in Part 2.If the defendant is picked up during non-business hours, the defendant will be processed on the warrant. The warrant will specify: "PRESENT TO MENTAL HEALTH COURT JUDGE IMMEDIATELY."*

7) If the defendant provides a reasonable explanation for missing the appointment, the community forensic evaluator or the hospital forensic coordinator will reschedule the appointment and will notify the court of the new date.

REQUEST FOR EXTENSION OF TIME TO COMPLETE EVALUATION

The law requires that the report be submitted to the court, State's Attorney and defense counsel within 7 days unless the judge grants an extension. The extension must be based upon good cause.

1) The screener or the forensic coordinator will fax the extension of time request to the *MHC* clerk. The clerk will insure that the file is immediately pulled, and that the file and the request are submitted to the *MHC* judge *or the administrative judge*.

2) The request must be based upon good cause and will contain the date the defendant is to be admitted to the hospital or DDA SETT Unit and the name of the hospital. The date of admission should be within 2 business days. In the case of an in-custody evaluation, the evaluator will certify that the defendant will not be at risk if confined in the jail until the date of admission.

3) *The clerk will insure that a copy of the request for extension has been given to the MHC State's Attorney and MHC Public Defender or private attorney and to FAST.*

4) The Order for Extension must be fully completed including the date of admission, the name of the admitting facility and the trial date. Include supplement to order regarding submission of discharge plan if the judges wants a plan. (See Forms CC-DC-CR 108 and 108A and sample). Include in comment section on "jail work," transport to (insert name of admitting facility) on (insert date of admission) and return to court upon completion of evaluation or trial date.

REPORT SUBMITTED ON 'TO BE RETURNED' DATE INDICATING THE EXAMINER BELIEVES THE DEFENDANT IS COMPETENT

1) The report is faxed to the *MHC* clerk who will insure that the court file and report are included on the docket. Copies of the report will be provided to the judge, *FAST*, the State's Attorney and the Public Defender.

2) *FAST will assess for Mental Health Court and follow referral process, if the defendant meets the criteria.*

3) If the defendant is eligible for Mental Health Court and agrees to participate, the case remains on the MHC docket. If the defendant is not eligible or does not wish to participate, schedule for trial in the criminal court of origin.

4) Competency hearing will be held, and if the judge finds the defendant competent, the bail will be reconsidered.

5) The *MHC* clerk will insure that the defendant is transported to court as ordered.

REPORT SUBMITTED INDICATING THAT EXAMINER BELIEVES DEFENDANT IS INCOMPETENT

1) The examiner or designee shall submit the evaluation report to the *MHC* clerk*, FAST*, *the MHC coordinator*, the State's Attorney, and defense counsel. The clerk should insure that the report is submitted on time and provided to the parties.

2) *MHC clerk shall immediately pull the file and submit with a copy of the report to the MHC judge.*

3) *If the report is submitted before the scheduled trial date, the competency hearing only will be scheduled for the next available Monday (Hargrove Part 5) or Thursday (Hargrove Part 2).*

JUDGE FINDS THE DEFENDANT INCOMPETENT AND DANGEROUS

1) After the competency hearing, the clerk shall prepare the appropriate order committing the defendant to the Department of Health and Mental Hygiene, including the name of the state psychiatric hospital or DDA residential center designated by the Department. The defendant is immediately transported to the designated facility. (CC-DC-CR-052)

2) A status conference on competency will be scheduled for 6 months or at intervals determined by the judge. Prior to the scheduled hearing, the Department shall submit a

report to the court and counsel, including the treatment plan and an opinion on the defendant's restorability.

3) The clerk will issue a writ for the defendant to be transported to the status conference **only if requested** by the judge or counsel. The Department shall submit a report two weeks prior to the hearing if opining a change in clinical status and at least two business days before the hearing if reporting no change. The report shall include information about the course of treatment, plans for discharge, and restorability. The forensic coordinator and treating psychiatrist will be summonsed, unless the judge believes the report is sufficient.

4) An annual review hearing shall be scheduled and a writ issued to the facility for DHMH to transport the defendant.

JUDGE FINDS THE DEFENDANT INCOMPETENT BUT NOT DANGEROUS

1) Clerk shall prepare appropriate order after hearing, including release conditions for recognizance or conditional bail.

2) If the evaluation was conducted inpatient, the proposed conditions of release should be submitted to Community Forensic Aftercare Program (CFAP) for review prior to hearing. If the evaluation was conducted in the jail or the community, the proposed conditions should be submitted to the court, *FAST and PTS.*

3) If the defendant is released with conditions, a release order will be prepared. (See CC-DC-CR 059, 132, 128)

4) Review hearings will be scheduled at intervals the judge determines to be appropriate *but, in no event, will hearings be less than every 6 months*. Give the defendant a summons with the date, time, and location of any status conference/hearing.

5) An annual hearing date should be scheduled. The Department requested that the annual hearing date be scheduled at the time of the IST finding.

6) The *courtroom clerk will flag the file for the MHC so notices of the review/status hearing will go out to all necessary parties, including the defendant, State, defense, and CFAP/PTS.*

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Section 2.5

Outpatient Evaluation

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OUTPATIENT EVALUATION

This type of evaluation is very difficult to coordinate and should only be used if there is a responsible party to insure that the defendant keeps the appointment.

1) The court clerk will contact the community forensic evaluator/ *CCMD* to obtain an appointment for screening. The clerk will fax a copy of the Order for Outpatient Competency Evaluation, charges, and application for charges to the evaluator/*CCMD.*

2) For those jurisdictions where "definitive" evaluations are performed, the outpatient evaluation will also be "definitive". However, if the evaluator opines that the defendant is incompetent, the defendant may not be admitted into the hospital, until the court makes the finding of incompetent and dangerous.

3) If the judge is reasonably confident that the defendant is incompetent and/or there is a need to complete the evaluation quickly, the judge may choose to bypass screening and have the evaluation performed at the hospital. This may be accomplished by contacting the forensic coordinator at the jurisdiction's state psychiatric hospital for an evaluation date and to determine whether the hospital evaluation can be arranged.

4) In the event an evaluation by DDA is required, contact the Director of Court Involved Services to obtain the information about the arrangements made by DDA.

5) The defendant will be given a summons with the appointment date, time, and location. The date will be within 7 days, unless the judge agrees to an extension. *The defendant will also be given a summons to appear at the Hargrove Courthouse in Part 2 (Thursday) or Part 5 (Monday).*

6) *The court file will be immediately sent to the Hargrove Courthouse, "Attention MHC clerk". If further evaluation is needed after screening, the evaluation will be scheduled to take place at Spring Grove Hospital Center. The appointment should be arranged by the CCMD and provided to the defendant at the conclusion of the screening. If for some reason the appointment date and location is not provided to the defendant, the forensic coordinator should be able to assist.*

7) *The trial date will be scheduled for the closest day to the original date in either H2 or H5*

8*) If the defendant does not appear for either the screening or the evaluation, and there is no valid reason presented, the judge will issue a bench warrant. The Hargrove Police Liaison will expedite the execution of the warrant. If the defendant is picked up during business hours, the defendant will be presented to the Mental Health Court judge, if that judge is available. Otherwise the defendant will be brought before the judge in Part 2. If the defendant is picked up during non-business hours, the defendant will be processed on the warrant. The warrant will specify: "PRESENT TO MENTAL HEALTH COURT JUDGE IMMEDIATELY."*

9) If the defendant provides a reasonable explanation for missing the appointment, the community forensic evaluator or the forensic coordinator will reschedule the appointment and will notify the court of the new date.

IF THERE ARE PROBLEMS MAKING TIMELY ARRANGEMENTS FOR THE OUTPATIENT EVALUATION, DO NOT HESITATE TO CONTACT THE DIRECTOR OF THE DHMH OFFICE OF FORENSIC SERVICES.

Section 2.6

Vulnerable Competency Evaluee

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VULNERABLE COMPETENCY EVALUEE

When competency to stand trial is an issue, and the judge finds that because of the severity of the mental illness or mental retardation a defendant in custody would be endangered by confinement in a correctional facility, the judge may order an outpatient evaluation or may order the Health Department, in the Department's discretion, to:

1) Confine the defendant pending examination in a medical facility that the Department designates as appropriate, or
2) Immediately conduct a competency evaluation.

Age, physical size, and health, coupled with the severity of the mental disorder or mental retardation, may be considerations for utilizing this method for obtaining an evaluation. An outpatient evaluation is often not a viable option for a variety of reasons, e.g., nature of charge, security or safety concerns, or transportation problems. Therefore, the immediate evaluation and/or an inpatient evaluation are the options available. The Department has typically been unable to perform the immediate evaluation, so an inpatient evaluation is usually easier to accomplish. In addition, in view of the court's concerns about the safety of the defendant in the detention center, the Department may share those concerns and opt for the inpatient evaluation. It is important to remember that a competency evaluation is not a vehicle for obtaining medical care or a safe place to stay, unless competency is clearly an issue.

MEDICALLY UNSTABLE COMPETENCY EVALUEE

1) If the defendant is medically unstable and is either hospitalized in the detention facility or in custody in a local hospital, the Department may choose to perform the immediate evaluation in the detention facility hospital or in the local hospital where the defendant is under guard.

2) If the evaluator opines that the defendant is incompetent to stand trial as a result of a mental disorder or mental retardation, as opposed to a temporary incompetence due to a medical condition and the incompetence will not likely resolve with treatment for the medical problem, the court may elect to proceed with the competency hearing.

3) If the evaluator opines that while the defendant may be incompetent to stand trial at the time of the evaluation, but the **incompetence results from the medical condition** and once the condition is treated the mental state will improve, the court may choose to delay the proceedings and order a reevaluation of competency when the medical problem is controlled.

4) Contact Brian Hepburn, MD, Acting Director of the Behavioral Health Adminstration Office of Forensic Services (410- 402-8452) to determine whether MHA will arrange for immediate evaluation or arrange for inpatient evaluation in a hospital.

5) If the primary reason for the competency evaluation is mental retardation or developmental disability, contact Leslie McMillan, Director of Court Involved Services, Developmental Disabilities Administration, (410) 767-5631, to determine whether DDA will arrange for immediate evaluation or will arrange for an inpatient evaluation in a hospital or at the SETT Unit or a DDA residential Center.

6) In the event that MHA or DDA chooses to arrange for an inpatient evaluation in a hospital, the name of the hospital and person at the hospital with whom the arrangements were made will be provided to the court for inclusion in the order.

OTHER SITUATIONS WHERE THE COURT FINDS THAT THE DEFENDANT WOULD BE ENDANGERED BY CONFINEMENT IN A DETENTION/CORRECTIONAL FACILITY FOR COMPETENCY EVALUATION

1) If the defendant is at court and MHA or DDA chooses to conduct the immediate evaluation, the court will be provided with the name of the evaluator and the details of the arrangements, e.g., estimated time of arrival.

2) Follow steps 4, 5, and 6 above.

TRANSPORTATION

1) If the defendant is at court and not in custody, and MHA and DDA choose to conduct the evaluation in a hospital, the police will provide transportation if no family member is available or able to transport.

2) If the defendant is at court and is in custody, the *BCDC Transportation Unit/* local detention center will transport.

Section 2.7

Dismissal and Status Conference

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DISMISSAL/PURPOSE OF STATUS CONFERENCES/REPORTS ON DEFENDANTS COMMITTED AS INCOMPETENT TO STAND TRIAL

DISMISSAL

(Criminal Procedure Article § 3-107)

1) Whether or not the defendant is confined and unless the state petitions the court for extraordinary cause to extend the time, the court shall dismiss the charge against a defendant found incompetent to stand trial:

- When defendant is charged with a capital offense—after expiration of 10 years.
- When defendant is charged with felony or crime of violence (CL § 14- 101), the lesser of expiration of 5 years or the maximum sentence for the most serious offense charged.
- When charged with any other offense, the lesser of the expiration of three (3) years or the maximum sentence for the most serious offense charged.

2) The court shall dismiss the charge without prejudice.

3) Charges may NOT be dismissed without providing the State's Attorney and victim/victim's representative who has filed a victim notification, advance notice, and an opportunity to be heard.

4) If individual confined within DHMH facility, need to advise DHMH of dismissal of charges and seek civil commitment.

5) Court must also advise victim/victim's representative and CJIS of dismissal.

DEFENDANT FOUND INCOMPETENT AND NOT LIKELY TO BECOME COMPETENT IN THE FORESEEABLE FUTURE

If the court finds that the defendant is incompetent and NOT likely to become competent in the foreseeable future, the court must:

1) Rescind the Incompetent to Stand Trial (IST) commitment to the Department, and

2) If the defendant was IST due to a mental disorder, convene a hearing on the issue of civil commitment. If defendant is found to meet civil commitment criteria, order commitment (See Order for Involuntary Civil Commitment to Psychiatric Facility CC-DC-CR 117) or,

3) If the Defendant was IST due to mental retardation, make a finding regarding whether the defendant because of mental retardation is a danger to self or others. If defendant is found dangerous, order confinement in a DDA facility. (See Order for Confinement to Developmental Disabilities Administration Facility CC- DC-CR 118)

PURPOSE OF STATUS CONFERENCES

At any time and on its own initiative, the court may hold a status conference. Although not required by statute, it is good practice to schedule status conferences at least every 6 months.

The State's Attorney, defense counsel, who is usually the Public Defender, the forensic coordinator, and, perhaps, the treating psychiatrist should attend the conferences. Unless there has been a change in the defendant's clinical status, at least two business days prior to the conference, the status report (See Form CC-DC-MH-00 1) should be submitted to the court and counsel by DDA, MHA, or CFAP.

The purposes of the status conferences are:

- To determine whether, with treatment, it is likely that the defendant will be restored to competency in the foreseeable future.
- If the defendant is not likely to be restored to competency and remains dangerous, does the Department plan to seek involuntary commitment?
- If it is likely that, with treatment, the defendant will be restored in the near future, what is the estimated time line for restoration? Upon restoration of competency, does the hospital opine that the defendant will continue to remain dangerous due to a mental disorder and require hospitalization, or will the defendant be able to be discharged? If the defendant can be safely discharged to the community, what is the discharge plan–what services will the defendant require in the community and when will those services be available (e.g., supervised housing, day treatment, vocational training)?
- If restoration is possible, and, with certain supportive services in the community, the defendant would not present a danger, what is the discharge plan and when will the plan be implemented?
- Does the Department want the court to authorize "on and off grounds privileges" to assist in the transition?
- Does the State plan to prosecute?
- If so, and the charge is a felony, does the State plan to indict or reduce?
- If it is expected that the defendant will be restored in the near future **and** the State plans to prosecute **and** the charges are within the jurisdiction of the District Court, does the Public Defender plan to file an NCR plea?

The status conference is an informal proceeding off the record, and the defendant will only be present if the court or defense counsel requests a writ. The conference is recommended as opposed to a hearing, because it is difficult to transport the defendant and, once at court, the defendant is held in the lockup. Many hours in a lockup for a seriously mentally ill or retarded individual is not only uncomfortable, but also anxiety provoking. However, the choice of conference or hearing is the court's prerogative. The Status Conference Report form, which follows this discussion, may be used to record who attended and what occurred at the status conference (See Form CC-DC-MH-002). This form should be maintained in the court file.

REPORTS ON DEFENDANTS COMMITTED AS IST

1) The Health Department shall report every 6 months from date of the finding of incompetent and dangerous and the IST commitment of the defendant and

2) Whenever the Department determines that the:

- Defendant is no longer incompetent to stand trial;
- The Defendant is no longer because of a mental disorder or mental retardation, a danger to self or person or property of others; or
- There is not a substantial likelihood that the defendant will become competent to stand trial in the foreseeable future.

3) If the Department opines that the defendant is competent or not a danger, a supplemental report should be provided that lists what services are recommended to facilitate the defendant remaining competent to stand trial or not dangerous as a result of mental disorder or mental retardation.

4) If the Department opines that the defendant is incompetent and not dangerous, the supplemental report should include recommended services for restoring competency, as well as maintaining the defendant safely in the community.

(a) Such services may include:

- Mental health treatment, including providers of care:
- Vocational, rehabilitative or support services;
- Housing;
- Case management services;
- Alcohol or substance abuse treatment; and
- Other clinical services.

(b) If community placement or services are recommended, the report should include:

- Location of placement.
- Names and addresses of recommended service providers.
- Statement indicating if service provider is willing and able to take defendant.
- If available, date of placement or service for the defendant.

(c) The clerk shall give State's Attorney and last counsel of record copies of all reports.

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Section 2.8

Subsequent Hearings

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SUBSEQUENT HEARINGS

A hearing on the record to determine whether the defendant continues to meet the criteria for commitment shall be held:

1) At least once a year from the date of commitment.

2) Within 30 days after the filing of a motion by the State's Attorney or defense counsel setting forth new facts or circumstances relevant to the determination; and

3) Within 30 days after receiving a report from the Department of Health and Mental Hygiene stating opinions, facts or circumstances that have not been previously presented to the court and that are relevant.

The court at any time, and on its own initiative, may hold a hearing on the record.

The defendant, State's Attorney, and defense counsel should be summoned, as well as the hospital's forensic coordinator or the Developmental Disabilities Administration's court liaison.

Burden of proof: The State has the burden to prove competent. The court may find:

- Competent to stand trial—then set in for trial on merits, rescind commitment, set conditions of pretrial release or bail to insure defendant remains competent and not dangerous.
- Incompetent and not dangerous—see "Incompetent and Not Dangerous."
- Incompetent and dangerous—if opinion competency is restorable, continue commitment. If opinion not restorable, see "Not Restorable."

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Section 2.9

Sentencing and Release Options

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SENTENCING AND RELEASE OPTIONS

SENTENCING

Competent defendant who is placed on probation and voluntarily admitted to the hospital while the discharge plan is finalized.

1) Defendant shall remain at _____ Hospital Center for as long as recommended by the facility.

2) Defendant shall comply with the terms of the discharge plan, which may include psychiatric treatment, substance abuse treatment, and residential services.

RELEASE

Incompetent and not dangerous defendant may be released on recognizance subject to conditions.

1) Community Forensic Aftercare Program (CFAP) will monitor release of those defendants who were evaluated in the hospital. *The MH PTS Agent will monitor the defendants who were found to be IST-ND after a community evaluation*.

2) Hospital or DDA forensic center must provide proposed release conditions for CFAP's approval before submitting to the court.

3) If the court agrees to release on recognizance, complete CC-DC-CR 132, 128 , or L01-013 and attach conditions.

4) Schedule status conference.

ON AND OFF GROUNDS PRIVILEGES

The order for on and off grounds privileges consistent with treatment needs was originally developed to allow defendants committed to the Department of Health and Mental Hygiene as incompetent and dangerous to make transitional visits to supervised housing programs, family homes, treatment programs, and vocational programs, in the hope of facilitating the defendants' return to the community. The treating psychiatrist or forensic coordinator will submit a written request for on and off grounds privileges. If granted, the privileges may be under the supervision of staff of the facility.

The use of this order has been expanded to include defendants committed to the DHMH/ADAA for substance abuse evaluation and treatment. The order would allow appropriate defendants to attend programs in the community that the defendant's counselor believes would advance the defendant's treatment progress. The defendant

continues to be dually committed to DHMH/ADAA and the local detention center, and usually is on a “no bail” basis. This order is not for the convenience of the defendant or the provider, but is solely for the purpose of furthering treatment. If the counselor believes that the defendant has progressed sufficiently in treatment and has demonstrated that he/she can be trusted to attend court with staff or in another manner approved by the counselor, the counselor may submit a written request to the court explaining the reason for the request. If granted, the order may include any limitations the court deems appropriate (e.g., for the purpose of attending NA meetings or appointments with a doctor only). (CC-DC-MH-006)

Section 2.10

Forms

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Copies of the forms listed below have been placed in the manual binders and may be obtained from the CourtNet forms index using the links below. The competency examination orders have been completed as sample guides.

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☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

_____ SID No.

_____ Address

_____ City, State, Zip Telephone

ORDER FOR OUT-PATIENT EXAMINATION AS TO COMPETENCY TO STAND TRIAL

(Criminal Procedure § 3-105)

The defendant having been given the opportunity to be heard, the court finds good cause to believe the defendant may be incompetent to stand trial for the following reasons: _____

_____

_____

_____

_____

_____

It is, therefore, this _____ day of _____ Month, _____ Year;

ORDERED, the defendant shall be:

☐ released on recognizance

☐ released upon posting bond in the amount of $ _____ and;

IT IS FURTHER ORDERED, the Maryland Department of Health examine the defendant on an out-patient basis on _____ Date at _____ Time ☐ a.m. ☐ p.m.

at _____ Screener/Hospital/Residential Center, ☐ at a date and location to be determined by the Department, as to competency to stand trial and;

IT IS FURTHER ORDERED, in the event the defendant does not appear for examination when notified to do so, the Department shall inform the court as soon as reasonably possible and;

IT IS FURTHER ORDERED, the Department shall send a complete report of its findings to the court, the State's Attorney, _____ Name and defense counsel, _____ Name or to the defendant within seven (7) business days of this order unless for good cause shown the court extends the time for examination. If the Department reports that in its opinion the defendant is incompetent to stand trial, the report shall state in a complete supplementary opinion whether because of mental retardation or mental disorder the defendant would be a danger to self or the person or property of another if released.

_____ Date _____ Judge ID Number

Send to: Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-106 (Rev. 08/2018) **Reset**

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

_____ SID No.

_____ Address

_____ City, State, Zip Telephone

COMMITMENT TO THE MARYLAND DEPARTMENT OF HEALTH FOR EXAMINATION AS TO COMPETENCY TO STAND TRIAL
(Criminal Procedure § 3-105)

The defendant having been given the opportunity to be heard, the court finds good cause to believe the defendant may be incompetent to stand trial for the following reasons: _____

It is, therefore, this _____ day of _____ Month, _____ Year

ORDERED, the defendant is committed to the Maryland Department of Health for examination as to competency to stand trial and;

IT IS FURTHER ORDERED

☐ the defendant be confined at _____; and held without bail.

☐ for the health and safety of the defendant, the defendant shall be held in a medical wing or other isolated and secure unit.

☐ because of the apparent severity of the mental disorder or mental retardation, the court has found that the defendant would be endangered by confinement in a correctional facility. The clerk shall notify the Maryland Department of Health, which shall in its discretion either immediately conduct an examination for competency or confine the defendant pending examination at a facility designated by the Maryland Department of Health. Unless the Department retains the defendant, the defendant shall be returned promptly to the court after examination.

IT IS FURTHER ORDERED the defendant shall be seen at _____ Screener/Hospital/Residential Center for evaluation on _____ Date, and shall be returned to court on, _____ Date unless for good cause the court extends the time for evaluation. The Department shall send a complete report of its findings to the court, the State's Attorney, _____ Name and defense counsel, _____ Name, or to the defendant within seven (7) business days of the order unless the court for good cause, extends the time. If the Department reports, that in its opinion the defendant is incompetent to stand trial, the report shall state in a complete supplementary opinion whether because of mental retardation or mental disorder the defendant would be a danger to self or the person or property of another if released.

IT IS FURTHER ORDERED _____ Transportation Unit shall transport the defendant when notified by the Department to do so and at the Department's direction shall return the defendant to the court.

_____ Date _____ Judge ID Number

Trial Date _____

CC-DC-CR-107 (Rev. 08/2018) **Reset**

REPORTABLE

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ (City/County)

Located at _____ (Court Address) Case No. _____

STATE OF MARYLAND vs. _____ (Defendant) _____ (DOB)

_____ (SID No.)

_____ (Address)

_____ (City, State, Zip) _____ (Telephone)

EXTENDED COMMITMENT TO THE MARYLAND DEPARTMENT OF HEALTH FOR EXAMINATION AS TO COMPETENCY TO STAND TRIAL

(Criminal Procedure § 3-105 (d))

Upon consideration of the preliminary report of the Maryland Department of Health or its designated program or agency, and having found good cause to extend the time for completion of the evaluation to determine whether the Defendant is competent to stand trial, it is this _____ day of _____ (Month), _____ (Year)

ORDERED the commitment of the Defendant to the Maryland Department of Health is continued, and the time for completion of the evaluation and report to the Court and counsel is extended for thirty days until _____ (Date) or until the date of trial, whichever occurs first. In the event the Department completes the evaluation and submits the report early, the Department may request the Court to advance the date of the Defendant's return to court;

IT IS FURTHER ORDERED because of the apparent severity of the mental disorder or mental retardation, and the Court has found that the Defendant would be endangered by confinement in a correctional facility, the Defendant shall be continued for evaluation at _____;

IT IS FURTHER ORDERED the Department shall notify the Court that the evaluation has been completed and that the Defendant will be returned to court, and the Department shall send a complete report of its findings to the Court, the State's Attorney, _____ (Name), and Defense Counsel, _____ (Name), or to the Defendant; at least three (3) days prior to the Defendant's return to court;

IT IS FURTHER ORDERED _____ (Transportation Unit) shall immediately transport the Defendant to _____ on _____ (Date), and at the Department's direction, shall return the Defendant to court on _____ (Date) or at an earlier date as set by the Court and communicated to the transporting authority by the Department;

IT IS FURTHER ORDERED if the Department reports that in its opinion the Defendant is incompetent to stand trial, the report shall state in a complete supplementary opinion, whether because of mental retardation or mental disorder, the Defendant would be a danger to self or the person or property of another, if released.

_____ (Date) _____ (Judge) _____ (ID Number)

CC-DC-CR-108 (Rev. 07/2017)

Reset

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

_____ SID No.

ADDENDUM TO ORDER FOR COMPETENCY EXAMINATION

IT IS FURTHER ORDERED, if the Department finds the defendant has a mental disorder or has mental retardation, and the defendant would be dangerous as a result of the mental disorder or mental retardation in the community without certain services, or the defendant is competent or incompetent but not dangerous because of the mental disorder or mental retardation, a supplemental report shall be submitted to the court. The report shall outline the community services recommended, including any necessary housing, psychiatric, substance abuse, and vocational services, and shall specify where and when the services will be available to the defendant, and

☐ **IT IS FURTHER ORDERED**, the Court-Designated Forensic Coordinator is authorized to receive any examination reports, supplemental reports, treatment plans, discharge plans, or any other information pertaining to the defendant's discharge.

_____ Date _____ Judge _____ ID Number

CC-DC-CR-108A (Rev. 10/2019) Reset

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ (City/County)

Located at _____ (Court Address) Case No. _____

STATE OF MARYLAND vs. _____ (Defendant) _____ (DOB)

_____ (Address)

_____ (City, State, Zip) _____ (Telephone)

SCHEDULING ORDER AFTER RECEIPT OF EXAMINATION REPORT

The ☐ competency evaluation ☐ competency evaluation and criminal responsibility evaluation report dated _____ (Date), for the Defendant in the above-entitled action has been received by the Court.

It is the opinion of the MDH examiner that the Defendant is:

- ☐ Competent
- ☐ Incompetent and dangerous
- ☐ Incompetent and not dangerous
- ☐ Criminally responsible
- ☐ Not criminally responsible

It is this _____ day of _____ (Month), _____ (Year), by the ☐ District ☐ Circuit Court for _____ (City/County) **ORDERED,** that the Office of the State's Attorney and defense counsel shall file within _____ days of this Order, notice of its intention to:

- ☐ Contest the conclusion of the examiner as to ☐ competency ☐ responsibility;
- ☐ Obtain an independent evaluation;
- ☐ Summons the examiner;
- ☐ File an NCR plea;
- ☐ Request a postponement. Include the reason for the request: _____

IT IS FURTHER ORDERED, that

- ☐ A hearing on competency to stand trial shall be scheduled for _____ (Date).
- ☐ A hearing on competency and trial shall be scheduled on _____ (Date), and the Clerk shall notify the parties and prepare a writ directing _____ to transport the Defendant.

_____ (Date) _____ (Judge) _____ (ID Number)

CC-DC-CR-127 (Rev. 07/2017)

Reset

REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ SID #

(2) _____ Address

City, State, Zip Telephone

COMMITMENT TO THE MARYLAND DEPARTMENT OF HEALTH AFTER A FINDING OF DEFENDANT'S INCOMPETENCY TO STAND TRIAL AND A FINDING THAT BY REASON OF A MENTAL DISORDER OR MENTAL RETARDATION THE DEFENDANT IS A DANGER TO SELF OR THE PERSON OR PROPERTY OF ANOTHER

(Criminal Procedure § 3-106)

The defendant having been charged with the commission of a crime and having been found incompetent to stand trial, and having been found because of ☐ a mental disorder ☐ mental retardation to be a danger to self or the person or property of another, it is

ORDERED that the defendant be and is hereby committed to the Maryland Department of Health until the court is satisfied the defendant is no longer incompetent to stand trial or is no longer, by reason of a mental disorder or mental retardation, a danger to self or the person or property of another.

ORDERED the Health Department admit the defendant to a designated health care facility as soon as possible, but no later than 10 business days after receipt of the order of commitment, and to notify the court of the date on which the defendant was admitted, and to which designated health care facility.

It is further ORDERED upon receipt of this order, the transportation unit named below will transport the defendant immediately to the facility designated by the Maryland Department of Health upon notification by the Maryland Department of Health:

Transportation Unit: _____

Recommended Facility: _____

☐ If committed because of a mental disorder, it is further ORDERED that as soon as possible after the defendant's admission, but not to exceed 48 hours, that the Health Department evaluate the defendant, develop a prompt plan of treatment for the defendant under § 10-706 of the Health General Article, and evaluate whether there is a substantial likelihood that, without immediate treatment, including medication, the defendant will remain a danger to self or the person or property of another.

It is further ORDERED an annual review hearing shall be convened no later than one year from the date of this order.

The annual hearing shall be held on the following date and time: _____ Date, _____ Time.

The Health Department shall submit a report pursuant to Criminal Procedure § 3-108 to the court and counsel at least two (2) weeks prior to the scheduled hearing and shall transport the defendant to court for hearing.

It is further ORDERED a status conference shall be convened on the following date: _____ Date.

The Health Department shall submit a status report to the court and counsel at least three (3) days prior to the scheduled conference.

_____ Date _____ Judge ID Number

CC-DC-CR-052 (Rev. 10/19/2018)

Reset

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

_____ SID No.

ORDER FOR ON AND OFF GROUNDS PRIVILEGES

It is hereby, on this _____ day of _____ Month, _____ Year,

ORDERED, the Defendant, _____ Name,

be allowed on and off grounds privileges consistent with the Defendant's treatment needs:

☐ under the supervision of _____ Hospital/Residential Center/Provider

☐ for the purpose of _____

_____

_____

_____ Date _____ Judge _____ ID Number

Copies to:

Public Defender
State's Attorney
Forensic Coordinator
Court file

CC-DC-MH-006 (Rev. 8/2014) Reset

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

JUDGE'S WORKSHEET AND ORDER TO VACATE JUDGMENT OF CONVICTION UNDER CRIMINAL PROCEDURE § 8-302 FOLLOWING REVIEW IN CHAMBERS

Having reviewed the moving party's Motion to Vacate Judgment of Conviction in chambers, the court FINDS:

1. ☐ The qualifying offense occurred within five (5) years before the filing of the motion and the moving party ☐ mailed ☐ did not mail a copy of the motion to the victim(s) or the victim(s)'s representative.
2. The moving party ☐ served ☐ did not serve a copy of the motion on the State's Attorney for this county.
3. The State's Attorney ☐ consents to the motion ☐ does not consent to the motion.
4. A victim or victim's representative ☐ objects to the relief requested ☐ no objection to the relief requested has been filed by a victim or victim's representative.
5. At least 60 days ☐ have ☐ have not elapsed since notice and service.
6. The motion ☐ does ☐ does not assert grounds upon which relief may be granted.
7. The moving party filed the motion ☐ in good faith. ☐ in bad faith. ☐ fraudulently. ☐ Unable to determine this fact without a hearing.
8. The motion ☐ offers ☐ does not offer additional evidence beyond that which has previously been considered by the court. ☐ Unable to determine this fact without a hearing.

THE COURT ORDERS THAT THE MOTION IS:

☐ **DISMISSED WITHOUT A HEARING**, as the motion:
- ☐ does not assert grounds upon which relief may be granted.
- ☐ was filed in bad faith or fraudulently.
- ☐ does not offer additional evidence beyond that which has previously been considered by the court.

☐ **GRANTED WITHOUT A HEARING and the conviction is VACATED**. The court finds that the motion satisfies all necessary requirements to find the moving party committed the qualifying offense as a direct result of being a victim of human trafficking, including mailing to victim, if required, service on the State's Attorney, the State's Attorney consents and no objection by victim/representative.

☐ The case is dismissed on motion of the State's Attorney.

☐ **SCHEDULED FOR HEARING** on _____ Date at _____ Time, at the above court location.

_____ Date _____ Judge _____ ID Number

CC-DC-CR-159 (06/2020) **Reset**

REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant _____ DOB

Charge: (1) _____ _____ Address

Charge: (2) _____ _____ City, State, Zip Telephone

ORDER OF PRETRIAL CONDITIONS OF RELEASE

Having considered the testimony and evidence, it is this _____ day of _____ Month, _____ Year, **ORDERED** that the Defendant identified above, is found incompetent to stand trial but not dangerous as a result of mental disorder or mental retardation if released subject to conditions.

IT IS FURTHER ORDERED, that the Defendant be released on recognizance subject to the following conditions:

☐ 1. The Defendant shall reside at _____ Address.

If Defendant is residing in supervised housing, Defendant shall follow all rules of the following provider:

_____ Provider, address, telephone number

Thereafter, any change in residence must be approved in writing by the therapist and sent to the court-appointed monitor. The Court and attorneys shall be notified prior to any change in level of supervision.

☐ 2. The Defendant shall receive clinical services from the following provider:

_____ Provider, address, telephone number

Thereafter, any change in clinicians, clinics or frequency of appointments must be approved in writing by the clinician or case manager prior to the change and sent to the court-appointed monitor.

☐ 3. The Defendant shall take medications as prescribed and submit to periodic blood tests, if requested by the physician, to confirm the presence and levels of prescribed medications.

☐ 4. The Defendant shall attend NA/AA meetings if and as often as directed by the therapist, and shall submit proof of attendance to the therapist.

☐ 5. The Defendant shall attend and participate in all additional programs as recommended and arranged by his/her therapist or case manager. Current recommendations are: _____ Programs, provider, address, telephone

☐ 6. The Defendant shall obey all laws and in the event he/she is arrested or convicted, he/she will notify the court-appointed monitor and his/her therapist.

☐ 7. The Defendant shall not use illegal drugs nor ☐ use ☐ abuse alcohol. His/her therapist, residential provider or court-appointed monitor shall have the right to request breathalyzer or urine samples at any time.

☐ 8. The Defendant shall not own, possess, use or have under his/her control, any weapon or firearm of any description.

☐ 9. Defendant shall not initiate any contact with: _____
Name

☐ 10. The Defendant shall immediately discuss with his/her therapist or case manager any of the following:

a. change in residence or employment
b. change in physical or mental health
c. trips outside the State of Maryland
d. failure to meet clinic or program appointments

and the Defendant shall agree to abide by any reasonable recommendations his/her therapist makes regarding those and other activities.

☐ 11. The Defendant agrees that the Department has the right to require him/her to participate in a psychiatric evaluation to determine if he/she remains incompetent to stand trial and is not dangerous by reason of a mental disorder or mental retardation, and if the Defendant is likely to be restored to competency to stand trial.

☐ 12. Defendant may seek voluntary admission to a hospital for purpose of inpatient psychiatric treatment. Hospitalization under these circumstances does not constitute a violation of this agreement.

☐ 13. If the treating mental health personnel recommend inpatient treatment and Defendant is unwilling to be voluntarily admitted to a hospital for psychiatric treatment, this refusal shall be deemed a violation of pretrial conditions of release.

☐ 14. If Defendant has a diagnosis of mental retardation or other developmental disability and clinical personnel recommend respite care in a DDA community based program and the Defendant fails to agree to the respite care, this refusal will be deemed a violation of pretrial conditions of release.

☐ 15. Defendant shall complete a Consent to Disclose Protected Health Information form (CC-DC-CR-110) to enable the court-appointed monitor to confirm Defendant's compliance with this Order.

☐ 16. The court-appointed monitor is:
- ☐ Pretrial Release Service Program
- ☐ MDH Community Forensic Aftercare Program (CFAP) [with their consent]

☐ 17. The _____ shall be responsible for supervising the conditions of the individual's pretrial release, including notification to all the necessary parties who will be asked to provide services to Defendant, informing those parties of monitor's duties.

☐ 18. The court-appointed monitor, the Maryland Department of Health, and the Office of the State's Attorney shall advise the Court if the Defendant is in violation of the Order and may include a recommendation regarding rescission, modification or continuation of conditions.

☐ 19. The Defendant shall attend all court hearings and reviews as scheduled by the Court.

☐ 20. A review hearing shall be held on _____ (Date), at _____ (Time) ☐ A.M. ☐ P.M.

☐ 21. Other _____

_____

_____ (Date) _____ (Judge) _____ (ID Number)

NOTICE

I, the undersigned Defendant, do acknowledge that I have been advised of the conditions of release and received a copy thereof, and I voluntarily agree to abide by the conditions. I further acknowledge that the Court may at any time revoke the Order of Release or change it to require additional or different conditions of release and may issue a warrant for my arrest immediately upon allegation of violation of the conditions of my release.

_____ (Date) _____ (Defendant's Signature)

CC-DC-CR-132 (Rev. 07/2017) Page 3 of 3 **Reset**

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

ADDITIONAL PRETRIAL RELEASE CONDITIONS

The following pretrial release conditions are imposed on the Defendant in addition to any conditions currently imposed in this case.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____

_____ Date _____ Judge _____ ID Number

CC-DC-CR-128 (Rev. 07/2017)

Reset

MARYLAND JUDICIARY

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____
City/County

Located at _____ Case No. _____
Court Address

STATE OF MARYLAND vs. _____
Defendant

_____
SID No.

Date of Incompetent To Stand Trial finding: _____

COURT EVENT LOG

PENDING CHARGES:

☐ Capital offense

☐ Felony or crime of violence Maximum sentence: _____

☐ Neither felony nor crime of violence Maximum sentence: _____

Dismissal of charges pursuant to CP § 3-107, unless Court finds extraordinary cause to extend time:

Capital offense: 10 years,

Felony or crime of violence (CL § 14-101): lesser of 5 years or maximum sentence for most serious charge

Not capital offense, felony or crime of violence: lesser of 3 years or maximum sentence for most serious charge.

Date of potential dismissal of charges: _____

Date of status conference _____

Date of annual hearing _____

☐ Victim notified by State's Attorney.

CC-DC-MH-003 (Rev. 8/2014)

Reset

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

_____ Address

_____ City, State, Zip Telephone

COMPETENCY STATUS REPORT

(To be completed by Forensic Coordinator or designee.)

Conference Date: _____

Hospital/Residential Center: _____

Form completed by: _____

Date of initial confinement, if known _____ Date of Incompetency Finding: _____

1. It is the opinion of the Department that the Defendant/Patient is
   - ☐ competent.
   - ☐ incompetent.
   - ☐ dangerous by reason of ☐ a mental disorder ☐ mental retardation.
   - ☐ not dangerous by reason of ☐ a mental disorder ☐ mental retardation.

