ADMINISTRATIVE OFFICE OF THE COURTS

MARYLAND JUDICIAL CENTER
580 TAYLOR AVENUE
ANNAPOLIS, MARYLAND 21401

Pamela Harris, State Court Administrator
410-260-1295

Faye D. Matthews
Deputy State Court Administrator
410-260-1257

Mark Bittner
Assistant Administrator
Judicial Information Systems
410-260-1001

Louis G. Gieszl
Assistant Administrator
Programs
410-260-3547

Melinda K. Jensen, CPA
Assistant Administrator
Operations
410-260-1240

Julie R. Linkins, Esq.
Assistant Administrator
Education
410-260-3549

Kelley O'Connor
Assistant Administrator
Government Relations
410-260-1560

Kathleen E. Wherthey, Esq.
Assistant Administrator
Internal Affairs
410-260-3453

January 21, 2015

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Maggie L. McIntosh
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair
House Health and Government Operations
241 House Office Building
Annapolis, MD 21401-1991

The Honorable Robert A. Zirkin
Chair
Senate Judicial Proceedings Committee
2 East Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Joseph F. Vallario, Jr.
Chair
House Judiciary Committee
101 House Office Building
Annapolis, MD 21401-1991

Re: 2014 Joint Chairmen's Report, Page 78 – Judiciary Commentary

Enclosed please find the Judiciary's Commentary on the Department of Health and Mental Hygiene's response pursuant to page 78 of the 2014 Joint Chairmen's Report.

Enclosure

COMMENTARY OF THE MARYLAND JUDICIARY ON THE DEPARTMENT'S RESPONSE TO THE JOINT CHAIRMAN'S REPORT, PAGE 78—TREATMENT AND SERVICE OPTIONS FOR CERTAIN COURT-INVOLVED INDIVIDUALS

This commentary on the Department's response to the Joint Chairman's Report, Page 78—Treatment and Service Options for Certain Court-Involved Individuals ("Response") is limited in its scope. While competency admission and Health General § 8-507 placement delays will be discussed in some detail, the core issue is the availability of necessary mental health and drug treatment services, sufficiently structured housing, and wraparound services. These services need to be both available in fact and readily and easily accessible to professionals associated with the courts in order for the services to be of direct utility to sentencing judges. Only in this way can these services have full efficacy as part of successful alternatives to incarceration.

As a result of the budget language, trial judges from throughout Maryland focused on the need for comprehensive and coordinated community treatment, wraparound services, and housing as they were surveyed at the beginning of the summer work group. It was universally felt that strengthened community resources would decrease revolving door incarceration and hospitalization. The appendices contain a brief summary of the information received from the trial judges (Appendix 1), as well as representative samples from Prince George's County (Appendix 2) and the Eastern Shore (Appendix 3). The surveyed judges decried the number of mentally ill and addicted defendants detained in jails and prisons, the insufficiency of inpatient psychiatric recourses, and most pointedly, the continued unavailability of readily accessible treatment and services for those mentally ill and addicted defendants who are the most difficult to sentence or divert appropriately.[1]

Obviously, the Department's Response is not a detailed mapping of all services. It does not focus specifically on gaps in services, or the utility of services, for sentencing judges in each jurisdiction. Nonetheless, the listings in the body of the Department's Response and appendices are helpful. Synchronizing the needs of each jurisdiction's criminal justice system to its behavioral health systems is an important and ongoing task which must be executed effectively. A comprehensive report on that endeavor's progress would be a much larger task requiring significant effort not only by the Department, but also by the Department of Public Safety and Correctional Services, the courts, partner criminal justice agencies such as the Office of the Public Defender, and others. However, Recommendation 1 is promising:

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[1] A further area of concern noted in the judges' survey relates to the Department of Public Safety and Correctional Services. A recurring theme of the survey respondents was the need for a more proactive approach by probation agents in monitoring mentally ill and addicted defendants and in interacting with these defendants' treatment providers. Since this issue is not directly related to the Department of Health and Mental Hygiene, it will not be addressed in this commentary. Nevertheless, the significance of the hands-on probation monitoring enjoyed by many Specialty Courts, and its value in other probation contexts, demands full exploration in the near future.

> Recommendation 1: There is a need for 10% more bed availability in the state hospital system. This may be accomplished by partnering with the private sector to use their beds and also decreasing length of stay in state hospitals by having more funding for housing and wrap around services. If this is not possible then there will need to be an extra 100 beds added to the state system. The Department should further examine barriers to clinically appropriate movement within the forensic service delivery system. This should include movement into and between regional hospitals and Clifton T. Perkins Hospital Center, transitions from hospitals into the community, and reasons for unsuccessful community placements that necessitate returns to the hospitals.

The implementation of this recommendation is critically needed. The recommendation will be discussed further in the following sections on competency and 8-507 placements, yet its import extends far beyond these areas.

COMPETENCY ADMISSION DELAYS

Criminal Procedure §§ 3-105 and 3-106 require prompt admission of a defendant either found not competent to stand trial or ordered to a hospital for further evaluation as to competency. The statutorily mandated time frames found in these code sections reflect the clear public policy that mentally ill and dangerous defendants, who lack the ability to rationally understand the nature or object of the criminal proceeding, or who are unable to rationally assist in their defense, should be restored to competency in a hospital and not in a jail. The vast majority of defendants who are found not competent are severely mentally ill or otherwise suffer from severe cognitive limitations.

There is no statutory authority for confining a defendant in a detention center once the defendant has been found not competent to stand trial. In a number of Maryland jurisdictions, evaluations are conducted by designated local psychologists or psychiatrists who conclusively opine as to a defendant's competency. Section 3-106 requires that the defendant be admitted to a Departmental facility upon a court's finding of incompetence and dangerousness. Thus, any wait time associated with the 935 cases listed in Table 1, "Average wait time after a not competent or not criminally responsible finding," on page 6 of the Department's Response, reflects days during which defendants were detained in jail without any recognizable statutory authority.

Criminal Procedure § 3-105(2) allows 7 days for the Department to complete a competency evaluation. In many jurisdictions, when the local evaluator finds that a defendant appears both likely to be not competent and likely to be dangerous, a further inpatient evaluation is ordered. It must be emphasized that all times listed for the 457 cases in the category "Average wait time after the signing of an inpatient evaluation order for a competency or not criminally responsible evaluation," in Table 1 on page 6 of the Department's Response, represent days in addition to the original 7 permitted for the local evaluator's examination. These are also days that have elapsed since the local, Departmentally-retained psychologist or psychiatrist opined that the defendant was most probably so seriously mentally ill that the defendant did not meet the test for competency.

