STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

December 12, 2014

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

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

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

The Honorable Peter A. Hammen
Chairman
House Health and Government Operations Committee
241 House Office Building
Annapolis, MD 21401

The Honorable Brian E. Frosh
Chairman
Senate Judicial Proceedings Committee
2 East Miller Senate Building
Annapolis, MD 21401

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

Re: 2014 Joint Chairmen's Report, Page 78, M00K01 – Treatment and Service Options for Certain Court-involved Individuals

Dear Chairmen Kasemeyer, Conway, Middleton, Hammen, Frosh and Vallario:

Pursuant to page 78 of the Joint Chairmen's Report of 2014, the Department of Health and Mental Hygiene, in consultation with the Judiciary, the Department of Public Safety and Correctional Services, the Office of the Public Defender, and the Maryland State's Attorneys' Association, respectfully submits this report on treatment and service options for certain court-involved individuals. Specifically, the report details wait times for certain residential placements at State-run psychiatric or intellectual disability centers; the demand for residential treatment beds generated from drug courts and placements under Section 8-507 of the Health-General Article; and the average wait time for placement in a treatment slot after the signing of an order under Section 8-505 or Section 8-507 of the Health-General Article. The report also outlines the availability of certain resources for court-involved individuals by jurisdictions and recommendations to improve treatment and service options for court-involved individuals.

If you have any questions, please contact Allison Taylor, Director of Governmental Affairs at 410-767-6481 or at Allison.Taylor@maryland.gov.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosures

cc: Gayle Jordan-Randolph, M.D.
Ms. Rianna Brown
Ms. Allison Taylor

Joint Chairmen's Report, Page 78
Treatment and Service Options for
Certain Court-Involved Individuals

In this Joint Chairmen's Report, the Department of Health and Mental Hygiene (DHMH, or Department) responds to a series of questions regarding the wait times for placements in various settings either operated by or under contract with the Department. The specific types of placements include: placements in DHMH facilities for evaluation as to criminal competency or criminal responsibility; commitments to DHMH facilities pursuant to findings that a criminal defendant is incompetent to stand trial or is not criminally responsible; and commitments to contracted substance use providers after a court has so ordered such a commitment.

In addition, the Department identifies the types of behavioral health and community correctional services available in Maryland's 24 jurisdictions and, in accordance with the Joint Chairmen's Report, makes "[r]ecommendations, based on an analysis of the data… above, to improve treatment and service options, including additional State-operated residential capacity, that will facilitate lower detention, imprisonment and hospitalization rates, and emergency room visits, for court-involved individuals with mental illness, intellectual disabilities, and substance use disorders."

This report includes the Department's response to the Joint Chairmen's inquiries and a discussion of the workgroup process used to develop recommendations contained in this report. In some instances, the requested information is provided in the form of data, with brief explanatory narratives, while in other instances, the response is narrative only as quantitative data is not readily available. For some inquiries, the Department's response is provided in the form of an appendix.

In addition to responding to the specific requests made in the Joint Chairmen's Report, this document will also provide background on the Department's Office of Forensic Services, including the integration of forensic operations previously managed separately by three administrations within DHMH. The report will conclude with the Department's recommendations as informed by the investigation conducted in order to respond to the Joint Chairmen's Report queries.