   Basis for above opinion: _____

2. If it is the opinion of the Department that the Defendant is incompetent and dangerous due to ☐ a mental disorder ☐ mental retardation, is there a substantial likelihood that the Defendant will be restored in the foreseeable future? ☐ Yes ☐ No
   a) If yes, when is restoration anticipated?
      - ☐ Within 30 days
      - ☐ Within 90 days
      - ☐ Within 6 months
      - ☐ Within 12 months
      - ☐ Over 12 months

   b) If not restorable, does the Defendant meet the criteria for civil commitment or admission pursuant to Title 7 to a Developmental Disabilities Administration facility? ☐ Yes ☐ No

   Basis for opinion for 2(a) and 2(b): _____

Case Number _____

3. If the Department believes that the Defendant is now competent or remains incompetent but would not be dangerous by reason of mental disorder or mental retardation with certain supportive services in the community, what is the recommended aftercare plan?

LIVING ARRANGEMENT ☐ With Relative ☐ Independent ☐ Supportive Housing

Referrals made to: _____ Date: _____

Will reside with: _____

Address: _____

Will be available on _____

MENTAL HEALTH TREATMENT Name of program: _____

Will begin on _____

SUBSTANCE ABUSE TREATMENT Name of program: _____

Will begin on _____

FINANCES

☐ Public Assistance (MA, AFDC, Pharmacy assistance, Food stamps)
Will receive on _____

☐ SSI Will receive on _____

☐ SSDI Will receive on _____

☐ Representative payee _____

EDUCATIONAL OR VOCATIONAL TRAINING Where? _____

Will begin on: _____

CASE MANAGEMENT OR SERVICE COORDINATION services to be provided by:

_____

Will begin on _____

Case manager met with Counselor and Defendant on _____

4. What services are clinically most appropriate to
(a) maintain the Defendant safely in the community? _____

_____

_____

(b) maintain competency or restore competency? _____

_____

_____

If the Defendant is incompetent due to mental retardation, has the DDA eligibility determination been completed? ☐ Yes ☐ No

If yes, determination is ☐ Eligible ☐ Not eligible

If not eligible, why? _____

_____

_____

Case Number _____

REQUEST FOR COURT INTERVENTION

☐ On and off grounds privileges

☐ Postpone due to: _____

☐ Schedule for hearing on competency

When will the plan be ready for implementation? Within:

☐ 30 days ☐ 90 days ☐ 6 months ☐ 12 months

Is the Defendant cooperating with the discharge plan? ☐ Yes ☐ No

5. Has referral been made to CSA?

When? _____

a. To whom? _____
Name

_____
Address

b. Was CSA involved in aftercare planning? ☐ Yes ☐ No

c. If not, why not? _____

d. If so, what assistance will the CSA provide for discharge? _____

CONTACTS WITH DEFENDANT'S COMMUNITY AGENCY/SUPERVISOR/MONITORING AGENT

(Pretrial Services or Probation Agents, Case Manager, Community Service Coordinator)

Name of agent/monitor: _____

Agency: _____

Telephone communication on: _____

Meeting on: _____

Plan reviewed on: _____

_____
Date

_____
Forensic Coordinator/Designee

_____
Printed Name

_____
Address

_____
City, State, Zip

_____
Telephone

_____
Fax

_____
E-mail

CC-DC-MH-001 (Rev. 8/2014)

Page 3 of 3

Reset

MARYLAND JUDICIARY

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

_____ SID No.

STATUS CONFERENCE COURT NOTES

Date of Conference _____

State's Attorney _____

Defense Attorney _____

Hospital Forensic Coordinator _____

DDA Liaison _____

Others _____

Hospital Opinion of Defendant's Mental Status:

☐ Competent ☐ Dangerous

☐ Incompetent ☐ Not dangerous with services

Charges still viable?

☐ Yes ☐ No

Finding:

☐ Status unchanged ☐ Restored

☐ Not restorable

State will nol pros if Defendant is civilly committed/admitted ☐ Yes ☐ No ☐ Undecided

☐ NCR filed Date: _____

Date of next conference/hearing _____

Writ to be issued ☐ Yes ☐ No

☐ In court review

☐ In chambers review Date of potential dismissal of charges _____

CC-DC-MH-002 (Rev. 8/2014) **Reset**

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

_____ SID No.

Scheduled Review Date: _____

MENTAL HEALTH / SUBSTANCE ABUSE STATUS UPDATE FORM

Please check the appropriate options below & return at least 2 days prior to the scheduled review/trial date to Court designee.

Reporting Agency: ☐ FAST ☐ Pretrial ☐ Parole & Probation ☐ CFAP ☐ DDA
☐ Other: _____

Monitoring Status: ☐ Pretrial ☐ Probation ☐ Incompetent to stand trial, not dangerous
☐ Committed to MDH

Reporting Compliance: ☐ Good ☐ Fair ☐ Poor
Date(s) of Missed Appointment(s): _____

Treatment:

Housing Resides w/Provider as required ☐ Yes ☐ No
Concerns: _____
Provider: _____

Mental Health Overall compliance ☐ Good ☐ Fair ☐ Poor
Date(s) of Missed Appointment(s): _____
Concerns: _____
Problem w/Meds ☐ Yes ☐ No

Substance Abuse Overall compliance ☐ Good ☐ Fair ☐ Poor
Date(s) of Missed Appointment(s): _____
Positive Toxicology Screen(s) ☐ Yes ☐ No
Date(s) of Positive Results: _____
Concerns: _____

Next Hearing Date: ☐ 2 Weeks ☐ 4 Weeks ☐ 6 Weeks ☐ 8 Weeks ☐ Other: _____

Issues to be addressed at hearing: _____

_____ Date _____ Signature

CC-DC-MH-005 (Rev. 07/2017)

Reset

REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

ORDER FOLLOWING RECONSIDERATION OF COMPETENCY AND COMMITMENT
(Criminal Procedure § 3-106)

☐ On suggestion of the Defendant or the State,

☐ On its own initiative,

☐ On suggestion of the Maryland Department of Health,

the court conducted a hearing to reconsider the prior determination of the defendant's competence to stand trial and determined the defendant is no longer incompetent to stand trial.

Trial in this matter is set for _____ Date, at _____ Time, at the following court location: _____ Court Name and Address

_____ Transportation Unit is to transport the defendant to _____ Correctional Facility for detention before trial unless bail in the amount of $ _____ is posted.

_____ Date _____ Judge ID Number

Send to: Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-055 (Rev. 08/2018) Reset

REPORTABLE

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

_____ SID No.

ORDER OF CONTINUED COMMITMENT
FINDING OF INCOMPETENCY TO STAND TRIAL AND FINDING THAT DEFENDANT IS A DANGER TO SELF OR THE PERSON OR PROPERTY OF ANOTHER DUE TO MENTAL DISORDER OR MENTAL RETARDATION

Upon review of the testimony and evidence presented, this court **FINDS** this _____ day of _____ Month, _____ Year, pursuant to Criminal Procedure Article § 3-106, the defendant remains not competent to stand trial and because of a ☐ mental disorder or ☐ mental retardation, is a danger to self or the person or property of another, and

FURTHER FINDS, there is a substantial likelihood the defendant will become competent to stand trial in the foreseeable future, and the court therefore

ORDERS the defendant's commitment be continued.

_____ Date _____ Judge _____ ID Number

cc: Office of State's Attorney
Office of Public Defender
Court File
Maryland Department of Health:
mdh.admissions@maryland.gov

CC-DC-CR-138 (Rev. 08/2018) Reset

MENTAL DISORDER REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

_____ SID No.

_____ Address

_____ City, State, Zip Telephone

ORDER FOR INVOLUNTARY CIVIL COMMITMENT TO PSYCHIATRIC FACILITY
(Criminal Procedure § 3-106)

Upon consideration of the evidence and testimony presented regarding the commitment of the defendant pursuant to CP § 3-106, it is the finding of the court that:

☐ the defendant remains incompetent to stand trial and is not likely to become competent in the foreseeable future; and

The court further finds, by clear and convincing evidence, that:

☐ the defendant has a mental disorder; and
☐ inpatient care is necessary for the defendant; and
☐ the defendant presents a danger to the life or safety of self or others; and
☐ the defendant is unable or unwilling to be voluntarily committed to a medical facility; and
☐ there is no less restrictive form of intervention that is consistent with the life and safety of the defendant.

It is therefore, on this date of _____, ORDERED that defendant shall be civilly committed to the Maryland Department of Health as an inpatient in a medical facility that the Department designates.

_____ Date _____ Judge _____ ID Number

Copies: Office of State's Attorney
Defense counsel
Defendant
Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-117 (Rev. 08/2018) **Reset**

REPORTABLE

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

_____ SID No.

_____ Address

_____ City, State, Zip Telephone

ORDER FOR CONFINEMENT TO DEVELOPMENTAL DISABILITIES ADMINISTRATION FACILITY

Upon consideration of the evidence and testimony presented regarding the commitment of the defendant pursuant to Md. Code Ann., Crim. Pro. § 3-106, it is the finding of the court that:

☐ the defendant remains incompetent to stand trial and is not likely to become competent in the foreseeable future;

☐ the defendant has mental retardation; and

☐ the defendant, because of mental retardation, is a danger to self or others;

As **ALL** of the above elements have been proven by clear and convincing evidence, it is this _____ day of _____ Month, _____ Year, by this court,

ORDERED, that the above captioned defendant is committed to the Maryland Department of Health for placement in a Developmental Disabilities Administration (DDA) facility for 21 days from the date of this Order, or until review or approval of admission to a State residential center pursuant to Md. Code Ann., Health-General §§ 7-502 and 7-503.

_____ Date _____ Judge _____ ID Number

Copies: Office of State's Attorney
Defense counsel
Defendant
Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-118 (Rev. 08/2018) **Reset**

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

_____ SID No.

NOTICE OF HEARING TO CONSIDER DISMISSAL OF CHARGES AGAINST THE DEFENDANT FOUND INCOMPETENT
(Criminal Procedure § 3-107)

1. Pursuant to Criminal Procedure Article § 3-107 a hearing will be held on _____ Date at _____ Time to determine if the charges in the above entitled case shall be dismissed.

2. This Court is unaware of requests for victim notification under CP § 3-107 (c), CP § 3-123(c), or elsewhere.

3. It is the Court's belief that the State's Attorney and defense counsel have received copies of all Maryland Department of Health reports, the latest dated _____.

4. The Clerk shall immediately notify the State's Attorney, defense counsel and Maryland Department of Health of the date, time, and location of the hearing.

_____ Date _____ Judge ID Number

CC-DC-MH-007 (Rev. 07/2017)

Reset

CHAPTER 3

CRIMINAL RESPONSIBILITY

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Section 3.1

Guidelines

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GUIDELINES
(Criminal Procedure Article Section 3-109 et. seq.)

HOW

Plea must be filed in writing alleging that at the time of the crime the defendant was not criminally responsible under the test for responsibility in Md. Criminal Procedure Code Ann. § 3-109 (2014). CP §3-110(a), (d), Md. Rule 4-242
.

WHEN

At the time provided for initial pleading unless the court, for good cause, allows the plea to be filed later. CP §3-110 (a)(2), Md. Rule 4-242(b)
The court has wide discretion to allow or deny a late filing. *Johnson v. State*, 348 Md. 337 (1998)

BY WHOM

- Personal decision of defendant, Md. CP §3-110(a), Md. Rule 4-242 (b)(1)
- Defense counsel may file plea for incompetent defendant, but if the defendant is found competent, the defendant may withdraw the plea.
  Treece v. State, 313 Md. 665, 681 (1988)

EXAMINATION

- Court may order DHMH to examine the defendant. CP § 3-111 (a)
- Court determines conditions of confinement, CP § 3-111 (b)
- For speedy trial purposes, delay caused by examination is charged to the defendant, *Lewis v. State,* 79 Md. App. 1, 24 (1989)
- Unless retained by DHMH, the defendant may be returned to the place of confinement after the examination, Md. Code Ann. CP 3-111 (b) (2)(ii).
- DHMH to send the report to the court and counsel within 60 days. CP § 3-111 (c).

TEST FOR CRIMINAL RESPONSIBILITY
(Criminal Procedure § 3-109)

At the time of conduct, because of mental disorder or retardation, defendant lacks substantial capacity to:

- Appreciate the criminality of the conduct, or
- Conform the conduct to the requirements of the law.

1) Mental disorder does not include an abnormality manifested only by repeated criminal or antisocial conduct.
2) Mental retardation is not included in the definition of mental disorder but is a separate basis for lack of criminal responsibility
3) Neither an amnesiac episode nor voluntary intoxication is a mental

disorder. However, alcohol psychosis may excuse responsibility.

4) Diminished capacity is not a defense, *Stebbing v. State,* 299 Md. 331, 347-49 (1984).

DEFINITION OF MENTAL DISORDER (Criminal Procedure § 3-101(g))

A mental disorder is a behavioral or emotional illness that results from a psychiatric or neurological disorder.

It includes a mental illness that so substantially impairs the mental or emotional functioning of a person as to make care or treatment necessary or advisable for the welfare of the person or for the safety of the person or property of another.

Mental disorder does not include mental retardation. Nor does mental disorder include an amnesiac episode or conduct which is merely antisocial.

MENTAL RETARDATION

There is no definition of mental retardation for the purposes of criminal responsibility. However, Md. Health General Code Ann. § 7-101 (k) (2014) defines intellectual disability as "a developmental disability that is evidenced by significantly sub-average intellectual functioning and impairment in the adaptive behavior of an individual." For a discussion of mental retardation as it relates to criminal responsibility, See *State v. Bricker,* 321 Md. 86, 98-101 (1990).

DEGREE OF PROOF

- First, the State must prove guilt beyond a reasonable doubt.
- Defendant must prove not criminally responsible by a preponderance of the evidence.

BURDEN OF PROOF

- Defendant must prove not criminally responsible
- Competent medical evidence required

WHO MAY TESTIFY

- Medically trained psychiatrist
- Psychologist licensed in Maryland and qualified as an expert witness may testify on ultimate issue. Md. COURTS AND JUDICIAL PROCEEDINGS Code Ann. § 9-120 (2013)
- Lay witness testimony can be relevant and admissible if the testimony is

based on personal observation. A lay witness can testify on an inference or conclusion drawn if the observations continued over a sufficient period of time to permit a conclusion. **Lay testimony alone does not satisfy a defendant's burden.** *State v. Bricker,* 321 Md. 86, 581 A.2d 9 (1990).

- Conclusion should not be phrased in terms of criminal responsibility but in terms of whether the defendant was behaving in a mentally normal or abnormal fashion at the time of the offense. *State v. Conn*, 286 Md. 406, 408 A.2d 700 (1979).

TRIAL

- If the defendant has entered an NCR plea and elected jury trial, either State or defense may move for bifurcated trial. Md. Rule 4-314 (a)
- Motion must be filed at least 15 days before trial unless otherwise ordered. Md. Rule 4-314 (b)
- Bifurcation is not required, but is the better practice *Treece v. State,* 313 Md. 665, 685, 547 A.2d 1054 (1988)
- If there is a verdict of guilty, a separate verdict must be entered determining whether the defendant has established that he/she was not criminally responsible. CP § 3-110(c)

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Section 3.2

Commitment and Post-Commitment Proceedings

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COMMITMENT PROCEEDINGS
AFTER VERDICT OF NOT CRIMINALLY RESPONSIBLE

COMMITMENT
(Criminal Procedure § 3-112)

- After a verdict of guilty but not criminally responsible, the court shall immediately commit the individual to the Health Department for institutional inpatient care and treatment.

- Defendants charged with crimes of violence (e.g., murder, rape, or arson) or who require a secure environment are usually placed at Clifton T. Perkins Hospital Center.

- If the defendant is not criminally responsible primarily because of mental retardation, the Department shall designate a facility for mentally retarded persons for care and treatment

- The court shall notify CJIS of any person committed under this section

EXCEPTION

The judge may order release either with or without conditions but only if:

- The court receives an evaluation report from the evaluating facility within 90 days before the verdict.

- The report states that the defendant would not be a danger to self or the person or property of others if released with or without conditions, **and**

- The defendant and the State's Attorney agree to any conditions imposed.

REPORT ON COMMITTED PERSONS
(Criminal Procedure Section 3-113)

- Within 10 days after commitment, the facility shall send an admission report to DHMH.

- The facility shall notify the State's Attorney any time a committed defendant is transferred, approved for temporary leave for more than 24 hours, or is absent without authorization.

POST-COMMITMENT PROCEEDINGS
(Criminal Procedure Section 3-114-119)

ELIGIBILITY FOR RELEASE

Discharge from commitment—Only if 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.

Conditional release—Only if 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 from commitment with conditions imposed by the court.

BURDEN OF PROOF

1) If the defendant was committed to DHMH prior to July 1, 1984, the State has the burden to establish by clear and convincing evidence that the defendant is **not** eligible for release.

2) If the defendant was committed after July 1, 1984, the defendant has the burden to establish by a preponderance of the evidence eligibility for discharge or conditional release.

TYPES OF RELEASE PROCEEDINGS

1) Initial hearing before Administrative Law Judge

2) Application by committed person
   - Administrative hearing
   - Court proceeding (Committed person may elect jury trial)

3) Application for conditional release by Health Department (See Section 3.3)

INITIAL RELEASE HEARING BEFORE ADMINISTRATIVE LAW JUDGE

1) Automatic hearing convened at the DHMH facility within 50 days of commitment unless:
   - Postponed for good cause or with the agreement of the committed person and DHMH.
   - The committed person waives the hearing.

2) Examination and report shall be completed by DHMH at least 7 days before the hearing, unless a report has been completed in the 90 days preceding the hearing.

3) Whether or not the release hearing is waived, the Health Department shall send copies of the evaluation report to the defendant, defense attorney, the State's Attorney, and the Office of Administrative Hearings.

4) Notice of the hearings shall be provided to the defendant, defense attorney, and the State's Attorney.

5) The Office may issue any appropriate subpoena, and the court may compel obedience to the subpoena

CONDUCT OF ADMINISTRATIVE HEARING

1) Formal rules of evidence do not apply, and ALJ may admit and consider any relevant evidence

2) Hearing recorded but not transcribed unless requested.
   - Transcription costs paid by requesting party.
   - If the court orders the transcript, the court pays the cost.

3) Any record that relates to the evaluation or treatment of the committed person by the Department shall be made available, on request, to the committed person or counsel for the committed person.

4) Health Department presents evaluation report and any other relevant evidence

5) Committed person entitled to representation. Public Defender provides representation if committed person is indigent

6) Committed person, State's Attorney, and Health Department entitled to be present, to offer evidence and to cross examine witnesses

ADMINISTRATIVE LAW JUDGE'S REPORT

1) To be prepared within 10 days of the hearing.

2) To include a summary of the evidence, recommendations as to whether the committed person proved his/her eligibility for discharge or release, and any recommended conditions of release.

3) In recommending conditions, ALJ must consider conditions recommended by facility, committed person or his/her counsel.

4) Copies go to the committed person, counsel for committed person, State's Attorney, court, and facility.

5) Exceptions may be filed within 10 days of receipt of ALJ's report

COURT REVIEW OF ALJ'S REPORT

ALJ's recommendation is not self-executing. Judicial action is required **within 30 days of receipt of ALJ's report.**

1) If no exceptions are filed and the court determines that the record supports the ALJ's recommendations, no hearing is required, and the court enters an order in accordance with the ALJ's recommendations.

2) Court **may** hold a hearing on its own initiative

3) If timely exceptions are filed (within 10 days of receipt of report) or the court requires more information, the court **shall** hold a hearing **UNLESS** committed person and State waive the hearing

4) Committed person is entitled to be present and represented

5) Hearing is on the record of the ALJ hearing, and court must utilize standard for administrative appeal
   - Was the evidence before the ALJ substantial enough to support the conclusion and recommendation?
   - Was there an error of law? *Byers v. State*, 184 Md. 499 (2009) [1]

6) The court may continue the hearing and remand to ALJ to take additional evidence

COURT ACTION ON REPORT

1) **Within 15 days of the hearing or waiver**, the court must determine in an order whether a defendant is, by a preponderance of the evidence*, eligible for release with or without conditions. *(See BURDEN OF PROOF for pre-1984 commitments)
   - Determination is based on standard for administrative appeal

2) Order must contain a concise statement of the findings and reasons for findings

3) Court may not enter an order **not** in accordance with the recommendations **unless** a hearing is held or waived

[1] In Byers v. State, 184 Md. 499 (2009), Judge Moylan exhaustively analyzed this statute and commented, "t[T]his statute urgently cries out for legislative clarification." The court concluded that the procedure included in §§ 3-114-118 is an administrative procedure.

4) Court may order:
- Continued commitment
- Conditional release (Maximum 5 years) or
- Discharge from commitment

<u>CAVEAT</u> The Court's authority appears to be limited, and the statutory procedure is vague at best. The following options are an educated guess.

- If eligibility for release not proven, continue commitment
- If error of law, either remand or continue commitment
- If more evidence is required, remand
- If eligibility for release has been proven, but there is a question about conditions of release, either remand or continue commitment*

*There are occasions when the variance is minor and the parties agree to the change e.g. drug treatment at Hopkins instead of drug treatment at University or the ALJ omitted a standard condition such as "obey all laws." Typically, the court makes these non- substantive changes, when all parties agree rather than delaying release for a remand.

APPLICATION FOR RELEASE
(Criminal Procedure Article Section 3-119)

- The committed person may apply for release not earlier than 1 year after initial release hearing ends or was waived.
- If the application is accompanied by an affidavit of a physician or licensed psychologist that states an improvement in the mental condition of the committed person since the last hearing, the committed person may file an application for release at any time.
- The committed person may choose a judicial hearing or an administrative hearing.

Administrative Procedure
- The committed person shall file an application for release with the Health Department and notify the court and State's Attorney in writing.
- Provisions governing administrative hearing and judicial determination of release apply.

Court Procedure
- The committed person shall file a petition for release with the committing court and send a copy of the petition to the Health Department and the State's Attorney.

- If a jury trial is requested, the trial shall be held in a Circuit Court with a jury as a civil action.
- The trier of fact determines if the committed person has proven eligibility for release by a preponderance of the evidence.
- Within 30 days after a verdict for conditional release, the court shall release the committed person under conditions in accordance with specific recommendations for conditions from the commitment facility.

APPEALS

- From the District Court, on the record in the Circuit Court
- From a Circuit Court order, by application to the Court of Special Appeals

Section 3.3

Conditional Release

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CONDITIONAL RELEASE

(Criminal Procedure Article Section 3-120 et. seq.)

GENERAL

- A defendant found not criminally responsible for a crime as a result of a mental disorder or mental retardation may be released from confinement subject to conditions.
- Similar to probation.
- Failure to comply results in a violation and issuance of a hospital warrant and the defendant's apprehension and return to a state psychiatric facility or a DDA facility

REQUEST BY HEALTH DEPARTMENT

- The Health Department may apply for conditional release to the committing court at any time the Department considers that a committed person is eligible.
- A Copy of application must be sent to the committed person, the State's Attorney, and to defense counsel by certified mail, return receipt requested.

COURT ACTION

Within 30 days after receipt of the application, the court **shall** issue an order for continued commitment or conditional release upon conditions it imposes after considering the recommendations from the Health Department.

APPLICATION FOR CHANGE IN CONDITIONAL RELEASE

- At any time, by the Health Department or the State's Attorney.
- By the committed person, not earlier than 6 months after the court-ordered conditional release unless, for good cause, the court permits an earlier application.
- Committed person may apply at any time if the application is accompanied by an affidavit of a physician or licensed psychologist stating improvement in the mental condition.
- Application must be sent to the court and other parties in writing, including reasons for the change.

BURDEN OF PROOF

The burden of proof rests with the applicant to prove any issue raised by the application.

COURT ACTION

After considering the application, the court shall:

1) Change the conditions.
2) Impose appropriate additional conditions.
3) Revoke the conditional release.
4) Continue the present conditions.
5) Extend the conditional release by an additional five (5) years.

LIMITATIONS

Court may not continue conditional release for more than 5 years, unless extended.

REAPPLICATION

Committed persons may reapply for a change not earlier than one year after the court action on the application and not more than once a year thereafter.

THE STATUTE IS SILENT ON THE NEED FOR A HEARING ON THE APPLICATION. HOWEVER, A HEARING IS STRONGLY ADVISED BECAUSE SUCH IMPORTANT LIBERTY INTERESTS ARE INVOLVED.

VIOLATION OF CONDITIONAL RELEASE

(Criminal Procedure Article Section 3-121)

REPORT ALLEGING VIOLATION

Either the court, Office of the State's Attorney, or the Health Department may receive a report that the committed individual allegedly violated a condition of the Order of Conditional Release. If the court receives the report, the court shall notify CFAP and the State's Attorney's Office, and provide the name, address, and telephone number of the person who reported the violation.

ACTION BY THE STATE'S ATTORNEY

1) Upon notification, the State's Attorney shall determine whether there is a factual basis for the complaint.

2) If no factual basis, the State's Attorney shall notify the person who made the report and take no further action.

3) If the State's Attorney finds a factual basis, the State's Attorney shall promptly notify the Health Department of the violation and file a Petition for Revocation or Modification.

IN PRACTICE, THE COMMUNITY FORENSIC AFTERCARE PROGRAM USUALLY WORKS WITH THE STATE'S ATTORNEY, AND CFAP PREPARES THE PAPERWORK TO INITIATE THE VIOLATION OR MODIFICATION.

CONTENTS OF THE PETITION

1) Statement that defendant has violated a term of conditional release and, therefore, the defendant no longer meets the criteria for conditional release.

2) Statement of conditions violated and factual basis for violation and opinion that defendant no longer meets the criteria for conditional release, e.g., why the individual needs to be recommitted.

3) The most recent evaluation report of the defendant.

4) Designation of DHMH facility to receive the returned defendant.

ACTION BY THE COURT

The court shall review the petition for Revocation of Conditional Release and determine if there is probable cause to believe that the defendant violated the Order for Conditional Release. If the court finds NO probable cause for violation, the court promptly SHALL:

1) Note finding of no probable cause on the petition, and file it in the court file, AND

2) Notify the State's Attorney, DHMH, and the person who made the report. If the court finds probable cause, the court promptly SHALL:

3) Issue a hospital warrant (See Section 5.2) for the defendant and direct that the defendant be taken to the facility designated upon apprehension, AND

4) Send a copy of the hospital warrant and petition to DHMH, State's Attorney, Public Defender, last counsel of record, person who reported the violation, and the Office of Administrative Hearings.

IT IS RECOMMENDED THAT A COPY ALSO BE SENT TO CFAP AND THE FORENSIC COORDINATOR OF THE FACILITY DESIGNATED TO RECEIVE THE DEFENDANT.

VICTIM'S RIGHTS

See Chapter 2.1 XI

REVOCATION HEARING

Within 10 days after the committed person is returned to the facility pursuant to the hospital warrant, the **OAH** shall hold a hearing **at the facility,** UNLESS:

1) The hearing is postponed or waived by agreement of the parties, or

2) The ALJ postpones the hearing for good cause.

HEARING PROCEDURE

- Right to counsel and Public Defender, if indigent.

- The defendant, State's Attorney, and the DHMH may offer evidence, cross-examine witnesses, and exercise any other rights the ALJ considers necessary for a fair hearing.

BURDEN OF PROOF

- State must prove by preponderance that the defendant violated the conditional release.

- Defendant must prove by preponderance that, nevertheless, he/she is eligible for conditional release (unless pre-July 1, 1984 finding of NCR, then DHMH has burden of proof by clear and convincing evidence to show not eligible for release).

REPORT AND EXCEPTIONS

- ALJ shall send a report of the hearing and determination to the court and copies to the defendant, defense counsel, State's Attorney, and DHMH.

- Defendant, State's Attorney, or DHMH may file exceptions to the determination of the ALJ.

COURT ACTION

WITHIN 10 DAYS after receipt of the report, and after the court considers the report, the evidence, and any exceptions filed, the court **SHALL:**

1) Revoke the conditional release and order the defendant returned to the designated facility.

2) Modify the conditional release as required by the evidence

3) Continue the present conditions of release.

4) Extend the conditional release by an additional 5-year term.

5) Notify CJIS of any revocation ordered.

6) The court may hold a hearing on any exceptions filed. The hearing is on the record created at the ALJ hearing.

APPEALS

1) Appeal from a District Court order shall be on the record to the Circuit Court.

2) Appeal from a Circuit Court order shall be by application to the Court of Special Appeals.

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Section 3.4

Forms

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Copies of the forms below may be obtained from the Courtnet forms index using the designated links. *

CC DC-CR 53 COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE F
http://www.courts.state.md.us/courtforms/internal/ccdccr053.pdf

CC DC-CR 54 COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE AFTER A VERDICT OF NOT CRIMINALLY RESPONSIBLE 202
http://www.courts.state.md.us/courtforms/internal/ccdccr054.pdf

CC DC-CR 60 ORDER OF RELEASE UPON A VERDICT OF NOT CRIMINALLY RESPONSIBLE 203
http://www.courts.state.md.us/courtforms/internal/ccdccr060public.pdf

CC DC-CR 62 ORDER UPON REVIEW OF PETITION FOR REVOCATION OF CONDITIONAL RELEASE 204
http://www.courts.state.md.us/courtforms/internal/ccdccr062public.pdf

CC DC-CR 114 HOSPITAL WARRANT
Not Available Online – Pre-numbered Form

CC DC-CR 63 ORDER FOLLOWING HEARING ON REVOCATION OR MODIFICATION OF CONDITIONAL RELEASE 205
http://www.courts.state.md.us/courtforms/internal/ccdccr063public.pdf

CC DC-CR 64 ORDER UPON REVIEW OF APPLICATION FOR CHANGE IN CONDITIONAL RELEASE 206
http://www.courts.state.md.us/courtforms/internal/ccdccr064public.pdf

CC DC-CR 56 ORDER FOR JUDICIAL HEARING ON ADMINISTRATIVE LAW JUDGE'S REPORT AFTER A FINDING OF NOT CRIMINALLY RESPONSIBLE 207
http://www.courts.state.md.us/courtforms/internal/ccdccr056public.pdf

CC DC-CR 57 ORDER FOR CONTINUED COMMITMENT, CONDITIONAL RELEASE OR DISCHARGE 208
http://www.courts.state.md.us/courtforms/internal/ccdccr057public.pdf

CC DC-CR 58 JUDICIAL DETERMINATION AFTER APPLICATION BY THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE 210
http://www.courts.state.md.us/courtforms/internal/ccdccr058.pdf

CC DC-CR 61 JUDICIAL DETERMINATION AFTER APPLICATION BY COMMITTED PERSON 211
http://www.courts.state.md.us/courtforms/joint/internal/ccdccr061.pdf

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REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ Address

(2) _____ City, State, Zip Telephone

COMMITMENT TO THE MARYLAND DEPARTMENT OF HEALTH FOR EXAMINATION AND REPORT AS TO DEFENDANT'S CRIMINAL RESPONSIBILITY AT THE TIME OF THE COMMISSION OF THE ALLEGED OFFENSE AND COMPETENCY TO STAND TRIAL

(Criminal Procedure § 3-111)

The defendant having been charged with the commission of a crime as set forth in the charging document, and the defendant having filed a written plea alleging the defendant was not criminally responsible when the alleged crime was committed, it is

ORDERED the defendant is hereby committed to the Maryland Department of Health (MDH) for examination and report as to whether the defendant was criminally responsible when the alleged crime was committed and whether the defendant is competent to stand trial, and

It is further ORDERED

☐ Pending trial, the defendant be RELEASED ☐ on the posting of bond in the amount of $ _____ subject to the following condition _____

☐ ROR, subject to the following conditions _____ and the defendant be examined on an out-patient basis on the following date and time: _____ at _____.

If bond is not posted, the Clerk of this Court will notify the Maryland Department of Health and the defendant will be confined at _____ Detention Facility until the MDH Community Evaluator or other agency designated by the Maryland Department of Health can perform the examination. The Department shall notify the court of the date of examination.

☐ The defendant be CONFINED at _____ Detention Facility, where the defendant shall remain confined before and after the examination, pending further order of the court.

☐ Having found such accommodation appropriate for the health and safety of the defendant, the defendant shall be held in a medical wing or other isolated and secure unit in the correctional facility and if not available, in _____ or such other medical facility as the Department may designate.

☐ _____ shall transport the defendant when notified by the Department to do so, and at the Department's direction shall return the defendant to the place of original confinement, promptly notifying the court when such return has occurred.

The Department shall send a report of its opinion to the court, the State's Attorney, _____, the defendant, and to defense counsel, who is _____, within sixty days of this order, unless for good cause shown the court extends the time for examination.

_____ Date _____ Judge _____ ID Number

Send to: Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-053 (Rev. 08/2018)

Reset

REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

COMMITMENT TO THE MARYLAND DEPARTMENT OF HEALTH AFTER A VERDICT OF NOT CRIMINALLY RESPONSIBLE

(Criminal Procedure § 3-112)

The defendant having been found to have been not criminally responsible at the time of the commission of the offense, it is ORDERED the defendant is hereby committed to the Maryland Department of Health at a facility designated by the Maryland Department of Health for institutional inpatient treatment and care until further Order of this court. It is ORDERED the Health Department admit the defendant to a designated health care facility as soon as possible, but no later than 10 business days after receipt of the order of commitment, and to notify the court of the date on which the defendant was admitted, and to which designated health care facility. Unless the Department's Transportation Unit is providing transportation,

_____ Local Detention Facility

is to transport the defendant immediately upon receipt of this order.

☐ If committed primarily because of a mental disorder, it is further ORDERED that as soon as possible after the defendant's admission, but not to exceed 48 hours, that the Health Department evaluate the defendant, develop a prompt plan of treatment for the defendant under § 10-706 of the Health General Article, and evaluate whether there is a substantial likelihood that, without immediate treatment, including medication, the defendant will remain a danger to self or the person or property of another.

_____ Date _____ Judge ID Number

CC-DC-CR-054 (Rev. 10/19/2018) Reset

REPORTABLE

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

ORDER OF RELEASE UPON A VERDICT OF NOT CRIMINALLY RESPONSIBLE
(Criminal Procedure § 3-112)

The above named defendant having been charged with the commission of a crime and having been found not criminally responsible, and the court having considered an evaluation report on the defendant made by the Maryland Department of Health within 90 days preceding the verdict, the report indicating that the individual would not be a danger, as a result of mental retardation or mental disorder, to self or to the person or property of others if released, with or without conditions, and the State's Attorney and the defendant having agreed to the release and to any conditions for release, it is ORDERED

☐ the defendant shall be unconditionally released.

☐ the defendant shall be released subject to the following conditions for a period of _____ years:

_____

_____

_____

_____ Date _____ Judge ID Number

Send to: Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-060 (Rev. 08/2018) Reset

REPORTABLE

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ Address

(2) _____ City, State, Zip Telephone

ORDER UPON REVIEW OF PETITION FOR REVOCATION OF CONDITIONAL RELEASE
(Criminal Procedure § 3-121)

Upon review of the Petition for Revocation of Conditional Release, the court finds

☐ there is not probable cause to believe the committed individual has violated the order of conditional release, and the court therefore ORDERS this determination be placed in the court file on the committed person, and the State's Attorney, the Health Department, and any person who reported the alleged violation shall be notified of this determination by transmittal of a copy of this order to them.

☐ there is probable cause to believe the committed individual has violated the order of conditional release, and it is this _____ day of _____ Month, _____ Year

ORDERED, pursuant to Criminal Procedure Article § 3-121, the clerk of the court shall cause a Hospital Warrant to be issued that any law enforcement officer is commanded to apprehend the above individual whose last known address is _____; and it is further

ORDERED, any appropriate law enforcement officer enter the issuance of the Hospital Warrant into the criminal history record information of the Criminal Justice Information System for the above individual; and it is further

ORDERED, upon execution of this warrant, the above named individual shall be transported by a law enforcement officer to _____ State Psychiatric Facility for evaluation and examination; and it is further

ORDERED, this matter be set for an administrative hearing at said facility within 10 days after the execution of the Hospital Warrant, unless postponed or waived by agreement of the parties or by the Administrative Law Judge upon good cause shown; and it is further

ORDERED, the clerk shall transmit a copy of the Petition for Revocation and a copy of the order and the Hospital Warrant to the State's Attorney, to the Public Defender, to the counsel of record for the committed person, to any person who reported the violation, to the Office of Administrative Hearings, and to the Maryland Department of Health (mdh.admissions@maryland.gov).

_____ Date _____ Judge ID Number

CC-DC-CR-062 (Rev. 08/2018) **Reset**

REPORTABLE

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant _____ DOB

_____ Address

_____ City, State, Zip _____ Telephone

ORDER FOLLOWING HEARING ON REVOCATION OR MODIFICATION OF CONDITIONAL RELEASE
(Criminal Procedure § 3-121)

The court having considered a report from the Administrative Law Judge concerning revocation or modification of the conditional release of the above named individual, and having considered any exceptions filed, and having found that the State ☐ has ☐ has not proved by a preponderance of the evidence, that the committed person violated conditional release, and having further found by a preponderance of the evidence that the committed person nevertheless ☐ has ☐ has not proved eligibility for conditional release,

It is ORDERED that:

☐ the conditional release be revoked and _____

be returned to _____

☐ the present conditions of release be continued.

☐ the conditional release be modified as follows: _____

_____

_____

_____

☐ the term of conditional release be extended for an additional term of five (5) years.

_____ Date _____ Judge _____ ID Number

Send to: Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-063 (Rev. 08/2018) Reset

REPORTABLE

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

ORDER UPON REVIEW OF APPLICATION FOR CHANGE IN CONDITIONAL RELEASE
(Criminal Procedure § 3-122)

Upon review of the Application for Change in Conditional Release submitted by the:

☐ committed individual

☐ and it is at least six (6) months after the court ordered the initial conditional release, or the court finds for the following reasons good cause for an earlier application: _____

☐ and it is at least one (1) year since court action on an application for change filed by the committed individual, or ☐ the application is accompanied by an affidavit of a physician or licensed psychologist that states an improvement in the mental condition of the committed person.

☐ Maryland Department of Health

☐ Office of the State's Attorney

and the evidence submitted, the court finds, that the application ☐ is ☐ is not supported by preponderance of the evidence, and the court **ORDERS**:

☐ The continuance of the present conditions of release;

☐ The Order of Conditional Release be amended as follows: _____

☐ The Order of Conditional Release shall be extended by an additional term of five (5) years.

☐ The Order of Conditional Release is terminated.

_____ Date _____ Judge ID Number

Send to: Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-064 (Rev. 08/2018)

Reset

REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

ORDER FOR JUDICIAL HEARING ON ADMINISTRATIVE LAW JUDGE'S REPORT AFTER FINDING OF NOT CRIMINALLY RESPONSIBLE
(Criminal Procedure § 3-117)

Pursuant to a verdict of not criminally responsible entered in the criminal proceeding, the defendant was on _____ Date, committed to the Maryland Department of Health.

An administrative release hearing having been held and a report together with the Administrative Law Judge's recommendation having been received by the court and

☐ exceptions to the Administrative Law Judge's recommendation having been filed

☐ on its own initiative

the court determined that a hearing is necessary, and the hearing is scheduled for _____ Date at _____ Time, at the following court location:

_____ Court Name and Address

_____ Date _____ Judge ID Number

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CC-DC-CR-056 (Rev. 08/2018) Reset

REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

ORDER FOR ☐ CONTINUED COMMITMENT ☐ CONDITIONAL RELEASE ☐ DISCHARGE
(Criminal Procedure § 3-118)

The Administrative Law Judge having forwarded a report and recommendations as to the release eligibility and ☐ hearing having been waived ☐ no timely exceptions having been filed:

☐ the court has determined a judicial hearing is not necessary.