Under Criminal Procedure § 3-105, the court may order an extension of time for further evaluation of a defendant for good cause shown. Good cause relates to the intrinsic needs of the particular evaluation. Lack of hospital bed space is not good cause. Thus, any amount of time a defendant spends in jail merely waiting for a hospital bed after the local evaluator has questioned the defendant's competency is not authorized detention as a result of good cause shown. Additionally, during the summer study, the State's Attorneys' representative and a number of judges raised a related concern expressed by community clinicians and monitors—that a lack of hospital beds might be deterring some requests for hospital warrants in order to return defendants who had deteriorated since release and become dangerous. This deterrent effect was not quantified, but it has the potential to seriously impact public safety.

As this summer's study commenced, many believed that Spring Grove Hospital Center had a substantial admission waiting list that was particularly injurious in Baltimore County and in Southern Maryland—an understanding that was later verified. It became clear during calendar year 2014 that on any given day, Spring Grove would have been unable to simultaneously admit all defendants ordered for further inpatient competency evaluation. During 2014, judges from throughout Spring Grove's catchment area witnessed a phenomenon, not unlike musical chairs, in which defendants from jurisdictions more poorly situated regarding the timing and generation of inpatient evaluation orders experienced longer waits.

The attached snapshot from Baltimore County court records, Appendix 4, shows persistent delay. An analysis of 27 defendants' wait times, from initial evaluation order to actual admission, demonstrates waits ranging from 0 to 98 days. The mean wait time, however, was 27 days and the median was 26 days. Baltimore City records likewise demonstrate episodic lengthy delays. A sample of 79 defendants from the City, included in Appendix 5, reveals wait times of 0 to 25 days, with a mean of approximately 9 days and a median of 7.5 days. Fifteen defendants waited 14 days or longer for admission to a hospital.

Last year also witnessed court hearings regarding the non-admission of individual defendants, pleas by hospital staff that there "simply was no room at the Inn," and last minute scrambling for beds at the eleventh hour before court hearings. Detention centers vocalized their frustration with continuing to house seriously mentally ill defendants who had been ordered transported to the hospital for further evaluation. As more information was presented, it became clearer that delays were not only prevalent in the Spring Grove catchment area of Baltimore County, Baltimore City, and Southern Maryland, but also could be found in the Springfield and Eastern Shore catchment areas. Admission problems at Clifton T. Perkins Hospital Center remain similarly acute.

The tone of the Department's Response minimizes the extent of statutory non-compliance and tends to blur failures to timely admit court ordered defendants. By focusing upon statewide means, medians, and averages, and by downplaying delay patterns at specific hospitals, in specific jurisdictions, and during acute periods, the Department's Response glosses over persistent failures to admit defendants within statutorily required time frames and, thus, it also glosses over the illegal confinement of defendants in detention centers.

Prompt, thorough aftercare planning and more financial commitment to community resources—including mental health treatment, substance abuse treatment, housing, and wraparound services—should allow for the more timely, safe conditional release of heretofore dangerous defendants. Many defendants who have been found incompetent and dangerous, and who may now be under consideration for conditional release or probation supervision, are members of a revolving door group—one that often has many prior arrests, frequent hospitalizations, a possible history of extensive trauma, and prior failed community placements. For this group to have fewer future arrests, detentions, and hospitalizations, highly structured living situations and specialized treatment and services often are needed. Incentivizing the development of durable continuity of care plans is critical, as is assuring the prompt availability—both in level and intensity—of the necessary community resources and support services.

Recommendation 1 is, therefore, encouraging, as is the energetic pursuit of Recommendation 1 by Dr. Hepburn and other Departmental officials. While proactive focus on the "hospital back door" through better aftercare planning and community resources is highly relevant to "front door" delay issues, the decades-old pattern of reduction of hospital beds and Assisted Living Units, without a concomitant increase in structured community resources, can not be ignored. The remedy may not be exclusively community-based. The present lack of sufficient hospital beds, Acute Care Units and like facilities is relevant to today's current admission delay issue. Prior exhaustive studies addressing the need for more beds should be revisited.[2] The solution may well be community-based *and* hospital-based, as referenced in Recommendation 1. Proactive management is key.

HEALTH GENERAL § 8-507 PLACEMENT DELAY

Health General §§ 8-505 and 8-507 provide a statutory mechanism for the commitment of addicted defendants—primarily to residential treatment. When addicted defendants are committed for such treatment, Health General § 8-507(e)(2) mandates prompt placement: "The Department shall facilitate the prompt treatment of a defendant." The mean delay of over 130 days noted in the Department's Response is not "prompt" within the plain meaning of this statute, and it is not consistent with the intent of the General Assembly.[3]

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[2] See, e.g., Cannon Design, Independent Study on Future Demand for State-Operated Psychiatric Hospital Capacity (Baltimore: July 17, 2012), conducted at the behest of the Department of Health and Mental Hygiene and the former Mental Hygiene Administration.

[3] The experience in Baltimore City is that placement delay is somewhat less than the statewide 133 day mean, with much sought after co-occurring beds (mental health and addiction beds) available at around 90 days in the City. Further, as noted on page 10 of the Department's Response, the statewide "average" placement delay approaches 167 days: "Table 3 and Figure 4 below provide data on the wait time to admit to an 8-507 mandated drug treatment slot beginning from the point of the initial 8-505 order in a case. The data demonstrates that, on average, it takes 167 days, or about 5½ months, for these individuals to be placed, and 50% of them are placed in 133 days, or about 4½ months."

The vast majority of Health General § 8-507 commitments are ordered for incarcerated defendants who are actively seeking residential treatment. Many incarcerated defendants at both the District and Circuit Court levels are deterred, however, by the lengthy wait for an available bed and opt, instead, for a set sentence to be served in either a prison or a local detention center, despite an earnest desire for treatment. Some defendants are put off from even seeking an 8-505 evaluation by the wait time. Other defendants begin the wait for placement but abandon the effort after months of delay. Many defendants who are ultimately placed in residential treatment have served months of incarceration after an 8-507 order has been signed.

The Department's Response obliquely references the chilling effect of delay, something which was repeatedly emphasized during the workgroup meetings by Public Defender, State's Attorneys' Association, and Judiciary representatives: "for certain stakeholders, this delay is very problematic as it creates disincentives for defendants and defense attorneys to access substance use treatment as other judicial outcome may be preferable" p. 13. Yet, the Department's Response does not make clear that the delay which results in preference for other "judicial outcomes" also violates the statute's clear mandate for prompt placement.[4]

It should be noted that 8-505(d)(1) requires an evaluation and a report within 7 days: "If a court orders an evaluation under this section, the evaluator shall: (i) conduct an evaluation of the defendant and (ii)submit a complete report of the evaluation within 7 days." This statement is a clear indication of the General Assembly's intent to mandate promptness throughout this process. On page 9 of its Response, the Department shows an unawareness of, or indifference to, this 7-day statutory requirement by indicating a 14-day or 15-day evaluation return time to court. It should also be noted that this protocol, as listed on page 9, is contrary to the protocol agreed upon by the Department and the Judiciary at the time of the most recent statutory revision of 8-505 and 8-507.[5]

Further, the Department's comparison of 8-507 placements to Drug Court placements, found on page 9, is misplaced:

> Before discussing this data, it is important to understand the relatively small role played by diversions to drug treatment via the evaluation and commitment process defined by Health General §§8-505 and 8-507. For the past two decades, specialized drug courts have arisen in Maryland, at both the District and the Circuit court levels, to try to use the leverage of the court system in engendering change among defendant populations. As shown in Table 2, many more

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[4] The Department's response on p. 12 notes: "The participating judges and other workgroup members were dissatisfied with the timeliness of placement in residential drug treatment via the 8-507 process. Because of this wait time, some courts, and especially some defense attorneys, elect not to pursue this for defendants in District Court even though drug treatment might be the optimal outcome for a given defendant."