Background

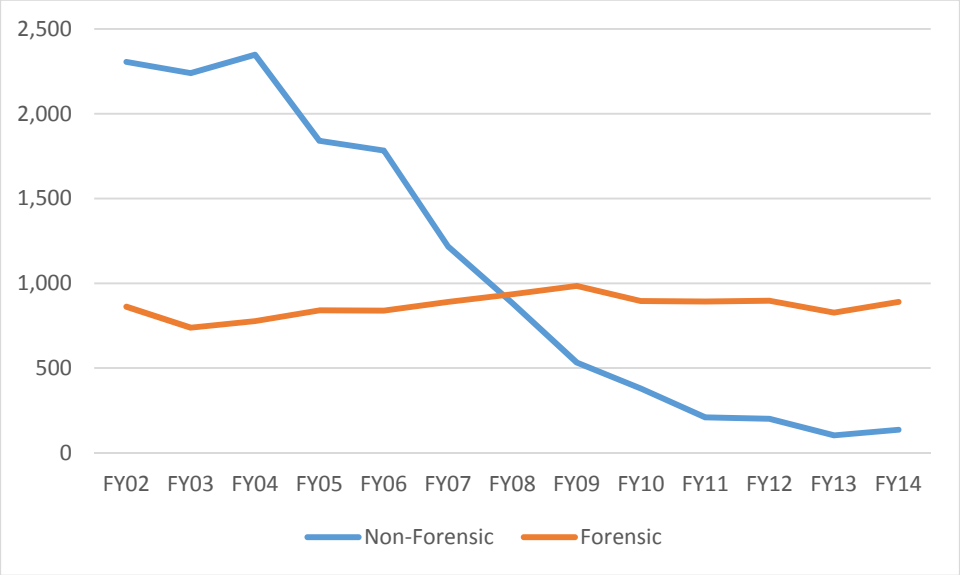
The Department's Behavioral Health Administration (BHA) operates an Office of Forensic Services, which is the entity within DHMH that interacts with the criminal courts of Maryland to respond to certain statutorily defined forensic questions. These specific questions are defined in the Criminal Procedure Article, Title 3, §§3-105, 106, 108, 111, 112 and 114-120; and in the Health-General Article, Title 8, §§8-505 and 507.

Pursuant to Criminal Procedure Article §§3-105 and 3-111, DHMH evaluates criminal defendants' competency to stand trial and/or their criminal responsibility for the crimes with which they are charged. This process begins with an evaluation at the local level. The Office of Forensic Services contracts with forensic evaluators in every jurisdiction. These evaluators conduct a forensic evaluation within the local detention center or, for defendants out on bond, in the community. The majority of these evaluations do not result in further forensic assessment, and the cases proceed through the criminal justice system. However, a minority of cases either require further assessment, in which case the defendant is referred to one of the state facilities for a more in-depth assessment, or result in a commitment to a state facility for treatment pursuant to Criminal Procedure Article §§3-106(b) or 3-112.

Forensic Admissions to Psychiatric Hospitals Remains Flat

The Department has tracked admission status to state psychiatric hospitals since fiscal year 2002. Starting in 2002, admissions without court involvement began to be referred to private hospitals regardless of insurance status. Consequently, the total number of admissions to state psychiatric hospitals went down by over 60%. Also during that time period the number of beds was decreased by approximately 21%. During this time, the Department continued to admit patients with court involvement to state psychiatric facilities, so that these cases now account for about 90% of all admissions. As shown in Figure 1 there has been essentially no change in forensic admissions over the past 13 years.

Figure 1
Forensic and Non-Forensic Admissions to
State Psychiatric Facilities
Fiscal 2002 - 2014



Court-Ordered Addiction Treatment

Pursuant to Health-General Article §8-505, the Department responds to criminal court orders requiring the evaluation of criminal defendants' need for and amenability to substance abuse treatment, and if appropriate, makes recommendations for services. If the court then orders services pursuant to Health-General §8-507, the Department has the responsibility to facilitate defendants' prompt placement into services.

Office of Forensic Services

Until approximately two years ago, evaluations were conducted independently by three involved administrations – the Mental Hygiene Administration (MHA), the Developmental Disabilities Administration (DDA) and the Alcohol and Drug Abuse Administration (ADAA) – each operated its own independent forensic program. At that time, with behavioral health integration on the horizon, DHMH determined that the Office of Forensic Services should also integrate and, under one administrative structure, provide all of the court-mandated evaluative services. Thus, the DDA and ADAA forensic evaluation operations were moved to the Jessup office where the MHA forensic operation has long been

housed, and each operation was moved under the leadership of a new Director of Forensic Services. This has permitted a much-improved collaboration between the various forensic staff, who are often dealing with a single defendant who may have more than one behavioral health or developmental issue. Thus, integrating the forensic evaluations is expected to streamline the evaluation and placement processes, thereby adding efficiency to the operation of this multi-agency effort, which includes not only the various Departmental administrations, but also the courts, local jails, and the Department of Public Safety and Correctional Services (DPSCS).