☐ a hearing having been held

the court finds the committed individual ☐ has ☐ has not proven eligibility for release by the preponderance of evidence upon review of the report and recommendations and oral arguments if any, hereby finds the recommendations are supported by the evidence and

It is ORDERED the

☐ commitment be continued.

☐ defendant be conditionally released on the following conditions:

_____

_____

☐ defendant be discharged.

A concise statement of the findings of the court, and the reasons for those findings, is provided by separate opinion of today's date, which is incorporated by reference into this order. ☐ Attached.

_____ Date _____ Judge ID Number

Send to: Maryland Department of Health - mdh.admissions@maryland.gov

Case No. _____

Date _____

OPINION OR STATEMENT OF FINDINGS AND REASON

REPORTABLE

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

JUDICIAL DETERMINATION AFTER APPLICATION BY MARYLAND DEPARTMENT OF HEALTH
(Criminal Procedure § 3-120)

The Maryland Department of Health having applied for the conditional release of the committed individual ☐ and a hearing having been held, the court finds the Department and the committed individual ☐ have ☐ have not proven eligibility for release by a preponderance of the evidence and ORDERS the committed individual

☐ be continued in commitment.

☐ be conditionally released on the following conditions:

_____

_____

_____

_____

_____ Date _____ Judge ID Number

Send to: Maryland Department of Health - mdh.admissions@maryland.gov

CC-DC-CR-058 (Rev. 08/2018) Reset

REPORTABLE

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

JUDICIAL DETERMINATION AFTER APPLICATION BY COMMITTED PERSON
(Criminal Procedure § 3-119)

A petition for release having been filed by the committed individual and a hearing having been held, the Court has determined that the committed individual:

☐ has proven eligibility for release by a preponderance of the evidence.

☐ has not proven eligibility for release.

It is ORDERED:

☐ commitment be continued.

☐ the committed individual be released on the following conditions: _____

_____

_____

☐ the committed individual be discharged from commitment.

_____ Date _____ Judge ID Number

CC-DC-CR-061 (Rev. 8/2014) Reset

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CHAPTER 4

PRESENTENCE PSYCHIATRIC EVALUATION

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Section 4.1

Referral Procedure

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REFERRAL PROCEDURE

Presentence psychiatric evaluations are performed only after the defendant is found guilty. The report describes treatable problems and recommends practical solutions to assist the judge in sentencing.

APPROPRIATE REFERRALS

1) Defendants who are competent and responsible, but who may have mental problems that contributed to the offense.

2) Chronic offenders with a history of psychiatric hospitalizations.

3) Offenders convicted of non-capital crimes whose risk of violent behavior requires professional assessment.

4) Defendants who may have recidivism reduced by mental health or substance abuse treatment.

PROCEDURE FOR MENTAL HEALTH COURT DEFENDANTS

1) In order to minimize missed appointments, the clerk will contact the Circuit Court Medical Services Division to schedule the date and time for evaluation. The clerk should fax a copy of the Presentence Psychiatric Evaluation Order, charging document and the criminal record, if available, to the Circuit Court Medical Services Division.

2) If Assistant Chief Medical Officer (Dr. Fey) is available, he will provide the next appointment. If Dr. Fey is not available, Ms. Deborah Farmer, Ms. Shelly Scruggs, Ms. Paula Schrader, or the Administrative Director will arrange the appointment. In any event, the defendant will be able to receive the appointment date and time from the courtroom.

3) Efforts will be made to complete the evaluation and report within 2 to 2 ½ weeks of the request.

4) The report will be submitted to the judge, State's Attorney, and defense counsel within 30 days.

PROCEDURE FOR ALL OTHER DEFENDANTS

1) The judge completes the Order for Presentence Psychiatric Evaluation (See Form CC-DC 120) and the clerk mails the order, the charging document, and the criminal record, if available, to the Responsible Person listed for the jurisdiction in the MHA Office of Forensic Services Directory of Service Providers. (See Chapter 11.2)

2) The clerk calls the “Responsible Person” and informs that individual of the order and whether the defendant is in custody. The clerk should also fax a copy of the order to the “Responsible Person.”

3) The Responsible Person sees incarcerated defendants in the local detention center. If the defendant is in the community, an appointment date, time, and location is mailed to the defendant.

4) The report will be submitted to the judge, State’s Attorney, and defense counsel within 30 days.

Section 4.2

Procedure for Joint Substance Abuse and Psychiatric Evaluation

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BALTIMORE CITY PROCEDURE FOR JOINT SUBSTANCE ABUSE AND PSYCHIATRIC EVALUATION

1) The court clerk will contact the BBHS court assessor (410-637-1900 ext. 249) for HG 8-505 evaluation date. This date and time will be included in a summons to be signed by the defendant, if the evaluation is to be conducted on an outpatient basis. If the defendant is in custody, the Orders (CC-DC-CR 102, 105, 109, and CC-DC-120) will accompany the jail work.

2) The court clerk will fax copies of all orders, Release of Information Forms, and other relevant information to the BBHS court assessor, the Circuit Court Medical Services Division (CCMSD) coordinator, and the Justice Services Unit of the Behavioral Health Division, Office of Forensic Services.

3) Since the presentence evaluation does not have to be completed within 7 days, the “return date” will be within 30-45 days. However, it is anticipated that arrangements for placement will commence as soon as the recommendation is made. This will avoid any unnecessary delay.

4) The BBHS court assessor and the CCMSD coordinator will collaborate on a date for the joint evaluation to take place in the CCMSD. If additional time is needed to conduct a joint evaluation, the BBHS court assessor will request an extension of time, and the original date may be postponed. A joint report will be submitted.

5) If the BBHS court assessor and the CCMSD coordinator are unable logistically to arrange a joint evaluation, a coordinated evaluation will be organized. The CCMSD will proceed with the Presentence Psychiatric Evaluation. The BBHS court assessor will receive a copy of the Presentence report and will submit a separate report to the court. The BSAS court assessor is encouraged to call the CCMSD examiner to discuss the case.

6) The report(s) to the court will include psychiatric findings and treatment recommendations, as well as the placement recommendation and an estimated date of admission, if residential drug treatment is suggested. The BBHS court assessor will provide the estimated date of admission.

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Section 4.3

Types of Evaluations

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TYPES OF EVALUATIONS

There are a variety of evaluations and investigations available to judges to assist in sentencing and for other special proceedings, and there are forms for each type of report requested. It is important for judges and clerks to insure that the correct form is used in order to receive the information intended and that the form goes to the agency responsible for conducting the evaluation or investigation.

TYPE	AGENCY	FORM
Competency	BHA	CC-DC-CR 106,107,108,108A
Criminal Responsibility	BHA	CC-DC-CR-053
Alcohol and Substance Abuse	Justice Services Unit, BHA	CC-DC-CR-101, 102, 103, 104
Sex Offender	BHA	CC-DC-CR-129
Juvenile Waiver *	DJS	CC-DC-CR-111, 112, 113
Presentence Psychiatric		CC-DC-020
Presentence Investigation	DPSCS (Parole and Probation)	CC-DC-CR-137

* The forms used for the Juvenile Waiver investigation are a modified PSI form and, if the judge would like a psychiatric evaluation, a modified Presentence Psychiatric Evaluation form. The modifications specify that the purpose of the investigation and evaluation is to address the transfer criteria.

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CHAPTER 5

LOCAL LAW ENFORCEMENT PROCEDURES

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Section 5.1

Expedited Service of Warrants

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EXPEDITED SERVICE OF WARRANTS

Baltimore City Police

1) FASTS, a PTS mental health agent, or a mental health probation agent will immediately submit any request for violation of probation or rescission of pretrial supervision directly to the Mental Health Court judge for issuance of warrant. The warrant will state PRESENT TO MENTAL HEALTH COURT JUDGE IMMEDIATELY UPON ARREST.

2) Once the warrant is signed by the judge, the submitting individual will coordinate with the Police Liaison for service. If appropriate, the Police Liaison will request that a BEST (Baltimore Emergency Services Team) officer serve the warrant. If this is not feasible, an officer from the District where the defendant resides will be contacted to execute the warrant.

3) If the defendant is located during business hours, the defendant will be presented to the MHC judge upon arrest. The judge may then recall the warrant and set a bail or release on recognizance and schedule a date for hearing on the violation.

4) If the defendant is arrested during non-business hours, the court commissioner will schedule a hearing date as early as possible.

5) In the case of a hospital warrant, the MHC State's Attorney will coordinate with the Police Liaison for service.

EVERY EFFORT WILL BE MADE TO RESPOND QUICKLY WHEN A VIOLATION OCCURS.

Baltimore County Police Department

1) Hospital warrants are served by the Sheriff's Office in Baltimore County.
Contact: Deputy Sheriff Rick Kelly, (410) 887-3151

2) All other mental health related warrants are processed through Central Records.
Contact: Lieutenant Theresa McQuaid, (410) 887-2140

See Appendix G for Baltimore County Police Department SOP for handling MHC warrants and hospital warrants. The Baltimore City SOP will be added to the Appendix when it is finalized.

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Section 5.2

Service of Hospital Warrants

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SERVICE OF HOSPITAL WARRANTS

(Criminal Procedure Article 3-101 (e))

An individual found not criminally responsible for a crime as a result of a mental disorder or mental retardation may be released from inpatient confinement subject to conditions. A Conditional Release Order is similar to an Order of Probation. The individual must comply with the conditions as set forth by the court. Failure to comply with the conditions of parole and probation may result in the issuance of a warrant, apprehension and detention of the individual and possible incarceration. Similarly, an individual charged with violation of conditional release may be apprehended, but the individual is detained in a health care facility, rather than a jail – thus the term ***"hospital warrant"***.

Upon notification of an alleged violation of conditional release, the State's Attorney may file a Petition for Revocation of Conditional Release. If the judge, after review of the petition, determines that there is probable cause to believe that the defendant has violated the terms of conditional release, the court will promptly issue a hospital warrant for the defendant and direct that on execution of the warrant the individual shall be transported to a facility designated by the Health Department. The name of the facility will be listed on the warrant. The issuance of the warrant is entered into the individual's criminal history record in the criminal justice information system.

Pursuant to §3-101 (e) of the Criminal Procedure Article, Ann. Code of Md., the hospital warrant authorizes **any law enforcement officer in the State** to apprehend the individual and transport the individual **to the designated facility**. The individual is not presented to the court prior to transport to the designated health care facility. The facility listed in the warrant will be a State psychiatric hospital or a DDA residential center or SETT. The defendant is not taken to a detention center prior to transport to the designated health care facility.

The law enforcement officer **must complete the warrant detailing the execution information**. The officer must also complete the Return of Service section indicating date and time the warrant was served, the officer's name, ID number, and agency address. Once the required forms have been completed, the designated facility may take custody of the patient/defendant. The officer is then required to submit the Return of Service to the issuing court. Unfortunately, officers are not always diligent in submitting the Return of Service, which results in a number of problems, since the various agency information systems have no knowledge or record of the apprehension of the defendant.

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Section 5.3

Crisis Intervention Teams

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CRISIS INTERVENTION TEAMS

A critical feature of pre-booking diversion efforts is a collaboration between law enforcement and the mental health system. With specialized training and support, these first responders have a unique opportunity to safely handle calls involving people with mental illness and to connect these individuals with treatment and services and avoid arrest, when appropriate. An obvious prerequisite of successful diversion is ready access to evaluation, hospitalization, when that level of care is needed, treatment, and a range of services and supports.

NAMI has been instrumental in assisting law enforcement in refining and providing training to officers. The training module created by NAMI is available for use by any jurisdiction interested in establishing specialized police-based crisis intervention or in educating officers about mental illness, available resources, and de-escalation strategies. The Police Academy now includes mental health training for all new recruits. There are three primary models for crisis intervention:

Police-Based Crisis Intervention

1) Crisis Intervention Team (CIT).
In this model, which was developed in Memphis, officers are trained to perform crisis intervention services and to act as liaisons with the mental health system.

2) Co-responder model
This approach partners law enforcement with mental health professionals, who provide consultation on mental health issues at the scene and assist in accessing treatment and supports.

Mental Health- Based Crisis Intervention

With the mental health-based approach, a team of mental health professionals responds to mental health crises and offers a clinical intervention, when appropriate. This model has limitations as a diversion from arrest tool because the teams are not connected to law enforcement and, therefore, do not play a direct role in providing alternatives to arrest. Mobile crisis teams provide services in several Maryland jurisdictions. [1]

[1] See Appendix F for CIT programs in each jurisdiction

BALTIMORE EMERGENCY SERVICES TEAM

In September 2001, Baltimore Mental Health Systems, Inc. (BMHS), the Baltimore City Police Department (BPD), and the National Alliance for the Mentally Ill Metropolitan Baltimore (NAMI) joined to address a major community problem: the ability of police officers to appropriately respond to citizens with a mental illness. A diverse citywide planning committee was established with the goal of developing a mental health/police initiative for Baltimore City. The initiative, named Baltimore Emergency Services Team, or BEST, started in the Central Police District and has expanded to officers throughout the city. The program is designed to increase the ability of the mental health system to support the police and has the following goals:

- Decrease police "down time"
- Decrease arrests and increase linkages to mental health services for individuals who previously would have been arrested
- Decrease police and citizen injury
- Decrease use of deadly force

The BEST training, which meets the criteria for an officer's in-service requirement, has received very favorable evaluations from participating officers. The training provides an all around introduction to the many facets of mental illness and strategies to use in intervening with individuals experiencing a psychiatric crisis.

Section 5.4

Warrants for Defendants Being Removed From Treatment or Absconding from Treatment

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BALTIMORE CITY PROCEDURE FOR DEFENDANTS BEING REMOVED FROM TREATMENT OR ABSCONDING FROM TREATMENT

PROVIDER REQUESTS REMOVAL OF DEFENDANT

Usually when a defendant disobeys program rules and is going to be terminated from the program, the defendant absconds before action can be taken. However, in those rare instances when the defendant remains, the following procedure should be followed:

1) Prepare the "no bail" bench warrant citing the reason for the contempt as "failure to comply with program rules." The warrant will specify, "RETURN THE DEFENDANT TO JUDGE _____ IMMEDIATELY UPON ARREST." The program will send written documentation including specific information about the rule violation/s to supplement the warrant.

2) Notify the Police Liaison, who will then arrange for an officer to pick up the defendant and return him/her to court, if court is in session. If the defendant is in a program located in another jurisdiction, the Police Liaison will contact the law enforcement agency in that jurisdiction, fax a copy of the warrant, and ask the law enforcement agency to go to the program, execute the warrant, and hold the defendant for an officer from the Fugitive Squad to return the defendant to Baltimore.

3) If court is in session, the defendant will be presented to the judge who issued the warrant. The judge may recall the warrant, set a bail, and schedule the violation for hearing.

4) If the judge who issued the warrant is not available, the defendant will be presented to the duty judge for the same action.

5) If court is not in session, the defendant will be taken to CBIF for booking.

DEFENDANT ABSCONDS FROM TREATMENT PROGRAM

Follow the same procedure as set forth above, except that the Police Liaison will notify the district where the defendant lives, and ask that the defendant be picked up as soon as possible. The expectation is that a concerted effort will be made to execute these warrants promptly.

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CHAPTER 6

DETENTION CENTER PROCEDURES

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INTRODUCTION

It is advisable as well as mutually advantageous for the court and the local detention center to have a collaborative working relationship that includes information sharing and reciprocal understanding of operating procedures as well as the ability to call on one another for assistance should the need arise. In view of the complex needs of the population, it is likely that the need will arise.

Mentally ill detainees frequently have multiple problems, including a variety of somatic issues. In order to insure that these incarcerated defendants receive the medication required for stability, it is critical that local detention center medical and psychiatric providers promptly receive current and accurate information about medication prescribed and any somatic conditions that require ongoing treatment. The local detention center has a responsibility to insure that detainees are safe, which involves being attentive to their medical and psychiatric needs. For a variety of reasons, early identification of mentally ill detainees is in the interest of both the detention center and the court. Not only are jails ill equipped to provide for the detainees' medical and psychiatric needs, but also the cost of medication and treatment, which can be quite high, is the responsibility of the custodial entity.

In addition, the local detention center plays an important part in the competency and criminal responsibility evaluation process, both in terms of transporting the detainee to the DHMH facility for evaluation and in insuring prompt access to the detainee if the evaluation is performed in the jail. Coordination and linkage between the detention center medical/psychiatric personnel and the DHMH facility enhances the quality of the evaluation, insures that the medication administered in the hospital is continued if the defendant is returned to the detention center, and helps in the transition to the community. In some instances, providers will request verification from detention center medical personnel that the detainee is "medically cleared" for release before agreeing to accept the individual for placement. Detention center personnel have an investment in facilitating the evaluation process, particularly if the evaluation will lead to the detainee's placement in an appropriate treatment setting or the development of a treatment plan for release that may help in reducing recidivism.

The Baltimore City Mental Health Court, the Division of Pretrial Detention and Services, and the Mental Hygiene Administration collaboratively developed most of the procedures and forms that follow. The protocols can easily be adapted for use in other jurisdictions to support information sharing and strengthen linkages between the court and partner agencies, if needed.

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Section 6.1

Requests for Competency Evaluation by Medical Staff

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PROCEDURE FOR REQUESTS FOR COMPETENCY EVALUATION FROM BALTIMORE CITY DETENTION CENTER

The MHC, the Division of Pretrial Detention and Services, and the Department of Public Safety and Correctional Services, enjoy a long-standing partnership to improve responses to the mentally ill offender. Early identification of seriously mentally ill detainees, including those defendants who appear to be incompetent to stand trial, is a mutual goal. Therefore, the parties developed the following procedure to expedite the competency evaluation process when medical or behavioral health staff encounters a detainee whom they believe to be incompetent to stand trial.

While the process described below is specifically designed for medical and behavioral health staff at the detention center when competency is an issue, identification and referral occurs from the time of arrest. Opportunities exist at every post arrest stage in the process, from booking, to the initial hearing before the court commissioner, to intake by the pretrial services investigator, to the attorney interview, to bail review and pretrial detention, to receive and deliver information about the mental health needs of the detainee so that an assessment can be made and appropriate action can be taken.

1) A Baltimore City Detention Center medical staff member will complete that portion of the Order for Competency Evaluation giving the reasons the psychiatrist/psychologist believes that the defendant is not able to understand the nature of the charges or to assist in his/her defense as a result of the mental disorder or mental retardation.

2) Fax a copy of the form order to: the Mental Health Court (MHC) Clerk at the Hargrove District Courthouse, (410) 878-8301; Medical Services Division of the Circuit Court, Attention: Yvonne Davis, (410) 625-2766; and to FAST, (410) 878-8330.

3) Upon receipt of the request, the clerk will prepare a writ for the defendant to be transported to the Hargrove District Courthouse for hearing the next business day. The clerk will obtain the court file, and provide a copy of the charging documents and form order to the MHC State's Attorney and the MHC Public Defender.

4) The established PROCEDURE FOR COMPETENCY EVALUATION will be followed.

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Section 6.2

Return of Property

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BALTIMORE CITY PROCEDURE FOR RETURN OF PROPERTY

PROPERTY

When defendants are committed to DHMH for evaluation and/or treatment, they are frequently in the hospital or treatment facility for an extended period of time. Most defendants are held without bail and remain in custody pending the outcome of the evaluation. They often have no friends or family members to retrieve their property. A procedure must be in place to insure that non-contraband property, including identification documents in the detainee's possession when arrested, is safeguarded for the owner and returned upon release. The Division of Pretrial Detention and Services, DHMH, and the District Court jointly developed the following procedure.

IDENTIFICATION

Identification documentation is critical for any application for entitlements or housing. Effective May 31, 2005, any identification in the detainee's possession when he/she is arrested is removed from the detainee and attached to the jail papers. In this way, the identification travels with the detainee.

OTHER BELONGINGS

Any other property which is not contraband and which the defendant had upon entering CBIF is stored in the Inmate Property Office. It is necessary to insure that the property is safeguarded and returned, particularly when the detainee is being evaluated and/or treated in an "outside" facility or program.

DEFENDANTS COMMITTED TO DHMH PSYCHIATRIC FACILITIES AND DDA FORENSIC CENTERS

1) The court clerk will fax a copy of the order committing the defendant to DHMH to the facility and to BCDC Central Records. This order notifies Pretrial Detention and Services (PTDS) of the defendant's whereabouts.

2) Upon receipt of the order, Central Records notifies the Inmate Property supervisor or the designee so that the property belonging to the defendant can be located and prepared for delivery.

3) The DHMH facility will also notify Central Records of the defendant's admission and will request any property including identification belonging to the defendant.

4) If the defendant did not have any property or identification upon entering CBIF, the supervisor of the Inmate Property Unit or the designee will indicate that fact on the DHMH form created for this purpose and will fax a copy of the form with entry to the forensic coordinator.

5) If property belonging to the defendant is being held, the supervisor of the Inmate Property Unit or the designee will contact the forensic coordinator or designee and make arrangements for delivery.

6) The supervisor of the Inmate Property Unit or the designee will deliver the defendant's property including identification to the defendant in the admissions office of the facility.

7) The forensic coordinator or the designee will insure that the defendant is present in the admission office at the agreed-upon time for the purpose of witnessing the return of the property and receiving the inventory sheet.

8) Any property that cannot be retained by the defendant for safety and/or security reasons (e.g., a knife) will be stored by the DHMH facility until the time of discharge.

Section 6.3

Transportation and Writs

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TRANSPORTATION AND WRITS

Transportation and the issuance of writs for defendants committed to DHMH for evaluation and/or treatment can be troublesome. BHA and DDA facilities establish their own policies for transporting defendants to and from court, and, as a result, practices can differ from facility to facility. The procedure outlined below is specific to Baltimore City in many details; however, in general, the DHMH expectation is that pretrial detainees are transported by the local detention center or whichever agency in the jurisdiction is responsible for transporting defendants to DHMH facilities and to the court. Defendants committed to DHMH as IST-D or NCR are transported by the DHMH facility Transportation Unit. The exceptions to the general rule are the practices of DDA and Clifton T. Perkins Hospital. It is also possible that some jurisdictions may have established other transportation and writ procedures.

The established practice should be clear and consistent in order to minimize confusion. The form orders include the court's direction on which agency should transport and when the transportation is to occur. Any questions or concerns about the terms of the order should be brought to the judge's attention for clarification or resolution.

BALTIMORE CITY PROCEDURE

As long as the defendant is committed to the local detention center, the BCDC Transportation Unit is responsible for transporting the defendant to the DHMH facility and for returning the defendant to court. Therefore, the BCDC Transportation Unit must be very attentive to the court order, which specifies the conditions of confinement (e.g., the name of the DHMH facility) and the transportation requirements (e.g., the date the defendant is to be returned to court). DHMH has given assurance that no facility will attempt to give instructions to the detention center Transportation Unit unless the order specifically authorizes this.

1) BCDC Transportation Unit will transport the defendant for screening at the Medical Services Division of the Circuit Court and will return the defendant to court on the "to be returned" date contained in the order.

2) If the court orders further evaluation in a hospital or DDA forensic center, BCDC will transport the defendant as directed by the Extended Order. If the Extended Order is completed before the "to be returned" date, the BCDC Transportation Unit will take the defendant to the hospital or forensic center instead of returning the defendant to the court. The order that is dated last in time prevails.

3) The court clerk will fax a copy of all orders for evaluation to BCDC Central Records as well as to the DHMH facility.

4) The order will specify a date and time for both transport to the DHMH facility and for return to court. If the defendant is committed to DHMH as incompetent and dangerous or NCR and dangerous, the BCDC Transportation Unit is responsible for transporting the defendant to the DHMH facility, but the hospital or forensic center Transportation Unit will bring the committed defendant to court for any further proceedings.

5) If a case is postponed or advanced, the court clerk will fax notice of the change to BCDC Central Records and to the DHMH facility. BCDC Central Records is responsible for communicating the change to BCDC Transportation.

ANY CONFUSION ABOUT THE TERMS OF A COURT ORDER WILL BE RESOLVED BY THE JUDGE.

WRITS FOR TRANSPORTATION

1) A writ must be issued to the Clifton T. Perkins Hospital Center and to the DDA Forensic Center (SETT Unit) for pretrial detainees held at those facilities for evaluation, in order for the defendant to be transported.

2. The BCDC Transportation Unit transports PRETRIAL DETAINEES from Spring Grove Hospital Center.

3) If, after a finding of incompetent and dangerous, a defendant is committed to DHMH for treatment, a writ must be issued to the facility to transport the defendant to court for status **hearings** or annual hearings. The defendant's presence is usually not required for a status **conference**, and a writ is, therefore, not needed.

Section 6.4

DHMH Policy for Transfer of Physical Custody to Detention Center

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Transfer of Physical Custody to Detention Facility For Mental Hygiene and Developmental Disabilities Administration of the Department of Health and Mental Hygiene (DHMH)

Purpose:
To establish a procedure for transferring physical custody to a detention or correctional facility for an individual committed to the Department for evaluation or impatient care or treatment.

Scope:
This policy applies to all hospital inpatient units, State Residential Centers (SRC) and Forensic Residential Centers (FRC) operated by the Behavioral Health Administration (BHA) and Developmental Disabilities Administration (DDA).

Definitions:
CFAP -- Community Forensic Aftercare Program within the Mental Hygiene Administration.

Committed for evaluation -- An individual committed to the Department for evaluation for competency to stand trial or not criminally responsible.

Committed for inpatient care or treatment -- An individual committed to the Department after a finding of incompetent to stand trial (IST) or not criminally responsible (NCR).

Committing Court -- Court that committed an individual to the Department for evaluation or treatment pursuant to Md. Ann. Code. Title 3, Criminal Procedure.

Facility -- Psychiatric hospital, State Residential Center, or Forensic Residential Center operated by DHMH.

Policy:
It is the policy of this facility to ensure that appropriate notification to the detaining facility is made to ensure that upon completion of the individual's detention or sentence an individual committed to the Department is returned to the custody of DHMH.

Procedure:

A. Committed for Evaluation - Individual receives new arrest charge. Facility receives request to remove the person to facilitate arrest/booking.

1. Upon notification that an individual who is committed to the Department for ***evaluation*** has been arrested on a new charge in

which authorities are requesting the individual be removed from the facility:

a. Advise the arresting authority that the individual is currently committed for evaluation and request that the individual remain in the facility until the evaluation is completed. NO ONE HAS THE RIGHT TO REMOVE AN INDIVIDUAL FROM A DHMH FACILITY WITHOUT THE FACILITY'S PERMISSION.

b. Advise the Office of the Public Defender of the situation and seek their assistance in having the individual processed without need for detention or jail.

c. If opined competent and/or responsible—anticipate the commitment order for treatment. Do not transfer the individual to serve a new sentence. Once the facility receives the commitment order for treatment, follow the procedure for IST/NCR new sentence. If individual's sentence is to the Department of Corrections, transfer to Clifton T. Perkins Hospital should be considered.

d. If not clinically appropriate to leave the facility, or the facility chooses not to permit the evaluee to leave, upon completion of the court ordered evaluation and termination of the evaluation order, discharge the individual back to committing jail, and advise the arresting authority where the individual is now located.

e. If the facility opines that the individual is clinically appropriate for a transfer to the jail and that an overnight stay is appropriate for safety reasons, the facility must obtain the consent of the Director of BHA or DDA, or their designee.

B. Individual committed for Evaluation – The facility is advised that the individual has received a sentence/incarceration in another case:

1. The facility should complete the court ordered evaluation as soon as possible.

2. If opined competent and/or responsible—anticipate returning the individual back to the committing jail. Advise the jail of the new sentence.

3. If opined incompetent or NCR and dangerous—anticipate the commitment order for treatment. Do not transfer the individual to serve a new sentence. Once the facility receives the commitment order for treatment, follow procedure for 1ST/NCR new sentence. If the individual's sentence is to the Department of Corrections, transfer to Clifton T. Perkins Hospital should be considered.

C. Individual is committed for treatment IST, and the individual receives a new arrest/charge. The facility receives a request to remove the individual to facilitate arrest/booking.

1. The treatment team should assess the individual to determine if the individual is clinically appropriate to leave the facility.

2. If not clinically appropriate to leave the facility, advise the arresting authority that The Department will not permit the individual to leave the facility at this time.

3. If clinically appropriate to leave the facility:
   a. Advise the Public Defender's Office of the new charge, and ask for assistance in facilitating the booking process. Please note:

      NO ONE HAS THE RIGHT TO
      REMOVE AN INDIVIDUAL FROM A DHMH
      FACILITY, WITHOUT THE FACILITY'S
      PERMISSION.

      WAIT IF NECESSARY TO THE GET THE PUBLIC
      DEFENDER INVOLVED.

   b. Facility staff should accompany the individual while being booked.

   c. If overnight stay is required at the jail, advise the jail in writing and orally, that individual is court committed to DHMH facility. Provide a copy of the committed order as detainer. Also advise jail of all medications the individual is currently prescribed. Advise the jail and the police officer that the individual should be returned to the facility upon completion of the booking process. If the individual remains in jail for more than 24 hours, advise the Director of BHA or DDA or their designee. Advise the jail that the facility will accept the individual back with a detainer for the new charge.

d. It is the policy of DHMH that individuals committed to the Department for treatment are the responsibility of the Department and should not remain in a jail. If the facility believes that due to security risks that the individual needs to remain in the jail, the facility must notify the Director of BHA or DDA.

4. The new charges may lead the person to be considered an escape risk. Please Note:

THE HOSPITAL SHOULD RECONSIDER ANY PRIVILEGE LEVELS.

D. If the individual is committed as NCR and receives a sentence of incarceration in a new case:

1. The treatment team should evaluate to determine if the individual is clinically stable and would not otherwise be a danger to self or others due to mental illness or mental retardation if transferred to a correction setting.

2. If not clinically appropriate, do not transfer and ensure the medical record includes a detainer. The individual's privilege level should reflect additional escape risk.

3. If clinically appropriate for transfer:
   a. The facility should apply for a conditional release of the individual with a condition that the individual shall reside in the named correctional setting. The order shall also contain a provision that upon completion of the sentence or should the sentence be overturned, the individual shall return to the DHMH facility. See CFAP facility. See CFAP for model order.

   b. Upon receipt of a signed order, the individual may be transferred to the correctional setting. The facility and CFAP shall ensure that the individual should not be released to the streets or to a work release program.

E. If the individual is committed as IST and receives a sentence of incarceration in another case:

1. The treatment team should evaluate to determine if the individual is clinically appropriate for transfer.

2. If not clinically appropriate, do not transfer and ensure the medical record includes a detainer. The individual's privilege level should reflect additional escape risk.

3. Evaluate the individual as to competency to stand trial and dangerousness. Individual was apparently found competent to stand trial in other case. Advise the committing court if the individual is now being opined competent and not dangerous, if released to serve sentence.

4. If the facility opines IST but can be transferred, the facility must ensure that the correctional setting is able to serve the individual.
   a. Upon receipt of an order from the committing court releasing the individual from commitment to DHMH, may arrange for transfer to correctional setting.

   b. It is the policy of DHMH that individuals committed to the Department for treatment are the responsibility of the Department and should not remain in a jail. If the Facility believes that due to security risks that individual needs to remain in the jail, the committing court will not terminate the commitment, the facility must notify the Director of BHA or DDA or designee.

   c. If the individual is transferred to jail and the committing court order is still in effect, the jail must be advised of the court commitment and be given a copy of the order as a detainer.

F. The facility has the final say over whether an individual committed to the Department leaves the facility. If the facility believes there are extraordinary circumstances that would lead to a deviation from this policy, the facility must obtain the approval of the Director of BHA, DDA or their designee.

July 2010

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Section 6.5

Procedure for Suicide Precautions

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PROCEDURE FOR SUICIDE PRECAUTIONS

When an inmate or detainee expresses suicide ideations or is believed to be suicidal, the following steps should be taken:

- The judge should enter the order, “Evaluate need for suicide precautions,” on the appropriate place in the court file (e.g., bail review sheet, pretrial docket, trial docket).

- The court clerk will insure that the judge’s directive is clearly reflected on the Commitment Order. An Order for Suicide Precaution Evaluation (CC/DC-CR 139) may be executed (see Orders § 6.7).

- Depending on the efficiency of the local detention center, as a precaution, it may be advisable for the court clerk to call the detention center contact person to inform them that a possibly suicidal inmate/detainee will be returning from court:

- *BCDC Central Records will provide a copy of the order to designated medical staff.*

- *BCDC should be instructed to keep the inmate/detainee on one-to-one observation for suicide risk and to immediately transport the inmate/detainee to the Inmate Mental Health Unit (IMHU). The inmate/detainee shall remain on suicide observation until evaluated by a mental health professional.*

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Section 6.6

Need for Medical or Psychiatric Treatment

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NEED FOR MEDICAL OR PSYCHIATRIC TREATMENT

If an inmate/detainee complains of an untreated mental illness or health problem, the judge may direct that the defendant be evaluated. The provider will then evaluate the inmate/detainee and will provide any appropriate medical and/or psychiatric treatment and medication.[1]

- An entry, "Examine the defendant and provide the appropriate treatment and/or medication," shall be clearly reflected on the Commitment Order. (See Orders § 6.7, LO-007)

- *The court clerk will contact a medical or psychiatric staff member to alert them of the order, so that arrangements for the examination can be made promptly.*

- *BCDC Central Records shall provide designated staff a copy of the order*.

- Medical/mental health staff shall conduct the examination as soon as possible.

[1] Baltimore City District Court and PTDS developed this procedure to assist in insuring that any immediate health care and/or medication needs of detainees are addressed.

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Section 6.7

Certification

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CERTIFICATION[2]

1) When a detainee/inmate has been certified, medical/psychiatric staff should initiate its referral by sending to the DHMH Office of Forensic Services (fax: 410-724-3179) the following information:
   a. Name of the detainee/inmate
   b. Date of birth of the detainee/inmate
   c. Information as to whether the detainee/inmate is deaf or hearing impaired
   d. Copies of the certifying paperwork
   e. Charges that are alleged

2) Upon receipt, the Office of Forensic Services will review the paperwork and forward the referral to the appropriate state facility.

3) The first available bed in a BHA facility will be located and arrangements for admission will be made. Efforts will be made to locate a bed in the facility closest to the detention center. Detention center referrals will be given priority.

4) Any complaints about the process should be directed to the Clinical Director BHA (410) 402-8441. If the Clinical Director cannot be reached, contact Brian Hepburn, MD, (410) 402-8452.

[2] Historically, the Baltimore City Detention Center has not utilized the certification process.

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Section 6.8

Orders

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RETURN OF PROPERTY

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____

Located at _____ Case No. _____

STATE OF MARYLAND vs. _____

SID # _____

ORDER

It is this _____ day of _____, _____, by the District Court of Maryland for Baltimore City,

ORDERED, that the Division of Pretrial Detention and Services shall return all property which is not contraband, including but not limited to money, keys, jewelry, identification and personal papers, and clothing, which is removed from a detainee who is in custody in a state psychiatric facility, state retardation center, or a residential alcohol or drug abuse treatment program. This property shall be returned within five business days of receipt of the request by the Central Records department.

_____
Judge

SUICIDE PRECAUTIONS

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____

Located at _____ Case No. _____

STATE OF MARYLAND vs. _____

SID # _____

ORDER FOR SUICIDE PRECAUTION EVALUATION

It is this _____ day of _____, 200___, by the District Court of Maryland for Baltimore City,

ORDERED, that the defendant immediately be evaluated for the need for suicide precautions. Until such time as the evaluation is conducted, the defendant shall remain on suicide observation.

_____ _____

Date Judge

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____
City/County

Located at _____ Case No. _____
Court Address

STATE OF MARYLAND vs. _____
DEFENDANT

SID # _____

ORDER FOR EVALUATION AND TREATMENT

The Defendant has appeared before the Court, and the Court finds good cause to believe that the Defendant requires a evaluation of health care needs for the following reasons:

☐ Medical issues _____

☐ Mental health issues _____

☐ Medication, including _____

☐ Suicide Precautions _____

It is this _____ day of _____, _____ by the Circuit/District Court for
Month Year

_____
City/County

ORDERED, that the defendant be promptly evaluated and that necessary medical/psychiatric treatment and/or medication be provided.

_____ _____
Judge ID NO.

L0-007 (10/2011)

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CHAPTER 7

EMERGENCY PSYCHIATRIC EVALUATION

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Section 7.1

Definitions

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DEFINITIONS
(Health General Article §10-620)

Emergency evaluee: "Emergency evaluee" means an individual for whom an emergency evaluation is sought or made under Part IV of this subtitle.

Emergency facility: "Emergency facility" means a facility that the Department designates, in writing, as an emergency facility.

(1) "Emergency facility" includes a licensed general hospital that has an emergency room, unless the Department, after consultation with the health officer, exempts the hospital.

Mental disorder:

(1) "Mental disorder" means the behavioral or other symptoms that indicate:

(i) To a lay petitioner who is submitting an emergency petition, a clear disturbance in the mental functioning of another individual; and

(ii) To the following health professionals doing an examination, at least one mental disorder that is described in the version of the American Psychiatric Association's "Diagnostic and Statistical Manual – Mental Disorders" that is current at the time of the examination:

1. Physician;
2. Psychologist;
3. Clinical social worker;
4. Licensed clinical professional counselor;
5. Clinical nurse specialist in psychiatric and mental health nursing (APRN/PMH)
6. Psychiatric nurse practitioner (CRNP-PMH); or
7. Licensed clinical marriage and family therapist.

(2) "Mental disorder" does not include intellectual disability.

Peace officer: "Peace officer" means a sheriff, a deputy sheriff, a State police officer, a county police officer, a municipal or other local police officer, or a Secret Service agent who is a sworn special agent of the United States Secret Service or Department of Homeland Security authorized to exercise powers delegated under 18 U.S.C. §3056.

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Section 7.2

Guidelines

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INTRODUCTION

The Petition for Emergency Psychiatric Evaluation is an important tool in the efforts to divert appropriate individuals from arrest and incarceration to the mental health system. However, in order to achieve optimal effectiveness, the involved agencies: the judiciary, law enforcement, and the emergency admitting facility, must prioritize the petition and expeditiously implement the execution, service, and evaluation process. If arrest can be avoided and the evaluee treated and connected to services in the community, the individual, the community, and the criminal justice system would benefit. Too often, the prioritization does not occur and the stakeholder agencies do not incorporate the emergency evaluation procedure into their operating systems, and the diversion potential of the process is not realized.

The judiciary could play an important leadership role as convener—to get the parties to the table, to identify barriers, and to encourage and support a collaborative approach to enhancing the diversion opportunities offered by the Petition for Emergency Psychiatric Evaluation. An efficient and effective Crisis Intervention Team (CIT) is a critical part of the pre-arrest diversion, but it is only one piece of a diversion system. A fully cooperative emergency admitting facility or crisis center and an immediately accessible range of community services are equally critical to success.

THE STATUTE

The Emergency Psychiatric Evaluation Statute (Health General §10-620 et seq.) authorizes any citizen, including peace officers, to petition to have an individual taken to an emergency room by police against the person's will for the purpose of examination to determine if the evaluee meets the criteria for admission to a psychiatric facility. While the urgency of the situation justifies the detention without a prior hearing, the emergency evaluation is a serious matter involving loss of liberty and possible stigmatization. Therefore, the law contains safeguards to prevent abuse of the procedure as well as exemption from liability for good faith actions.