[5] In Baltimore City, BHS Baltimore, the Department's designee for § 8-505 evaluations, has consistently complied with this 7-day requirement although, as noted above, there are significant placement delays in Baltimore City.

> individuals are diverted via drug court than are diverted via a §8-505/507 process. From fiscal 2012 through 2014, a total of 5,483 defendants entered drug courts, while only 1,533 were placed into a §8-507 residential drug treatment placement. Neither of these diversionary mechanisms come close to addressing the thousands of criminal defendants with substance use disorders for whom diversion is never considered, either because their cases are resolved without addressing the substance use disorder, or because they are remanded to jail or prison to serve a sentence.

Drug Court and 8-507 placements are both popular diversionary vehicles which avert incarceration and associated costs. The expansion of Drug Courts has been a welcome development. Co-occurring residential treatment through 8-507 is frequently recommended as the appropriate 'least restrictive' placement for defendants released from mental hospitals. Many Drug Courts, including those in Baltimore City, utilize 8-507 for specific co-occurring placements. Individual sentencing judges make case specific decisions to retain supervision under 8-507 or refer probation supervision to a Specialty Court. Thus, 8-507 is a mechanism through which any Maryland sentencing judge may commit a defendant for treatment if the commitment criteria of 8-507 are satisfied.[6]

Commitment for residential treatment under 8-507 is no more costly than continuing a defendant's stay in a jail or prison. During the workgroup sessions, it was learned that the per diem costs for 8-507 residential treatment is slightly less than the per diem cost for detention—a critical fact not mentioned in the Department's Response. While a sentencing court, mindful of public safety considerations, makes the ultimate 8-507 commitment decision, the clinical need for treatment, the level of treatment required, and the designation of a specific treatment provider is exclusively the Department's determination pursuant to this statutory scheme.[7] Clinically appropriate 8-507 placements, judicially determined to be consistent with public safety, further the public policy of Maryland. There is no viable public policy rationale that can justify delay

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[6] While some defendants facing longer sentences are not troubled by a four-month wait for bed availability, the phenomenon of forgoing 8-507 commitment for a set jail sentence is particularly prevalent in District Court. Indeed, many District Court judges who were surveyed flatly stated that delays undercut the utility of 8-507 residential treatment for District Court defendants. However, placement delays also significantly deter many Circuit Court defendants from pursuing residential treatment. In light of that, the following analysis, in the Department's Response p.10, is puzzling:

> The timeframe for these placements is, however, consistent with Circuit Court cases, which generally have a more deliberate process, and for inmates in the custody of the Division of Corrections pursuing sentencing modification, but not for the relatively minor defendants managed in District Court where the cases are processed much more quickly.

[7] Health General § 8-507 directly and indirectly references the Department in several subsections: in (a), "treatment that the Department recommends"; in (b)(3), "evaluation of the Defendant under § 8-505 or § 8-506," conducted, of course, by the Department, and pursuant to (b)(4), the court shall "[c]onsider the [Department's] report on the defendant's evaluation"; in (b)(5), "treatment the Department recommends"; and (e)(1)(i), "The Department gives notice that an appropriate treatment program is able to begin treatment of the defendant."

and further unnecessary incarceration simply because the comparably priced, 'least restrictive' alternative of residential treatment is currently unavailable.

Budget allocation should not preempt a judicial determination as to public safety and a Departmental clinical determination as to treatment needs. Maryland treatment providers, in fact, have available residential slots. With comparable per diem costs, it is a question of spending available state funds, not on jail or prison days contrary to the sentencing judge's determination, but rather on prompt residential treatment as ordered by the sentencing judge.

Mere study, as suggested in the Department's Recommendation 2, is inadequate:

> Recommendation 2: The initial analysis of 8-505 and 8-507 wait times revealed that additional evaluation is necessary to assess delays in the evaluation and placement process. Among other things, this evaluation should: (1) assess the various funding streams for publicly funded drug treatment placements; and (2) identify the number of placements made through the various funding streams, including the timing to placement and whether there is a waitlist for services. Finally, the Department is developing a streamlined, centralized approach to receiving court orders and will notify all administrative judges and criminal court clerks regarding how to forward orders to receive the most expedient response.

Health General § 8-507 is a straightforward vehicle for the commitment of addicted incarcerated defendants who continuously assent to residential treatment, whose residential placement has been determined to be consistent with public safety by the trial court, and who have been determined to be clinically appropriate for such treatment by the Department. Complex funding streams and delay patterns are important but not new areas relevant for data collection. The funding and wait time for each defendant is already known. The statute's mandatory provisions require forthright action by the Executive Branch to assure compliance. Further study of the above factors would be helpful. Present statutory compliance is required.

CONCLUSION

The hospital admission delays discussed above are serious and consequential. The failure to admit incompetent and likely incompetent defendants to state hospitals is contrary to governing statutory authority. The delays result in seriously mentally ill defendants remaining in jail despite court orders committing the defendants for evaluation and/or treatment.

Proactive management is necessary. While Recommendation 1 is welcome and requires prompt implementation, the extent of admission delays and the need for hospital bed space should not be minimized.

Likewise the 130-day delay in 8-507 placements prolongs the detention or incarceration of defendants contrary to a sentencing judge's specific order for prompt placement in a residential facility. The delays occur in contravention of statutory authority and Maryland's

unambiguous public policy. Since residential placements are no more expensive per day than is jail, delay does not conserve or reduce costs.

The 8-507 statutory scheme must be viewed as complementary to other options, such as intensive outpatient treatment, pretrial diversionary programs, and Specialty Courts. Still, the availability of complementary alternatives in no way justifies extrajudicial delay that deters the clinically appropriate use of 8-507 placements—a well-established, effective, 'least restrictive' alternative to incarceration and hospitalization.