The Office of Forensic Services oversees various units including the Community Forensic Aftercare Program, Juvenile Forensic Services, addiction-related Justice Services, and Developmental Disability Forensic Services. Among other things, staffing for each division includes forensic evaluators. There are also evaluators on staff at the State's five psychiatric hospitals and two Secure Evaluation and Therapeutic Treatment (SETT) units.[1] Facility-based evaluators respond to court orders related to criminal defendants committed to DHMH and referred to their facility. Cases are referred to facilities based on the following logic for individuals committed due to a mental disorder: (1) criminal defendants under the age of 18, regardless of the crime, are referred to the Spring Grove Hospital Center Adolescent Unit; (2) criminal defendants charged with serious crimes, such as murder, arson, rape, and kidnapping, are referred to Clifton T. Perkins Hospital Center; (3) those charged with less serious crimes are referred to the remaining facilities operated by BHA – Eastern Shore Hospital Center, Springfield Hospital Center, Spring Grove Hospital, and Thomas B. Finan Hospital Center – based on the county in which the referring court sits. Individuals committed because of an intellectual disability are sent to one of the SETTs.

Outpatient Services Programs Stakeholder Workgroup

In addition to the activities of the workgroup established to develop this report, the Department is examining access to outpatient mental health services, including housing and rehabilitative treatment services, through the Outpatient Services Programs Stakeholder Workgroup. This workgroup was established under House Bill 1267/Chapter 353 and Senate Bill 882/Chapter 352 of the Acts of 2014. Among other things, the workgroup must examine the development and implementation of assisted outpatient treatment programs, assertive community treatment programs, and outpatient service programs in the State; develop a proposal for a program in the State; and evaluate the dangerousness standard for involuntary admissions and emergency evaluations. Moreover, House Bill 1267/Senate Bill 882 requires the proposal to address key issues regarding assisted outpatient treatment that were recently identified by the Continuity of Care Advisory Panel in its report to the Secretary of Health and Mental Hygiene.

The Workgroup held a series of 7 meetings from May through August of 2014. Two of these meetings were devoted to enhancements to outpatient mental health services. The workgroup's final report will be delivered to the legislature in December 2014. This report will contain a proposal to enhance access to outpatient mental health services. A draft of this proposal was circulated in August of 2014 and recommended enhancements in the following areas: (1) Assertive Community Treatment; (2) peer support; (3) housing: and (4) crisis services. A summary of the recommendations is provided below:

[1] It is important to note that the Office of Forensic Services does not directly oversee the evaluators based in facilities, each of which has its own forensic organizational structure. However, the Office does set standards for evaluations, runs regular training programs for new evaluators, and is in the process of initiating a peer-review program that will include all evaluators.

- **Assertive Community Treatment:** The Department should increase funding to expand Assertive Community Treatment for individuals seeking services voluntarily.
- **Peer Support:** It was recommended that additional funding be appropriated to expand peer support services within each jurisdiction. Expansion should include the public mental health service delivery system, local detention centers, courts and primary care.
- **Housing:** Written comments submitted by stakeholders consistently identified housing as an area that needed enhancement in the public mental health system. Multiple stakeholders noted that housing is a key component to ensuring an individual is stable and can remain stable in the future. Similar input was solicited through the Continuity of Care Advisory Panel. Based on stakeholder input it was recommended that the Department increase funding for rental subsidies.
- **Crisis Services:** All jurisdictions offer crisis services; however services vary by jurisdictional need and funding sources. A variety of gaps remain in the crisis services continuum. It was recommended that additional funding be appropriated to further integrate and enhance crisis services statewide.

Many of the concerns voiced in the Outpatient Services Programs Stakeholder Workgroup – such as a need for additional community resources to ensure continuity of care – was echoed by the workgroup convened to respond to this Joint Chairmen's inquiry. While some of these concerns are noted in this report, the final report of the Outpatient Services Programs Stakeholder Workgroup will further address these issues.