In 2005, the statute was revised, changing three important features of the law:

I. Standard of Dangerousness

The old standard of dangerousness ("clear and imminent danger of doing bodily harm") has been replaced by the standard used in civil commitment hearings ("poses a danger to the life or safety"). "Danger" may now encompass acts of omission or passive dangerousness, as well as overt acts like an assault. Examples: serious medical effects of not eating or drinking; neglect of serious or life-threatening medical conditions; or an inability to recognize actions with serious harmful consequences (e.g., walking on the roadway in heavy traffic or wearing inadequate clothing in sub-freezing weather) that result from mental disorder.

II. Peace Officer Must Observe Individual or Behavior

The law changed the phrase "a peace officer who has personally observed the individual" to "a peace officer who has personally observed the individual or the individual's behavior" so that peace officers can file petitions in a case where they have seen the person but not the person's dangerous behavior.

III. Petition May be Based on Credible Information

The revision allows for the consideration of other pertinent information bearing on the individual's mental disorder or dangerous behavior. This gives the peace officer greater latitude in filing a petition on individuals they have seen, but whose mental symptoms and dangerous behavior are known only through the statements of witnesses (e.g., parents or spouse, or by the physical effects of the individual's behavior, e.g., wounds on the individual or others or physical damage to property).[1]

[1] Ortega, Richard. (2003). Maryland Emergency Petition Law Change. The Maryland Psychologist, 49(1), 19

Who May Initiate an Emergency Petition?

- Any interested person – but a judge must endorse.

- Peace officers, including a Secret Service agent who is a sworn special agent of the United States Secret Service or Department of Homeland Security authorized to exercise powers delegated under 18 U.S.C. §3056 (but special police are excluded by the Attorney General's opinion of June 30, 1998).

- Healthcare professionals:
  - Physicians (M.D., D.O.)
  - Licensed Psychologists (Ph.D., Psy.D., Ed.D)
  - Clinical social workers (LCSW-C)
  - Licensed clinical professional counselors (LCPC)
  - Clinical nurse specialists in psychiatric and mental health nursing (APRM/PMH)
  - Psychiatric nurse practitioners (CRNP-PMH)
  - Health officer (of a county) or health officer designee
  - Licensed clinical marriage and family therapist
    (Healthcare professionals must put their professional license number on the petition.)

Exemption from Liability
(HG §10-629)

Anyone who submits or completes an EP in good faith and with reasonable grounds cannot be held liable either civilly or criminally. A peace officer who acts as custodian of an evaluee in good faith and with reasonable grounds is not liable either criminally or civilly for the action. An emergency facility or an agent or employee of an emergency facility acting in compliance with the Emergency Evaluation statute is exempt from civil or criminal liability.

Financial Responsibility
(HG §10-628)

If an emergency evaluee does not have insurance that covers the charges for emergency services, the Department will pay the appropriate party for the initial consultant examination by a physician, transportation to an emergency facility and for involuntary admission to an admitting facility. The Department is subrogated against any insurance coverage available to the patient for charges related to emergency service, initial consultant examination, and transportation to an emergency facility.

Juveniles

While there may be better ways to address the situation, an EP may be filed for a juvenile. If the juvenile is less than 18 years of age, a parent or guardian is authorized by law to sign for admission. In addition, the Juvenile Court, through the CINA law, has the authority to commit a minor to a psychiatric hospital, if the judge finds that the minor meets the standards for commitment. The Juvenile Court also has access to services in the event some less restrictive alternative is available. In addition, both Circuit and District Courts have jurisdiction to consider Petitions for Emergency Psychiatric Evaluation, so the EP could be handled in the Juvenile Court.

PROCEDURE

The first step in the process is completion of the Petition for Emergency Psychiatric Evaluation (EP) (CC/DC 13). The form is readily available through courts, hospitals, police, mental health providers, and the internet. A Peace Officer who has seen the evaluee or a health care professional, who has examined the evaluee, may complete the petition and have the police act on it without a judge's endorsement. All other petitioners must appear before the judge and present the Petition for Emergency Psychiatric Evaluation. If the judge finds probable cause to believe that the evaluee has a mental disorder and poses a danger to the life of safety of himself or others, the judge endorses the petition. A petition that has been endorsed by the court is valid for five days.

ROLE OF THE JUDGE

The judge should promptly respond to the submission of an EP, whether this occurs during or after business hours. The statute provides that the petitioner "appears before" the court. The judge should explain to the petitioner that the endorsement only authorizes examination of the evaluee and that the decision about hospitalization is up to the examining physician. It is also good practice for the judge to encourage the petitioner to coordinate with the officer who will be executing the petition and, if possible, to respond to the emergency facility to provide any needed information to the examiner.

ROLE OF THE PETITIONER

The petitioner should complete the petition fully so the examiner is able to make an informed decision. It is also important for the petitioner to speak with the police officer about the execution of the petition and whether the officer should expect a struggle or weapons. It is advisable for the petitioner to go to the emergency admitting facility when the evaluee is transported, so any background information needed by the examining physician can be provided.

ROLE OF THE POLICE OFFICER

When notified that the court has granted an Emergency Petition, the officer should respond promptly to obtain the endorsed petition, take the evaluee into custody, and transport the evaluee to the nearest emergency admitting facility. Upon transfer of custody of the evaluee to the emergency facility medical staff, the officer is generally not required to remain. However, if the evaluee is violent, the physician may request that the officer's supervisor allow the officer to remain with the evaluee. The officer should promptly submit the completed return of service to the Clerk's Office

ROLE OF THE PHYSICIAN

Upon presentation of a properly executed EP, the emergency facility must accept the evaluee for examination. A physician, who does not have to be a psychiatrist, is required to conduct the examination within six hours of the evaluee's arrival at the emergency facility. The evaluee may not be detained for more than 30 hours, and must be discharged unless he or she agrees in writing to a voluntary admission or is certified by two physicians or one physician and one licensed psychologist as meeting the requirements for involuntary commitment. If the evaluee meets the standards for involuntary admission, the examining physician shall take the necessary steps for admission to an appropriate facility, which may be a general hospital with a licensed psychiatric unit. In the event the examining physician is unable to carry out the admission, the physician shall notify the Department. Within six hours, the Department shall provide admission to an appropriate facility.[2]

WHAT HAPPENS NEXT

Within ten days of admission, and unless the individual is discharged or signs an application for voluntary admission, an Administrative Law Judge decides in a hearing whether the criteria for involuntary admission have been met by clear and convincing evidence. If so, the evaluee is retained and if not, the evaluee is discharged.

[2]Janofsky, Jeffrey. "Maryland's New Emergency Petition Law." Maryland's Psychiatric News Aug/Sept 2003: Vol (4), 7.

Section 7.3

Emergency Evaluation of Arrested Person

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EMERGENCY EVALUATION OF ARRESTED INDIVIDUAL (HG §10-626)

Health General §10-626 is rarely used for a variety of reasons, including the fact that many people are unaware of its existence. Police dislike the statute because the process is labor intensive and time consuming. The officer must both transport the evaluee/arrested individual and remain with the evaluee during the examination. Unless the evaluee is admitted, the officer must return the evaluee to court or jail. The examining physician is required to prepare a brief report of the findings, which the officer must give to the court. If court is not in session when the evaluation is concluded, the officer must bring the evaluee and the report to court the next business day. The court order operates as a detainer.

If competency is an issue, many people find that the competency evaluation is the preferable route to take. It achieves the goal of evaluation and treatment, if needed. The mentally ill arrestee who is at risk in the jail is placed in a hospital setting, and the competency evaluation moves the case forward. However, there may be occasions when this statute would be useful, such as when an arrestee has a mental disorder and presents a danger, but is competent to stand trial.

It should also be noted that some local detention centers use the certification process for mentally ill detainees who meet the criteria for involuntary admission. Baltimore City Detention Center does not. A problem with this approach is that the detainee is in custody by court order, and the court is not involved with the involuntary admission by certificates. Most emergency admitting facilities do not have locked wards.

Procedure for Emergency Evaluation of Arrested Individuals

- Court finds probable cause to believe that the arrested individual presents a danger to the life or safety of the individual or others;
- Court order must state the grounds;
- Unless the court states otherwise, the individual shall stay in the custody of the officer until admission or return to court or jail;
- Examining physician shall send a brief report of the evaluation to the court;
- If the arrestee does not meet the criteria for involuntary admission, the officer shall return the order and the physician’s report; to the court,
- If court is not in session, the officer shall take the individual to jail and the next business day shall return the individual and the report to the court ;
- Order operates as a detainer.

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Section 7.4

Baltimore City Procedure

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BALTIMORE CITY
EMERGENCY EVALUATION PROCEDURE

1. FAST staff at Eastside and Hargrove will assist the petitioner in completing the petition. The petition must be filled out completely. If FAST staff is not available, the designated clerk will assist the petitioner.

2. The petition is to be presented to the presiding judge in the district in which the evaluee resides. If that judge is not available, or if the evaluee resides in a district in another court location, the petition is presented to the duty judge.

3. After the judge signs the order, court personnel will contact Police Communications at (410) 396-2284, which will arrange for an officer to pick up the order and execute it.

4. An entry will be made of the time the call was made and the time the officer arrived to pick up the petition, as well as the officer's name and District. If no officer appears after 30 minutes from the time of the call, court personnel will notify the duty judge, and the judge will take whatever action he/she deems necessary (e.g., contact the District Shift Commander). Every effort will be made to expedite the process.

5. The petitioner is encouraged to remain until the officer arrives to pick up the order, so that the petitioner may coordinate with the officer about executing the order, (e.g., time frame, admitting facility, and whether the evaluee is combative or has special needs).

6. Court personnel will insure that the officer has a "return of service" form.

7. If the order has been signed by one of the judges at civil, and the officer has not arrived to pick up the order by 4:30 p.m., the petition and order shall be delivered to the commissioner at Central, who will deliver the petition and order to the officer when he/she arrives. The commissioner will note the officer's name and district on the copy of the petition and order to be returned to civil court for processing, and will insure that the officer has the "return of service" form.

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Section 7.5

Forms

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Copies of the forms listed below are available on CourtNet. The form Petition for Emergency Psychiatric Evaluation is available to the public online. The Evaluation of Arrested Individual form is not available to the public.

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MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ (City/County)

Located at _____ (Court Address) Case No. _____

In the Matter of _____

PETITION FOR EMERGENCY EVALUATION
(Maryland Code, Health General Article § 10-620 et seq.)

The Petitioner, _____ (Name of Petitioner), requests that this Court order an emergency evaluation of _____ (Name of Person to be evaluated (Evaluee)) and in support of this Petition states as follows:

1. Petitioner: Address _____
   Cell Phone/Pager # _____ Home Phone _____ Work Phone _____
   If Petitioner is a physician, psychologist, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, licensed clinical marriage and family therapist, or health officer or designee of a health officer who has examined the Evaluee, then the Petitioner's specialty is _____ and the Petitioner's license number is _____.
   Relationship to or interest in Evaluee _____
2. Evaluee: Address _____ DOB _____
   Sex _____ Race _____ Ht. _____ Wt. _____ Hair _____ Eyes _____ Complexion _____
   Other _____
3. If not Petitioner, name of spouse, child, parent, or other relative, or other individual interested in the Evaluee:
   Name _____ Relationship _____
   Address _____
   Home Phone _____ Work Phone _____
4. A petition for emergency evaluation of the Evaluee was filed previously on _____ (Date(s)) and was ☐ granted ☐ denied.
5. The Evaluee has been hospitalized in the past at the following facilities:

When	Where	Diagnosis

6. The Evaluee currently is receiving psychiatric treatment from:

Name	Address	Phone

7. The Evaluee has been prescribed the following medication for his/her mental disorder: _____
8. The Evaluee ☐ **is** ☐ **is not** taking the medication as prescribed **OR** ☐ I do not know whether the Evaluee is taking medication as prescribed.
9. The Evaluee is demonstrating the following behavior that leads me to conclude that he/she currently has a mental disorder: _____
   (Attach additional sheet if necessary)
10. The Evaluee presents a danger to the life or safety of the Evaluee or others because: _____
    (Attach additional sheet if necessary)
11. The Evaluee has access to the following firearms/weapons: _____

I solemnly affirm under the penalties of perjury that the contents of the foregoing paper are true to the best of my knowledge, information, and belief.

_____ (Date) _____ (Petitioner)

_____ (Fax) _____ (E-mail)

CC-DC-013 (Rev. 7/2014) (front)

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ (City/County)

Located at _____ (Court Address) Case No. _____

In the Matter of _____

PETITION FOR EMERGENCY EVALUATION
(Maryland Code, Health General Article § 10-620 et seq.)

The Petitioner, _____ (Name of Petitioner), requests that this Court order an emergency evaluation of _____ (Name of Person to be evaluated (Evaluee)) and in support of this Petition states as follows:

1. Petitioner: Address _____
   Cell Phone/Pager # _____ Home Phone _____ Work Phone _____
   If Petitioner is a physician, psychologist, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, licensed clinical marriage and family therapist, or health officer or designee of a health officer who has examined the Evaluee, then the Petitioner's specialty is _____ and the Petitioner's license number is _____.
   Relationship to or interest in Evaluee _____
2. Evaluee: Address _____ DOB _____
   Sex _____ Race _____ Ht. _____ Wt. _____ Hair _____ Eyes _____ Complexion _____
   Other _____
3. If not Petitioner, name of spouse, child, parent, or other relative, or other individual interested in the Evaluee:
   Name _____ Relationship _____
   Address _____
   Home Phone _____ Work Phone _____
4. A petition for emergency evaluation of the Evaluee was filed previously on _____ (Date(s)) and was ☐ granted ☐ denied.
5. The Evaluee has been hospitalized in the past at the following facilities:

When	Where	Diagnosis

6. The Evaluee currently is receiving psychiatric treatment from:

Name	Address	Phone

7. The Evaluee has been prescribed the following medication for his/her mental disorder: _____
8. The Evaluee ☐ **is** ☐ **is not** taking the medication as prescribed **OR** ☐ I do not know whether the Evaluee is taking medication as prescribed.
9. The Evaluee is demonstrating the following behavior that leads me to conclude that he/she currently has a mental disorder: _____
   (Attach additional sheet if necessary)
10. The Evaluee presents a danger to the life or safety of the Evaluee or others because: _____
    (Attach additional sheet if necessary)
11. The Evaluee has access to the following firearms/weapons: _____

I solemnly affirm under the penalties of perjury that the contents of the foregoing paper are true to the best of my knowledge, information, and belief.

_____ (Date) _____ (Petitioner)

_____ (Fax) _____ (E-mail)

CC-DC-013 (Rev. 7/2014) (front)

TO THE PETITIONER: You may be required to appear before the Court. You have made the statements above under penalties of perjury. If an evaluation is ordered, it would be helpful if you could accompany the Evaluee to the emergency facility and provide facility authorities with all information that is pertinent to this Petition. A Petitioner who, in good faith and with reasonable grounds, submits or completes the Petition for Emergency Evaluation is not civilly or criminally liable for submitting or completing the Petition.

ENDORSEMENT AND ORDER

In the matter of the emergency evaluation of .....

(Case No .....), the Petitioner having presented to the Court and the Court having reviewed the Petition and considered all pertinent data presented, the Court:

- ☐ Finds probable cause to believe that the named individual (Evaluee) has shown the symptoms of a mental disorder and presents a danger to the life or safety of the Evaluee or others and, therefore, ORDERS that any peace officer take into custody and transport the Evaluee to the nearest emergency facility, for examination by a physician within six hours after arrival at the facility and, if in the physician's opinion necessary, for emergency care and treatment; provided that the facility may not keep the Evaluee for more than 30 hours under this Order but is not precluded from voluntary or involuntary admission in accordance with Maryland Code, Health-General Article.
- ☐ Denies the Petition, finding no probable cause.

....
Date Judge ID Number

A. Duties of Peace Officer
   1. Caution to Petitioner. A peace officer shall explain to a physician, psychologist, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, a licensed clinical marriage and family therapist, or a health officer or designee of a health officer, who presents a petition to the peace officer:
      a. the serious nature of the Petition; and
      b. the meaning and content of the Petition.
   2. Delivery to Facility. A peace officer shall take an Evaluee to the nearest emergency facility if the officer has a petition that:
      a. has been endorsed by a court within the last 5 days; or
      b. is signed and submitted by a physician, psychologist, clinical social worker, licensed clinical professional counselor, clinical nurse specialist in psychiatric and mental health nursing, psychiatric nurse practitioner, a licensed clinical marriage and family therapist, or a health officer or designee of a health officer, or peace officer.
   3. Documentation of Delivery. A peace officer shall complete a Return of Service by Peace Officer form (CC-DC 27) and have an agent for the emergency facility sign the form.
   4. Remaining with Evaluee.
      a. After a peace officer takes an Evaluee to an emergency facility, the officer need not stay unless, because the Evaluee is violent, a physician asks the officer's supervisor to have the officer stay.
      b. A peace officer shall stay until the officer's supervisor responds to the request for assistance.
   5. Return of Service. A peace officer shall file a completed Return of Service with the Court issuing the Endorsement and Order immediately after an Evaluee is delivered to an emergency facility or immediately after expiration of the five-day period for taking the Evaluee into custody.

B Duty of Supervisor. A supervisor shall allow a peace officer to stay with a violent Evaluee.

C. Duties of Emergency Facility
   1. Documentation of Delivery. An agent of the emergency facility shall sign the Return of Service by Peace Officer form completed by a peace officer transporting an Evaluee to the facility.
   2. Examination. If a physician asks that a peace officer stay, a physician shall examine the Evaluee as promptly as possible to determine whether the Evaluee meets the requirements for involuntary admission. In any event, a physician shall examine an Evaluee within six (6) hours after an officer brings the Evaluee to the facility.
   3. Release or Admission. Promptly after an examination, an Evaluee shall be released unless the Evaluee:
      a. asks for voluntary admission; or
      b. meets the requirements for involuntary admission.
   4. Detention Period. An emergency Evaluee may not be kept at an emergency facility for more than thirty (30) hours.

CC-DC-013 (Rev. 7/2014) (back) **Reset**

CERTIFICATION BY PEACE OFFICER

I am a ☐ sheriff, ☐ deputy sheriff, ☐ State police officer, ☐ county police officer, ☐ municipal or other local police officer, or ☐ Secret Service agent who is a sworn special agent of the United States Secret Service or Department of Homeland Security authorized to exercise powers delegated under 18 U.S.C. § 3056.

As to _____ (Evaluee), I have personally observed the ☐ Evaluee or ☐ Evaluee's behavior and, based on the ☐ observation or ☐ other information, have reason to believe that the Evaluee has a mental disorder and presents a danger to the life or safety of the Evaluee or others. Pursuant to Maryland Code, Health–General Article § 10-622, I have transported the Evaluee to _____ _____ (emergency facility) for evaluation.

_____ Date and Time

_____ Peace Officer

_____ Department

_____ ID Number

CERTIFICATIONS BY OTHER PERSON QUALIFIED UNDER HG § 10-622 AND PEACE OFFICER

I am a ☐ physician, ☐ psychologist, ☐ clinical social worker, ☐ licensed clinical professional counselor, ☐ clinical nurse specialist in psychiatric and mental health nursing, ☐ psychiatric nurse practitioner, ☐ a licensed clinical marriage and family therapist, ☐ health officer or ☐ designee of a health officer. I have examined _____ (Evaluee). Based on ☐ the examination or ☐ other information, I have reason to believe that the Evaluee has a mental disorder and presents a danger to the life or safety of the Evaluee or others and, in accordance with Maryland Code, Health–General Article § 10-622, have completed the attached Petition for Emergency Evaluation and have requested a peace officer to take into custody and transport the Evaluee to the nearest emergency facility for evaluation by a physician. The Peace Officer explained to me the serious nature, meaning, and content of the Petition and I asked the officer to proceed.

_____ Date and Time

_____ Physician or other Qualified Person under HG § 10-622

_____ License No.

I have explained to the Petitioner the serious nature of the Petition and the meaning and content of the Petition.

_____ Date

_____ Peace Officer

_____ Department

_____ ID Number

CC-DC-014 (Rev. 7/2014)

Reset

MARYLAND JUDICIARY ☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant DOB

Charge: (1) _____ _____ Address

(2) _____ _____ City, State, Zip Telephone

ORDER FOR EMERGENCY EVALUATION OF AN ARRESTED INDIVIDUAL
(Health General § 10-626)

The above named Defendant has been arrested, and the Court finds that there is probable cause to believe that the Defendant has a mental disorder, and that he/she presents a danger to the life or safety of himself/herself or of others because _____; it is therefore

ORDERED as follows:

1. The Defendant shall be transported by a peace officer to _____ (facility) and that an emergency evaluation of the Defendant shall be made by the staff of said facility;
2. The Defendant shall remain in the custody of the peace officer until the Defendant is either admitted to an appropriate facility or returned to the Court or an appropriate jail;
3. If the Defendant does not meet the requirements for involuntary admission, the examining physician shall complete a brief report of the evaluation, and the peace officer shall return the Defendant, the Court Order, and the report of the examining physician to the Court;
4. If the Defendant is returned when the Court is not in session, the peace officer shall take the Defendant to an appropriate jail and shall return the Defendant and the report of the examining physician to the Court before the end of the next day that the Court is in session;
5. This Order shall be a detainer against the release of the Defendant until the charges against the Defendant are dismissed, nol prossed, or stetted, or until the Defendant appears in court; and
6. _____

_____ Date _____ Judge _____ ID Number

PRESENT BOND: _____

DESCRIPTION OF DEFENDANT:

Sex _____ Race _____ Ht. _____ Wt. _____ Hair _____ Eyes _____ Complexion _____

Driver's License No. _____ Other _____

COMPLAINING WITNESS (If witness is family member or if offense is family-related):

Name _____ Home Phone _____ Work Phone _____

Address _____

KNOWN RELATIVE OF DEFENDANT:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Address _____

CC-DC-015 (Rev. 7/2014) **Reset**

☐ CIRCUIT COURT ☐ DISTRICT COURT OF MARYLAND FOR _____ (City/County)

Located at _____ (Court Address) Case No. _____

STATE OF MARYLAND vs. _____ (Defendant) _____ (DOB)

IN THE MATTER OF THE EMERGENCY EVALUATION OF: _____

RETURN OF SERVICE BY PEACE OFFICER

I HEREBY CERTIFY that on this _____ day of _____ (Month), _____ (Year),

☐ I took into custody the Emergency Evaluee, _____ (Name) and

transported him/her to _____ (Emergency Facility)

at _____ (Time) ☐ a.m. ☐ p.m. .

☐ I could not locate and transport the Emergency Evaluee, _____ (Name)

to an emergency facility within five (5) days of the Court's Endorsement and Order.

_____ (Date)

_____ (Signature of Peace Officer)

_____ (Printed Name)

_____ (Agency) _____ (Sub-agency) _____ (Officer ID Number)

RECEIPT

The Emergency Evaluee was transported to the emergency facility on the date and time indicated above.

_____ (Date)

_____ (Signature of Agent for Emergency Facility)

_____ (Printed Name)

RETURN OF SERVICE MUST IMMEDIATELY BE FILED WITH THE COURT.

CC-DC-027 (Rev. 10/2014)

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CHAPTER 8

ADMISSION, DISCHARGE AND PLANNING

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Section 8.1

Civil Admission Proceedings

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VOLUNTARY ADMISSION TO STATE PSYCHIATRIC FACILITY
(Health General 10-608 et seq.)

Requirements

In order to be eligible for voluntary admission, the individual must:

1) Be at least 16 years old;
2) Have a mental disorder susceptible to care or treatment;
3) Understand the nature of the request for admission; and
4) Be able to give continuous assent to retention by the facility and to ask for release.

The voluntary admission process may not be an option for some incompetent defendants. The admission agreement is, in essence, a contract, and before accepting a voluntary admission from a defendant found to be incompetent to stand trial, care should be taken to insure that the defendant has sufficient understanding of the admission and release process to validly make the request and continuously assent.

INVOLUNTARY ADMISSION

Certificate for Involuntary Admission

1) Based on personal examination of the physician or psychologist who signs.
2) Examination may not be performed more than one week before the certificate is signed.
3) Examiner may not have a financial interest through ownership or compensation in a proprietary facility to which the defendant is being certified.

Requirements

1) Has a mental disorder.
2) Needs inpatient care or treatment.
3) Presents a danger to the life or safety of the individual or others.
4) Unable or unwilling to be voluntarily admitted.
5) No available, less restrictive form of intervention that is consistent with the health or safety of the individual.
6) May not admit an individual aged 65 or older unless a geriatric evaluation team determines that there is no available, adequate, less restrictive alternative.

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Section 8.2

Individual Treatment Plan and Aftercare Plan

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INTRODUCTION

When an individual, including a court committed defendant, is admitted to a state psychiatric hospital, DDA forensic center, or residential drug program, clinical staff must develop an individual treatment plan. The patient/resident's strengths and weaknesses are identified, goals and objectives are established and treatment is prescribed.

Shortly after admission, the treatment team, or treatment provider should, with input from the patient, begin formulation of the discharge or continuing care plan. For court committed individuals, the services outlined in the aftercare plan frequently become the conditions of probation or terms of release. A comprehensive plan including housing, treatment, and entitlements is critical to the defendant's successful transition to the community. The overarching goals are improved health, stability, safety, and enhanced quality of life. Ideally, with the defendant's investment in the plan and careful monitoring and support, future hospitalization and recidivism can be reduced.

INDIVIDUAL TREATMENT PLAN

Both federal and state laws require the development of an individual plan of care for every patient admitted to a psychiatric hospital.[1] An individual plan of therapeutic services must also be formulated for individuals committed to DDA forensic centers.[2]

BHA Individual Treatment Plan

- Active treatment which aims at the arrest, reversal, and amelioration of illness symptoms
- Based on diagnostic evaluation that includes an examination of individuals' specific needs and problems
- Reflects the need for inpatient care
- Developed by a team of professionals in consultation with the patient, the patient's parents, or caretakers
- Measurable goals and objectives
- Integrated program of therapies, activities, and experiences
- **At an appropriate time, an aftercare plan**
- **Coordination of inpatient services with community services to ensure continuity of care**

[1] 42 CFR §441.155, 456.180-181, COMAR 10.09.29.01, 10.21.03.03
[2] COMAR 10.07.13.06

DDA Forensic Center Services

- Are designed to prepare the individual for productive community living
- Address issues of dangerousness
- Are based on interdisciplinary team assessment
- Consider least restrictive interventions

Therapeutic services include:

- Competency attainment services (for individuals committed as IST-D)
- Behavioral and mental health plans and services
- Physical, speech and occupational therapies (as clinically appropriate)
- Habilitation services and
- **Development of aftercare plan**

AFTERCARE PLAN
(Health General Article § 10-809)

Before a facility releases an individual, the head of the facility or a designee shall:
- Prepare a written aftercare plan
- With the individual's consent, send the plan to the community treatment program

Aftercare services mean services:
- For individuals who no longer receive inpatient services for a mental disorder, and
- That enhance the opportunity to maintain a mentally ill individual in the community and to assist in the prevention of homelessness.

Aftercare services include:
- Medical care;
- Psychiatric care;
- Vocational and social rehabilitation;
- Supportive housing; or
- Case management services.

The aftercare plan shall include:
- Diagnoses, including existing psychiatric, somatic, and mental diagnoses;
- Treatment utilized;
- Medications prescribed, dosage and amount given on release, and information necessary to help the individual obtain the medication in the community;
- Date of release;
- Location of community placement;
- Plan for continuing treatment; and
    - List of referrals including:
        1. Public social services
        2. Legal Aid
        3. Educational services
        4. Vocational services, and
        5. Medical treatment

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Section 8.3

Benefits

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Most justice involved individuals are dependent upon the public health system for both somatic and behavioral health treatment and services. In addition, access to financial entitlements and housing assistance upon discharge are critical components of stability in the community. Connection to benefits is also essential to successful reentry from incarceration. State psychiatric hospitals, DDA Forensic Centers, and residential alcohol and drug programs are required to include benefits in the patient's aftercare or discharge plans.

Federal Income Support Programs

1) SSI for low-income people with disabilities
2) SSDI for people who have worked and paid Social Security taxes

Health Care Benefits

1) Medicaid covers anyone qualified for SSI benefits
2) Medicare covers people eligible for SSDI (and those over age 65)

APPLICATION FOR BENEFITS
(Health General Article § 10-810 (d)(3))

Section 10-810 of the Health General Article provides that "[W]ith the individual's consent and as early as possible after admission, staff shall assist the individual or parent, guardian, or other representative in applying for federal or state benefits for which the individual may be eligible."

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Section 8.4

Levels of Care

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Public Mental Health System

The Behavioral Health Administration oversees the public mental health system (PMHS), which is comprised of state psychiatric hospitals and community programs. At the local level, BHA delegates management responsibilities to the Core Service Agencies (CSA).[3]

HOW IS THE PMHS FUNDED?

- Medicaid "carve out"[4] and State only dollars
- Majority of services are reimbursed through a "fee for service" (FFS) system
- An Administrative Services Organization (ASO) serves as the managed care organization (currently ValueOptions)

WHO IS ELIGIBLE?

- Individuals with a mental illness who meet low income/low assets requirement (priority given to people with a serious mental illness)[5]
- Individuals with Medical Assistance (MA) (Maryland's name for Medicaid) are eligible for all services
- Individuals with Primary Adult Care (PAC) are eligible for all except inpatient and partial hospitalization services
- Uninsured individuals are eligible only if certain criteria are met and funding is available
- ASO authorizes services based on medical necessity criteria[6]

The levels of care are grouped into two broad categories, acute and ongoing care, with an array of services within each category. For a full description of available services, the ValueOptions and Network of Care Behavioral Health Care websites are a resource.[7] The services most often used by the forensic population will be highlighted.

---

[3] Unless otherwise cited, the source for this section on MHA Levels of Care is Baltimore Mental Health Systems, Inc. (9/20/10). Mental Health Services for Adults in Baltimore City: A Guide to Services Available in the Public Mental Health System: Baltimore, Md.

[4] Seven managed care organizations provide somatic care and substance abuse treatment. Mental health services have been carved out and are provided by a separate network of providers.

[5] See Appendix D for diagnostic categories

[6] http://maryland.valueoptions.com/provider/prv_man.htm, see p.72.

[7] Ibid. Network of Care is accessed through MHA website, http://dhmh.md.gov/mha
http://dhmh.md.gov/mha

ACUTE CARE

Acute care provides short-term intensive services in a highly monitored environment to individuals who are experiencing a crisis or whose symptoms cannot be stabilized in a less restrictive setting.

- **Inpatient care**
  - Average length of stay: 5 days

- **Emergency Services in a licensed hospital emergency room**

- **Residential Crisis**
  - This service provides an alternative to inpatient care, in a community based, non hospital setting, for individuals who are experiencing a mental health crisis and who would benefit from 24 hour intensive treatment and support, but who do not need a high level of medical supervision
  - Average length of stay: 6 days[8]

- **Partial hospitalization (PHP)**
  - Partial hospital program services, also known as psychiatric day treatment services, are short-term, intensive psychiatric treatment services provided by a multidisciplinary team that parallel the intensity of services provided in an inpatient hospital setting. Services are provided in a hospital setting and the individual is expected to return to their residence at the end of the day.
  - A minimum of 4 hours of treatment is provided per day.

ONGOING CARE

Many individuals with serious and persistent mental illness will need ongoing care for support in the community. These services are not time limited and may include mental health treatment, rehabilitation, and/or case management.

- **Residential Rehabilitation (RRP)**
  - RRPs provide services, including case management; medication monitoring; psychosocial assessment; and support with daily living skills, to individuals who need extensive support and a structured living environment
  - Residents have access to on call staff 24/7
  - Residents attend outpatient treatment off site
  - RRPs cannot be used solely for housing.
  - General level has a minimum of 3 contacts per week or 17 per month. Intensive level has a minimum of 23 contacts per month

[8] The average lengths of stay pertain only to civil admissions.

- **Baltimore City Capitation Program**
  - Capitation provides a comprehensive array of services to participants who are stable enough to live in the community but have difficulty managing treatment and services independently.
  - There is 24/7 access to staff, and staff has small caseloads with 8-10 cases per clinician.
  - The providers receive a predetermined amount of funding for all of the individual's psychiatric care including inpatient. The Capitation provider authorizes expenditures rather than the ASO.
  - No frequency of contact requirement.

- **Assertive Community Treatment (ACT)**
  - ACT is an evidence-based practice that requires mobile treatment team providers to receive specialized training and evaluation.
  - Like the Capitation Program, both ACT and Mobile Treatment teams provide an array of services to individuals who are stable enough to live in the community but who have difficulty managing their mental health and whose treatment needs have not been met through routine, traditional outpatient treatment.
  - Services are provided flexibly and in the various community settings determined by the needs of the individual.
  - ACT enables the individual to: achieve recovery, fully participate in community life, attain stable permanent housing and employment, and reduce the individual's unnecessary admissions to emergency rooms and inpatient psychiatric services, and incarceration in detention centers.
  - Duration, frequency and intensity of services are higher than Mobile Treatment.
  - ACT provides some services that Mobile Treatment does not: substance abuse treatment, supported employment, peer support, daily review of progress toward goals, and the use of more assertive engagement techniques.
  - Minimum of 4 contacts per month, with a home visit every 90 days (contacts several times a week to adhere to EBP).

- **Forensic Assertive Community Treatment (FACT)**
  - FACT is an ACT team that provides services to individuals with current justice system involvement.

- **Mobile Treatment**
  - The services are available to adults as well as to children, adolescents, and their families who require more intensive intervention in order to clinically stabilize the child's or adolescent's psychiatric condition, to promote family preservation, and/or to return functioning and quality of life to previously established levels, as soon as possible.
  - Both ACT and Mobile Treatment have access to staff 24/7.
  - Services include: psychiatric evaluation and treatment; medication management, administration and monitoring; individual, group and family therapy; support with daily living skills; assistance in obtaining housing; entitlements coordination; and case management.

- Minimum of 4 contacts per month and a home visit every 90 days.

- **Targeted Case Management**
  - Assessment of need and coordination of care with priority given to individuals, who are not linked to mental health services, lacks basic supports for housing, food, and income or are transitioning from one level of care to another.
  - 24/7 access to staff.

- **Outpatient Mental Health Clinics**
  - Individual treatment plans determine duration, intensity, and frequency
  - Minimum of 1 contact every 90 days.

- **Psychiatric Rehabilitation (PRP)**
  - Rehabilitative and support services including: case management; assistance with entitlements; transportation to appointments; and liaison with outside services such as somatic care, substance abuse and mental health treatment.
  - Services may be provided on site or off site.
  - Mental health treatment is provided elsewhere.

- **Supported Employment**
  - See Chapter 10.2.

Developmental Disabilities Administration

HOW ARE SERVICES PROVIDED?

- Regional model
- Initiation of services dependent on availability and allocation of funding
- State mandated eligibility process (can take up to 60 days)

TYPES OF SERVICES

- Behavioral support services
- Family support services
- Individual support services
- Day/Vocational/Supported employment services
- Summer camps
- Resource/Service coordination
- Transitioning youth services
- Community supported living arrangements
- Residential services
- Respite services

FORENSIC CENTERS & PROGRAMS

- Secure evaluation and therapeutic treatment (SETT) designed to provide specialized clinical evaluation, treatment, habilitation, security and service planning for court committed individuals with mental retardation
  - Jessup SETT (12 bed evaluation unit)
  - Sykesville SETT (20 bed longer term unit)
- Potomac Center
  - Step Down Unit (4 beds)
  - Program for individuals, many of whom are court involved, with co-occurring mental illness and intellectual or developmental disability
- State psychiatric hospital initiative for individuals with co-occurring mental illness and intellectual disability (some with substance abuse)

Alcohol/Substance Abuse

The vast majority of justice-involved individuals with mental illness also have a co-occurring substance abuse problem. In general, treatment programs and services are described as follows:

Addiction-Only Service (AOS)

- Cannot accommodate psychiatric illnesses no matter how stable and well-functioning the individual may be.
- Policies and procedures do not accommodate dual diagnosis (e.g., psychotropic medications not accepted; coordination/collaboration with mental health not routinely present; mental health issues not addressed in treatment).

Dual Diagnosis Capable (DDC) Programs

- Routinely accept co-occurring disorders.
- Can meet needs if psychiatric disorders are sufficiently stable and mental disorders do not interfere with addiction treatment.
- Address dual diagnosis in policies, procedures, assessment, treatment planning, program content, and discharge planning.
- Have arrangements for coordination and collaboration with mental health services.
- Can provide psychopharmacologic monitoring and psychological assessment/consultation on site or well coordinated off-site.

Dual Diagnosis Enhanced (DDE) Programs

- Can accommodate unstable/disabled individuals needing specific psychiatric, mental health support, monitoring and accommodation necessary to participate in addiction treatment.
- Not so acute/impaired to present severe danger to self/others, nor need for 24-hour psychiatric supervision.
- Psychiatric, mental health and also addiction treatment professionals. Cross-training for all staff. Relatively high staff to patient ratios; close monitoring of instability and disability.
- Policies, procedures, assessment, treatment and discharge planning accommodate dual diagnosis.
- Dual diagnosis specific with mental health symptom management groups is incorporated in addiction treatment. Motivational enhancement therapies are more likely (particularly in outpatient settings).
- Close collaboration/integration with mental health program for crisis back-up services and access to mental health case management and continuing care.

Treatment Options

Medically Monitored Inpatient Detoxification

Program that provides a planned regimen of 24 hour professional directed evaluation, care, and treatment to an acutely intoxicated individual in an inpatient setting and meets the certification requirements for detoxification services. The service is short term (3-10 days).

Residential

Long Term Residential Care
Facility for those with chronic addiction who have failed in other treatment modalities. The program offers a structured environment in combination with medium intensity treatment and ancillary services to promote recovery.

Intermediate Care
Program provides a planned regimen of 24-hour professional directed evaluation, medical monitoring, and addiction treatment. Typically, a 28-day residential program.

Therapeutic Community
Highly structured environment in combination with moderate to high intensity treatment and ancillary services to promote recovery.

Halfway House
Three to twelve month residential program. Must have had a 28-day type program experience within the preceding year.

Traditional Housing
An organization that provides alcohol and drug free housing to individuals in recovery, but does not provide alcohol or drug treatment services (e.g., recovery house).

Outpatient

Detoxification
Short term services for acutely intoxicated individuals that monitors the amount of alcohol or other toxic agents in the body, manages withdrawal symptoms, and motivates the individual to participate in addiction treatment.

Medication Assisted Treatment
Uses pharmacological intervention, including but not limited to methadone, buprenorphine, and suboxon to provide treatment, support, and recovery to opioid addicted Individuals.

Intensive Outpatient Services
Sessions are three to five days a week, full days or evening sessions with a gradual reduction of number of sessions per week.

Traditional Outpatient
One to three times a week. Various modalities include: individual, group, couples, family, and multi-family. Group types include: relapse prevention, women's, men's, pregnant addicts, mothers, and some offer specific group by drug of choice.

Alcohol/Drug Education
Usually six to twelve weeks of classroom education for those who do not show signs of addiction or as a beginning phase of a longer course of treatment.