APPENDIX 1

Memorandum

To: Gayle Jordan –Randolph MD

From: George M. Lipman

Re: Preliminary Survey of Trial Judges Regarding DHMH Budget Language(not including Prince Georges County, Harford County and Baltimore City)

This memorandum is a preliminary survey; not, in any sense, a final document. Yet, it may help in the creation of an informed response to the applicable budgetary language. Busy trial judges were asked to comment.[1] I received a number of polished documents which are attached.[2]

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[1] My email to the judges reads:

I do not want to add another burden. However, please find attached budget language placed by the General Assembly in DHMH's budget with the support of the Judiciary and DHMH. Hopefully, the effort associated with satisfying this budget language will result in more available treatment, services, supervision and co-ordination for mentally ill and addicted defendants.

Please review the budget language itself. Note the rather specific provisions as to delay regarding competency, NCR and 8-507 evaluations and placement. But, also note the paragraphs calling for more general descriptions and more detailed analysis.

For now, please focus on paragraph (2): " the availability of …resources for court-involved individuals with mental illness, intellectual disabilities and substance abuse disorders" including "assessment staff", "on site clinicians", " case management", "wrap around services", "transportation" and "intense supervision" . At present, I am requesting that you email me a brief description of such resource availability in your jurisdiction. Please also email a copy to Gray Barton and Robert Pointer of the Problem Solving Court's Office. I am requesting that you get back to us by Wednesday June 17.

The key concept is de facto availability. What is out there? Who, if any, clinicians help you to determine appropriateness and availability for a particular defendant? Most significantly, to what extent are necessary resources, in fact, accessible, in a reasonable manner, for a defendant who you or your colleagues divert, sentence or otherwise place in the community or a treatment facility rather than prison or jail? I certainly am not requesting any grand research paper or extensive resource directory. Yet, I do feel the legislative intent is clear. See particularly Paragraph 3. Possibly a few hours or your thought and a few focused paragraphs from you within the next two weeks will help in order to get this project started on a proper footing; from a trial court's perspective. To summarize:

1) What treatment resources are available for court involved individuals with mental illness, intellectual disabilities and substance use disorders, including, "assessment staff", "on site clinicians", "case management", "wrap around services", "transportation" and "intense supervision" ?

2) What clinicians help you to determine treatment needs, service needs, and availability of the recommended treatment services for a particular defendant, for example: substance abuse assessors, court medical office staff, court based social workers

3) To what extent are necessary resources, in fact, accessible in a reasonable manner for a defendant that you or your colleagues divert, sentence or otherwise place in the community or a treatment facility rather than prison or jail?

However, I also received email notes and many phone calls. Fortunately, the substance of the phone calls and notes were echoed by various paragraphs in the attached written responses. Identifiable patterns are apparent whether presented by a more formal written response, a brief email or a phone conversation. I am confident that the points made below are representative.

This preliminary rough survey is limited in scope in another way. The thoughts of trial judges in the jurisdictions with fully established mental health courts: Prince Georges County, Harford County and Baltimore City are **not** included; neither are the thoughts of the Drug Courts through the Office of Problem Solving Courts. Comments from those sources should follow. Nevertheless, I feel that this current exercise did yield relevant information of broad applicability.

Inpatient Competency Evaluation Delays

The local competency screening evaluators are **not** cited as a factor causing delay. Indeed a number of judges specifically noted the efficiency of the local screening evaluations. Finan Center received praise not only for prompt inpatient evaluations but for good coordination of services. Judge Janice Ambrose, Frederick District Court, noted:

> Dr. Julie Smith of the Finan Center does our evaluations. She is very accommodating, accessible and reasonable to work with. Facilities and practices are very similar. In addition to the Finan Center we have access to our Way Station in Frederick City for some of our out-patient programs. As I have said many times, the Finan Center does a very good job dealing with our court ordered patients.

Eastern Shore Hospital Center is generally perceived as prompt in admitting appropriate defendants but with exceptions. Judge John E Nunn III, Kent County District Court notes:

> Dr. Charisse Chappell does competency and NCR screenings on an outpatient basis. The screenings are timely and arrangements are made for inpatient placement if needed. If an inpatient evaluation is needed the wait time is minimal. The Court coordinates with admissions at Eastern Shore to keep wait times at a minimum. The wait if a bed is not available has been a week or two at most here

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4) A short email response by Wednesday June 17, if possible, please.

[2] Attachments include (1) the budget language (2) Memorandum , John E. Nunn III, Kent County District Court, (3) Resources for court-involved individuals, Nancy M. Purpura Circuit Court Baltimore County (incorporating the memorandum of Donald Zaremba, District Public Defender for Baltimore County), (4) Resource Analysis, Ronald A. Silkworth, Circuit Court for Anne Arundel County , (5)Email response H. Jack Price Jr., Washington County District Court, and (6) Email response, Eugene Wolfe, Administrative Judge, Montgomery County District Court.

> in Kent County. However, I am aware of other cases on the Mid Shore where defendants have waited over two months for a bed.

However, delay in accessing beds at Spring Grove was universally noted by judges in Spring Grove's catchment area: Southern Maryland, Harford County, Baltimore County and Baltimore City. Judge Helen Harrington's comments are reflective of those that I received from throughout the Spring Grove catchment area.

> My personal view is that the delays in getting into Spring Grove are a serious problem -- for example, one (District Court) client of mine who is severely schizophrenic just sat in his cell for 2-3 weeks with a blanket over his head refusing to talk to anyone, and it took a lot of effort to get him out. Once he got to Spring Grove and back on his medication he was restored to competency within about 2-3 weeks, got a stet, and is back outdoing well. I fail to see why DHMH does not allow an inmate who is in dire need of a bed at a DHMH facility to go to the first facility that has space, rather than making a Charles County inmate wait for Spring Grove specifically to have a bed.

Judges surveyed noted bed limitations, delays and return to jail issues as perennial problems at Perkins.

Continuity of Care and Supervision

The need for comprehensive and workable aftercare plans (continuity of care plans) is seen as a paramount issue: whether for defendants released from the hospital to the community, defendants released from the hospital to court or simply for criminal defendants found to be suffering from severe and persistent mental illness as evaluated by local clinicians. The inquiry of the judges resulted in a clear consensus on the need for significant improvement in the development and implementation of continuity of care plans for defendants suffering from serious mental illness. The following quote from Judge Purpura's memo, while focused on the specific area of conditional release of incompetent and not dangerous defendants, expresses a widely held sentiment applicable to the many areas where through continuity of care planning is needed:

> As for those defendants that are adjudicated to be Incompetent to Stand Trial, I have found that the most prevalent barrier to accessing services in the community has been a failure on the part of DHMH staff to prepare a concrete plan for services in the community, even after being ordered by the court to do so. The result has been an increase in the length of stay for these defendants in DHMH facilities (where bed space IS a concern).