Joint Chairmen's Report Workgroup Process

A series of three meetings were held during the summer to discuss the quantitative and qualitative findings and to develop responses to the Joint Chairmen's Report. The meetings were chaired by Dr. Gayle Jordan-Randolph, Deputy Secretary for Behavioral Health and Disabilities at DHMH. Stakeholders at these meetings, as required by the Joint Chairmen's Report, included representatives from: the Office of Forensic Services; the Judiciary; the Governor's Office of Crime Control and Prevention (GOCCP); the Department of Public Safety and Correctional Services (DPSCS); the Office of the Public Defender; the State's Attorneys' Association; the Office of the Attorney General; and the local behavioral health authorities. Participants from the Department of Legislative Services were also present. At the first meeting, the Department presented the data requested by the Joint Chairmen's Report. At the second meeting, the Judiciary presented findings from its survey of local courts. The final meeting was dedicated to the discussion of possible recommendations.

For the purposes of this report, it is important to explain the ways in which these responses were developed. The queries were divided broadly into those requiring data-based responses and those that were more qualitative. For data-based responses, the Office of Forensic Services collected data from its own sources and from the various facilities conducting the evaluations and managing committed cases. Qualitative information was obtained by both the Office of Forensic Services and other stakeholders, including the Judiciary.

Wait times for Residential Placements in State-run Psychiatric or Intellectual Disability Centers

For fiscal 2012, 2013, and 2014, the Joint Chairmen's Report directed the Department to provide information related to forensic evaluations and commitments specified in the Criminal Procedure Article, Title 3. These evaluations focus on mental health or cognitive factors related to a crime or to a criminal proceeding. More specifically, the Department was required to report:

(1) the average wait time for residential placement in a State-run psychiatric facility or State intellectual disability center after a not competent or not criminally responsible finding; and

(2) the average wait time for residential placement in a State-run psychiatric facility or State intellectual disability center after the signing of an inpatient evaluation order for a competency or not criminally responsible evaluation;

Table 1 presents the number of cases, the range, the average time in days from the date of the order to the date of the admission, the median number of days from order date to admission date, and various cutoffs tied to the specific order type. The average wait time for admission was 5.17 days for commitments as incompetent to stand trial and dangerous and 4.70 days for commitments as not criminally responsible. Moreover, 50% of individuals found incompetent to stand trial and dangerous were admitted in 3 days or less, and 50% of individuals found not criminally responsible were admitted in 2 days or less. Overall, 81% of all cases committed as incompetent to stand trial and dangerous and 83% of all cases committed as not criminally responsible were admitted within one week of the court's order.

Table 1 also presents data regarding the times to admission for defendants ordered confined in a Department facility for evaluation as to their competency to stand trial and/or their criminal responsibility. The average wait time for admission for these cases was 11.56 days for a competency to stand trial evaluation and 23.68 days for a criminal responsibility evaluation. Fifty percent of competency to stand trial evaluations were admitted within 8 days, and 50% of criminal responsibility evaluations were admitted within 18 days. It is important to understand why these admissions are admitted less quickly than the commitments discussed in the above paragraph. The statutory and forensic purpose of the confinements in this paragraph is for an ***evaluation*** to determine if a subsequent commitment order is necessary, while in the cases discussed above, that has already happened and a decision has been made that the defendant requires a criminal commitment to a Department facility. Thus, orders committing a person to ***treatment*** (due to a finding that the defendant is either incompetent to stand trial and dangerous or not criminally responsible) represent both a higher priority for the committing court and for the Department, and also describe more needy people than do orders confining a person only for ***evaluation*** (competency to stand trial or criminally responsible). While this is not mandated by statute, it is the Department's approach to prioritizing court orders.