Self Help Groups
Voluntary fellowships or groups that support patients in recovery from alcohol or other drug abuse or dependency. May be a companion to professional treatment and provides alcohol or drug free social life and maintenance of the lifestyle after treatment ends (e.g., AA or NA).

CODES	LEVELS OF CARE	DEFINITIONS	EXAMPLES
0	Early Intervention	Early stages of alcohol and/or drug abuse or dependency	Counseling with at risk individuals and DUI Programs
1	Outpatient Treatment	Require services for less than 9 hours weekly	Office practice, health clinics, primary care clinics, mental health clinics, “Step Down “ programs
1 OMT	Opioid Maintenance Therapy	Receive pharmacological interventions including, but not limited to, methadone, LAMM	Methadone maintenance programs
II	Intensive Outpatient Treatment	Receive 9 or more hours weekly	Day or evening outpatient programs
II.5	Partial Hospitalization	Day treatment with 9 or more hours weekly	
III.I	Clinically Managed Low Intensity Residential Treatment	Residential care and at least 4 hours of treatment per week	Day treatment programs; halfway houses with “Recovery or Discovery” services; sober houses; boarding houses, or group homes with in-house Level I services and a structured recovery environment
III.3	Clinically Managed Medium-Intensity Residential Treatment	Residential long term care with structured environment and treatment	Therapeutic Rehabilitation Facility for extended or long term care
III.5	Clinically Managed High- Intensity Residential Treatment	Residential care with highly structured, high intensity treatment and ancillary services	Therapeutic Community or Residential Treatment Center and Step-Down from Level III.7
III.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient treatment program	Inpatient Treatment Center, ICF
IV	Medically Managed Intensive Inpatient	Acute hospitals, Acute psychiatric hospitals	Acute care general hospital or Unit within a general hospital; licensed chemical dependence specialty hospital with acute care medical and nursing staff

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Section 8.5

Forms

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The judiciary worked closely with DHMH to develop the forms, which contain critical information for the sentencing or specialty court judge. The forms were designed to include the components of an aftercare plan. The completed form should be submitted to the court in advance of any annual hearing (IST-D and IST-ND), and status hearing/conference.

BEHAVIORAL HEALTH ADMINSTRATION
HEALTH GENERAL
§8-507 MONTHLY PROGRESS REPORT 351

CC DC-CR-122
HEALTH GENERAL §8-507 PROGRESS REPORT..... 357
(The Justice Services Unit or its designee should submit the progress report form to the court and counsel in advance of any review hearing for a defendant committed to BHA pursuant to Health Gen. §8-507. Usually, the residential provider is delegated the responsibility for completing the form.)
http://www.courts.state.md.us/courtforms/internal/ccdccr122.pdf

See Chapter 2.10 for the following report forms for defendants found to be incompetent to stand trial.

CC DC MH 001
COMPETENCY STATUS REPORT..... 164
http://www.courts.state.md.us/courtforms/internal/ccdcmh001.pdf

CC DC MH 008
COURT STATUS/ANNUAL REPORT INCOMPETENT TO STAND TRIAL
AND NOT DANGEROUS TO STAND TRIAL IN THE COMMUNITY 172
http://www.courts.state.md.us/courtforms/internal/ccdcmh008.pdf

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MARYLAND ALCOHOL AND DRUG ABUSE ADMINSTRATION
HEALTH GENERAL 8-507
MONTHLY PROGRESS REPORT

The progress report should be forwarded to ADAA by the 5th of every month. In addition, a current report must be submitted to Parole/Probation, and the court. Submit report to the court two (2) days prior to the date of any court hearing. The report should summarize the defendant's progress during the previous month.

Please type or print your responses. Please place **N/A** next to any questions that do not apply to the defendant.

HEARING DATE: _____

DEFENDANT'S NAME: _____

ADMISSION DATE: _____

PROJECTED DISCHARGE DATE: _____

PROGRESS REPORT FOR PERIOD FROM _____ **TO** _____

PROGRAM: _____ **PHONE**: _____

COUNSELOR: _____ **FAX**: _____

LEVEL OF COMPLIANCE WITH TREATMENT PLAN:

_____ Excellent _____ Very Good _____Good _____ Fair _____ Poor

SUBSTANCE ABUSE TREATMENT

LEVEL OF INSIGHT INTO SUBSTANCE PROBLEM:

- ☐ Denies illness
- ☐ Minimizes illness
- ☐ Increasing insight
- ☐ Behavior change based on insight

Treatment strategy employed to improve insight:

_____

_____

ATTENDANCE AND PARTICIPATION:

☐ Met attendance requirement for program

Compared to last report, attendance & participation is:

_____ Improving _____ Declining _____ No change

Plan to address problem:

_____

_____

_____

URINALYSIS

Submitted _____ out of _____ samples. _____ Positive tests.

MENTAL HEALTH TREATMENT

DIAGNOSTIC IMPRESSION:

_____

MEDICATION PRESCRIBED:

_____

Reason for any change in medication:

_____

MEDICATION COMPLIANCE: _____ Compliant _____ Noncompliant _____NA

Plan to address compliance problems:

_____

_____

_____

TREATMENT SERVICES PROVIDED:

_____ Individual _____ Group _____ Both _____ Other (Describe)

_____

Treatment provided by:

_____ Psychiatrist _____ Psychologist _____ Clinical Social Worker

_____ Substance Abuse Counselor _____ Psychiatric Nurse

_____ Other

_____ Psychiatrist provides medication management only. Frequency:

_____

Attended _____ out of _____ individual sessions

Attended _____ out of _____ group sessions

Plan to address any attendance problems:

_____

_____

_____

MEDICAL

SIGNIFICANT HEALTH PROBLEMS:

_____

_____

MEDICATIONS:

_____

_____

AFTERCARE PLAN

LIVING ARRANGEMENT:

- ☐ Halfway house
- ☐ Recovery house
- ☐ With relative
- ☐ Independent
- ☐ Will reside with:

_____

Address:

_____

Will be available on:

_____

EMPLOYMENT:

Name of business: _____

Address: _____

Will begin on: _____

EDUCATIONAL OR VOCATIONAL TRAINING:

Where: _____

Will begin on: _____

FINANCES: Public Assistance (MA, AFDC, Pharmacy Assistance, Food Stamps)

PRIMARY ADULT CARE (PAC):

_____ Yes _____ No ____ Application submitted

Will receive on: _____

SSI: Will receive on _____

Social Security: Will receive on: _____

SUBSTANCE ABUSE TREATMENT:

Name of Program: _____

Will begin on: _____

MENTAL HEALTH TREATMENT:

Name of Program: _____

Will begin on: _____

CASE MANAGEMENT services to be provided by:

_____

Will begin on: _____

Case manager met with counselor and defendant on _____

Trauma Counseling:

Name of program: _____

Will begin on: _____

Parenting Counseling:

Name of program: _____

Will begin on: _____

Medical (Describe):

_____

Appointment scheduled: _____

CONTACTS WITH DEFENDANT'S SUPERVISING/MONITORING AGENT

Name of Agent/Monitor:_____

Agency: Telephone communication on:_____

Meeting on: _____

Plan reviewed on: _____

REQUEST FOR COURT INTERVENTION

- ☐ On and off grounds privileges
- ☐ Sanction
- ☐ Meeting with Supervising/Monitoring Agent (PTS, Probation, FAST, ADAA or designee)
- ☐ Termination due to noncompliance
- ☐ Permission to transport defendant to Court
- ☐ Postpone due to excellent compliance

COMMENTS

Signature: _____ **Date**: _____

☐ **CIRCUIT COURT** ☐ **DISTRICT COURT OF MARYLAND FOR** _____ City/County

Located at _____ Court Address Case No. _____

STATE OF MARYLAND vs. _____ Defendant

_____ SID No.

HEALTH GENERAL § 8-507 PROGRESS REPORT

The progress report should be forwarded to _____ (Monitoring agency) by _____ Date .

In addition, a current report must be submitted to _____ (Monitoring agency) , _____ No. of Days days prior to the date of any court hearing. The report should summarize the Defendant's progress during the previous month. Please type or print your responses.

Hearing Date _____ Defendant's Name _____

Admission Date _____ Projected Discharge Date _____

Progress Report for Period from _____ to _____

Program _____ Phone _____

Counselor _____ FAX _____

Level of Compliance

☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

SUBSTANCE ABUSE TREATMENT

Level of Insight into substance problem:

☐ Denies illness ☐ Minimizes illness ☐ Increasing insight ☐ Changing behavior

Treatment Strategy Employed to Improve Insight:

_____

_____

Attendance and Participation:

Attended _____ out of _____ individual sessions

Attended _____ out of _____ group sessions

Urinanalysis

Submitted _____ Out of _____ Samples

Positive tests _____

Compared to last report, attendance and participation is: ☐ Improving ☐ Declining ☐ No change

Plan to address problem: _____

_____

_____

Case No. .....

PSYCHIATRIC TREATMENT

Diagnosis: ☐ Schizophrenia ☐ Bipolar ☐ Mood disorder ☐ Other (Specify) .....

Medication prescribed: .....

Reason for any change: .....

Medication Compliance ☐ Compliant ☐ Noncompliant ☐ NA

Plan to address any compliance problems: .....

.....

.....

Type of treatment ☐ Integrated ☐ Parallel ☐ Sequential

Type of modality ☐ Individual ☐ Group ☐ Both ☐ Other (Describe) .....

.....

Treatment provided by ☐ Psychiatrist ☐ Psychologist ☐ Clinical Social Worker

☐ Substance Abuse Counselor ☐ Psychiatric Nurse ☐ Other .....

Psychiatrist provides medication management only ☐ Frequency .....

Treatment Compliance:

Attended ..... out of ..... individual sessions

Attended ..... out of ..... group sessions

Plan to address any compliance problems: .....

.....

AFTERCARE PLAN

Living arrangement ☐ Halfway house ☐ Recovery house ☐ With relative ☐ Independent

Will reside with .....

Address .....

Will be available on .....

Employment

Name of business .....

Address .....

Will begin on .....

Educational or vocational training

Where .....

Will begin on .....

Finances

☐ Public Assistance (including Medical Assistance, Pharmacy Assistance, Food stamps)

Will receive on .....

☐ SSI Will receive on ..... ☐ Social Security Will receive on .....

Case No. .....

TREATMENT/COUNSELING

Substance Abuse Treatment:

Name of Program: ..... Will begin on .....

Psychiatric Treatment:

Name of Program ..... Will begin on .....

Case management services to be provided by .....

Will begin on .....

Case manager met with counselor and Defendant on .....

Trauma Counseling:

Name of Program ..... Will begin on ..... ☐ NA

Parenting Counseling:

Name of Program ..... Will begin on ..... ☐ NA

Other Counseling (Describe) .....

CONTACTS WITH DEFENDANT'S SUPERVISING/MONITORING AGENT

Name of Agent/Monitor .....

Agency .....

Telephone Communication on ..... Meeting on ..... Plan reviewed on .....

REQUEST FOR COURT INTERVENTION

☐ On and off grounds privileges (PTS, Probation, FAST, JS/OFS, or designee)

☐ Sanction

☐ Meeting with Supervising/Monitoring Agent

☐ Termination due to noncompliance

☐ Postpone due to excellent compliance

☐ MDH designee

☐ Permission to transport Defendant to Court

COMMENTS:

.....

.....

.....

.....
Date

.....
MDH employee/agent

.....
Printed Name

.....
Address

.....
City, State, Zip

.....
Telephone Number

....
Fax E-mail

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CHAPTER 9

EVALUATION, DIAGNOSIS, AND MEDICATION

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Section 9.1

Evaluations

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ASSESSMENTS

A distinction is made between “screening” and “assessment,” and assessments can have different features and purposes depending on who is performing the assessment.

Generally speaking, a **screening** is a process for evaluating the possible presence of a particular problem. And the outcome is normally a simple yes or no (e.g., a competency screening). An **assessment** is a more in depth process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem.

The following types of assessments are the ones that practitioners and judges most frequently encounter in criminal courts.

Psychiatric or Psychological Assessment

This type of assessment is usually carried out for clinical and therapeutic purposes to determine a diagnosis and to plan the individual’s care and treatment. It may be performed by a psychiatrist or psychologist or by a multi-disciplinary team. [1]

Mental Status Examination

The mental status examination (MSE) is a "structured way of describing a patient's current state of mind, under domains of appearance, attitude, behavior, speech, mood and affect, thought process, thought content, perception, cognition (including for example orientation, memory, and concentration), insight and judgment. It is a core part of a psychiatric assessment.”[2]

Psychosocial Assessment

The psychosocial assessment is a tool to create a comprehensive picture of an individual in order to establish a treatment plan. While other types of professionals may carry out this type of assessment, in the criminal justice system it is most often performed by clinical social workers.

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[1] Psychiatric & Psychological Consultants. Retrieved July 2, 2012, from http://ppcltd.uk/assessments

[2] Trzepacz, P., Baker, R. (1993). The psychiatric mental status examination. Oxford: Oxford Press.

Forensic Assessment

This type of assessment is usually performed in order to formulate an opinion for the court as to a defendant's competency to stand trial or criminal responsibility. It could also be for the purpose of judicial consideration in sentencing (Pre-Sentence Psychiatric Evaluation) or a risk assessment.

Risk Assessment

A risk assessment is for the purpose of providing an opinion about the relationship between a defendant's mental illness/disorder and the risk of future violent behavior. In cases of competent defendants, the judge may use the Presentence Psychiatric Evaluation (CC DC 20) to inquire about future risk or dangerousness stemming from the defendant's mental disorder.

Substance Abuse Assessment

This type of assessment is often performed by substance abuse assessors, but can also be conducted by professionals in other disciplines.

Evaluation/Examination

The terms evaluation and examination are generally used interchangeably. The competency and criminal responsibility statutes use "examination."

Types of Evaluations Ordered by Courts [3]

Competency

Criminal Responsibility

Alcohol and Substance Abuse

Sex Offender

Juvenile Waiver *

Presentence Psychiatric

Presentence Investigation

[3] See Chapter 4.3

Section 9.2

Diagnosis

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DIAGNOSIS

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)

Mental health professionals across clinical settings use the DSM-IV as the standard classification of mental disorders. There are three major components: diagnostic classification, diagnostic criteria sets, and descriptive text. The diagnostic classification is the list of mental disorders that are part of DSM system, and each diagnostic label has a corresponding code that is used for billing purposes and data collection. The criteria sets increase diagnostic reliability by specifying which symptoms must be present and for how long. [4]

The DSM utilizes a multi-axial assessment system.
Axis I: Clinical Syndromes
Axis II: Developmental Disorders and Personality Disorders
Axis III: Physical Conditions
Axis IV: Severity of Psychosocial Stressors
Axis V: Highest Level of Functioning[5]

Clinical Formulation (Case Formulation)

A clinical formulation is a theoretically based explanation of the information obtained from a clinical assessment and is considered an alternative to the more categorical approach of psychiatric diagnosis.[6] Formulations are used to offer a hypothesis about the cause and nature of the presenting problem and provide a framework for developing a treatment approach.[7]

---

[4] DSM. American Psychiatric Association. Retrieved July 1, 2012, from http://www.psych.org
[5] American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Arlington, VA: Author.
[6] Bond, F., Bruch, M. (1998). Beyond diagnosis: case formulation approaches in CBT. New York. Wiley
[7] Mace, C., Binyon, S. (2005). "Teaching psychodynamic formulation to psychiatric trainees. Part 1: Basics of formulation". Advances in Psychiatric Treatment 11(6): 416-422.

DIAGNOSES [8]

The following descriptions include general information about the diagnoses most frequently seen in cases that come before the court. The DSM IV is the authoritative source, and the NAMI and NIMH websites are also good resources.

MENTAL ILLNESS/MENTAL DISORDER

The definitions of "mental illness and mental disorder", "serious mental illness", and "serious and persistent mental illness" are inextricably tied into health policy on both a state and national level. The categories are significant for funding reasons, and, therefore, prioritization for services. The judiciary is primarily concerned with fashioning an appropriate sentence or case disposition, and availability and accessibility of services may be relevant.

"Mental disorder" was described in the U. S. Surgeon General's report as a health condition characterized by changes in thought, mood, or behavior (or some combination thereof) associated with distress and/or impairment in social, occupational or other areas of functioning.[9] Mental illness and mental disorder are usually used interchangeably. Some people believe that "mental disorder" is a more neutral term than "mental illness". The competency statute uses the term "mental disorder" and specifically excludes mental retardation from the definition of mental disorder.

SAMSHA has defined "serious mental illness" (SMI) as "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." [10]

In Maryland, the most impaired individuals meet the criteria for "serious and persistent mental disorder " (SPMI). This category includes schizophrenia, other psychotic disorders, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder.[11] The distinction between the levels of mental illness becomes significant when determining service needs and eligibility.

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[8] Unless otherwise cited, the source for information in this section on Diagnoses is from:
American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Arlington, VA: Author. and/or
National Institute of Mental Health. (2009). Mental Health Information. Retrieved May, 1, 2012, from http://www.nimh.nih.gov/health/

[9] U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. Rockville, Md.: DHHS.

[10] Epstein, J., Barker, P, Vorburger, M., & Murtha, C. (2004). Serious mental illness and its co-occurrence with substance use disorders, 2002 (DHHS Publication No. SMA 04-3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

[11] COMAR 10.09.45.02B. (22)

CLINICAL DISORDERS (AXIS I)

PSYCHOTIC DISORDERS [12] [13]

- Conditions characterized by loss of contact with reality (e.g., schizophrenia, schizoaffective disorders, delusional disorders).
- Symptoms include: [14]
  - Psychosis- usually involves hallucinations and/or delusions
  - Illusion (e.g., stick on the floor is a snake)
  - Delusions
    - Grandiose delusion (e.g., individual believes he is Napoleon)
    - Somatic delusion (e.g., individual thinks they have tumors in their brain)
    - Paranoid delusion (e.g., individual believes they are being watched by aliens)
  - Catatonia

There are many types of psychotic disorders. Some are classified according to the duration of the psychosis and some according to the cause. The following are examples that may be relevant:

- Brief psychotic disorder: Lasts less than a month and usually psychotic behavior occurs in response to a stressor such as a death
- Schizophreniform disorder: Symptoms of schizophrenia that last between one and six months
- Paraphrenia: Type of schizophrenia that occurs in the elderly population
- Psychotic disorder NOS (not otherwise specified)
  - Psychotic symptoms about which there is insufficient information to make a diagnosis, contradictory information, or disorders with psychotic symptoms that do not fit the criteria for a specific psychotic disorder
- Substance induced psychotic disorder
- Psychotic disorder due to a medical condition (e.g., brain tumor)

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[12] National Alliance on Mental Illness. Mental Illnesses. First episodes of psychosis. Retrieved June 10, 2012, from www.nami.org

[13] American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Arlington, VA: Author

[14] Lundbeck Institute (2011). Schizophrenia. Fact sheet: Overview of mental disorders. Retrieved June 11, 2012, from www.brainexplorer.org/further_reading/Further_Schizophrenia.shtml

Schizophrenia[15] [16]

- A chronic, severe, and disabling brain disease "characterized by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and sense of self. No single symptom is definitive for diagnosis; rather the diagnosis encompasses a pattern of signs and symptoms."[17]

- Positive symptoms are psychotic behaviors that can come and go and vary in severity or intensity.
  - Hallucinations (may be visual, auditory, olfactory or tactile e.g., hearing voices or seeing things)
  - Delusions
  - Thought and speech disorders are unusual or dysfunctional ways of thinking or speaking
    - Disorganized thoughts- difficulty in organizing thoughts or connecting them logically (e.g., derailment in speech or looseness of association)
    - Thought blocking- stops talking abruptly in the middle of a thought
    - May make up meaningless words i.e. neologisms or combine words in a disorganized way (e.g., "word salad" or "clanging")
  - Movement disorders (e.g., agitated or repetitive movements or the other extreme, catatonia)

- Negative symptoms are more difficult to recognize as part of the disorder and relate to disruptions to normal emotions and behavior. These symptoms may result in lack of attention to personal hygiene and the need for help with everyday tasks.
  - Flat affect
  - Lack of pleasure in everyday life
  - Alogia or "poverty of speech" that may reflect, "thought blocking." Speaking little even when forced to interact.
  - Avolition or loss of motivation [18]

- Cognitive symptoms
  - Poor "executive functioning" (ability to understand information and use it to make decisions)
  - Trouble focusing or paying attention
  - Problems with "working memory" (ability to use information immediately after learning it)

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[15] American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Arlington, VA: Author
[16] NIMH. Mental Health Information. What are the symptoms of schizophrenia? Retrieved June 1, 2012, from www.nami.org
[17] International Mental Health Research Organization. (2009) Schizophrenia Symptoms. Retrieved June 1, 2012, from www.schizophrenia.com
[18] See Chapter 12.1 for definitions of terms

Schizoaffective Disorder

- Primary symptoms of schizophrenia along with periods where he/she also has symptoms of major depression or a manic episode
- Two subtypes are bipolar subtype and depressive subtype

Delusional Disorder

- Presence of delusions involving real life situations that could be true (e.g., being poisoned)
- Absence of criteria for schizophrenia
- Delusions persist for at least one month

MOOD DISORDERS (AFFECTIVE DISORDERS)

- Persistent disturbance of mood characterized by one or more episodes of either overwhelming feelings of depression or mania, or alternating periods of mania and depression
- Common types of depressive disorders
  - Major depressive disorder (clinical depression or unipolar depression)
  - Bipolar disorders I – one or more manic episodes, possibly alternating with major depressive episodes
  - Bipolar disorder II- at least one major depressive episode and at least one hypomanic episode

ANXIETY DISORDERS

- Mental and physical manifestations of anxiety that are not attributable to real danger and occur either in attacks or as a persistent state
- Common types of anxiety disorders
  - Panic disorder
  - Obsessive-compulsive disorder (OCD)
  - Post-traumatic stress disorder (PTSD)
  - Generalized anxiety disorder (GAD)- persistent and excessive worry and anxiety for at least six months
  - Phobias

ADJUSTMENT DISORDERS

- Emotional or behavioral symptoms related to a life stressor (e.g. losing a job) that is greater than the expected response and impacts functioning
- Usually develops within 3 months of the stressor and lasts less than six months

SUBSTANCE-RELATED DISORDERS

- Substance induced disorders including substance intoxication and withdrawal
- Substance use disorders including substance abuse and dependence

PERSONALITY DISORDERS AND INTELLECTUAL DISABILITIES (AXIS II)

PERSONALITY DISORDERS

- Long term disruptive and dysfunctional behavior including frequent crises and problems in social and personal relationships and, in some cases, threatened or actual self- injury.
- Types of personality disorders most likely seen in criminal justice population:
  - Borderline personality disorder: A prolonged disturbance of personality function characterized by emotional dysregulation. Symptoms may include fear of abandonment, unstable relationships, self-image, and identity, self-damaging impulsivity, suicidal behavior and severe dissociation.[19]
  - Anti-social personality disorder-: A longstanding pattern of disregard for, and violation of the rights of others occurring since age 15 and continuing until adulthood. [20] Symptoms may include failure to abide by lawful behavior without remorse, impulsivity, deceitfulness, and aggressiveness. [21]

MENTAL RETARDATION

- A diagnosis of mental retardation is made if an individual has:
  - Significantly sub average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly sub-average intellectual functioning).
  - Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
  - The onset is before age 18 years.

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[19] Judges' Criminal Justice/Mental Health Leadership Initiative. (2007). Judges' guide to mental health jargon: a quick reference for justice system practitioners. p. 56. Delmar, NY: CMHS GAINS Technical Assistance and Policy Analysis Center for Jail Diversion.
[20] American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). p. 645. Arlington, VA: Author
[21] JLI. p. 55.

- There are four different degrees of mental retardation:
  - Mild (IQ level 50-55 to approximately 70)
  - Moderate (IQ level 35-40 to 50-55)
  - Severe (IQ level 20-25 to 35-40)
  - Profound (IQ level below 20-25)[22]

[22] American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Arlington, VA: Author

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Section 9.3

Medication

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INVOLUNTARY ADMINISTRATION OF PSYCHIATRIC MEDICATION

(Health General Article Section 10-708)

Involuntary medication may be administered to a hospitalized individual under the following circumstances.

EMERGENCY

1. Order of physician, and

2. Individual presents a danger to life or safety of self or others.

This is a short-term response, usually up to 72 hours. If a patient continues to be unable or unwilling to give consent, the hospital should pursue either guardianship or clinical review panel.

DHMH v. Kelly, 105 Md.App.147, 918 A2d 479 (2007) Patient must present a danger to self or others due to mental illness in the hospital in order to be involuntarily medicated pursuant to a clinical review panel.

NON-EMERGENCY

1. Involuntarily hospitalized (certified and retained at ALJ hearing) or committed for treatment (finding of incompetent and dangerous or NCR.) **AND**

2. Approved by clinical review panel, pursuant to Health General §10-708.

3. The patient has the right to appeal the decision of the clinical review panel within 48 hours of receipt of the panel's decision. If the decision is appealed, medications may not be given unless authorized by the Administrative Law Judge.

4. An Administrative Hearing is held at the hospital within 7 days. The patient may appeal the decision to the Circuit Court. Since the medication may be administered pending the decision by the court, the appeal is expedited.

May not involuntarily medicate a patient who is either voluntarily admitted or committed for evaluation.

MEDICATING FOR THE SOLE PURPOSE OF RENDERING COMPETENT TO STAND TRIAL

In Maryland, there are **no** statutory provisions for involuntary administration of medication *solely* for the purpose of rendering the non-dangerous accused competent to stand trial. The procedures for "forced medication" outlined above must be followed.

Some states have enacted "Sell laws" incorporating the holding of the U.S. Supreme Court in *Sell v. U.S.*, 539 US 166, 1235 S.Ct. 2174, (2003), which established standards for the involuntary administration of medication solely for the purpose of rendering a non-dangerous pretrial detainee competent. The Court held that the government may involuntarily medicate the defendant for the purpose of rendering him/her competent to stand trial if:

1. The government has an "important interest in trying the defendant;

2. Involuntary medication will "significantly further" that interest;

3. Involuntary medication is "necessary" to further the government's interest; and

4. Administration of the drugs is "medically appropriate. *Sell v. U.S.,* 539 US 166, 169 (2003).

PSYCHOTROPIC MEDICATION

COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS [23]

These commonly used psychotropic medications are usually prescribed by a psychiatrist and occasionally by a primary care physician. Some of the medications have non-psychiatric uses (for example, Tegretol is also used to control seizures). However, if a person is prescribed one of these medications, it is a good indication that the individual has been diagnosed as having a mental illness.

The typical anti-psychotic medication was developed in the 1950s. It reduced psychotic symptoms, but had many undesirable side effects, such as tremors and tardive dyskenesia. In the 1990s the atypical anti-psychotics were introduced. While there are fewer side effects with the newer medications, there are some that could be experienced, including weight gain, drowsiness, and reduced sexual function.

Typical Anti-psychotics
Haldol (haloperidol)
Loxitane (loxapine)
Moban (molindone)
Mellaril (thioridazine)
Prolixin (fluphenazine)
Stelazine (trifluoperazine)
Thorazine (chlorpromazine)

Atypical Anti-psychotics
Abilify (aripiprazole)
Clozaril (clozapine)
Geodon (ziprasidone)
Risperdal (risperidone)
Seroquel (quetiapine)
Zyprexa (olanzapine)

Mood Stabilizers
Mood stabilizers used in the treatment of bipolar disorder or personality disorder, with the exception of lithium, are either anticonvulsant medication or atypical anti-psychotic medication. Lithium was the first mood stabilizer approved by the FDA in the 1970's.

Depakene (valproic acid)
Depakote (Divalproex sodium)
Eskalith (lithium carbonate)
Gabitril (tiagabine)
Lamictal (lamotrigene)
Lithobid (lithium)
Neurontin (gabapentin)
Tegretol (carbamazine)

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[23] The sources for the information contained in this section on Psychotropic Medication are:
National Institute of Mental Health. (2002). Mental Health Medications. Retrieved: March 12, 1212 from www.nimh.nih.gov. and
Judges' Criminal Justice/Mental Health Leadership Initiative. (2007). Judges' guide to mental health jargon: A quick reference for justice system practitioners. pp. 61-72. Delmar, NY: CMHS GAINS Technical Assistance and Policy Analysis Center for Jail Diversion.

Medications to treat side effects
Cogentin (benztropine)
Artane (trihexyphenidyl)
Benadryl (diphenhydramine)

Antidepressants
Antidepressant medications are designed to balance some of the neurotransmitters in the brain. SSRIs (selective serotonin reuptake inhibitors) are the most popular types of medications used to treat depression. SNRIs (serotonin and norepinephrine reuptake inhibitors) are another type of drug used to treat depression. Wellbutrin is an anti-depressant that works on the neurotransmitter, dopamine. Older antidepressant medications are trycyclics and MAOIs (monoamine oxidase inhibitors).

SSRIs
Celexa (citalopram)
Lexapro (escitalopram)
Paxil (paoxetine)
Prozac (fluoxetine)
Zoloft (sertraline)

SNRIs
Cymbalta (duloxetine)
Effexor (venlafaxine)

Trycyclics
Anafranil (clomipramine)
Aventyl (nortriptyline)
Desyrel (trazadone)
Elavil (amitriptyline)
Sinequan (doxepin)

MAOIs
Nardil (phenelzine)
Marplan (isocarboxazid)

Anti-anxiety Medications
Many of the antidepressants are also used to treat anxiety disorders. In addition, there are anti-anxiety medications, benzodiazepines that work more quickly than the anti-depressants. However, benzodiazepines can be habit forming and can be sold on the street, so the potential for abuse may be an issue.

Benzodiazepines
Klonopin (clonazepam)
Ativan (lorazepam)
Xanax (alprazolam)

MEDICATIONS USED TO TREAT SUBSTANCE ABUSE

Acamprosate, brand name Campral, is a relatively new medication used to treat alcohol cravings.

Antagonists
Antagonist medications block the effect of a drug or alcohol. An example is Depade or ReVia (naltrexone), which is used to treat both alcohol and opiate abuse.

Aversion Therapy
Aversion therapy medications produce acute withdrawal symptoms if the abused drug is consumed. An example of this type of medication is Antabuse, which causes nausea in a person who has consumed alcohol.

Opiate Agonists
Opiate agonists are classified as either full agonists (e.g., Methadone) or partial agonists (e.g., Buprenorphine (Suboxone)), and they stabilize the craving for the abused drug.

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CHAPTER 10

HOUSING AND EMPLOYMENT

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Section 10.1

Housing

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Introduction

In Maryland, as well as nationwide, the lack of accessible affordable housing has been identified as a primary barrier to diversion of mentally ill justice involved individuals and to re-entry of this population from jails, prisons, and hospitals. In the absence of quality, affordable housing, many people with mental illness live on the streets, in homeless shelters, or in substandard housing. The relationship between homelessness and arrest is well documented, as is the over representation of the mentally ill in the criminal justice system. [12]

A basic understanding of State and Federal housing assistance programs and the types of housing needed by and available to the mentally ill offender is necessary in order to develop and implement viable and sustainable continuing care plans. A range of promptly available housing opportunities is critical not only to timely discharge from hospitals, but also to maintaining stability and enhanced quality of life in the community. The public mental health system must take an active role in expanding the range of sustainable housing models for consumers, and the judiciary and the criminal justice partners should support and encourage efforts made to address the longstanding housing needs of the justice involved population.

PUBLIC HOUSING REQUIREMENTS

One potential obstacle for some offenders is the admission criteria for public housing. Local Public Housing Authorities (PHA) have a great deal of underutilized discretion in the application of their policies, particularly with regard to exclusion of certain offenders. Many jurisdictions in Maryland apply stricter policies than required by federal law. HUD requires all PHAs to perform background checks on applicants, and Federal law mandates the PHAs to permanently deny admission for some criminal offenses. However, PHAs have the authority to create local admission criteria for individuals with certain criminal histories and for those with substance abuse problems, and exercising this discretionary authority would be an important step toward expansion of the range of accessible, affordable housing for mentally ill offenders.

[1] Steadman, H.J., Osher, F.C., Robbins, P.C., Case, B., Samuels, S. Prevalence of Serious Mental Illness Among Jail Inmates, Psychiatric Services, Jun 2009; 60:761-765.

[2] Council of State Governments. (January 2005).Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community. Retrieved March 10, 2012, from www.reentrypolicy.org/report.

MANDATORY

Federal law requires PHAs to permanently ban admission to applicants for two offenses:

1) Conviction of methamphetamine production on the premises of federally-funded housing, or
2) If the applicant is subject to a lifetime registration requirement under a state sex offender registration program.

DISCRETIONARY

PHA's may establish local admission and eviction policies for:

- Individuals who, during a reasonable time period prior to the application for housing, have engaged in any drug-related or violent criminal activity or other criminal activity which would adversely affect the health, safety, or right to peaceful enjoyment of the premises.

- Individuals who are illegally using a controlled substance, or have a history of abuse of drugs or alcohol that may interfere with the health, safety, or right to peaceful enjoyment of the premises by other residents.

- Any individual who has been evicted from federally assisted housing because of drug-related criminal activity in the previous three years. This applies to an individual and the entire household.

- PHAs may evict an individual or household under HUD's "One Strike" policy, which provides that evictions may occur if any member or guest of a household engages in any criminal activity that threatens the health, safety, or right to peaceful enjoyment of the premises by other tenants or any drug-related criminal activity, on or off the premises.

In each of these circumstances, PHAs have the discretion to shorten the period of restriction from admission and to consider mitigating factors, such as the severity of the crime and completion of a rehabilitation program.

Private landlords have greater flexibility than state or federally subsidized programs in the selection of tenants, but they are subject to Fair Housing Laws, which prohibit discrimination on the basis of: sex; race; age; disability; color, creed or national origin; religion or familiar status. However, as a practical matter in the private rental market, income based barriers are the primary reason for exclusion.[3]

[3] Office of Mental Health and Substance Abuse Services (OMHSA). (2010). Housing and Sequential Intercept Model-A How to Guide. Glenside, PA. Myers, D.

FEDERAL AND STATE RENTAL ASSISTANCE PROGRAMS

The U.S. Department of Housing and Urban Development (HUD) provides federal subsidy programs that allow low and moderate-income individuals and families to rent from private landlords under the Housing Choice Voucher Program (formerly known as Section 8). The two federal tenant based rental assistance programs are the Certificate Program and the Housing Voucher Program. The primary difference between the two programs is that there is no cap on rent level in the Voucher Program. If the tenant is willing to pay more than the allocated rental subsidy, they may do so. The Certificate Program is being phased out in favor of vouchers.

Certificate Program

The certificates issued to qualified households are "tenant based," which means that they may be used in any rental unit where the landlord agrees to participate in the program and to accept no more than the HUD established fair market rent (FMR) for each county and metropolitan area. In most rental certificate programs, a family pays either 30% of its monthly adjusted gross income, 10% of its monthly gross income, or the welfare assistance designated for housing toward rent, whichever is greater. The public housing authority (PHA) calculates the family's share of the rent, and the family pays that amount to the landlord. The PHA will pay the difference between the family's portion of the rent and the total amount of the rent for the housing (Contract Rent).

Housing Voucher Program

In the Housing Voucher Program, the PHA determines a payment standard that is used to calculate the amount of rental assistance a family will receive. However, this does not affect the amount of rent a landlord may charge or the family may pay. A family or individual is free to choose any housing that meets the requirements of the program where the owner agrees to rent under the program. Rental units must meet minimum standards as determined by the PHA. [4]

State of Maryland's Rental Allowance Program (RAP)

The purpose of the Rental Allowance Program (RAP) is to award grants to local governments to provide flat rent subsidies to low-income families who either are homeless or have an emergency housing need. The goal of the program is to enable these households to move from homelessness or temporary emergency housing into more permanent housing and to return to self-sufficiency. This is not a HUD program.

County governments and Baltimore City administer RAP by accepting applications from eligible residents, coordinating the program with other social services offered, and

[4] United States. Department of Housing and Urban Development. (2012) Public and Indian Housing. Retrieved February 12, 2012, from www.hud.gov

providing staff to ensure program requirements are being met. RAP is usually administered by the local social services office, the PHA, or is contracted by the county to a private nonprofit organization for administration.[5]

HOUSING OPTIONS AND PROGRAMS FOR HOMELESS

People with mental illness are disproportionately represented in the homeless population, so the housing assistance and programs for the homeless are particularly relevant. The first significant federal legislation aimed at addressing homelessness was the McKinney Homeless Assistance Act of 1987. This law has been reauthorized as the McKinney/Vento Act and amended as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. On January 4, 2012, final regulations implementing changes to HUD's definition of "homeless" contained in the HEARTH Act took effect (See Housing Terms).

The McKinney Act provided a range of programs to homeless people, including Continuum of Care Programs [6]which include the following:

1) Supportive Housing Program (SHP) which includes:

    - Permanent housing for people with disabilities: Community based housing and support services for homeless people with disabilities.
    - Transitional housing: Supportive housing that is designed to move homeless people into permanent housing.
    - Supportive services only: Supportive services provided separately from housing.
    - Safe havens: A structure or clearly identifiable portion of a structure that serves hard to reach homeless people with serious mental illnesses.
2) Shelter Plus Care (S+C)**:** Provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services.
3) Single Room Occupancy (SRO): Housing units for single individuals with shared facilities.

HUD-VETERANS AFFAIRS SUPPORTIVE HOUSING PROGRAM

In 1992, HUD and the VA partnered to establish the HUD-VASH program, which is designed to assist Veterans with a disability, mental illness, chronic homelessness, or other issues that can be helped by participating in on going case management services. Veterans who have spouses or dependent children are also eligible. The program

[5] State of Maryland. Department of Housing and Community Development. Rental Assistance Program Fact Sheet (2012) Retrieved February 12, 2012, fromwww.dhcd.state.md.us/website/programs/rap

[6] United States. Department of Housing and Urban Development (2012).Homeless Assistance. Retrieved February 15, 2012, from www.hud.gov. (See also, section on Housing Terms)

combines Housing Choice Voucher rental assistance for homeless Veterans with clinical services and case management. The services are provided at VA medical centers and community based outreach clinics.

Eligibility Requirements

- Currently homeless (Veterans in transitional housing or residential treatment programs are eligible)
- Eligible for VA medical care
- Identified clinical need for case management
- May not exceed income limits
- May not be required to register on any lifetime sex offender registry

With the exception of screening to determine if the Veteran or other household member is subject to sex offender registration requirements, the PHA does not have the authority to screen potentially eligible participants or to deny assistance for other criminal convictions or activity. [7]

[7] United States. Department of Veteran Affairs. HUD-VASH Program. Retrieved March 12, 2012, from www.va.gov/homeless/hud-vash.asp

HOUSING DEFINITIONS[8]

Affordable housing: Housing where the occupant pays no more than 30% of their adjusted gross income for housing costs, including utilities. The housing is developed by nonprofit community-based organizations, private for-profit developers, or quasi-public agencies (PHAs), and is offered at lower-than-market costs either through zoning ordinances that require developers to set aside affordable units when they build a particular number of market-rate units, or through public subsidies.