In reviewing the trial judges written comments and in recalling my phone conversations, I am struck with the consistency which many judges speak holistically about interconnected functions and services that may ,at times, be pigeonholed by providers and others as "mental health treatment," "drug treatment", "probation supervision" , "ancillary services" "case management" or the like. For example, Judge Nunn's memorandum addresses a particular lack of treatment services in Kent County

> Kent County Behavioral Health is the only option for individuals without insurance; this program provides mental health and substance abuse services. The program is understaffed, appointments are not immediate, and valuable time goes by before they are seen by a doctor or clinician. Kent County Behavioral Health has only two psychiatrists who work a total of 26 hour per week. There are no practicing psychiatrists at the local hospital operated by University of Maryland. KCBH has approximately 600 patients; approximately 80% are prescribed medications. Typically, clients see a therapist 2 times per month and a doctor 1 time per month to review medications.

However, Judge Nunn's memo also highlights the broadly expressed concern with continuity of treatment, the availability of other services, case-management and criminal justice monitoring through probation or otherwise:

> Community Supervision/Parole and Probation is often the Court's only option. The Court will make it a condition of probation or pretrial supervision that a defendant be referred to KCBH for mental health or substance abuse issues. Communication between KCBH, Community Supervision and the Court through this probation process is cumbersome and needs to be streamlined if Community Supervision is to become an effective tool to see that services are provided in a timely fashion. There is no case management following these individuals and Community Supervision views them as another probationer with mental health issues. So the court is not always timely informed if the defendant is not taking medication or keeping appointments.

Judge Nunn's comments from Kent County are echoed by those of Judge Ronald A. Silkworth, Circuit Court of Anne Arundel County.:

> Necessary resources are not readily assessable to Defendants placed on probation. In cases where Defendants are placed on probation with a condition of treatment for a drug/alcohol/mental health issues, unless they are specifically followed by the sentencing judge, they come under the supervision of agents at Parole & Probation who are not trained or equipped

> to be able to deal with and manage effectively the condition. Parole and Probation has no in house resources. They depend upon resources through the County and generally they are income based.

Judge Louis Becker, Circuit Court for Howard County, while primarily focusing on probation supervision issues, nonetheless, highlighted in email comments to me the inadequately met need for coordination of supervision, treatment and case management.

> There is persistent disconnect regarding treatment and counseling conditions ordered by the courts and their supervision by P & P: Late reporting of non-compliance; sometimes long after probation has expired, concerns about the efficacy of random testing for substance abuse. Are defendants actually being tested when ordered? Is it truly random? Lack of P & P truly monitoring compliance with treatment conditions; sometimes attributable to the cultural divide between those two diverse entities.
>
> Next is my strong suggestion is that there needs to be an ongoing mechanism(s) for dealing with the continuing interrelationships, recurring problems and need within appropriate limits for coordination of actions at the State as well as local levels between the bench, P & P and health care providers and not just ineffectual dealings on a crisis or piece meal bases.

Probation Supervision

Probation Supervision may have been the most discussed area. There was praise for the skill and creativity of specialized agents working with Problem Solving Courts and other special programs. However, there was much concern expressed as to the lack of sufficient agents dedicated to and trained for working with treatment providers, mentally ill and addicted defendants and the courts. The lack of agents with time and the expertise to communicate effectively not only with providers but with the court and defendants with co-occurring issues was repeatedly cited, as was the need for intensive, not routine, supervision of addicted and mentally ill probationers: truly random drug and alcohol testing, unexpected home visits, communication with care providers.

Transportation and Housing

Transportation was listed by respondents as a critical need; poorly satisfied in nearly all jurisdictions with the possible exception of Washington County as described by Judge Price. Adequate housing for mentally ill and addicted defendants is perceived as a clear need by all reporting trial judges.

Clinicians Available for the Courthouse

The attachments from Judge Wolfe regarding Montgomery County and Mr. Zuremba's regarding Baltimore County ably describe the various relevant clinicians, who identify mentally ill and addicted defendants, in those populous jurisdictions. Both jurisdictions have detention center staffs attuned to mental health issues; detention centers in these counties serve as active sites for such evaluation and diversion. Montgomery's ready access to services is noteworthy.

The addendum accompanying Judge Silkworth's memorandum also references active detention center based evaluation and assessment for Anne Arundel County. However, it should be noted that both Judge Silkworth for Anne Arundel County and Judge Becker for Howard County pointedly note the unfortunate absence of comprehensive evaluation and placement capacity more tightly connected to their respective courts. Judge Becker after recalling his 25 year experience on the District and Circuit Courts for Howard County noted in an email to me:

> We had Health Department screeners years ago in District Court in Howard County who provided timely evaluations that were incorporated into probation orders right at sentencing and defendants were directed then and there to the Probation Department [with treatment plans]. Now, we have no screeners. Evaluations are done days or weeks later at the Health Department at a greater distance from the court house causing disconnects and deficiencies in formulating appropriate court orders with effective conditions.

Judges Price and Nunn report an absence of court house based clinicians, which appears to be the norm for the less populated jurisdictions. While travel distances to clinics is noted as a problem by a number of judges in the smaller areas, their comments may suggest a closer working relationship with the local health department or other entity providing evaluation and placement planning. Yet, the primary complaint voiced by the trial courts in these smaller locals may be the absence of needed treatment services and delay in treatment appointments.

8-507

While 8-507 continues to be an important and useful mechanism for providing clinically appropriate residential therapeutic drug and co-occurring residential treatment, this survey points to a number of factors that significantly deter its use by sentencing courts. Judge Nunn's statement summarizes the comments of numerous trial judges throughout the State decrying delays in placement dates: "8-505/8-507 evaluations are done timely but long bed wait times of over five months for placement is not practical for defendants serving local sentences. Often defendants serving local sentences are released before a bed becomes available".

Judges Becker and Silkworth also note lack of confidence in probation supervision as it relates to defendants completing the residential portion of an 8-507 commitment. Indeed, difficulties with post residential planning, as well as supervision have been frequently mentioned.

Judge Purpura and Donald Zaremba's comments raise further concerns. Mr. Zaremba cites a lack of confidence by the Baltimore County Bench in Gaudenzia's treatment as deterring defense attorneys from pursuing 8-507 placements on behalf of their clients. Judge Purpura notes:

> With regard to treatment for substance abuse, it is true that many judges are not satisfied with the services of Gaudenzia, and I concur that having the option of more than one vendor would be helpful. I believe, however, that the current reluctance to utilize 8-507 commitments stems from problems with ADAA staff. You will recall the history of inordinate delays in placing defendants once an order was signed. That problem still exists in some cases. A more serious problem has been brought to light regarding inaccurate and misleading communication from ADAA to the Court. Attached is a copy of my June 9, 2014 to Acting Director, Kathleen Rebbert-Franklin in which I reported several incidents where judges were advised by ADAA that offenders had successfully completed treatment when the opposite had occurred. As of this date, I have yet to receive a response. All of these difficulties coupled with ADAA's refusal to respond to direct communication from the Court have reduced the number of offenders that are placed in treatment. At the present time only fifteen (15) defendants from Baltimore County are in Gaudenzia, yet there are beds available.