Building specific housing: This program involves units located in identified buildings that are owned by private landlords, nonprofit organizations, or public entities, and often involves purchasing and developing the building or partnering with a private housing developer. The public mental health commission selects a building or development and helps the consumer rent there. If the tenant moves out, the program moves another consumer into the unit. The building specific model can be either mixed population or single purpose housing**.** Tenants represent several groups in **mixed population housing**, including people with mental illness, the elderly, low income and moderate-income individuals and families**.** In **single purpose housing**, people with mental illness occupy all units, and the building is not integrated**.**

Chronically Homeless: An **unaccompanied individual** who is homeless with a **disabling condition**, who has either been continuously homeless for a year or more, OR has had at least four (4) **episodes of homelessness** in the past three (3) years and has been sleeping in a place not meant for human habitation (i.e., living on the streets) and/or in an emergency homeless shelter.[9]

- **Unaccompanied individual**: A single homeless person who is alone (i.e., not part of a homeless family or with a child).
- **Disabling condition:** A diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including co-occurrence of two or more of these conditions that limits an individual's ability to work or perform one or more activities of daily living.
- **Episode of homelessness:** A separate, distinct, and sustained stay on the streets and/or in an emergency shelter and the person must be unaccompanied and disabled during each episode.[10]

Emergency Housing: Emergency housing is short-term housing, either in emergency shelters or motel rooms, that is made available in response to a crisis.

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[8] Unless otherwise cited the source of the information in the section Housing Terms is: National Alliance on Mental Illness. A Housing Toolkit: Information to help the public mental health community meet the housing needs of people with mental illness. Retrieved March 14, 2012, from http://www.nami.org.

[9] The McKinney-Vento Homeless Assistance Act as amended by S.896 HEARTH Act of 2009. 42 U.S.C. 11382(2)

[10] U.S. Department of Housing and Urban Development (HUD). (2007) Defining chronic homelessness: A technical guide for HUD programs. Retrieved August 1, 2012, from http://www.hudhre.info/documents/DefiningChronicHomeless.pdf p.8.

Fair Market Rent (FMR): FMR is a gross rent estimate that includes the cost of the actual rent plus the cost of utilities, except telephone. The FMRs for every county can be found at: www.huduser.org/datasets/fmr.html.

HOME Program: HUD program that provides the largest federal block grant funding to state and local governments designed exclusively to create affordable housing for low-income households. Communities often use HOME funds to partner with community-based organizations to support such activities as building, buying, and rehabilitating affordable housing units for rent or future sale. HOME funds are also used to provide direct rental assistance to low-income people.

Homeless: The HUD definition of homelessness includes:

1) Individuals and families who lack a fixed, regular, and adequate nighttime residence including:
   a) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
   b) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals);
   c) an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2) Individuals and families who will imminently lose their primary nighttime residence including:
   a) persons who are about to be evicted from a rental unit via a court order obtained legally by the owner and that notifies the individual or family that they must leave within 14 days;
   b) persons who lack the resources to self-pay for a stay in a hotel or motel; and
   c) persons who are no longer being allowed to stay in housing by the owner or renter of the housing.

3) A single person under the age of 25 ("youth") or a family (at least one adult and one minor) who doesn't qualify as homeless under this definition but who qualifies as homeless under other federal statutes. Along with qualifying as homeless under other federal statutes the person or family:

   a) Must not have had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;

b) Must have experienced persistent instability as measured by two moves or more during the 60 day period immediately preceding the date of applying for homeless assistance; and
c) Can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood abuse (including neglect); the presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree or GED, illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment.

4) Individuals and families attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence. To qualify, the person can have no other residence; and must lack the resources or support networks (e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing).[11]

Housing Choice vouchers (Section 8): Assistance to individuals that can be used for rental payments and security deposits (tenant based vouchers), or direct subsidies to landlords (project-based vouchers). These vouchers can only be used for very low-income residents (individuals earning less than 50 percent of the area's median income level), who lease housing units in the private market or in subsidized housing projects. Tenant payments are usually limited to not less than 30 percent of the tenant's income.

Housing First: A program that features quick access to permanent housing for people who are homeless. Support services are available following the placement in order to provide housing stability and meet individual needs. However, housing is contingent only upon meeting the terms of a lease rather than with treatment compliance.

Housing Ready: Housing Ready approaches are transitional and highly structured. These programs often require individuals to progress through several types of housing placements before receiving access to permanent housing.

Low Demand Housing: Low-Demand Housing allows people in need of support services to determine the type and intensity of services they receive instead of requiring them to comply with pre-existing service plans. Permanent supportive housing is an example of PATH Low- Demand Housing.

PATH (Projects for Assistance in Transition from Homelessness): PATH is a formula grant to the State that supports services designed for individuals with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at risk of becoming homeless. The services include

[11] McKinney-Vento Act §103(a). 42 USC 11302

community-based outreach, mental health, substance abuse, case management and other support services, as well as some limited housing services.

Permanent Housing: Housing which is intended to be the tenant's home for as long as they choose. In the supportive housing model, services are available to the tenant, but accepting services cannot be required or in any way impact the tenancy.

Permanent housing for homeless persons with disabilities. (Permanent supportive housing): SHP funds long-term housing for people with disabilities who meet HUD's definition of "homeless." Projects are generally community-based housing and support services that help tenants live as independently as possible in a permanent setting. The supportive services may be provided by the organization managing the housing or coordinated by the applicant and provided by other public or private service agencies. Permanent housing can be provided in one structure, in several structures at one site, or in multiple structures at scattered sites.[12]

Person With A Disability: HUD defines a "person with a disability" as: a person who is determined to: 1) have a physical, mental, or emotional impairment that is expected to be of continued and indefinite duration, substantially impedes his or her ability to live independently, and is of such a nature that the ability could be improved by more suitable housing conditions; or 2) have a developmental disability, as defined in the Developmental Disabilities Assistance and Bill of Rights Act or 3) HIV/AIDS. [13]

Project Based Rental Assistance (PBRA): PBRA is a rental subsidy that is associated with specific housing units made affordable to low income households.

Public Housing: Housing assistance offered pursuant to the U.S. Housing Act of 1937 or under any state or local program that has the same general purposes as the federal program. This type of housing is limited to individuals and families whose income is below 80 percent of the median income in the county or metropolitan area in which they live.

Public Housing Authorities (PHA): Any state, county, municipal, or other governmental entity or public body authorized under state enabling legislation to engage in the development or administration of low-rent public housing or slum clearance. Typically, PHAs are the entities that administer both public housing and Housing Choice vouchers in any community.

Qualified Allocate Plan (QAP): The QAP is a federally mandated planning requirement that states annually use to explain the basis for distribution of their Low Income Housing Tax Credit (LIHTC) Programs allocations. The LIHTC managed by the Department of Treasury's Internal Revenue Service, is currently the largest source of federal subsidy for adding new or rehabilitated rental housing units to the affordable housing stock in the United States.

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[12] Mc-Kinney-Vento Act. § 424. 42 USC 11384 (c)
[13] Mc-Kinney-Vento Act. §422 (2) ; 42 USC 11382(2) ;24 CFR 582.5.

Reasonable Accommodation: Under the Fair Housing Act, "reasonable accommodation" is a change, exception, or adjustment to a rule, policy, practice, or service that may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces. The Act makes it unlawful to refuse to make reasonable accommodation for the individual's disability.

Safe havens: A type of supportive housing in which a structure or clearly identifiable portion of a structure meets the following: 1) serves hard to reach homeless people with serious mental illnesses who are on the street and who have been unable or unwilling to participate in supportive services; 2) provides a 24 hour a day residence for unspecified duration; 3) provides private or semi-private accommodations; and 4) has overnight occupancy limited to 25 people. A safe haven may also provide supportive services on a drop in basis to non-residents.

Scattered site housing: Scattered site housing refers to a program that supports individuals who live in apartments throughout a community. In the **tenant based scattered site model**, tenants find their own apartments in the community, and negotiate lease and rent terms. In the **sponsor based** model, a nonprofit organization or a public mental health commission locates and contracts for the apartments and then sublets to the consumer.

Shelter Plus Care: The Shelter Plus Care program provides housing and long-term support services for people with disabilities who are homeless (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families. The program allows for a variety of housing choices, and a range of supportive services funded by federal, state, local, or private sources, designed to meet the needs of the hard-to-reach homeless population with disabilities.

Single room occupancy (SRO): Housing units for single individuals that do not necessarily have individual bathrooms or kitchens, but instead have shared facilities.

Supportive Housing: Supportive housing combines affordable housing with voluntary services to help people live more stable, productive lives. The services include assistance with household chores, mental health and/or substance abuse counseling, and to employment services. Supportive housing works well for people who face the most complex challenges, including serious and persistent issues such as substance use, mental illness, and HIV/AIDS. Services, such as Case Management or Vocational Rehabilitation, may be offered onsite or at locations in the community.

Supportive services only: Supportive services that are provided separately from transitional or permanent housing projects (case management, housing search, employment assistance, etc.). Services may be offered at a central facility or at scattered sites.

Subsidized Housing: The housing in which tenants pay less than the going market rate for rent through use of government subsidies. Subsidized housing receives financial assistance from one or more public agencies to build or operate the development, or to help pay for some of the rent and utility costs. Rents are typically set according to Fair Market Rents (FMRs)

Tenant-Based Rental Assistance (TBRA): TBRA is used to assist low and very low income families to obtain safe, and sanitary housing in the private rental market, by making up the difference between what they can afford and the approved rent for an adequate housing unit.

Transitional Housing: Transitional Housing programs determine when people are ready to move beyond an emergency shelter or institutional setting (often within 24 months) into a more independent living situation, and may offer apartment style, group, or shared family housing. These programs emphasize the importance of people developing independent living skills and achieving some clinical stability before moving into permanent housing. Support services may be provided in house or by a collaborating agency.

VASH: The HUD-VASH program combines Housing Choice Voucher (HCV) rental assistance for homeless veterans with case management and clinical services

Voucher: A voucher generally refers to a voucher provided by a local Housing Authority to a low or moderate income person but can also refer to an emergency voucher or short-term motel voucher for a homeless person. The voucher issued by Housing Authority makes up, in payment directly to the landlord, the difference between what a low or moderate-income tenant can pay for rent (roughly 30% of their income) and the Fair Market Rent (more or less an average rent). Most vouchers are **"tenant-based**" meaning that the voucher holder can shop for an apartment or house rental on the private market, while others are "**project based**," meaning that they are not portable, but can only be used in a specific building.

TYPES OF HOUSING[14]

Type of Housing	Definition/Services Available	Eligibility Criteria	Application Process	Other Relevant Info.
Transitional Shelter	Temporary shelter; Services include semi-private room, basic case management services, meals, medication monitoring		Apply through individual programs; May need to be referred by case manager. Some do not have waiting lists, must call every day to ask about opening.	Unlike traditional emergency shelters, residents can remain in facility during day.
Care Provider/ Assisted Living Providers	Private assisted living homes, managed by owners, staffed by residential staff & nurses. Usually 3-6 residents per home. Provide supervised care, assistance with all ADL's Varying levels of structure; usually have curfew, designated meal times, requirement to attend day program.	● Stable Income ● Need Intensive assistance with ADLs ● No dangerous behaviors	Apply through individual providers (case managers usually have contacts in community). Can request list of licensed providers from DHMH.	
Residential Rehabilitation Program	Supported Housing Semi Independent: Live in apartment with 1-2 other clients or home with 5-7 other people (up to 16 in co.) Levels: **General**-resident responsible for own ADL's and meds Staff monitor progress, help to resolve issues with residents, neighbors, etc. **Intensive**-40 hr./week on-site staff, more intensive supervision.	● Serious &Persistent Mental Illness ● Need assistance with independent living skills (i.e. budgeting, socialization, cooking, house chores/management		Goal is independent living. Program becomes representative payee, client provided with food money & allowance. Avg. Wait List for: General: 3-6 months (city), 1-12 months (co) Intensive: 18 mos./males (city), 6-36 mos./males (co.), 6 mos./females (co.) MISA: 24-36 mos. Clients required to participate in structured daytime activity-i.e. Day program, school. State psychiatric hospital referrals receive first priority for all openings, regardless of wait time.

[14] Farinholt, K. Housing and Homelessness. NAMINews (Spring 2010). Retrieved March 14, 2012, from www.namimetrobaltimore.org

Type of Housing	Definition/Services Available	Eligibility Criteria	Application Process	Other Relevant Info.
Project Based Section 8 Units	PHA and privately owned and managed properties subsidized by the Housing Choice voucher Program Project-based program. Voucher use limited to a specific complexes approved by HUD.	Low income. There are preferences given to Veterans and individuals with disability.	Apply at Housing Authority	Tenant assisted as long as they live in unit qualify for the program. The unit (not the tenant) "receives" the subsidy. Tenants pay 30% of their income for rent and utilities. The balance of their housing costs are paid by the program.
Tenant-based (Portable) Section 8	Tenants are given a Section 8 voucher to use in finding a place to live with a private property owner. The voucher can be used anywhere. Voucher is portable and provides assistance to families when they move to another housing unit.		Apply Housing Authority	The family pays approximately 30 percent of their income toward the rent, with the balance of the monthly rent, up to a fair market rent, paid by the Section 8.
Rental Allowance Program	The Rental Allowance (RAP) provides monthly rent assistance. The monthly payments are fixed amounts, depending upon the size of the family and the location of the rental-housing unit. Eligible housing can include rooms, boarding house rooms, other single-room occupancy arrangements, apartments, group homes, transitional housing (provided it is not temporary emergency housing), single-family houses, and mobile homes.	Low income families who are homeless or have an emergency housing need with income not exceeding 30% of statewide or area median income whichever higher.	Apply at: Baltimore City Housing Authority Baltimore City and Baltimore County Department of Social Services	Payments can be received for up to 12 months, and may be extended under special circumstances.

Type of Housing	Definition/Services Available	Eligibility Criteria	Application Process	Other Relevant Info
Room & Board Provider	Not licensed, more independent private or semi-private room. Residents share common areas.	● Must be able to handle own ADL's, medications ● Stable Income	Personal referrals (case managers) Local CSA's may be able to assist	Usually $300 - $400/month, utilities included
Shelter Plus/CHA		● Serious & Persistent Mental Illness and considered disabled. ● Income 50% below median income. ● Must be able to handle own ADL'S ● Homelessness (for Shelter+) as defined by MHA. ● Limited to 5 years of service/person	City: Submit application to Core Service Agency (BMHS), Must be submitted by case manager/therapist. After application is submitted, letter sent out to confirm place on waiting list (waiting list is several years in city). County: Prologue Homeless Outreach (PHO) team sends case managers to local shelters to serve those who are homeless and mentally ill. Any person receiving case management from PHO will be referred for SPC if eligible for the service. PHO case manager will aide eligible persons with finding an appropriate rental unit in Baltimore County.	CSA either owns property (city only) or rents from private landlords or leasing agencies. Client required to have case manager; Case Manager/CSA serves as liaison between landlord & client. CM can also assist client with applying for benefits Section 8,and linkage with other needed services.
Shared Apartment/House	Live with other individuals, share expenses.	● Able to afford rent and other housing expenses Good credit/rental history. ● May require criminal back-ground check. ● Must be able to live independently.	Rental Application; Properties can be found in the newspaper, through management companies, or by personal referrals	No need to disclose information about illness.

Types of Housing	Definition/Services Available	Eligibility Criteria	Application Process	Other Relevant Info.
Care Connections (Baltimore City)	Assistance provided to client to assist in maintaining independent placement. Counselor assigned to client to assist with ADL's, i.e. shopping ,cleaning, budgeting.	● Medical Assistance ● Serious & Persistent Mental Illness	Call Care Connections, case manager/therapist can submit application	
Market Rate Rental Housing	Traditional housing with no supportive services provided.	Housing is not contingent on compliance with services; instead participants must comply with a standard lease agreement. Income requirements vary.	Apply directly to a private landlord. The landlord must agree to accept the market rent set by HUD as the total rent for the unit.	Section 8 Certificate or Voucher may be used if housing unit meets the program requirements.
HUD-VA Supportive Housing Program (HUD-VASH)	Combines HUD long-term rental assistance with ongoing VA case management and clinical services to homeless veterans.	Homeless veterans with income at or below 50% of the area median income. Discharge status other than dishonorable. Veterans can qualify even if staying with friends or relatives or have past periods of homelessness.	VA screens and selects veterans for program Contact the VA directly	
Public Housing	Owned and managed by the PHA. Public housing comes in all sizes and types (family, mixed population developments, senior only buildings and mixed income).	Elderly, a person with a disability or a family with low income. U.S. Citizenship or eligible immigration status.	Apply at Public Housing Admissions and Leasing Center	Written lease between PHA and tenant.

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SECTION 10.2

SUPPORTED EMPLOYMENT

INTRODUCTION

In 2001, the Mental Hygiene Administration established the evidence-based practices program at the University of Maryland. The following year, MHA—in partnership with CSAs and DORS—began implementing the EBP approach to supported employment. Services are funded by the public mental health system and are provided by a Mental Health Vocational Program (MHVP). MHA was awarded a national Science and Service Award from SAMSHA in 2007 for its success in implementing evidence-based supported employment.[15]

Ideally, MHCs and courts with mental health dockets can play a role in encouraging the expansion of evidence-based supported employment programs and developing relationships in order to facilitate referrals of participant defendants. The importance of meaningful employment for people with serious mental illness and those with cognitive limitations cannot be overstated. An example of collaboration between a MHC and a supported employment program is the Baltimore City MHC's partnership with the Goodwill Step Program.

What is Supported Employment?

Supported Employment is paid competitive employment in an integrated setting with ongoing support for individuals with the most severe disabilities (i.e., psychiatric, mental retardation, significant learning disabilities, traumatic brain injury, deafness and blindness, extreme mobility impairments, and other severe disabilities) for whom competitive employment has not traditionally occurred. Supported employment provides assistance such as job coaching and job placement; assistance in interacting with employers; on-site assistive technology training; specialized job training; and individually tailored supervision. These services help consumers to become employed and stay employed and assist the consumer in finding a job that matches the consumer's interests, preferences and skills.[16]

There are four steps in the Supported Employment program:

(1) Pre-Placement Phase: During this phase, the consumer is provided with services, including: an assessment of the consumer's situation by a Mental Health Vocational Program; a referral for assistance by the Division of Rehabilitative Services (DORS); counseling about a variety of financial assistance programs; and discussions about the risks and benefits of telling an employer about the consumer's mental illness.

[15] McNeal, M. & Hansen, E. (2010) The Evidence-Based Practice of Supported Employment. NAMI Connections, (Spring Issue) Retrieved from http://www.namimd.org

[16] What is IPS Supported Employment? Dartmouth IPS Supported Employment Center. Retrieved 4/12/12 from http://www.dartmouth.edu/~ips/

(2) Placement in a Competitive Job: The consumer is assisted in negotiating with the employer regarding pay and/or benefits, and, if a consumer so chooses, in obtaining reasonable accommodations provided by the Americans with Disabilities Act.

(3) Intensive Job Coaching Phase: This phase includes a variety of techniques to help the consumer learn to perform the job wanted by the consumer. The consumer is taught interpersonal skills necessary for the work place and for living in the community. Furthermore, job coaching is provided to help the consumer keep his/her job.

(4) Extended Support Services Phase: This phase is focused on helping the consumer stay employed and includes an assessment of the consumer's job performance; advocacy on behalf of the consumer; counseling; and support services provided at the job site or at a different location. Support services are available as long as the consumer wants to continue receiving them.

Maryland Supported Employment Programs (SEPs) include two additional components for the consumer with mental illness.

1) Psychiatric rehabilitation program services: These are service interventions designed to assist the consumer with symptom management and to manage his/her illness while on the job.
2) Treatment coordination: This service includes regular meetings and coordination with the consumer's treatment providers in order to integrate supported employment efforts with mental health treatment.[17]

What is Evidence-based Supported Employment?

Evidence-based supported employment is also known as Individual Placement and Support (IPS). Programs that implement the evidence-based approach to supported employment must follow the principles and strategies outlined in a "toolkit" developed by experts in the field in order to attain "high fidelity status." Demonstration of high fidelity status enables programs to bill at enhanced rates.

Core Principles of EBP Supported Employment

- Eligibility is based on consumer choice
- Supported employment is integrated with mental health treatment
- Competitive employment is the goal
- Job search starts soon after the consumer expresses interest in working
- Follow along supports are continuous
- Personalized benefits counseling is provided
- Consumers' preferences are important [18]

[17] Baltimore Mental Health Systems, Inc. (9/20/10). Mental Health Services for Adults in Baltimore City: A Guide to Services Available in the Public Mental Health System (p.12): Baltimore, Md.

IMPAIRED - RELATED WORK EXPENSES (IRWE)

One of the concerns of some individuals who want to work is how their benefits will be affected by employment. Benefits counseling is one of the components of supported employment.

In order to assist people with disabilities who want to work, the Social Security Administration allows some people to keep a certain amount of their SSI or SSDI payments after the person becomes employed. The amount of future payments is based on the person's income. Impaired-Related Work Expenses, such as the cost of medication or psychiatric treatment, which the person needs to be able to work, may be subtracted from the earned income. As a result of this incentive, consumers are able to keep more of their SSI or SSDI payments.

[18] Bond, G. & Campbell, K. (2005) Supported Employment: An Evidence-Based Practice. Retrieved 3/12/12 from www.nami.org

CHAPTER 11

COMMUNITY CONTACTS

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Section 11.1

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Section 11.2

Directory of Community Screeners

Revised March 2014

For update information call
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DIRECTORY OF SERVICE PROVIDERS

NOTE: CLINICIANS PERFORM BOTH PRETRIAL SCREENINGS AND PRESENTENCE EVLAUATIONS, UNLESS NOTED OTHERWISE.

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(Rev. 3/14)

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Section 11.3

Core Service Agencies

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Core Service Agencies

The CSAs are the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level. CSA exist under the authority of the Secretary of the Department of Health and Mental Hygiene and also are agents of the county government, which approve their organizational structure. The functions of core service agencies are to plan, develop, and manage a full range of treatment and rehabilitation services for persons with serious mental illness in their jurisdiction as stipulated by the Health General Article, 10-10-1203, Annotated Code of Maryland. Organizationally, the CSA can exist in a number of forms: as a unit of county government (e.g. health department), as a quasi-public authority, or as a private, non-profit corporation. Whatever the structure selected, the CSA is an agent of county government, and as such the County is the appropriate body to decide on the organizational structure. The model selected should emerge from a local process, which involves citizens, consumers, providers, policy makers, and advocates. Those jurisdictions applying for core service agency designation must ensure that. The CSA must be governmental or not-for-profit in nature. The CSA must be able to link with other human service agencies to promote comprehensive services for individuals in MHA's priority population who have multiple human needs. [1]

See Appendix C. for the MACSA (Maryland Association of Core Service Agencies) Directory of Core Service Agencies

[1] http://dhmh.maryland.gov/mha/SitePages/csa.aspxx

Section 11.4

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National Affiliate

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NATIONAL ALLIANCE ON MENTAL ILLNESS

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NAMI

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ON OUR OWN

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These organizations have local affiliates serving jurisdictions throughout Maryland.

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CHAPTER 12

GLOSSARY

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Section 12.1

Behavioral Health Terms

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BEHAVIORAL HEALTH TERMS[1]

Abuse/misuse: A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Abstinence: Discontinuance and avoidance of further use of a drug.

Activity Therapy: An umbrella term used to describe services including recreation therapy or therapeutic recreation, occupational therapy and art and music therapy.

Acute Care: Short term, intensive services to resolve mental health crises and stabilize psychiatric symptoms**.** Individuals who need high-level support and/or 24 hour monitoring may benefit from acute care services. (See Chapter 8.4)

Addictive Personality: An addictive personality is a trait, or set of traits, that develops in response to habit forming drugs/alcohol or compulsive behavior (gambling overeating, sex).

Administrative Service Organization (ASO): An organization that is under contract with the Mental Hygiene Administration to provide administrative services, including reviewing the utilization of public mental health system, giving authorization for mental health care, processing payment to the mental health care providers, and conducting quality assurance audits and surveys.

Adult Protective Services: A unit within the Department of Social Services that provides services to protect the welfare of elderly adults and people over 18 years of age with disabilities, who are victims of actual or potential abuse, neglect or exploitation.

Advanced Directive: A legal document prepared while a person is mentally competent, stating how decisions should be made in regard to treatment, in the event that the person becomes incompetent.

Aftercare Plan: A comprehensive written plan developed by the inpatient facility for the consumer after he/she is discharged. (See Chapter 8.2)

AIDS Drug Assistance Program (ADAPT): ADAPT is a federally funded program to provide medication to people without adequate resources or insurance for treatment of HIV/AIDS. It can also be used to purchase health insurance or for services that improve success with drug treatment.[2]

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[1] Unless otherwise cited, the source for information in this section Behavioral Health Terms is from:
American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Arlington, VA: Author. and
Baltimore Mental Health Systems, Inc. (9/20/10). Mental Health Services for Adults in Baltimore City: A Guide to Services Available in the Public Mental Health System: Baltimore, Md.

[2] Judges' Criminal Justice/Mental Health Leadership Initiative. (2007). Judges' guide to mental health jargon: a quick reference for justice system practitioners. p. 27. Delmar, NY: CMHSGAINS Technical Assistance and Policy Analysis Center for Jail Diversion.

Alcoholics Anonymous (AA): A voluntary fellowship founded in 1935, which follows twelve suggested steps designed for personal recovery from alcoholism. AA is a proponent of the disease model of alcoholism.

Alcoholism: "Alcoholism is a primary chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestation. The disease is often progressive, and is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic".[3]

Alogia: Lessening of speech fluency thought to reflect thought blocking or slowing as a symptom of schizophrenia.

Ambivalence: The condition of holding opposite feelings (such as love and hate) for the same person or object.

Amphetamine: Behavioral stimulant.

Anosognosia: An inability to see one's own illness.

Anhedonia: Absence of or inability to experience pleasure[4]

Assertive Community Treatment: An evidenced-based clinical model designed to provide intensive, mobile, assertive mental health treatment and support services delivered by a multidisciplinary treatment and support team to adults with SMI whose mental health treatment needs have not have not been met through routine, traditional outpatient mental health programs. (See Chapter 8.3)

Assessment: The process of interviewing the individual to obtain the sociological background, psychological makeup, educational and work history, family and marriage difficulties and medical issues to better determine the need for treatment.

Aversive Conditioning: A form of behavior therapy that is used to reduce the occurrence of undesirable behavior, such as sexual deviations or drug addiction, by employing repeated pairing of some unpleasant stimulus with a stimulus related to the undesirable behavior. Currently, this type of therapy is not often used.

Avolition: In schizophrenia, a symptom consisting of reduction, difficulty or inability to start or complete goal directed behavior.

Barbiturate: A type of sedative-hypnotic drug that causes sleepiness and relaxation.

---

[3] Morse, R. & Flavin, Daniel. "The Definition of Alcoholism." JAMA 268(8): (1992): 1012-1014.
[4] Lundbeck Institute (2011). Mood Disorders. Retrieved June 11, 2012, from http://es.brainexplorer.org/factsheets/Psychiatry%20Diagnosis.pdf

Behavioral Therapy: A form of psychotherapy that focuses primarily on helping the individual understand how changing their behavior can lead to changes in the way they are feeling. Behavioral therapy is a process of rewards and reinforcement for appropriate behavior and elimination of undesired behaviors.

Blood Alcohol Level or Concentration (BAC): The concentration of alcohol in the blood, usually expressed in percent by weight. This measurement is often used to determine the extent of alcohol consumption for legal purposes.

Buprenorphine: A narcotic analgesic that is a prescription medication for people addicted to heroin or other opiates that acts by relieving symptoms of withdrawal.

Case Management: The service assesses need and links consumers to mental health services and related support services.

Catatonia: Motor immobility and mental stupor.

Circumstantiality: Speech that is highly detailed and rambling.

Clanging: A symptom of a thought disorder whereby words are paired that have no relationship to each other beside the fact that they rhyme or sound alike.

Clinical Criteria: The factors considered to determine whether a specific treatment setting, such as, inpatient or outpatient, is the appropriate level of mental health care for a particular individual.

Cognitive Therapy/Processing: A form of psychotherapy based on the belief that psychological problems are the products of faulty ways of thinking about the world. Cognitive therapy involves identifying and correcting negative, self-destructive or distorted thinking patterns and replacing such thoughts with a healthy outlook. [5]

Community Mental Health Program: Community Mental Health Programs are Mental Hygiene Administration (MHA) regulated and include: Therapeutic Nursery Programs, Mobile Treatment Services, Psychiatric Rehabilitation Programs and Residential Rehabilitation Programs, Residential Crisis services, Outpatient Mental Health Centers, Mental Health Vocational programs.

Community Rehabilitation Program (CRP): The Division of Rehabilitative Services (DORS) terminology for private and non-profit programs that provide rehabilitation services including career assessment, work adjustment training, job placement services and supported employment for disabled people who are eligible for DORS services**.**

[5] Judges' Leadership Initiative (JLI), p. 17-18.

Most CRP's are Mental Hygiene Administration (MHA) regulated programs, such as a Psychiatric Rehabilitation Program (PRP).[6]

Compulsion: Irresistible impulse or urge to perform an act despite the rationality (e.g., checking locks, washing hands).

Co-occurring Disorders: Two or more disorders occurring simultaneously. Typically, a person with a mental health disorder and substance abuse is said to have co-occurring disorders. However, this term also refers to other combinations of mental illnesses, physical illnesses, developmental disabilities, and other disorders.

Core Service Agency (CSA): CSAs are agents of city and county government that, in collaboration with MHA, are responsible for planning, managing, and monitoring publicly funded mental health services in their area.

Cultural Competence: In health care, the term describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.

Day Treatment: Intensive mental health treatment including group and individual therapy, which is not provided in a residential facility.

Delusion: False belief that is not part of the individual's culture and that remains fixed.

Denial: The refusal to admit to one's self the truth or reality (i.e., a person who refuses to admit that they have a problem with alcohol or drugs).

Depression: A state of sadness marked by inactivity and inability to concentrate: reduction of the functional activity of the body.

Depressant: Any of several drugs that sedate by acting on the central nervous system: medical uses include the treatment of anxiety, tension, and high blood pressure.

Derailment: A characteristic of a thought disorder where a person's speech jumps from one to another, often unrelated, topic.

Designated Emergency Facility: Hospitals designated by DHMH to perform mental health evaluations of persons who have been transported to the hospital via a Petition for Emergency Evaluation.

Detoxification: Removal of a toxic substance such as a drug or alcohol from the body, a) Acute Detoxification – Detoxification service to individuals for whom the consequences of withdrawal merit assistance from medical and/or nursing personnel.

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[6] Maryland State Department of Education. Division of Rehabilitation Services. Community Rehabilitation Programs. Retrieved on May 1, 2012, from www.dors.state.md.us

b) Sub-Acute Detoxification – Prescription medication is not provided for the management of withdrawal, and service is provided in a supportive home-like environment.

Dialectical Behavioral Therapy (DBT): DBT uses cognitive behavioral techniques to help the individual better identify and manage destructive behavior and emotions by applying new skills to tolerate difficult life events and improve interactions with others. This therapy was developed to treat borderline personality disorder.[7]

Disease Model: A theory of alcoholism endorsed by the AMA, APA, The World Health Organization, NCADD and AA, in which alcoholism is seen as a disease rather than a psychological or social problem.

Discharge Plan: A written plan summarizing the course of treatment or rehabilitation services provided to an individual including recommendations for further services. (See Chapter 8.2)

Discharge Summary: When the consumer is discharged from a mental health facility or program, the provider writes a summary describing the consumer's course of treatment and progress while at the facility.

DORS: The Division of Rehabilitative Services. DORS is a division of the Maryland State Department of Education that provides services to disabled persons and pays for rehabilitative needs, including job coaching, training, and high school and college courses.

Downers: Barbiturates, tranquilizers, alcohol and depressants.

Drug Tolerance: A state of progressively decreased responsiveness to a drug.

Dual-Diagnosis: Generally used to describe the condition of mental patients who are also addicted to a mind-altering drug.

Eligible Uninsured (Formerly known as **Gray Zone**): A term used to describe consumers who are uninsured or under-insured and who meet financial eligibility requirements and other criteria to receive public mental health services.

Emergency Medical Treatment and Labor Act (EMTALA): A federal statute, which requires that hospitals provide emergency treatment to all persons, including persons who do not have insurance and are unable to pay.

Enhanced Support Services: Enhanced Support Services are short-term services given in the consumer's home that consist of in person supervision and assistance to an individual experiencing an increase or instability of psychiatric symptoms. These

[7] JLI. p. 18.

services supplement other mental health services, and only a provider of psychiatric rehabilitation services (PRP), residential rehabilitation services (RRP) or mobile treatment services delivers the services.[8]

Evidence Based Practices: Service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes.

Family Psychoeducation (FPE): An evidence-based clinical intervention for consumers and their identified family members employing a strengths-based approach to address illness related concerns.[9]

Fee-for-Service: A billing system that pays for individual services delivered in Maryland. Public mental health system providers bill and are reimbursed after the service is provided. (See Chapter 8.4)

Fetal Alcohol Syndrome (FAS): A pattern of birth defects, cardiac abnormalities, and developmental retardation seen in some babies of alcohol abusing and/or alcoholic mothers.

Fetal Drug Syndrome (FDS): A pattern of developmental birth defects characterized by low birth weight, growth retardation, and premature delivery.

Global Assessment of Functioning (GAF): GAF comprises Axis V of the DSM-IV. The instrument is used by mental health clinicians to evaluate an individual's current psychosocial and occupational functioning.[10]

Group Home: A private residence for a minimum of 4 and a maximum of 16 individuals with mental illness who reside and receive services in a homelike environment.

Hallucination: A psychotic symptom characterized by perception or sensations with no real external cause. Hallucinations can be auditory, visual, or involve the sense of touch or smell.

Hallucinogen: Chemical substance which can distort perceptions to induce delusions or hallucinations.

Health Promotion and Training: This type of training involves having the consumer engage in activities to increase awareness of his/her physical and mental health and the resources needed to help promote good health.[11]

Home Health Psychiatric Services: A licensed home health agency provides intensive psychiatric services to the consumer in the consumer's home.

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[8] COMAR 10.21.17.02 (20).
[9] Stewart, B. (2010). Evidence-based practice: family psychoeducation (FPE). NAMI MD Connections, 28(4), p. 10.
[10] JLI pp. 58-59.
[11] COMAR 10.21.17.02 (29).

Illusion: An incorrect perception (e.g., the stick on the floor is a snake).[12]

Inhalant: Volatile substance that is introduced into the body through the lungs.

Inpatient Hospital Psychiatric Care: This type of care involves skilled psychiatric services, including psychiatric, medical, and nursing care, in a hospital setting. (See Chapter 8.4)

IRP (Individual Rehabilitation Plan): An IRP describing the plan for service is required for consumers in Psychiatric Rehabilitation Programs (PRP). At least every 6 months, the rehabilitation coordinator and the consumer review the Individual Rehabilitation Plan (IRP). [13]

IRP Continuing Evaluation: IRP Continuing Evaluation is required for consumers in Psychiatric Rehabilitative Programs (PRP). The staff of the rehabilitation program must write down all significant contacts with the consumer, including the dates, locations, and types of contacts documenting services provided, progress, changes in status, and any suggested modifications.[14]

IRWE (Impaired-Related Work Expenses): IRWE is an SSA work incentive that helps some consumers who receive SSI or SSDI maintain eligibility for benefits longer until they can work to a level of self-sufficiency. (See Chapter 10.2)

ITP (Individual Treatment Plan): An ITP, outlining the services to be provided, is required for consumers in both Out Patient Mental Health Centers (OMHC) and inpatient settings. (See Chapter 8.2)

CPC: Licensed Certified Professional Counselor.

LCSW: Licensed Certified Social Worker.

LCSW-C: Licensed Certified Social Worker – Clinical is the highest level of license for a social worker. To obtain this license, the social worker must complete a graduate program and have two years of clinical experience.

LGSW: Licensed Graduate Social Worker is the first level of license given to a social worker after completion of a graduate program.

Loosening of associations: Characteristics of speech whereby ideas jump from one track to another.

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[12] Lundbeck Institute (2011). Diagnosing Mental Disorders. Retrieved June 11, 2012, from http://es.brainexplorer.org/factsheets/Psychiatry%20Diagnosis.pdf
[13] COMAR 10.21.21.06 C.
[14] COMAR 10.21.21.06 D.

Managed Care Organization (MCO): An organization that has a contract with the state Medicaid agency to provide medical services to consumers for a monthly capitation rate for each consumer.

Manic episode: A state of uncharacteristic elevated mood often resulting in rapid speech, decreased need for sleep, loss of social inhibitions, and over activity.

Medical Model: A theory of drug abuse or addiction in which the addiction is seen as a medical issue rather than as a social problem.

Medically Necessary: The Public Mental Health System will only provide those mental health services, which are medically necessary. Medically necessary services include those procedures, treatments, tests, or services, which are clearly indicated, not excessive, and sufficient.

Medicare: Medicare is a national insurance program administered by the federal government, which collects F.I.C.A. payments from workers' paychecks. Medicare pays for health care, including mental health care, for eligible senior citizens and people with disabilities. A person who receives Medicare must pay small deductibles and some co-payments.

Medication Monitoring: A mental health worker monitors medications by: (1) assisting the consumer in complying with taking medication and (2) as needed, reviewing the appropriateness of the medication with the psychiatrist. Medication monitoring does not include: (1) prescribing medication, (2) measuring or pouring medication, (3) preparing a syringe for injection, or (4) administration of medication.[15]

Mental Health Case Management: This service is contracted by the CSAs to services providers. The goal of Mental Health Case Management is to link, refer, coordinate and monitor consumers with needed services and supports. This type of service is provided for a limited period of time. (See Chapter 8.4)

Mental Retardation: A developmental disability that is evidenced by significantly subaverage intellectual functioning and impairment in the adaptive behavior of an individual.

Methadone: A synthetically produced, long-acting opiate (trademark Dolophine).

Mobile Treatment: Mobile Treatment Services are community-based, intensive outpatient and rehabilitation services that are provided to adults and minors by a multi-disciplinary team in the individual's natural environment (i.e., home, street, shelter). (See Chapter 8.4)

Morphine: Major sedative and pain-relieving drug found in opium, being approximately 10% of the crude opium exudates.

[15] COMAR 10.21.17.02 (41).

Narcotic: A drug having the power to produce a state of sleep or drowsiness and to relieve pain with the potential of being dependence producing

Neologism: A symptom of schizophrenia whereby words are combined to make an indefinable "new word."

Network of care: Network of care is a website that provides health resources and service provider directories for areas across the country. Baltimore City's Network of Care can be accessed at: http://baltimorecity.md.networlofcare.org/mh/home/index.cfm[16]

Obsession: Disturbing and recurrent thought, idea, or impulse.

Occupational Therapy (OT): Occupational Therapy involves assessment of a consumer's functioning and services to improve functioning in activities of daily living, cognitive skills, sensory-motor skills, and psycho-social skills.

Ongoing Care: Ongoing care services are less intensive and restrictive than acute care. These services have no time limitation and are required by some individuals with mental illness to maintain and improve their mental health. (See Chapter 8.4)

Opiate: Any substance, natural or synthetic that is related in action to morphine. Some writers use it just to mean opium, morphine, codeine, and heroin.

Outpatient Mental Health Clinic (OMHC): OMHCs offer community-based services, such as assessment, evaluation, and individual, group and family therapies.

Outpatient Treatment: Treatment that does not include admission to a hospital or a residential program.

Panic attack: A sudden overwhelming anxiety producing intense fear, terror, and a sense of impending doom as well as notable physiological and psychological changes.

Partial Hospitalization (PHP) (Day Treatment): Partial Hospitalization is outpatient, short-term, intensive psychiatric treatment that may include medical and nursing supervision and interventions. (See Chapter 8.4)

Peer Specialist: An individual with mental illness and, often, experience with the criminal justice system, who provides support to another justice-involved individual with mental illness.[17]

Pervasive developmental disorders (PDD): PDDs are a group of conditions that involve delays in the development of many basic skills, most notably the ability to

[16] BMHSI. p. 21
[17] JLI p 30.

socialize with others, to communicate, and to use imagination. Asperger's syndrome is an example of a PDD.

Phobia: Intense fear of something that poses little or no actual danger and that results in avoidance and heightened anxiety.

Primary Adult Care (PAC): A program that provides health coverage for a limited set of services for income eligible adults.

Prognosis: The prospect of recovery as anticipated from the usual course of a disease.

Projects for Assistance in Transition from Homelessness (PATH): A program funded by grant money to provide community services for seriously mentally ill people who are homeless or on the verge of becoming homeless.
(See Chapter 10.1)

Provider: A provider is a person, facility, or program that provides mental health care.

Psychiatric Rehabilitation Program (PRP): A community based rehabilitation program for adults with serious mental illness. The program provides employment training, socialization, and support. (See Chapter 8.4)

Psychopharmacology: The study of the effects of drugs on mood, sensation, consciousness, or other psychological or behavioral functions.

Psychosis: A complex of symptoms involving loss of contact with reality and usually including hallucinations and/or delusions. [18]

Public Mental Health System (PMHS): The Public Mental Health System is a network of publicly funded mental health services for people who meet low-income and low-assets requirements.

Rehabilitation: Rehabilitation is a service that assists individuals build life and recovery skills.

Rehabilitation Coordinator: A staff person at a Psychiatric Rehabilitation Program (PRP) who is responsible for coordinating and providing rehabilitation services to the consumer.

Relapse: Referring to alcoholism or substance abuse, a recurrence of symptoms of the disease after a period of sobriety.

[18] Lundbeck Institute (2011). Psychotic Disorders. Retrieved June 11, 2012, from http://es.brainexplorer.org/factsheets/Psychiatry%20Diagnosis.pdf

Relapse Prevention: A therapeutic process or skill set designed to reduce the likelihood that symptoms will reappear or the individual will revert to unhealthy behavior. Strategies include self-monitoring to recognize drug cravings and coping skills in high-risk situations.[19]

Residential Crisis Services (RCS): Residential Crisis Services are short-term, intensive, mental health and support services for children, adolescents, and adults in a community-based, non-hospital, residential setting. (See Chapter 8.4)

Residential Rehabilitation Program (RRP): A Residential Rehabilitation Program is a rehabilitation service that is targeted to restoring independent living skills in a homelike environment for adults with Severe and Persistent Mental Illness (SPMI) who are unable to reside in their own home without support services. (See Chapter 8.4)

Self-help Group: Group of individuals with similar problems that meets for the purpose of providing support and information to each other and for mutual problem solving.

Section 1115 Waiver: The United States Department of Health and Human Services provides waivers from the general Medicaid regulations to allow states to provide managed care programs for consumers.

Seeking Safety: An intervention to aid in the recovery of people with trauma histories and a substance use disorder.[20]

Serious Mental Illness: Diagnoses designated by the PMHS as most likely to cause functional impairment**.** These diagnoses are used to prioritize services for individuals most likely in need of services.

Social Security Disability Income (SSDI): SSDI provides payments for daily living expenses of people with disabilities who worked for a specific number of years and thus paid Social Security taxes (F.I.C.A.).

Social Skill Training: Assistance provided to consumers to acquire, maintain or develop social skills and other interpersonal skills. Assistance is also provided to the consumer to lessen tendencies to become isolated or withdrawn.

Splitting: In borderline personality disorder, a switch between idealizing and demonizing others. [21]

Supplemental Security Income (SSI): SSI is a federally funded program to supplement the income of older people and people with disabilities who have low incomes and low assets.

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[19] JLI. p. 35.
[20] Seeking Safety: A Model for Trauma and/or Substance Abuse. Retrieved May 1,2012, from www.seekingsafety.org
[21] National Alliance on Mental Illness. *Borderline personality disorder*. Retrieved June 10, 2012, from www.nami.org

Supported Employment (SE): Supported Employment provides on-going support services to people who have Serious Mental Illness (SMI) and who have been unable to maintain full-time employment. (See Chapter 10.2)

Supportive Housing: Supportive housing is a combination of housing and services that is widely believed to work well for those who face the most complex challenges—low income individuals and families confronted with homelessness and those who also have serious, persistent issues that may include substance abuse, alcoholism, mental illness, and HIV/AIDS. (See Chapter 10.1)

Support Services: Rehabilitative services aimed at improving a consumer's functional capacity and may include assistance to maintain independent housing, education, and employment.

Therapeutic Community: A highly structured, residential substance use treatment model with an emphasis on personal accountability and responsibility.[22]

Transitional Living: Non-medical residential program providing training for living in a setting of greater independence (e.g., halfway houses and recovery houses).

Trauma Informed Services: These services involve understanding, anticipating, and responding to issues, expectations, and special issues that people with trauma may experience in a given setting.[23]

Trauma Specific Services: Interventions designed to address the specific consequences of exposure to physical, sexual, and emotional abuse.

Treatment: Treatment services help individuals manage the symptoms of their mental illness through the provision of psychiatric evaluation and diagnosis; medication management; and a range of therapeutic interventions including individual, group and family counseling.

Treatment Coordinator: A staff member of an Outpatient Mental Health Clinic (OMHC) who is responsible for coordinating and providing mental health care to the consumer.

Ups or Uppers: Stimulants; amphetamines.

Urgent Care: Urgent care is appropriate when a consumer is becoming unstable and needs prompt treatment in order to prevent the consumer from having a psychiatric crisis, having to go to the hospital emergency room, and having to be hospitalized.

[22] JLI p.35.
[23] JLI. p. 36.

Value Options: The company currently serving as the ASO for Maryland's public mental health system. www.maryland.valueoptions.com

Waivers: The Secretary of the United States Department of Health and Human Services may, upon the request of a state, give a waiver allowing the state to receive federal Medicaid matching grants, even though the state is not in compliance with specific requirements or limitations of the federal Medicaid statute.

Withdrawal Syndrome: The group of reactions or behavior that follows abrupt cessation of the use of a drug upon which the body has become dependent. May include anxiety, insomnia, DTs, perspiration, hot flashes, nausea, dehydration, tremors, weakness, dizziness, convulsions, and psychotic behavior. If untreated in some individuals, can be the cause of death.

Word salad: A symptom of schizophrenia where words and phrases are combined in a completely disorganized fashion.

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Section 12.2

Statutory Definitions

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STATUTORY AND REGULATORY DEFINITIONS

Active treatment: "Active treatment" means inpatient psychiatric services, which involve implementation of a professionally supervised individual plan of care, described in 42 CFS§441.155:
(a) Developed and implemented not later than 14 days after admission; and
(b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time. *COMAR 10.09.29.01 B. (1)*

Acute psychiatric services: "Acute psychiatric services" mean psychiatric services rendered in response to a severe psychiatric condition requiring intervention in order to bring the patient's symptoms under control. *COMAR 10.09.29.01 B. (2)*

Administrative Services Organization: "Administrative Services Organization (ASO)" means the entity with which the Mental Hygiene Administration may contract to provide the services described in COMAR 10.09.70 for the public mental health system. *COMAR 10.09.45.02. B. (1)*

Addiction: "Addiction" means a disease, which is characterized by a pattern of pathological use of alcohol or a drug, or both with repeated attempts to control the use and with significant negative consequences in at least one of the following areas of life:
(a) Financial;
(b) Legal;
(c) Medical; or
(d) Psychosocial *COMAR 10.08.02.03 B. (3)*

Addiction facility: "Addiction facility" means any facility, which provides or proposes to provide treatment for an addiction. *COMAR 10.08.02.01 B. (4)*

Addiction Severity Index: "Addiction Severity Index" means a standardized method for the assessment of adults regarding addictions severity and patient need. *COMAR 10.47.01.02 B. (1)*

Alcohol abuse: "Alcohol abuse" means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psychosocial. *HG §8-101 (d); COMAR 10.47.01.02 B. (6)*

Alcohol Dependence: "Alcohol dependence" means a disease characterized by:
(1) Alcohol abuse; and
(2) Physical symptoms of withdrawal or tolerance. *HG §8-101 (e); COMAR 10.47.01.02 B. (7)*

Alcohol misuse: "Alcohol misuse" means:
(1) Unlawful use of alcohol;
(2) Alcohol abuse; or
(3) Alcohol dependence. *HG §8-101 (f)*

Alternative living unit: "Alternative living unit" means a residence that:
1) Provides residential services for individuals who, because of developmental disability, require, specialized living arrangements;
2) Admits not more than 3 individuals; and
3) Provides 10 or more hours of supervision per unit, per week.
HG §7-101 (d); COMAR 10.22.01.01 B. (2)

American Society of Addiction Medicine (ASAM) Patient Placement Criteria: "American Society of Addiction Medicine (ASAM) Patient Placement Criteria" means an instrument designed to indicate patient placement guidelines for admission, continued stay, and discharge. *COMAR 10.09.80.01 B. (2); COMAR 10.47.01.02 B. (8)*

Appropriate Evaluation: "Appropriate Evaluation" means the assessment of an individual using accepted professional standards to document the presence of a:
(a) Developmental disability as defined in Health-General Article, 7-101, Annotated Code of Maryland; or
(b) Disability that qualifies the individual for individual support services only as defined in Health-General Article 7-403 (c). *COMAR 10.22.33.03 B. (5)*

Assessment: "Assessment" means the process of ascertaining the treatment needs of the patient regarding addiction and other social issues.
COMAR 10.47.01.02.B. (9)

Care Plan: "Care Plan" means the plan prepared according to the requirements outlined in this chapter that delineate the plan of care for a specific participant.
COMAR 10.09.45.02 B. (2)

Care Provider: "Care provider" means an individual who is responsible for the daily operation of an individual family care home as defined in § B. (26) of this regulation. *COMAR 10.22.01.01 B. (10)*

Case Management: "Case Management" means the process of coordinating and monitoring the services provided to a patient both within the program and in conjunction with other providers. *COMAR 10.47.01.02 B. (11)*

Case manager: "Case manager" means a community support specialist. *COMAR 10.09.45.02 B. (3)*

Children's residential center: "Children's residential center" means a residential treatment center that admits patients 12 years or younger. COMAR 10.09.29.01 B. (3-1)

Community mental health facility: "Community mental health facility" means a facility where one or more of the following mental health programs is provided, or is proposed to be provided:
(a) Inpatient services;
(b) Outpatient services;
(c) Partial care services, including day care services and night care services;
(d) 24-hour emergency services;
(e) Aftercare services;
(g) Education services;
(h) Community rehabilitation services. *COMAR 10.08.02.03 B. (8)*

Committed person: "Committed person," means a person committed to the Health Department as not criminally responsible under the test for criminal responsibility. *CP §3-101 (6)*

Community support specialist: "Community support specialist" means an individual who is employed by a mental health case management provider to deliver case management services*. COMAR 10.09.45.02 B. (4)*

Community Supported Living Arrangements:
(a) "Community Supported Living Arrangements (CSLA)" means services to assist an individual in non-vocational activities necessary to enable that individual to live in the individual's own home, apartment, family home, or rental unit, with
(i) No more than two other nonrelated recipients of these services; or
(ii) Members of the same family regardless of their number.
(b) "Community supported living arrangements (CSLA)" include:
(i) Personal assistance services;
(ii) Supports that enhance the individual's opportunity for community participation and to exercise choice and control over the individual's own life;
(iii) Training and other services necessary to assist the individual in achieving and maintaining increased integration, interdependence, and productivity;
(iv) 24-hour emergency assistance;
(v) Assistive technology;
(vi) Adaptive equipment;
(vii) Resource coordination;
(viii) Environmental modifications;
(ix) Respite services; and
(x) Other services as approved by the Secretary or the Secretary's designee.
COMAR 10.22.01.01 B. (14); COMAR 10.22.12.03 B. (6-1)

Community Supported Living Arrangement Home: "Community supported living arrangement home" means a residence:
(a) Which is rented or owned by an individual or the individual's family or proponent or held in trust for an individual;
(b) Where an individual lives as a roommate without the individual's name appearing on the lease or title; or
(c) Where the licensee is the guarantor of rental or mortgage payments for an individual receiving CSLA services. *COMAR 10.22.01.01 B. (13)*

Comprehensive substance abuse assessment: "Comprehensive substance abuse assessment" means the process of gathering data about an individual's biopsychosocial problems to determine whether substance abuse treatment is needed and, if so, at what level of care. *COMAR 10.09.80.01 B. (5)*

Confined: "Confined" means an order by the court pursuant to Criminal Procedure Article, §3-106(d)(2), Annotated Code of Maryland. *COMAR 10.07.13.02 B. (1)*

Court-ordered evaluation: "Court-ordered evaluation" means an evaluation ordered by the court under Criminal Procedure Article, §§3-105 and 3-111, Annotated Code of Maryland, to assist the court to determine if an individual is incompetent to stand trial or is not criminally responsible because of mental retardation. *COMAR 10.07.13.02 B (2)*

Core service agency: "Core service agency" means the designated county or multicounty authority that is responsible for planning, managing, and monitoring publicly funded mental health services. *HG §10-1201 (b)*

Detoxification facility: "Detoxification facility" means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social, and emotional needs of the individual by:
(1) Monitoring the amount of alcohol and other toxic agents in the body of the individual;
(2) Managing withdrawal symptoms; and
(3) Motivating the individual to participate in the appropriate addictions treatment programs for alcohol or drug abuse. HG §8-101 (g)

Developmental disability: "Developmental disability" means a severe chronic disability of an individual that:
(1) Is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments;
(2) Is manifested before the individual attains the age of 22;
(3) Is likely to continue indefinitely;
(4) Results in an inability to live independently without external support or continuing and regular assistance; and

(5) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are individually planned and coordinated for the individual. *HG §7-101(e); COMAR 10.22.01.01(16)*

Developmental disability facility: "Developmental disability facility"
(a) Means any facility, which provides or proposes to provide services for individuals with disabilities, whether the facility is hospital-based, a clinic, vocational, day, or residential site.
(b) For purpose of this definition, facility does not include a Veterans Administration hospital. *COMAR 10.08.02.01 B. (10)*

Discharge plan: "Discharge plan" means a written description of specific goals and objectives to assist the recipient upon leaving treatment.
COMAR 10.09.80.01 B. (7); COMAR 10.47.01.02 B. (27)

Drug: "Drug" means:
(1) A controlled dangerous substance that is regulated under the Maryland Controlled Dangerous Substances Act;
(2) A prescription medication; or
(3) A chemical substance when used for unintended and harmful purposes.
HG §8-101 (i)

Drug abuse: "Drug abuse" means a disease which is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social. *HG §8-101 (j); COMAR 10.47.01.02 B. (31)*

Drug dependence: "Drug dependence" means a disease characterized by:
(1) Drug abuse; and
(2) Physical symptoms of withdrawal or tolerance.
HG §8-101 (k); COMAR 10.47.01.02 B. (32)

Drug misuse: "Drug misuse: means:
(1) Unlawful use of a drug;
(2) Drug abuse; or
(3) Drug dependence*. HG §8-101 (1)*

Eligibility for Support Services Only: "Eligibility for support services only" means an individual shall have a severe chronic disability that is:
a) Attributable to a physical or mental impairment other than the sole diagnosis of mental illness or to a combination of mental and physical impairment; and
(b) Likely to continue indefinitely.
COMAR 10.22.01.01 B. (18); COMAR 10.22.12.03 B. (11);

Evaluation unit: "Evaluation unit" means a part of the forensic residential center dedicated to performing court-ordered evaluations pursuant to Criminal Procedure Article, Title 3, Annotated Code of Maryland. *COMAR 10.07.13.02 (4)*

External support: "External support" means:
(1) Periodic monitoring of the circumstances of an individual with respect to:
(i) Personal management;
(ii) Household management; and
(iii) The use of community resources; and
(2) Rendering appropriate advice or assistance that may be needed*.*
HG §7-101 (g)

Facility: "Facility" means any public or private clinic, hospital, or other institution that provides or purports to provide treatment or other services for individuals who have mental disorders. "Facility" does not include a Veterans' Administration hospital. *HG §10-101 (e)*

Facility: "Facility" means a:
(a) Public community mental health facility, addiction facility, or developmental disabilities facility that is wholly owned by, and operated under, the authority of a county or municipal corporation; or
(b) Nonprofit community mental health facility, addiction facility, or developmental disabilities facility that is wholly owned by, and operated under, the authority of a nonprofit organization or corporation. *COMAR 10.08.02.03 B. (11)*

Family Support Services: "Family support services" means a program designed to enable a family to provide for the needs of a child with developmental disability living at home. Family support services include:
(a) Individual and family counseling;
(b) Personal care;
(c) Day care;
(d) Specialized equipment;
(e) Health services;
(f) Respite care;

(g) Housing adaptations;
(h) Transportation; and
(i) Other necessary services. *COMAR 10.22.12.03 B. (12)*

Forensic Residential Center: "Forensic Residential Center (FRC)" means a facility that is:
(a) Licensed to provide a continuum of integrative services to individuals with mental retardation:
(i) Ordered by the court for an evaluation or to be confined;
(ii) Court-committed for care or treatment to the Department as incompetent to stand trial or not criminally responsible who are dangerous as a result of mental retardation; or
(iii) On conditional release and returned to the facility either voluntarily or on hospital warrant;
(b) A related institution as defined in Health-General Article, §19-301 (o), Annotated Code of Maryland; and
(c) Not an extended care or comprehensive rehabilitation facility.
COMAR 10.07.13.02 B. (5); COMAR 10.22.01.01 B. (20-1)

Group home: "Group home" means a residence that:
(1) Provides residential services for individuals who, because of developmental disability, require specialized living arrangements;
(2) Admits at least 4 but not more than 8 individuals; and
(3) Provides 10 or more hours of supervision per home, per week.
HG §7-101; ;(h); COMAR 10.22.01.01 B. (25)

Habilitation: "Habilitation" means a process by which a provider of services enables an individual to acquire and maintain life skills to cope more effectively with the demands of the individual's own person and environment and to raise the level of the individual's mental, physical, social, and vocational functioning.
HG §7-101 (h)

Hospital warrant: "Hospital warrant" means a legal document issued by a court that:
(1) authorizes any law enforcement officer in the state to apprehend a person who is alleged to have violated an order for conditional release and transport the person to a facility designated by the Health Department; and
(2) requires that the issuance of the warrant is entered in the person's criminal history record information of the criminal justice information system.
CP §3-101 (e)

Incompetent to stand trial: "Incompetent to stand trial" means not able:
(1) to understand the nature or object of the proceeding; or
(2) to assist in one's defense. *CP §3-101 (f)*

Individual Family Care Home: "Individual Family Care Home (IFC)" means a private single family residence licensed by the Department under COMAR 10.22.08 which:
(a) Under supervision, provides a home for individuals with developmental disability in a family atmosphere; and
(b) Provides habilitation services for one to three individuals who are not related to the caregiver. *COMAR 10.22.01.01 B. (27); COMAR 10.22.12.03 B. (16)*

Individual plan of care: "Individual plan of care" means a written plan developed for each recipient in accordance with 42CFR §441.155 (individual plan of care). The plan of care shall:
(a) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;
(b) Be developed by a team of professionals in consultation with the recipient and the recipient's parents, legal guardian, or other in whose care the recipient will be released after discharge;
(c) State treatment objectives;
(d) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
(e) Include, at an appropriate time, post-discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge. *COMAR 10.09.29.01 B. (7)*

Individual support services: "Individual support services" means an array of services that are designed to increase or maintain an individual's ability to live alone or in a family setting including:
(1) In-home assistance with meals and personal care;
(2) Counseling;
(3) Physical, occupational, or other therapies;
(4) Architectural modification; and
(5) Any other services that the Administration considers appropriate to meet the individual's needs.
Individual support services do not include full day or residential services. *HG §7-101 (j); COMAR 10.22.12.03 B. (17)*

Individualized treatment plan: "Individualized treatment plan" means a written plan of action that is developed, periodically updated, and revised to address a recipient's specific service needs. *COMAR 10.09.80.01; COMAR 10.47.01.02 B. (36)*

Intellectual disability. "Intellectual disability" means a developmental disability that is evidenced by significantly sub-average intellectual functioning and impairment in the adaptive behavior of an individual. *HG §7-101 (k)*

Intermediate care facility: "Intermediate care facility" means a facility that provides a planned regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an impatient setting. *COMAR 10.09.80.01. B. (37)*

Live independently: "Live independently" means:
(1) For adults:
(i) Managing personal care, such as clothing and medication;
(ii) Managing a household, such as menu planning, food preparation and shopping, essential care of the premises, and budgeting; and
(iii) Using community resources, such as commercial establishments, transportation, and services of public agencies; or
(2) For minors, functioning in normal settings without the need for supervision or assistance other than supervision or assistance that is age appropriate.
HG §7-101 (1)

Low Intensity Support Services: "Low intensity support services" means support services in accordance with COMAR 10.22.06. Services qualifying for this category are:
(a) Designed to be one-time only;
(b) Low cost with a cap of $3,000 per individual per year; or
(c) Approved by the regional office only if the cost of the services exceeds $3,000 or the services are needed beyond 1 calendar year.
COMAR 10.22.12.03B. (20)

Mental disorder:
(1) "Mental disorder" means a behavioral or emotional illness that results from a psychiatric or neurological disorder.
(2) "Mental disorder" includes a mental illness that so substantially impairs the mental or emotional functioning of a person as to make care or treatment necessary or advisable for the welfare of the person or for the safety of the person or property of another.
(3) "Mental disorder" does not include mental retardation/ intellectual disability.
CP §3-101 (g), HG § 10-101 (f)

Mental health case management services: "Mental health case management services" means services covered under this chapter which assist participants in gaining access to the full range of mental health services, as well as to any additional needed medical, social, financial assistance, counseling, education, housing, and other support services. *COMAR 10.09.45.02*

Mental health services: "Mental health services" means those services described in COMAR 10.09.70.10C rendered to treat an individual for a diagnosis set forth in COMAR 10.09.70.10A. *COMAR 10.09.45.02 B. (13)*

Progress note: "Progress note" means an objective documentation of the recipient's progress in relation to specific treatment goals and objectives. *COMAR 10.09.80.01 B. (14)*

Qualified developmental disabilities professional (QDDP): "Qualified developmental disabilities professional" means an individual who coordinates and monitors the delivery of services for individuals with mental retardation. *COMAR 10.07.13.02*

Recovery support services: "Recovery support services" means community-based services provided to people and their families during the initiation, on-going, and post-acute stages of their recovery from substance abuse. *COMAR 10.09.80.01 B. (16)*

Resource Coordinator: "Resource coordinator" means a professional;
(a) Designated by the Developmental Disabilities Administration;
(b) Not employed by a direct service provider;
(c) Who has knowledge and experience in community support for individuals with developmental disabilities; and
(d) Who meets the requirements of COMAR 10.22.09. *COMAR 10.22.01.01 B. (51)*

Respite: "Respite" means relief services provided to the family or care provider to meet planned or emergency situations. *COMAR 10.22.01.01 B. (52)*

Screening: "Screening" means the utilization of a valid tool or instrument approved by the Administration to determine whether or not an individual may have alcohol or other drug abuse or dependence or both and will need further evaluation. *COMAR 10.47.01.02 (53)*

Self-help group: "Self-help group" means a voluntary fellowship or group that supports patients in recovery from alcohol and other drug abuse or dependence. *COMAR 10.47.01.02 (55)*

Serious and persistent mental disorder: "Serious and persistent mental disorder" means a disorder that is:
(a) Manifested in an individual 18 years old or older; and
(b) Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association that is recognized by the Secretary as:
(i) Schizophrenic disorder
(ii) Major affective disorder
(iii) Other psychotic disorder; or
(iv) Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct. *COMAR 10.09.45.02 B. (22)*

Serious emotional disturbance: "Serious emotional disturbance" means a condition that is:
(a) Manifested in an individual younger than 18 years old;
(b) Diagnosed according to a current diagnostic classification system that is recognized by the Secretary, excluding the following, unless they coexist with a diagnosable psychiatric disorder:
(i) Developmental disorders;
(ii) Substance abuse; and
(iii) Disorder classified under the "V" code; and
(c) Characterized by a functional impairment that substantially interferes with, or limits the minor's functioning in, the family, school, or community. COMAR 10.09.45.02 B. (23)

Services: "Services" means residential, day, or other services that provide for evaluation, diagnosis, treatment, care, supervision, assistance, or attention to individuals with developmental disability and that promote habilitation of these individuals. *HG §7-101 (n)*

Service coordination. "Services coordination" means a service that consists of the following 3 major functions that are designed to assist an individual in obtaining the needed services and programs that the individual desires in order to gain as much control over the individual's own life as possible:
(1) Planning services;
(2) Coordinating services; and
(3) Monitoring service delivery to the individual*. HG-§7-101 (o*)

Services Coordinator: "Service coordinator" means a professional who is assigned the responsibility for assisting the consumer in accessing the service delivery system more efficiently and effectively. This assistance is effected through planning, monitoring, and coordinating the medical, social, habilitative, and vocational services necessary to meet the identified needs of the consumer, as agreed upon and specified in the consumer's individualized service plan. *COMAR 10.22.12.03 B. (30)*

Services to person with mental illnesses: "Services to persons with mental illnesses" means the health care and community support rendered to a recipient primarily in connection with diagnosis, evaluation, treatment, case management, rehabilitation, or supervised housing for individuals. *HG. §10-1201 (c)*

State facility: "State facility" means a facility that is owned or operated by the Department. *HG §10-101 (h)*

State residential center: "State residential center" means a place that:
(1) Is owned and operated by the State;
(2) Provides residential services for individuals with an intellectual disability and who, because of that intellectual disability, require specialized living arrangements; and

(3) Admits 9 or more individuals with an intellectual disability. *HG §7-101 (p); COMAR 10.22.01.01 B. (55)*

Substance abuse "Substance abuse" means a maladaptive pattern of substance use leading to clinically significant impairment or distress and manifested by recurrent and significant adverse consequences related to the repeated use of substances. *COMAR 10.09.80.01. B. (17)*

Supports: "Supports" means the assistance provided to individuals or their families to enable greater participation in the community and enhanced quality of life. *COMAR 10.22.01.01 B. (56).*

Therapeutic care unit: "Therapeutic care unit" means an FRC or part of an FRC dedicated to providing care or treatment to individuals who are court-committed or confined. *COMAR 10.07.13.02 B. (9)*

Treatment: "Treatment" means any education, training, professional care or attention, or other program that is given to an individual with developmental disability. *HG §7-101 (q)*

Treatment: "Treatment" means any professional care or attention that is given in a facility, private therapeutic group home for children and adolescents, or Veterans Administration hospital to improve or to prevent the worsening of a mental disorder. *HG §10-101(i)*

Treatment plan: "Treatment plan" means a written plan that addressed the individual's biopsychosocial needs through goals and objectives and is updated as needed according to the modality. *COMAR 10.09.80.01 B. (18)*

Vocational services: "Vocational services" means a service that provides job training and placement, supported employment and training in acceptable work behaviors, and vocationally-related social and other skills. *HG §7-101 (r)*

Section 12.3

Acronyms and Abbreviations

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Acronyms and Abbreviations

ACT	Assertive Community Treatment
ADAA	Alcohol and Drug Abuse Administration
ADAP	AIDS Drug Assistance Program
ADL	Activities of Daily Living
AOT	Assisted-Outpatient Treatment
BJA	Bureau of Justice Assistance (Federal)
BJS	Bureau of Justice Statistics (Federal)
CBT	Cognitive Behavioral Therapy
CCMSD	Medical Services Division of the Circuit Court
CFAP	Community Forensic Aftercare Program
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services (Federal)
CMS	Centers for Medicare and Medicaid Services (Federal)
COD	Co-Occurring Disorders
CSAP	Center for Substance Abuse Prevention (Federal)
CSAT	Center for Substance Abuse Treatment (Federal)
CSG	Council of State Governments
CSRRC	Community Services Rate Reimbursement Commission
DBT	Dialectical Behavioral Therapy
DDA	Developmental Disabilities Administration
DHMH	Department of Health and Mental Hygiene
DSM	Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association)

EBP	Evidence-Based Practice
EMR	Electronic Medical Record
FACT	Forensic Assertive Community Treatment
FAST	Forensic Alternative Services Team
FICM	Forensic Intensive Case Management
FRC	Forensic Assertive Community Treatment
GAINS	CMHS National GAINS Center
HCRC	Health Care Resources Commission
HMO	Health Maintenance Organization
HHS	U.S. Department of Health and Human Services (Federal)
HRSA	Health Resources and Services Administration (Federal)
HOT	Homeless Outreach Team
HUD	U.S. Department of Housing
ICM	Intensive Case Management
IDDT	Integrated Dual Disorders Treatment
IGSR	University of Maryland Institute of Governmental Service and Research
IMR	Illness Management and Recovery
IOC	Involuntary Outpatient Commitment
IST	Incompetent to Stand Trial
IST-D	Incompetent and Dangerous
IST-ND	Incompetent and Not Dangerous
MA	Medical Assistance
MCCJTP	Maryland Community Criminal Justice Treatment Program

MCVETS	Maryland Center for Veterans Education and Training
MHA	Mental Hygiene Administration
MHC	Mental Health Court
MHCMD	Mental Health Case Management Docket (Circuit Court Baltimore City)
MIS	Management Information Systems
MPI	Model Program Initiative
MSE	Mental Status Examination
MTC	Modified Therapeutic Community
MTU	Mobile Treatment Unit
NCR	Not Criminally Responsible
NIDA	National Institute on Drug Abuse
OETAS	Office of Education and Training for Addiction Services
OPSC	Office of Problem Solving Courts
PACT	Program of Assertive Community Treatment (same as ACT)
PATH	Programs for Assistance in Transition for Homeless
PHA	Public Housing Authority
PTSD	Post-Traumatic Stress Disorder
QDDP	Qualified Developmental Disabilities Professional
RAP	Rental Assistance Program
SAMSIS	Maryland Substance Abuse Management Information System
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SMART	State of Maryland of Automated Record Tracking

SMHA	State Mental Health Agency/Authority
SMI	Serious Mental Illness
SNRI	Serotonin-norepinephrine Reuptake inhibitor
SPMI	Serious and Persistent Mental Illness
SRO	Single Room Occupancy
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSRI	Selective Serotonin Reuptake Inhibitor
TAMAR	Trauma, Addictions, Mental Health and Recovery
TAPA	Technical Assistance and Policy Analysis Center for Jail Diversion (CMHS Gains)
TAY	Transitional Age Youth
TC	Therapeutic Community
VA	Veterans Administration
WRAP	Wellness Recovery Action Plan

DHMH FACILITIES

CTPHC	Clifton T. Perkins Hospital Center
ESHC	Eastern Shore Hospital Center
HC	Holly Center (DDA)
PC	Potomac Center (DDA)
RICA	Regional Center for Children and Adolescents
SETT	Secure Evaluation Therapeutic Treatment (DDA)
SHC	Springfield Hospital Center
SGHC	Spring Grove Hospital Center
TFC	Thomas B Finan Center (Cumberland Maryland)

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APPENDIX A

COMPETENCY

CC DC-CR 106	ORDER FOR OUT-PATIENT EXAMINATION AS TO COMPETENCY TO STAND TRIAL http://www.courts.state.md.us/courtforms/internal/ccdccr106public.pdf
CC DC-CR 107	COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR EXAMINATION AS TO COMPETENCY TO STAND TRIAL http://www.courts.state.md.us/courtforms/internal/ccdccr107.pdf
CC DC-CR 108	EXTENDED COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR EXAMINATION AS TO COMPETENCY TO STAND TRIAL http://www.courts.state.md.us/courtforms/internal/ccdccr108.pdf
CC DC-CR 108A	ADDENDUM TO ORDER FOR COMPETENCY EXAMINATION http://www.courts.state.md.us/courtforms/internal/ccdccr108apublic.pdf
CC DC-CR 127	SCHEDULING ORDER AFTER RECEIPT EXAMINATION REPORT http://www.courts.state.md.us/courtforms/internal/ccdccr127public.pdf
CC DC-CR 52	COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE AFTER A FINDING OF DEFENDANT'S INCOMPETENCY TO STAND TRIAL AND A FINDING THAT BY REASON OF A MENTAL DISORDER OR MENTAL RETARDATION THE DEFENDANT IS A DANGER TO SELF OR THE PERSON OR PROPERTY OF ANOTHER http://www.courts.state.md.us/courtforms/internal/ccdccr052.pdf
CC DC-MH 06	ORDER FOR ON AND OFF GROUNDS PRIVILEGES http://www.courts.state.md.us/courtforms/internal/ccdcmh006public.pdf
CC DC-CR 59	ORDER FOR RELEASE AFTER A FINDING THAT THE DEFENDANT IS INCOMPETENT TO STAND TRIAL http://www.courts.state.md.us/courtforms/internal/ccdccr059public.pdf
CC-DC-CR 132	ORDER OF PRETRIAL CONDITIONS OF RELEASE http://www.courts.state.md.us/courtforms/internal/ccdccr132public.pdf
CC DC-CR 128	ADDITIONAL PRETRIAL RELEASE SPECIAL CONDITIONS http://www.courts.state.md.us/courtforms/internal/ccdccr128.pdf

CC DCMH 03	COURT EVENT LOG http://www.courts.state.md.us/courtforms/internal/ccdcmh003.pdf
CC DCMH 01	COMPETENCY STATUS REPORT http://www.courts.state.md.us/courtforms/internal/ccdcmh001.pdf
CC DCMH 08	COURT STATUS/ANNUAL REPORT INCOMPETENT TO STAND TRIAL AND NOT DANGEROUS IN COMMUNITY http://www.courts.state.md.us/courtforms/internal/ccdcmh008.pdf
CC DCMH 02	STATUS CONFERENCE COURT NOTES http://www.courts.state.md.us/courtforms/internal/ccdcmh002.pdf
CC DCMH 05	MENTAL HEALTH/SUBSTANCE ABUSE STATUS UPDATE FORM http://www.courts.state.md.us/courtforms/internal/ccdcmh005.pdf
CC DC-CR 55	ORDER FOLLOWING RECONSIDERATION OF COMPETENCY AND COMMITMENT http://www.courts.state.md.us/courtforms/internal/ccdccr055public.pdf
CC DC-CR 138	ORDER FOR CONTINUED COMMITMENT FINDING OF INCOMPETENCEY TO STAND TRIAL AND FINDING THAT DEFENDANT IS A DANGER TO SELF OR THE PERSON OR PROPERTY OF ANOTHER DUE TO MENTAL DISORDER OR MENTAL RETARDATION http://www.courts.state.md.us/courtforms/internal/ccdccr138public.pdf
CC DC-CR 117	ORDER FOR INVOLUNTARY CIVIL COMMITMENT TO PSYCHIATRIC FACILITY http://www.courts.state.md.us/courtforms/internal/ccdccr117public.pdf
CC DC-CR 118	ORDER FOR CONFINEMENT TO DEVELOPMENTAL DISABILITIES ADMINISTRATION FACILITY http://www.courts.state.md.us/courtforms/internal/ccdccr118public.pdf
CC DCMH 07	NOTICE OF HEARING TO CONSIDER DISMISSAL OF CHARGES AGAINST THE DEFENDANT FOUND INCOMPETENT http://www.courts.state.md.us/courtforms/internal/ccdcmh007.pdf

CRIMINAL RESPONSIBILITY

CC DC-CR 53	COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR EXAMINATION AND REPORT AS TO DEFENDANT'S CRIMINAL RESPONSIBILITY AT THE TIME OF THE COMMISSION OF THE ALLEGED OFFENSE AND COMPETENCY TO STAND TRIAL http://www.courts.state.md.us/courtforms/internal/ccdccr053.pdf

CC DC-CR 54	COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE AFTER A VERDICT OF NOT CRIMINALLY RESPONSIBLE http://www.courts.state.md.us/courtforms/internal/ccdccr054.pdf
CC DC-CR 60	ORDER OF RELEASE UPON A VERDICT OF NOT CRIMINALLY RESPONSIBLE http://www.courts.state.md.us/courtforms/internal/ccdccr060public.pdf
CC DC-CR 62	ORDER UPON REVIEW OF PETITION FOR REVOCATION OF CONDITIONAL RELEASE http://www.courts.state.md.us/courtforms/internal/ccdccr062public.pdf
CC DC-CR 114	HOSPITAL WARRANT Not Available Online – Pre-numbered Form
CC DC-CR 63	ORDER FOLLOWING HEARING ON REVOCATION OR MODIFICATION OF CONDITIONAL RELEASE http://www.courts.state.md.us/courtforms/internal/ccdccr063public.pdf
CC DC-CR 64	ORDER UPON REVIEW OF APPLICATION FOR CHANGE IN CONDITIONAL RELEASE http://www.courts.state.md.us/courtforms/internal/ccdccr064public.pdf
CC DC-CR 56	ORDER FOR JUDICIAL HEARING ON ADMINISTRATIVE LAW JUDGE'S REPORT AFTER A FINDING OF NOT CRIMINALLY RESPONSIBLE http://www.courts.state.md.us/courtforms/internal/ccdccr056public.pdf
CC DC-CR 57	ORDER FOR CONTINUED COMMITMENT, CONDITIONAL RELEASE OR DISCHARGE http://www.courts.state.md.us/courtforms/internal/ccdccr057public.pdf
CC-DC-CR 58	JUDICIAL DETERMINATION AFTER APPLICATION BY DEPARTMENT OF HEALTH AND MENTAL HYGIENE http://www.courts.state.md.us/courtforms/internal/ccdccr058.pdf
CC-DC-CR 61	JUDICIAL DETERMINATION AFTER APPLICATION BY COMMITTED PERSON http://www.courts.state.md.us/courtforms/internal/ccdccr061.pdf

SUBSTANCE ABUSE

CC DC-CR 101	ORDER FOR OUT-PATIENT EVALUATION FOR DRUG OR ALCOHOL TREATMENT (HG §8-505) http://www.courts.state.md.us/courtforms/internal/ccdccr101public.pdf
CC DC-CR 102	COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR IN-CUSTODY EVALUATION FOR DRUG OR ALCOHOL TREATMENT (HG §8-505) http://www.courts.state.md.us/courtforms/internal/ccdccr102.pdf