It must be emphasized that nearly all defendants placed in residential treatment through 8-507 would otherwise occupy jail or prison cells and that only defendant's evaluated by ADAA or its designees as appropriate for 8-507 residential treatment are statutorily eligible for committed to residential treatment through 8-507. To deter otherwise clinically appropriate 8-507 placements is to prolong unnecessary and costly jail detention and DOC incarceration.

Services and Ending

There is little to add to the descriptions of providers and services contained in the attachments. Candidly, I did not press those judges who phoned or sent brief emails for verbal listings of services and providers. Yet it should be noted that provider understaffing and appointment delays were recurring themes that were expressed.

It is to be emphasized that the above points should not be construed as "findings" or "conclusions". However, the consistency with which the above themes were stated should add to their weight during further analysis in accordance with the budget language.

APPENDIX 2

Problem Solving Courts

DISTRICT COURT OF MARYLAND

District Five

14735 Main Street

Upper Marlboro 20772

August 4, 2014

In Re: Resources in Prince George's County for court-involved individuals with Mental Health Disorders, Substance Abuse Disorders, or Intellectual Disabilities

Competency Evaluation:

Dr. Katz is contracted for Mental Health Court competency evaluations. He is reliable, prompt, and accessible. MHC Case Managers/Resource Specialists (CM/RS), report that most competency evaluations are conducted within a week of the evaluation order. There were also no reports of excessive wait times for treatment slots in Springfield Hospital for state-run psychiatric hospital placement.

In general, minimal issues were reported regarding competency/NCR evaluations and/or placement with state-run psychiatric hospitals. In fact, most concerns directly related to aftercare plans and continuity of care for individuals once released from the hospitals into the community. That is, inadequate resources pose significant barriers to successful transition into the community for many of our clients. These issues are addressed below regarding availability of resources.

Availability of Resources:

A. On-Site Clinicians or behavioral health assessment staff at court locations

Mental Health

The Department of Health and Mental Hygiene funds a single Clinical Social Worker for our Mental Health Court Program. However, she primarily functions as a clinical advisor to the program's CM/RS. As a result, client's needs are not assessed in-house. The program refers clients to outside providers for such assessments. An in-

house needs assessment would greatly improve the CM/RS's ability to connect clients with the most appropriate treatment.

Substance Abuse

Substance abuse assessments are conducted through the Health Department. For Drug Court, every participant is referred for assessment during the intake process. A liaison from the Health Department is available at weekly Drug Court meetings to help with this process. For the most part, this is a relatively smooth and quick procedure.

B. Case management and other wrap-around services, including transportation grants and subsidies

Mental Health

There are a number of agencies that provide these types of services to our client population. We are able to connect defendants to basic mental health services like medication management, and clinical therapy. However, more intensive services, such as Assertive Community Treatment (ACT) or Case Management are often more difficult to access. Both Mental Health and Drug Court Cm/RS noted that, while resources are available, there is simple not enough to meet the need.

Day Programs

Day programs, including mental health and substance abuse treatment, vocational, educational, and volunteer, represent a major deficiency for participants in both Mental Health and Drug Courts. Case Managers reported that clients often relapse or are re-arrested during the day-time hours when they do not have a productive way to spend the time. Unfortunately, these types of resources are very limited in Prince George's County and pose a major challenge for our programs.

Housing

Housing is the most glaring resource shortage. For placement in Residential Rehabilitation Programs, clients released from all state-run psychiatric hospitals in the entire state of Maryland now have priority over individuals living in our local community. That said, little to no resources are available to clients for whom supervised housing is a key component to their success in the community. Too often, clients return to unstable living situations, or spend time incarcerated waiting for a housing placements.

Below, please find data regarding Residential Rehabilitation housing referrals for Mental Health Court participants in FY2014. As you can see, only 18% of individuals referred were actually placed in RRP housing in PG County.

Month	# RRP Referrals	# RRP Placements	Success Rate
July 2013	9	2	22.22%
Aug. 2013	2	1	50%
Sep. 2013	5	2	40%
Oct. 2013	7	1	14.29%
Nov. 2013	6	0	0%
Dec. 2013	5	0	0%
Jan. 2014	7	0	0%
Feb. 2014	8	5	62.5%
Mar. 2014	8	1	12.5%
Apr. 2014	6	0	0%
May 2014	6	0	0%
June 2014	3	1	33.33%
Total	**72**	**13**	**18.05%**

APPENDIX 3

Address Reply To: 103 N. Cross St.
Chestertown, Md. 21620

MEMORANDUM **Date: June 17, 2014**

To: George Lipman

From: John E. Nunn III, Kent County District Court

Re: Response to your email of 6/4/14 inquiring about, Mental Health, Intellectual Disabilities, and Substance Abuse

IN KENT COUNTY – THE COURT has **NO** assigned staff for mental health, intellectual disabilities or substance abuse. For any forensic evaluation, this Court can refer the individual to Mid Shore Mental Health which is located in Easton, for a forensic evaluation. If an individual is currently receiving mental health services at Kent County Behavioral Health, the Court will rely on recommendations from their counselor.

PRETRIAL/POST-TRIAL

Court can refer to Mid Shore Mental Health for a Forensic Evaluation. However once a report and recommendations are received, there are limited resources available in Kent County to address the needs.

Community Supervision/Parole and Probation is often the Court's only option. The Court will make it a condition of probation or pretrial supervision that a defendant be referred to KCBH for mental health or substance abuse issues. Communication between KCBH, Community Supervision, and the Court through this probation process is cumbersome and needs to be streamlined if Community Supervision is to become an effective tool to see that services are provided in a timely fashion. There is no case manager following these individuals and Community Supervision views them as another probationer with mental health issues. So the court is not always timely informed if the defendant is not taking medication or keeping appointments.

Kent County Behavioral Health is the only option for individuals without insurance; this program provides mental health and substance abuse services. The program is understaffed, appointments are not immediate, and valuable time goes by before they are seen by a doctor or clinician. Kent County Behavioral Health has only two psychiatrists who work a total of 26

hours per week. There are no practicing psychiatrists at the local hospital operated by University of Maryland. KCBH has approximately 600 patients; approximately 80% are on prescribed medications. Typically, clients see a therapist 2 times per month and a doctor 1 time per month to review medications.

Crossroads Community is a residential placement and day program serving Kent County. The wait times are long to be accepted. The other problem is it is not uncommon for defendants, with mental health issues, to be on the criminal dockets for problems which arose at Crossroads and they are not able to return to the program.

Transportation to and from appointments is a major problem as Kent County has no public transportation system, no buses, subway, light rail or taxis. The only service is rural transportation through U-Star with limited service.

Recently, the Mid Shore has started a Mobile Treatment Team. This program is responsive and has been able to divert some clients from jail and provide medication. The program serves the Mid Shore and is already at capacity with a waiting list. The program provides wrap around services and case management service. This program could be a resource in the future if expanded, so it will be able to serve more than 40 people on the Mid Shore. Additionally, because of insurance regulations you cannot receive services from both the local mental health clinic and Mobile Treatment. This makes it difficult to transition people from intensive services to less intensive services once their situation improves.