CC DC-CR 103	COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR INPATIENT EVALUATION FOR DRUG OR ALCOHOL TREATMENT (HG §8-506) http://www.courts.state.md.us/courtforms/internal/ccdccr103.pdf
CC DC-CR 104	EXTENDED COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR EVALUATION FOR DRUG OR ALCOHOL TREATMENT (HG §8-505) http://www.courts.state.md.us/courtforms/internal/ccdccr104.pdf
CC DC-CR 105	COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR DRUG OR ALCOHOL TREATMENT (HG §8-507) http://www.courts.state.md.us/courtforms/internal/ccdccr105.pdf
CC DC-CR 109	CONSENT TO TREATMENT (HG §8-507) http://www.courts.state.md.us/courtforms/joint/ccdccr109.pdf
CC DC-CR 110	CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION http://www.courts.state.md.us/courtforms/internal/ccdccr110.pdf
CC DC-CR 120	COURT CLERK'S CHECKLIST FOR EVALUATIONS AND COMMITMENTS TO JUSTICE SERVICES / OFFICE OF FORSENIC SERVICES http://www.courts.state.md.us/courtforms/internal/ccdccr120.pdf
CC DC-CR 121	CRIMINAL HEARING SHEET http://www.courts.state.md.us/courtforms/internal/ccdccr121.pdf
CC DC-CR 122	HEALTH GENERAL § 8-507 PROGRESS REPORT http://www.courts.state.md.us/courtforms/internal/ccdccr122.pdf
CC DC-CR 126	ORDER FOR EXTENSION OF HEALTH GENERAL § 8-507 COMMITMENT http://www.courts.state.md.us/courtforms/internal/ccdccr126public.pdf
CC DC-CR 131	ORDER FOR EXTENSION OF PROBATION FOR TREATMENT UNDER HEALTH GENERAL § 8-507 http://www.courts.state.md.us/courtforms/internal/ccdccr131public.pdf
CC DC-CR 141	MOTION FOR EVALUATION PURSUANT TO HEALTH GENERAL § 8-505 AND COMMITMENT PURSUANT TO HEALTH GENERAL § 8-507 http://www.courts.state.md.us/courtforms/internal/ccdccr141.pdf

EVALUATIONS

COMPETENCY

CC DC-CR 106 ORDER FOR OUT-PATIENT EXAMINATION AS TO COMPETENCY TO STAND TRIAL
http://www.courts.state.md.us/courtforms/internal/ccdccr106public.pdf

CC DC-CR 107 COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR EXAMINATION AS TO COMPETENCY TO STAND TRIAL
http://www.courts.state.md.us/courtforms/internal/ccdccr107.pdf

CC DC-CR 108 EXTENDED COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR EXAMINATION AS TO COMPETENCY TO STAND TRIAL
http://www.mdcourts.gov/courtforms/internal/ccdccr108.pdf

CC DC-CR 108A ADDENDUM TO ORDER FOR COMPETENCY EXAMINATION
http://www.courts.state.md.us/courtforms/internal/ccdccr108apublic.pdf

CRIMINAL RESPONSIBILITY

CC DC-CR 53 COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR EXAMINATION AND REPORT AS TO DEFENDANT'S CRIMINAL RESPONSIBILITY AT THE TIME OF THE ALLEGED OFFENSE AND COMPETENCY TO STAND TRIAL
http://www.courts.state.md.us/courtforms/internal/ccdccr053.pdf

SUBSTANCE ABUSE

CC DC-CR 101 ORDER FOR OUT-PATIENT EVALUATION FOR DRUG OR ALCOHOL TREATMENT (HG §8-505)
http://www.courts.state.md.us/courtforms/internal/ccdccr101public.pdf

CC DC-CR 102 COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR IN-CUSTODY EVALUATION FOR DRUG OR ALCOHOL TREATMENT (HG §8-505)
http://www.courts.state.md.us/courtforms/internal/ccdccr102.pdf

CC DC-CR 103 COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR INPATIENT EVALUATION FOR DRUG OR ALCOHOL TREATMENT (HG §8-506)
http://www.courts.state.md.us/courtforms/internal/ccdccr103.pdf

CC DC-CR 104 EXTENDED COMMITMENT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR EVALUATION FOR DRUG OR ALCOHOL TREATMENT (HG §8-505)
http://www.courts.state.md.us/courtforms/internal/ccdccr104.pdf

CC DC-CR 141 MOTION FOR EVALUATION PURSUANT TO HEALTH GENERAL § 8-505 AND COMMITMENT PURSUANT TO HEALTH GENERAL § 8-507
http://www.courts.state.md.us/courtforms/internal/ccdccr141.pdf

PRESENTENCE PSYCHIATRIC

CC DC 20 ORDER FOR PRESENTENCE PSYCHIATRIC EVALUATION
http://www.courts.state.md.us/courtforms/internal/ccdc020public.pdf

PRESENTENCE INVESTIGATION

CC DC-CR 137 ORDER FOR DPSCS/DIVISION OF PAROLE AND PROBATION PRESENTENCE INVESTIGATION
http://www.courts.state.md.us/courtforms/internal/ccdccr137public.pdf

JUVENILE

CC DC-CR 111 MOTION FOR TRANSFER TO JUVENILE COURT AND FOR OTHER APPROPRIATE RELIEF
http://www.courts.state.md.us/courtforms/internal/ccdccr111.pdf

CC DC-CR 112 ORDER FOR STUDY UPON MOTION TO TRANSFER TO JUVENILE COURT
http://www.courts.state.md.us/courtforms/internal/ccdccr112public.pdf

CC DC-CR 113 ORDER FOR PRESENTENCE PSYCHIATRIC EVALUATION (JUVENILE TRANSFER HEARING)
http://www.courts.state.md.us/courtforms/internal/ccdccr113public.pdf

CC DC-CR 129 PRESENTENCE INVESTIGATION AND MENTAL HEALTH ASSESSMENT AFTER DEFENDANT HAS BEEN FOUND GUILTY OF SEXUAL ABUSE OF A MINOR
http://www.courts.state.md.us/courtforms/internal/ccdccr129.pdf

EMERGENCY PSYCHIATRIC EVALUATION

CC DC 13 PETITION FOR EMERGENCY EVALUATION
http://www.courts.state.md.us/courtforms/joint/ccdc013.pdf

CC DC 14 CERTIFICATION BY PEACE OFFICER, ETC.
http://www.mdcourts.gov/courtforms/joint/ccdc014.pdf

CC DC 15	ORDER FOR EMERGENCY EVALUATION OF AN ARRESTED INDIVIDUAL http://www.courts.state.md.us/courtforms/internal/ccdc015public.pdf
CC DC 27	RETURN OF SERVICE BY PEACE OFFICER http://www.courts.state.md.us/courtforms/internal/ccdc027.pdf

SUICIDE /MEDICAL

CC DC-CR 139	ORDER FOR SUICIDE PRECAUTION EVALUATION http://www.courts.state.md.us/courtforms/internal/ccdccr139public.pdf

LOCAL FORMS

BALTIMORE CITY

L01-006	MENTAL HEALTH COURT BROCHURE http://www.mdcourts.gov/district/forms/mh/L01-006.pdf
L01-014	MENTAL HEALTH COURT AGREEMENT http://www.mdcourts.gov/district/forms/mh/L01-014.pdf
DCMH 04	MENTAL HEALTH COURT REFERRAL FORM FOR FAST SCREENING http://www.mdcourts.gov/district/forms/mh/dc-mh-004.pdf
L01-007	ORDER FOR EVALUATION AND TREATMENT http://www.mdcourts.gov/district/forms/mh/L01-007public.pdf
L01-013	ORDER TO REPORT TO PRETRIAL SERVICES http://www.mdcourts.gov/district/forms/mh/L01-013public.pdf
L01-008	DRUG COURT BROCHURE http://www.mdcourts.gov/district/forms/mh/L01-008.pdf

PRINCE GEORGE'S COUNTY

L05-007	REQUEST FOR PROGRESS REPORT http://www.mdcourts.gov/district/forms/mh/L05-007.pdf
L05-008	REFERRAL FOR COURT ORDERED SERVICES http://www.mdcourts.gov/district/forms/mh/L05-008.pdf

HARFORD COUNTY

L09-003	ORDER FOR EVALUATION http://www.mdcourts.gov/district/forms/mh/L09-003public.pdf

APPENDIX B

RESOURCES

Center for Mental Health Services
http://mentalhealth.samhsa.gov/cmhs

Center for Substance Abuse Treatment
http://csat.samhsa.gov

CMHS GAINS TAPA Center for Jail Diversion
www.gainscenter.samhsa.gov

Conference of Chief Justices
http://ccj.ncsc.dni.us

Council of State Governments Justice Center
www.justicecenter.csg.org

Judges' Criminal Justice Leadership Initiative
www.consensusproject.org/jli

Judge David L. Bazelon Center for Mental Health Law
www.bazelon.org

Maryland Association of Core Service Agencies (MACSA) Directory
www.marylandbehavioralhealth.org/core-service-agency-directory

National Center for State Courts
www.ncsconline.org

National Judicial College
www.judges.org

Directory

22 South Market Street, Suite 8
Frederick, Maryland 21701
Phone: 301-682-9754 Fax: 301-682-6019
macsa@mhma.net
www.marylandbehavioralhealth.org

Donna Wells, President
410-313-7350 wells@hcmha.org

Karyn Black, Vice President
301-609-5757 karynm.black@ maryland.gov

Lesa Diehl, Treasurer
301-759-5070 lesa.diehl@maryland.gov

Heather Brown, Secretary
410-632-1100 heather.brown@maryland.gov

Updated: July 2014

Allegany County

Allegany County Mental Health System's Office
P.O. Box 1745
Cumberland, Maryland 21501-1745
Phone: 301-759-5070 **Fax:** 301-777-5621
Achd.mhso@maryland.gov
Director: Lesa Diehl
Chief Financial Officer: David Sell
C&A Coordinator: Laura Miller
Adult Coordinator: Kara Lankford

Anne Arundel County

Anne Arundel County Mental Health Agency
Box 6675, MS 3230, 1 Truman Parkway
Suite 101
Annapolis, Maryland 21401
Phone: 410-222-7858 **Fax:** 410-222-7881
mhaaac@aol.com
Executive Director: Adrienne Mickler, ajmickler@aol.com
Clinical Services Director: Catherine Gray, cgray@covad.net
Crisis Response Director: Jennifer Corbin, jjcorbin18@aol.com
Chief Financial Officer: Karen Ancarrow-Rice, krice@covad.net
www.AAMentalHealth.org

Baltimore City

Behavioral Health System Baltimore
One North Charles Street, Suite 1600
Baltimore, MD 21201-3718
Phone: 410-637-1900 **Fax:** 410-637-1911
Director: Bernard McBride, bernard.mcbride@bhsbaltimore.org
http://www.bhsbaltimore.org

Baltimore County

Baltimore County Department of Health, Bureau of Behavioral Health
6401 York Road, Third Floor
Baltimore, Maryland 21212
Phone: 410-887-3828 **Fax:** 410-887-3786
Chief, Bureau of Behavioral Health: Dave Goldman,
dgoldman@baltimorecountymd.gov
Adult Services Program Manager: Mary Viggiani,
mviggiani@baltimorecountymd.gov
C&A Program Manager: Lee Ohnmacht, lohnmacht@baltimorecountymd.gov
Chief Financial Officer: Joyce Beverly, jbeverly@baltimorecountymd.gov

Calvert County

Calvert County Core Service Agency
P.O. Box 980
Prince Frederick, Maryland 20678
Phone: 410-535-5400 ext. 311 **Fax:** 410-414-8092
Director: David Gale, david.gale@maryland.gov
Adult Services Coordinator: Nancy Porter, nancy.porter@maryland.gov
C&A Services Coordinator: Loida Walker, loida.walker@maryland.gov
Chief Financial Officer: Marla Behrens, marla.behrens@maryland.gov

Caroline County – see Mid-Shore Counties

Carroll County

Carroll County Core Service Agency
290 South Center Street
Westminster, Maryland 21157
Phone: 410-876-4800 **Fax:** 410-876-4832
Director: Sue Doyle, sue.doyle@maryland.gov
Director, Treatment Services: Cathy Baker, cathy.baker@maryland.gov
Director, Recovery Services: Amy Baker, amy.baker@maryland.gov
Director, Quality Assurance, Accreditation & Prevention: Dawn Brown, dawn.brownd@maryland.gov
C&A and Adult Coordinator: Jackie Mazurick, jackie.mazurick@maryland.gov
Chief Financial Officer: Shannon Barnes, shannon.barnes@maryland.gov
www.carrollhealthdepartment.dhmh.md.gov/

Cecil County

Cecil County Core Service Agency
401 Bow Street
Elkton, Maryland 21921
Phone: 410-996-5112 **Fax:** 410-996-5134
Director: Shelly Gulledge, shelly.gulledge@maryland.gov
Chief Financial Officer: Laurie Humphries, laurie.humphries@maryland.gov
Adult Clinical Manager: Shana O'Brien, Shana.o'brien@maryland.gov

Charles County

Department of Health, Core Service Agency
P.O. Box 1050, 10480 Theodore Green Blvd.
White Plains, MD 20695
Phone: 301-609-5757 **Fax:** 301-609-5749
Director: Karyn Black, karynm.black@maryland.gov
Adult Coordinator: Constance Garner, constance.garner@maryland.gov
C&A Coordinator: Candice Nelson, candicem.nelson@maryland.gov

Dorcester County - see Mid-Shore Counties

Frederick County

Mental Health Management Agency of Frederick County
22 South Market Street, Suite 8
Frederick, Maryland 21701
Phone: 301-682-6017 **Fax:** 301-682-6019
Director: Robert Pitcher, rap@mhma.net
Chief Financial Officer: Barbara Hood, bhood@mhma.net
Adult Coordinator: Joyceann Sundergill Schmid, jss@mhma.net
C&A Coordinator: Robert Pitcher

Garrett County

Garrett County Core Service Agency
1025 Memorial Drive
Oakland, Maryland 21550-1943
Phone: 301-334-7440 **Fax:** 301-334-7441
Director: Fred Polce, 301-334-7443, fred.polce@maryland.gov
Chief Financial Officer: Jennifer.Loughry, 301-334-7447, jennifer.loughry@maryland.gov
Adult Coordinator: Diana Boller, 301-334-7442, diana.boller@maryland.gov
C&A Coordinator: Fred Polce
Administrative Assistant: Janice Winebrenner, 301-334-7440, gccsa.gchd@maryland.gov
www.GarrettHealth.org/departments/Core.htm

Harford County

Office on Mental Health of Harford County
125 N. Main Street
Bel Air, Maryland 21014
Phone: 410-803-8726 **Fax:** 410-803-8732
Director: Terence Farrell, tfarrell@harfordmentalhealth.org
Chief Financial Officer: Leah Keenan, lkeenan@harfordmentalhealth.org
Adult Coordinator: Jessica Kraus, jkraus@harfordmentalhealth.org
C&A Coordinator: Jamie Miller, jmiller@harfordmentalhealth.org
www.HarfordMentalhealth.org

Howard County

Howard County Mental Health Authority
9151 Rumsey Road, Suite 150
Columbia, Md 21045
Phone: 410-313-7350 **Fax:** 410-313-7374
Email: hcmha@hcmha.org
Director: Donna Wells, wells@hcmha.org
Chief Financial Officer: Rachel Choo Quan, rchooquan@hcmha.org
Adult Coordinator: Janet Jones, jmjones@hcmha.org
C&A Coordinator: Kenyatta Cully, kcully@hcmha.org

Kent County - see Mid-Shore Counties

Mid-Shore Counties

(Includes Caroline, Dorchester, Kent, Queen Anne and Talbot Counties)
Mid-Shore Mental Health Systems, Inc.
28578 Mary's Court, Suite 1
Easton, Maryland 21601
Phone: 410-770-4801 **Fax:** 410-770-4809
Director: Holly Ireland, hireland@msmhs.org
Community Programs: Nancy Fauntleroy, nfauntleroy@msmhs.org
Clinical Coordinator, Adult: Johanna Walter, jwalter@msmhs.org
Clinical Coordinator, C&A: Rebecca Hutchison, rhutchison@msmhs.org
www.msmhs.org

Montgomery County

Department of Health & Human Services, Montgomery County Government
401 Hungerford Drive, 1st Floor
Rockville, Maryland 20850
Phone: 240-777-1400 **Fax:** 240-777-1145
Director: Raymond Crowel, raymond.crowel@montgomerycountymd.gov
Behavioral Health Planning and Management: Scott Greene,
scott.greene@montgomerycountymd.gov
Chief Financial Officer: Kevin (Tao) Wang,
tao.wang@montgomerycountymd.gov
Child Mental Health: Shawn Lattanzio,
Shawn.lattanzio@montgomerycountymd.gov
Adult Coordinator: Ken Weston, ken.weston@montgomerycountymd.gov

Prince George's County

Health Department, Behavioral Health Services
Prince George's County Core Service Agency
9314 Piscataway Road
Clinton, Maryland 20735
Phone: 301-856-9500
Division Manager: L. Christina Waddler, lcwaddler@co.pg.md.us
Chief Financial Officer: Harold Gwynn, hgwynn@co.pg.md.us
Adult Coordinator: Margueritte Parker, mlparker@co.pg.md.us
C&A Coordinator: Eugenia Greenhood, eagreenhood@co.pg.md.us

Queen Anne's County - see Mid-Shore Counties

St. Mary's County

St. Mary's County Department of Aging and Human Services
23115 Leonard Hall Drive, PO Box 653
Leonardtown, Maryland 20650
Phone: 301-475-4200 ext. 1680 **Fax:** 301-475-4000
Division Manager: Cynthia Brown, cynthia.brown@stmarysmd.com
Chief Financial Officer: John Jiang, john.jiang@stmarysmd.com
www.StMarysMD.com

Talbot County - see Mid-Shore Counties

Washington County

Washington County Mental Health Authority
339 E. Antietam Street, Suite #5
Hagerstown, Maryland 21740
Phone: 301-739-2490 **Fax:** 301-739-2250
Director: Rick Rock, rickr@wcmha.org
Chief Financial Officer: Sharon Norberg, sharonn@wcmha.org
Adult Coordinator: Rick Rock
C&A Coordinator: Brooke Kerbs, brookek@wcmha.org
www.WCMHA.org

Wicomico/Somerset Counties

Wicomico Somerset Behavioral Health Authority
108 East Main Street
Salisbury, Maryland 21801
Phone: 410-543-6981 **Fax:** 410-219-2876
Director: Heather Brown, heatherl.brown@maryland.gov
Chief Financial Officer: Brandy Wink, brandy.wink@maryland.gov
Adult Coordinator: Lisa Renegar, lisa.renegar@maryland.gov
C&A Coordinator: Chalarra Sessoms, chalarra.sessoms@maryland.gov
RRP Coordinator: Amanda Rotruck, amanda.rotruck@maryland.gov

Worcester County

Worcester County Core Service Agency
P.O. Box 249
Snow Hill, Maryland 21863
Phone: 410-632-3366 **Fax:** 410-632-0065
Acting Director: Jennifer LaMade, jennifer.lamade@maryland.gov
Chief Financial Officer: Ed Frampton, edward.frampton@maryland.gov
Adult and C&A Services Coordinator: Jessica Sexauer, jessica.sexauer@maryland.gov

APPENDIX D [1]

Eligibility for Public Mental Health System

Diagnostic criteria determine eligibility for public mental health system services. Individuals with diagnoses designated as "serious mental illnesses" are eligible for all services, and individuals with other primary mental illnesses (e.g., anxiety and trauma related disorders) may be eligible for some services. Individuals with certain other primary diagnoses (listed below) are not eligible for PMHS services.

Diagnoses Designated as Serious Mental illnesses

- Bipolar I Disorder
- Bipolar II Disorder
- Borderline Personality Disorder
- Delusional Disorder
- Major Depressive Disorder
- Psychotic Disorder NOS
- Schizoaffective Disorder
- Schizophrenia
- Schizophreniform Disorder
- Schizotypal Personality Disorder

Diagnoses that can disqualify (when Primary)

- Mental Retardation
- Learning Disorder
- Motor Skills Disorder
- Communication Disorder
- Pervasive Developmental Disorder
- Tic Disorder
- Sexual Dysfunctions except paraphilia and Gender Identity Disorder
- Antisocial Personality Disorder
- Relational Problems
- Delirium, Dementia, Amnesiac, other cognitive disorders
- Mental Disorders due to a General Medical Condition
- Substance-related Disorder
- Substance-induced Disorder
- Sleep Disorder

[1] Baltimore Mental Health Systems, Inc. (9/20/10). Mental Health Services for Adults in Baltimore City: A Guide to Services Available in the Public Mental Health System (p.23). Baltimore, MD: Author.

APPENDIX E

Community Forensic Evaluation Program

Definitive Evaluations and Screenings by County

Definitive = Complete evaluation done in the detention center or community (for on-bond defendants) by the community evaluator, not admitted until after an Incompetent/Dangerous (IST/D) or Not Criminally Responsibility (NCR) Commitment Order is signed. Exception for Perkins level charges and DDA only cases which are still screened.

Screening[1] = Brief evaluation done in the detention center or community by the community evaluator.

The statue (Criminal Procedure 3) allows for the court to order DHMH to complete competency only evaluations or competency & criminal responsibility evaluations.

Which jurisdictions have which services:

Definitive Competency and Competency & Criminal Responsibility Evaluations (including conditional release development if appropriate):

Anne Arundel
Baltimore City Circuit Court
Calvert
Charles
Cecil
Garrett
Harford
Montgomery
Prince George's

St. Mary's

Exception—Perkins-level charges and DDA-only cases which are screening only.

Eastern Shore — Dorchester, Somerset, Talbot, Wicomico, Worcester - the evaluations are for both MHA and DDA (one evaluator)

Definitive Responsibility Evaluations (including conditional release development if appropriate), Competency is done as a Screening:

Baltimore County

[1] Description of screening process contained in the original document was edited for consistency with procedures described in this volume.

Exception—Perkins-level charges, DDA-only cases, and joint DDA-MHA evaluations which are screenings only.

Definitive Competency Evaluations, Responsibility is done as a Screening:

Howard District Court

Exception—Perkins-level charges, DDA-only cases, and joint DDA-MHA evaluations which are screenings only.

Screening (no definitives):

Allegany
Baltimore City District Court (MH Court)
Carroll
Eastern Shore — Caroline, Kent, Queen Anne's
Frederick
Howard Circuit Court
Washington

Defendants in the DPSCS who need pretrial evaluations:

Baltimore City—completed by Circuit Court Medical Office at the courthouse.
Baltimore County— completed by Baltimore community evaluator at the courthouse.
Western MD—completed by community evaluator at the DOC facility.

DDA Cases – if the community evaluator determines the defendant is possibly incompetent or possibly not responsible due only to a DD/MR (developmental disability or mental retardation) the case is referred to DDA for this administration to complete the evaluation. If it is not clear if the issue is DD/MR or mental illness (MI) the referral is to the MHA facility for a joint evaluation (evaluator from each agency). If we learn the defendant is known to DDA (eligible/receiving services/in DDA placement) and it is not clear if the issue is DD/MR or MI we ask DDA to take the lead on the evaluation and it may be done jointly at the SETT-J unit or in the detention center with the MHA community or facility evaluator participating.

Questions – contact Debra Hammen, LCSW-C at MHA/Office of Forensic Services 410-724-3178 or 410-724-3171.

3/5//11 update DH

APPENDIX F

Police Crisis Intervention Teams in Maryland

	Jurisdiction	Program Name	Program Description	CIT Contact Information
1	Allegany County	N/A		
2	Anne Arundel County	Mobile Crisis Team	Police Officers are a part of the team	410-768-5522
3	Baltimore City	BEST- Behavioral Emergency Services Team	New recruit training designed to educate officers responding to calls relating to mentally ill citizens	Steve Johnson - BMHS 410-837-2647
4	Baltimore County	Mobile Crisis Team	Police Officers and Masters Level Clinicians are paired together to provide on-site, immediate response to any Baltimore County citizen in crisis. The team conducts mental health assessments, provides crisis resolution, family education, information and linkages. The team is available from 10:00am-1:00am, seven days a week.	410-931-2214
5	Calvert County	N/A		
6	Caroline County	N/A	1 of 8 Eastern Shore Counties serviced by 2 Mobile Crisis Teams No Law Enforcement Pairing	
7	Carroll County	N/A	Work Group to begin in July '12 to begin planning for a MH Crisis Response Program	
8	Cecil County	N/A	2 of 8 Eastern Shore Counties serviced by 2 Mobile Crisis Teams No Law Enforcement Pairing	
9	Charles County	N/A		

10	Dorchester County	N/A	3 of 8 Eastern Shore Counties serviced by 2 Mobile Crisis Teams No Law Enforcement Pairing	
11	Frederick County	N/A	Mobile Crisis Team No Law Enforcement Partnership	
12	Garrett County	N/A		
13	Harford County	CIT	3 day course offered to selected law enforcement officers, who are taught specialized techniques for recognizing and responding more safely and compassionately to people with serious mental illnesses, while also enhancing public safety and reducing officer injuries	Lt. Marc Junkerman 410-638-3860
14	Howard County	N/A	Two mental health professionals respond to a psychiatric crisis identified by the police and provide support to de-escalate the crisis. Services are provided to any Howard County resident or any individual in Howard County at the time of a mental health crisis. The team refers the individual and family members to community resources and follows-up to assure linkage. In the event of an issue of safety, police assistance is available to have the person transported to Howard County General Hospital Emergency Room for a psychiatric evaluation. The team is available from Noon to 11:00pm, seven days a week.	410-531-6677
			4 of 8 Eastern Shore Counties serviced by 2 Mobile Crisis Teams	

15	Kent County	N/A	No Law Enforcement Pairing	
16	Montgomery County	CIT Mobile Crisis Team	40-hour class where officers learn how to best respond to a person in mental health crisis when on a call. Team of Mental Health professionals and 2 police officers respond to mental health crisis, 24/7. When available, CIT Trained officers accompany the team.	Officer Scott Davis 240-773-5057 240-777-4000
17	Prince George's County	Crisis Response System	Team of 2 mental health professionals responds to mental health crisis. Partnership with the police department - an officer is not part of the team, but is available as needed. The team is available 24/7.	301-429-2185
18	Queen Anne's County	N/A	5 of 8 Eastern Shore Counties serviced by 2 Mobile Crisis Teams No Law Enforcement Pairing	
19	St. Mary's County	N/A	Have had the sheriff and select officers trained in CIT, but there is no formal training in place. No Crisis Response Team in the county	Julie Ohman 301-475-4200 ext 1682
20	Somerset County	N/A	6 of 8 Eastern Shore Counties serviced by 2 Mobile Crisis Teams No Law Enforcement Pairing	
21	Talbot County	N/A	7 of 8 Eastern Shore Counties serviced by 2 Mobile Crisis Teams No Law Enforcement Pairing	
22	Washington County	N/A		
			8 of 8 Eastern Shore Counties serviced by 2 Mobile Crisis Teams	

23	Wicomico County	N/A	No Law Enforcement Pairing	
24	Worcester County	IRT – Integrated Response Team	Only Eastern Shore County that has an IRT. Team of a mental health professional and a police officer.	Tracy Tilghman 410-629-0146

Appendix G

501

BALTIMORE COUNTY POLICE DEPARTMENT
Standard Operating Procedure

ISSUING COMMAND: Operations Bureau	S.O.P. # 2012 - 03
ISSUE DATE: September 27, 2012	EFFECTIVE DATE: September 27, 2012
REVISION DATE: N/A	REVISION # N/A
SUBJECT: Mental Health Court Warrants	
SUB – TOPIC:	
REFERENCES: CALEA – Chapter 74; Field manual 4-3.2.1; Maryland Judiciary Office of Communications and Public Affairs - 7/2011	

Background

The Baltimore City Mental Health Court was created through a collaborative effort between the judicial, mental health, corrections, and law enforcement communities. The court is located at the Baltimore City District Court – John R. Hargrove Sr. Courthouse – 700 East Patapsco Avenue, Baltimore, Maryland 21225. The purpose of the court is to direct eligible offenders with serious mental illness away from incarceration and into appropriate community treatment. The Mental Health Court has four broad purposes:

- To preserve public safety.
- To reduce inappropriate incarceration of mentally ill offenders and promote their safety and well being.
- To reduce repeated criminal activity by offenders with mental illness (legal recidivism).
- To reduce length and frequency of hospitalization of mentally ill offenders (clinical recidivism)*.

Participation is voluntary and is subject to review by the Forensic Alternative Services Team (FAST). Once accepted into the court, the defendant is assisted in developing an appropriate community-based treatment plan that addresses his/her specific behavioral and mental health needs. The treatment plan is presented to the court for approval. If approved, the treatment recommendations are court-ordered conditions of pretrial release or probation.

There are various outcomes for eligible offenders who are handled through the Mental Health Court. The defendant, the clinical court coordinator, and the supervising agent attend review hearings to report on progress, along with various members of the treatment team. If noncompliance occurs, the court may adjust the plan to motivate adherence, employ non-jail-based sanctions, or order incarceration. Participants who are successful in complying with their treatment plan may be eligible for a nol pros, stet, probation before judgment, probation in lieu of incarceration, or early termination of probation.

SUBJECT: Mental Health Court Warrants	S.O.P. # 2012 - 03

When noncompliance occurs, the court will sometimes issue a Hospital, Violation of Probation (VOP), or Bench Warrant for the offender. Due to the importance of the offenders complying with their identified treatment-based sentencing guidelines, the Mental Health Court is requesting the service of the warrants issued by the court in an expedited manner. On occasion, the court has jurisdiction over offenders that are living within Baltimore County. Personnel coming in contact with or receiving information on a subject who may be wanted on a Baltimore City Mental Health Court Hospital or Mental Health warrant may not receive a NCIC hit. The following procedures have been put in place to assist with the service of hospital and mental health warrants issued by the court.

Purpose

To establish policy and procedures regarding warrants issued by the Mental Health Court.

Relationship to Department Values

We are committed to excellence by continually providing quality ***SERVICE*** to our citizens. By coordinating our efforts with Baltimore City's Mental Health Court, we demonstrate our commitment to improve the quality of life to citizens throughout the communities of Baltimore County.

Procedures

In order to effectively and efficiently assist the Baltimore City Mental Health Court with the expedited service of mental health related warrants, the following procedures have been established:

1. Upon issuance of a Hospital or Mental Health Court warrant, the warrant will be entered into the Baltimore City local system through the Baltimore City Police Department (BPD) Hot Desk. The warrant will be stamped "Mental Health Court".

2. If the warrant contains a county address, the Baltimore City Police Department will contact a Warrant Apprehension Task Force (WATF) county supervisor during normal business hours. The Warrant Apprehension Task Force will handle the initial attempts to serve the Hospital or Mental Health Court warrant.

    a. If attempts to serve the Hospital or Mental Health Court warrant are negative during the WATF's regular shift hours and WATF determines the defendant does not live at the address on the warrant and no additional Baltimore County addresses can be located, the warrant will be returned to Baltimore City per established policy.
    b. If attempts to serve the Hospital or Mental Health Court warrant are negative during the WATF's regular shift hours and WATF personnel determine the address on the warrant is the confirmed residence of the defendant, the warrant must be delivered to Warrant Control for entry in the Baltimore County local system. The original warrant will then be delivered to the on duty shift commander of the affected precinct for additional service attempts. Normal warrant tracking systems at the precinct will be utilized.

3. Warrant service will be attempted and documented on a form 179.

SUBJECT: Mental Health Court Warrants	S.O.P. # 2012 - 03

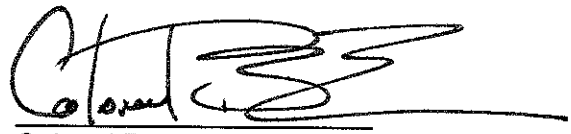
4. Personnel receiving information on a subject that may be wanted on a Baltimore City Mental Health Court hospital, bench, or VOP warrant will check the Baltimore County local warrant system. If no information can be found in the local system, personnel will call the Baltimore City Police Department "Hot Desk" to verify warrant status.

5. Upon a successful service of a Hospital or Mental Health Court warrant (VOP or Bench):

   a. Standard prisoner processing procedures will be followed.
   b. Personnel will follow the court procedures listed on the warrant.
      Note: On most of the VOP and Bench warrants, the defendant will have to be seen in the jurisdiction of issue. Personnel will arrange for pick-up or transfer to Baltimore City. On Hospital warrants, the defendant will be taken to the listed mental health facility.
   c. A notation will be made in the Arrest Narrative of the arrest report (E166/166). The notation will be "MENTAL HEALTH COURT WARRANT SERVICE".
   d. A copy of the arrest report will be faxed to the Mobile Crisis Team. If possible, fax a copy of the warrant as well.

6. If attempts and investigative leads have been exhausted to serve the Hospital or Mental Health Court warrant, the court document will be returned to warrant control utilizing normal warrant return procedures.

7. Should there be any questions related to Hospital or Mental Health related warrants, members can contact the BPD supervisor responsible for the Mental Health Court. The numbers will be kept on file with the police liaison.



Colonel Peter Evans
Chief
Operations Bureau

Appendix H
District Court Designated Mental Health Judges

District One (Baltimore City)

Judge George M. Lipman

District Two

Somerset County: Judge Paula A. Price
Wicomico County: Judge John P. Rue, II
Worcester County: Judge Gerald Purnell
Dorchester County: Judge Melvin Jews

District Three

Cecil County: Judge Stephen J. Baker
Judge Bonnie G. Schneider
Kent County: Judge John E. Nunn, III
Queen Anne's County: Judge Frank M. Kratovil
Talbot County: Judge William H. Adkins, III
Caroline County: Judge Douglas H. Everngam

District Four

Judge Robert B. Riddle

District Five (Prince George's County)

Judge Patrice E. Lewis
Judge Robert W. Heffron, Jr.
Judge Karen H. Mason

District Six (Montgomery County)

Judge Eugene Wolfe

District Seven (Anne Arundel County)

Judge Danielle Mosley

District Eight (Baltimore County)

Judge Alexandra N. Williams
Judge Steven Donald Wyman

District Nine (Harford County)

Judge Mimi R. Cooper

District Ten

Howard County: Judge Mary C. Reese
Carroll County: Judge Brian D. Green

District Eleven

Frederick County: Judge Janice R. Ambrose
Washington County: Judge Mark T. Thomas

District Twelve

Allegany County: Judge H. Jack Price, Jr.
Garrett County: Stephan M. Moylan

Appendix I

Department of Health and Mental Hygiene
Mental Hygiene Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2014

Allegany County
Western Maryland Health System 12500 Willowbrook Rd. Cumberland, MD 21502 (240) 964-1399

Anne Arundel County	
Anne Arundel Medical Center 2001 Medical Parkway Annapolis, MD 21401 (443) 481-1000	UMD Baltimore Washington Medical Center 301 Hospital Drive Glen Burnie, MD 21061 (410) 787-4565

Baltimore City	
Bon Secours Baltimore Health System 2000 W. Baltimore Street Baltimore, MD 21223 (410) 362-3075	Johns Hopkins Hospital & Health System 600 N. Wolfe Street Baltimore, MD 21287 (410) 955-5964
Johns Hopkins Bayview Medical Center 4940 Eastern Avenue Baltimore, MD 21224 (410) 550-0350	UMD Medical Center Midtown Campus 827 Linden Avenue Baltimore, MD 21201 (410) 225-8100
Sinai Hospital of Baltimore *(Lifebridge Health)* 2401 W. Belvedere Avenue Baltimore, MD 21215 (410) 601-9000	Medstar Union Memorial Hospital 201 E. University Parkway Baltimore, MD 21218 (410) 554-2000
University of Maryland Medical Center 22 S. Greene Street Baltimore, MD 21201 (410) 328-8667	

Department of Health and Mental Hygiene
Mental Hygiene Administration
Designated Psychiatric Emergency Facilities
Calendar Year 2014

Baltimore County

Franklin Square Medical Center *(MedStar Health)* 9000 Franklin Square Drive Baltimore, MD 21237 (443) 777-7046	Northwest Hospital 5401 Old Court Road Randallstown, MD 21133 (410) 521-5950

UMD St. Joseph Medical Center
7601 Olser Drive
Towson, MD 21204
(410) 337-1226

Calvert County

Calvert Memorial Hospital
100 Hospital Rd.
Prince Frederick, MD 20678
(410) 535-8344

Caroline County

UMD Shore Medical Center at Easton 219 S. Washington Street Easton, MD 21601 (410) 822-1000	UMD Shore Medical Center at Chestertown 100 Brown Street Chestertown, MD 21620 (410) 778-3300

UMD Shore Medical Center at Dorchester
300 Byrn Street
Cambridge, MD 21613
(410) 228-5511

Carroll County

Carroll Hospital Center
200 Memorial Avenue
Westminster, MD 21157
(410) 848-3000

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Cecil County

Union Hospital
106 Bow Street
Elkton, MD 21921
(410) 392-7061

Charles County

UMD Charles Regional Medical Center
5 Garrett Avenue
La Plata, MD 20646
(301) 609-4000

Dorchester County

Dorchester General Hospital
(Shore Health System)
300 Byrn Street
Cambridge, MD 21613
(410) 228-5511

Frederick County

Frederick Memorial Hospital
400 W. Seventh Street
Frederick, MD 21701
(240) 566-3300

Garrett County

Garrett County Memorial Hospital
251 N. Fourth Street
Oakland, MD 21550
(301) 533-4000

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Harford County	
Upper Chesapeake Medical Center *(Upper Chesapeake Health System)* 500 Upper Chesapeake Drive Bel Air, MD 21014 (443) 643-2000	Harford Memorial Hospital *(Upper Chesapeake Health System)* 501 S. Union Avenue Havre de Grace, MD 21078 (443) 843-5500

Howard County
Howard County General Hospital *(Johns Hopkins Health System)* 5755 Cedar Lane Columbia, MD 21044 (410) 740-7777

Kent County	
UMD Shore Medical Center at Chestertown 100 Brown Street Chestertown, MD 21620 (410) 778-3300	UMD Shore Medical Center at Dorchester 300 Byrn Street Cambridge, MD 21613 (410) 228-5511

Montgomery County	
Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910 (301) 754-7500	Medstar Montgomery Medical Center 18101 Prince Philip Drive Olney, MD 20832 (301) 774-8900
Shady Grove Adventist Hospital *(Adventist Health Care)* 9901 Medical Center Drive Rockville, MD 20850 (301) 279-6053	Suburban Hospital 8600 Old Georgetown Road Bethesda, MD 20814 (301) 896-3880
Washington Adventist Hospital 7600 Carroll Ave. Takoma Park, MD 20912 (301) 891-7600	

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Prince George's County

Laurel Regional Hospital 7300 Van Dusen Road Laurel, MD 20707 (301) 497-7954	Prince George's Hospital Center 3001 Hospital Drive Cheverly, MD 20785 (301) 618-3162

Medstar Southern Maryland Hospital Center
7503 Surratts Road
Clinton, MD 20735
(301) 877-4500

Queen Anne's County

UMD Shore Medical Center at Easton 219 S. Washington Street Easton, MD 21601 (410) 822-1000	UMD Shore Medical Center at Chestertown 100 Brown Street Chestertown, MD 21620 (410) 778-3300

UMD Shore Medical Center at Dorchester
300 Byrn Street
Cambridge, MD 21613
(410) 228-5511

St. Mary's County

Medstar St. Mary's Hospital
25500 Point Lookout Road
Leonardtown, MD 20650
(301) 475-6110

Somerset County

Peninsula Regional Health System
100 E. Carroll Street
Salisbury, MD 21801
(410) 543-7101

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Talbot County
UMD Shore Medical Center at Easton 219 S. Washington Street Easton, MD 21601 (410) 822-1000

Washington County
Meritus Medical Center 11116 Medical Campus Road Hagerstown, MD 21742 (301) 790-8300

Wicomico County
Peninsula Regional Health System 100 E. Carroll Street Salisbury, MD 21801 (410) 543-7101

Worcester County
Peninsula Regional Health System 100 E. Carroll Street Salisbury, MD 21801 (410) 543-7101

*10 Beds total for all three counties