COMPETENCY AND NOT CRIMINALY RESPONSIBLE

Dr. Charisse Chappell does competency and NCR screening on an outpatient basis. The screenings are timely and arrangements are made for inpatient placement if needed. If an inpatient evaluation is needed the wait times have been minimal. The Court coordinates with admissions at Eastern Shore to keep wait times a minimum. The wait if a bed is not available has been a week or two at most here in Kent County. However, I am aware of other cases on the Mid Shore where defendants have waited over two months for a bed.

SUBSTANCE ABUSE

8-505/8-507 evaluations are done timely but long bed wait times of over five months for placement is not practical for defendants serving local sentences. Often the defendants serving local sentences are released before a bed becomes available. Consequently, the Court uses this procedure most often for defendants serving DOC sentences.

SUBSTANCE ABUSE SERVICES

Kent County Behavioral Health provides outpatient services and the A.F. Whitsitt Center is an inpatient facility. The Court has no detox facility and because of the growing heroin problem detox often occurs in the jail.

There is only one doctor who can work only 12 hours a month to prescribe suboxone for heroin addictions. He is currently treating 60+ patients.

The A.F. Whitsitt Center currently has a waiting list of over 40 people for inpatient treatment. Kent County has experienced a number of deaths from heroin and having a waiting list of over 40 people is not helpful.

This facility is located at the Upper Shore Mental Health Facility which was closed and sits partially empty. Attempts have been made to utilize the empty rooms for related outpatient treatment beds but insurance regulations will not allow it because the beds are under the same roof as the inpatient facility. However, regulations would allow for reimbursement if the program was in a row house/townhouse next to the inpatient treatment center. As a result the old Upper Shore Facility is a resource that could be used for individuals with dual diagnosis or possibly detox beds.

The necessary resources do not exist in Kent County to divert individuals from jail. In fact, Kent County Behavioral Health has on more than one occasion indicated to the Court that a defendant needs to be placed in jail to get the medication needed to stabilize his or her mental health condition. Also, there are not enough inpatient beds for patients requiring inpatient hospitalization. A number of Kent County residents are being placed in hospitals in Delaware to meet their mental health needs because of a lack of facilities on the Eastern Shore.

APPENDIX 4

Baltimore County Inpatient Evaluation

SAMPLE 2014

ITEM	Name	Case No.(s)	Judge(s)	Circuit	District	Date Admitted	Days from Eval Order to Admission
1	Baptist, Vladimir M.	03K13005208	Wilson		X	06/17/14	19
2	Boone, Emily Elizabeth	2C00399576	Chester		X	06/02/14	13
3	Cobbs-Fox Tonya Jeanette	6C00392846; 5B02237821	Ryan		X	02/12/14	1
4	Daniels, Juanita M.	1C00400310	Wilson		X	08/15/14	54
5	Dorsey, Christian	03K14003570	Ryan		X	02/18/14	26
6	Epps, Richard Raekwon	03K14000590	Souder	X		04/21/14	33
7	Fancher, Juanita L.	0C00395941	Tirabassi; Fletcher		X	04/15/14	60
8	Finney, James H.	3C00394614	Ryan		X	02/12/14	20
9	Fitzhugh, Warren	4C00393474	Stone		X	03/11/14	26
10	Gaylord, Allison C.	0C00399609	Tirabassi		X	06/30/14	25

ITEM	Name	Case No.(s)	Judge(s)	Circuit	District	Date Admitted	Days from Eval Order to Admission
11	Harley, Isaiah Jr.	4C00337901	Williams		X	02/24/14	32
12	Hartridge, Thadduse Lee	03K13004215	Stringer; Ballou-Watts	X		04/08/14	47
13	Hice, Antonio Rico	03k14001455	Wilson		X	04/22/14	26
14	Hook, Harry Campbell	0C00400778	Jung		X	08/14/14	6
15	Leathers, Dennis Leon	5C00391305; 6C00390613	Jung; Wilson; Chester; Pate		X	05/29/14	98
16	Luca, Christopher T.	3C00379606	Chester		X	02/05/14	23
17	Martin, Edward Christian	3C00393123	Rasinsky		X	05/05/14	18
18	Neary, Linda Ann	4C00393264	Stone; Mayer		X	05/02/14	18
19	Oliver, Craig Jr.	03K13002444	Purpura	X		05/20/14	42
20	Rogers, Joshua Edward	0C00390516	Chester		X	02/05/14	27
21	Sanders, Ronald Isiah	5C00396359; 4C00396365	Tirabassi; Jung		X	03/21/14	0
22	Sanders, Tavon Donell	0C00393666	Tirabassi;		X	03/31/14	18
23	Serrano, Miguel David	03k13003589	Cox	X		05/07/14	23
24	Shepperson, Douglas Wade	0C00398881	Fletcher		X	04/21/14	31
25	Strine, Lisa Renee	2C00399002; 6C00397732	Pate; Chester		X	05/20/14	12
26	Trochez, Roberto	3C00397498; 2C00399618	Levitz; Jung		X	07/10/14	42
27	Washington, Maurice Charles	2C00396769	Dugan	X		05/23/14	35

APPENDIX 5

BALTIMORE CITY ADMISSION DATA

	Defendant	Case Numbers	Date Extended	IST Ruling	Date of Admit	Time to Admit (days)
1	Brandon Williams	5B02263735 0B02200100	6/16/2014	7/24/2014	6/27/14	11
2	Shirley Johnson	6B02266347	6/12/2014	7/24/2014	7/1/14	19
3	Donald Smith	1B02262345	6/19/2014	7/24/2014	7/3/14	14
4	Margaret Couplin	6B02262049	6/12/2014	7/17/2014	6/24/14	12
5	Redell Hunt	6B02266004 2B02266266	6/5/2014	7/10/2014	6/12/14	7
6	Cordeaire Davis-Gray	1B02266328	6/9/2014	7/10/2014	6/16/14	7
7	Michael Robinson	5B02248790	5/15/2014	6/12/2014	5/21/14	6
8	Victor Leonard	1B02238636	5/27/2014	6/19/2014	06/03/14	7
9	Timothy Browning	5B02204130 0B02121371	5/1/2014	6/5/2014	05/05/14	4
10	Larry Smith	6B02265724	5/5/2014	6/5/2014	05/12/14	7
11	Hugo Tanner	3B02248641	4/21/2014	5/23/2014	05/01/14	10
12	Stewart Farquhar	2B02238651	4/14/2014	5/15/2014	4/21/14	7
13	Carlton Bradie	1B02258985	4/14/2014	5/15/2014	04/22/14	8
14	Torenio Melton	0B02256289	4/7/2014	5/1/2014	04/17/14	10
15	Travon Holloway	1B02248870	4/3/2014	5/1/2014	04/17/14	14
18	Donald Stover	3B02235691	3/24/2014	4/24/2014	04/02/14	9
19	Dedrick Samuels	4B02241187	3/6/2014	4/17/2014	03/20/14	14
20	Namid Rawls	3B02244770 5B02236722 4B02240746	4/3/2014	5/1/2014	04/17/14	14
21	Freddie Jones	0B02252957	2/24/2014	3/27/2014	03/14/14	18
24	Michelle Handy	5B02252318 4B02245793	2/6/2014	3/6/2014	02/11/14	5

	Defendant	Case Numbers	Date Extended	IST Ruling	Date of Admit	Time to Admit (days)
25	Charles McGilberry	0B02245761	1/30/2014	2/27/2014	2/11/14	12
26	Kevin Haley	2B02248136	1/27/2014	2/27/2014	02/10/14	14
27	Jacqueline Bruce	5B02241461	1/16/2014	2/24/2014	01/28/14	12
28	Victor Robinson	0B02244144	1/21/2014	2/20/2014	02/06/14	16
29	Albert Tabi	4B02248145	1/6/2014	1/30/2014	01/24/14	18
30	Nana Hodgson	5B02238164 4B02245485	12/23/2013	1/23/2014	01/17/14	25
31	Doretta Cornish	2B02243320	12/19/2013	1/23/2014	01/09/14	21
32	Mark Perlstein	2B02238805	12/23/2013	1/23/2014	01/02/14	10
33	Marcus Coulthard	5B02227405	12/19/2013	1/9/2014	12/23/13	4
34	Jayvon Allen	4B02247662	12/19/2013	1/16/2014	12/30/13	11
35	Anthony Miller	6B02237094 6B02197971	12/12/2013	1/9/2014	12/17/13	5
36	Andre Mayobey	5B02243449	12/12/2013	1/9/2014	12/18/13	6
37	Sierra Anderson	2B02238448 5B02184481	12/9/2013	1/9/2014	12/13/13	4
38	Jason Parks	2B02224658	12/2/2013	1/2/2014	12/13/13	11
39	Scott Bartlett	1B02218000	11/21/2013	12/19/2013	12/04/13	13
40	Alexander Jiggetts	1B02245342	11/21/2013	12/19/2013	12/3/13	12
41	Arnez Tindall	2B02206437	11/12/2013	12/12/2013	11/21/13	9
42	Brittany Perrin	4B02234852	11/14/2013	12/12/2013	11/20/13	6
43	Troy Dixon	6B02176558	10/28/2013	12/5/2013	11/04/13	7
44	Travonne Fitzgerald	2B02242396	10/31/2013	12/5/2013	11/5/13	5
45	Maile Oshea	2B02217749 0B02240714 5B02190417	10/31/2013	12/5/2013	11/12/13	12
46	Theresa Floyd	6B02236408	11/7/2013	12/15/2013	11/20/13	13
47	Kevin Peterson	4B02233410 3B02233255	10/24/2013	11/21/2013	11/1/13	8

	Defendant	Case Numbers	Date Extended	IST Ruling	Date of Admit	Time to Admit (days)
48	Jeffrey Handy	3B02240591 3B02240591	10/10/2013	11/7/2013	10/23/13	13
49	Roger Williams	2B02240898 4B02240508	10/3/2013	11/14/2013	10/25/13	22
50	Robert Murphy	6B02235078	10/3/2013	11/7/2013	10/17/13	14
51	Joy Rogers	6B02234665	10/3/2013	10/31/2013	10/21/13	18
52	Rayford White	0B02081394	10/3/2013	10/31/2013	10/10/13	7
53	Guy Brooks	4B02236406 6B02236058	10/3/2013	10/31/2013	10/16/13	13
54	Reginald Williams	3B02223259 5B02236351	9/26/2013	10/24/2013	10/02/13	6
55	Darryl McCallum	5B02232067	9/26/2013	10/24/2013	10/3/13	7
57	Jeffrey Carter	2B02233093	9/19/2013	10/17/2013	09/26/13	7
58	Joseph Manns	1B02199667	9/19/2013	10/17/2013	9/26/13	7
59	Edmond Meintyon	6B02198076	9/12/2013	10/10/2013	09/18/13	6
60	Tirra Durosomo	3B02212164	9/12/2013	10/10/2013	09/19/13	7
61	Brandon Randolph	0B02204489	9/16/2013	10/10/2013	09/23/13	7
62	Reggie Carter	2B02212618	9/5/2013	10/10/2013	09/10/13	5
63	Eric LeCount	3B02212115 4B02212116	9/16/2013	10/10/2013	09/24/13	8
64	James Mauler	1B02191729	8/22/2013	9/5/2013	08/22/13	0
65	Marvarney Edmond	1B02212568	8/5/2013	9/5/2013	08/12/13	7
66	Willie Hall	6B02214918	7/18/2013	8/15/2013	07/19/13	1
68	Donald Williams	0B02205966	7/18/2013	8/15/2013	07/22/13	4
69	James Stokes	1B02230495 2B01517119	7/29/2013	8/29/2013	07/31/13	2
70	John Creaghan	0B02223319	8/1/2013	8/29/2013	08/15/13	14
71	Dwayne Thompson	3B02228852	7/18/2013	8/15/2013	07/24/13	6

	Defendant	Case Numbers	Date Extended	IST Ruling	Date of Admit	Time to Admit (days)
72	Quinton Thompson	2B02171885	7/1/2013	8/1/2013	07/09/13	8
73	Rydricus Coleman	6B02189522	7/1/2013	8/1/2013	07/09/13	8
74	Margaret Littlepage	5B02205565	5/23/2013	7/25/2013	05/23/13	0
75	Miguel Johnson	6B02218229	4/29/2013	6/6/2013	05/06/13	7
76	Mekhael Tyson	3B02218282 1B02221304	4/29/2013	6/6/2013	5/6/13	7
77	Brittini Tyson	3B02219626	5/1/2013	5/30/2013	5/9/13	8
78	Scott Bartlett	1B02218000	4/22/2013	5/23/2013	04/29/13	7
79	Craig Nasteff	1B02217923	4/18/2013	5/23/2013	04/29/13	11
80	Terrence Trent	6B02188388	4/18/2013	5/23/2013	05/01/13	13
81	Willie Floyd	5B02162865 2B02215649	4/18/2013	5/16/2013	04/23/13	5
82	Kenneth Praglowski	0B02187423	4/11/2013	5/16/2013	04/12/13	1
84	Cordeaire Davis-Gray	3B02216595	4/4/2013	5/2/2013	04/10/13	6
85	Damon Franklin	0B02137779	4/4/2013	5/2/2013	04/09/13	5
86	Phillip Slick	0B02192365	3/25/2013	4/18/2013	03/26/13	1
87	David Bradby	6B02207750	3/14/2013	4/11/2013	03/19/13	5