Table 1
Average Wait Time for Residential Placement
in a State Psychiatric Facility or State Intellectual Disability Center
Fiscal 2012 – 2014

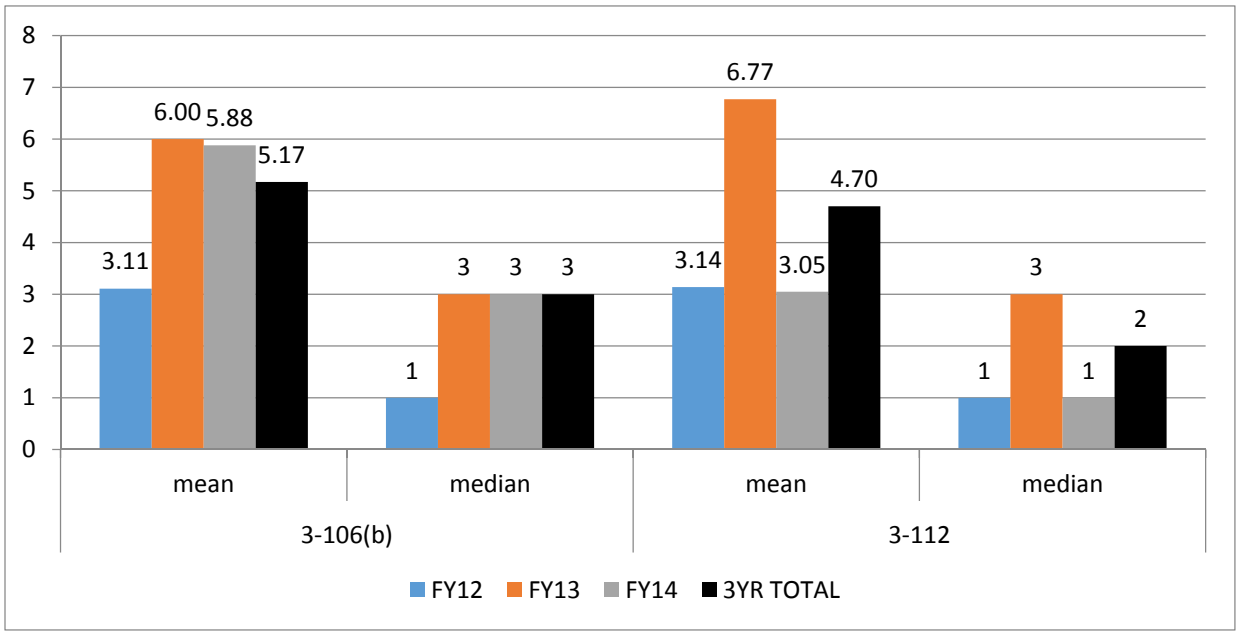
			2012	2013	2014	2012-2014 Total
Average wait time after a not competent or not criminally responsible finding	Incompetent to stand trial and dangerous	Total Number of Cases	256	353	326	935
		Range (days)	0-36	0-85	0-71	0-85
		Average number of days	3.11	6.00	5.88	5.17
		Median number of days	1	3	3	3
		Percentage admitted more than 7 days after an order	8.9%	20.6%	24.2%	18.7%
	Not criminally responsible	Total Number of Cases	14	39	36	89
		Range (days)	0-18	0-50	0-20	0-50
		Average number of days	3.14	6.77	3.05	4.70
		Median number of days	1	3	1	2
		Percentage admitted over 7 days after an order	7.1%	20.5%	16.7%	16.7%
Average wait time after the signing of an inpatient evaluation order for a competency or not criminally responsible evaluation	Competency to stand trial	Total Number of Cases	59	175	223	457
		Range (days)	0-42	0-98	0-53	0-98
		Average number of days	9.10	10.59	12.98	11.56
		Median number of days	7	7	10	8
		Percentage admitted over 7 days after an order	42.4%	48.6%	60.5%	53.6%
		Percentage admitted over 14 days after an order	18.6%	21.7%	32.7%	26.7%
	Criminally responsible	Total Number of Cases	11	34	17	62
		Range (days)	1-68	0-113	0-50	0-113
		Average number of days	31.00	24.68	16.94	23.68
		Median number of days	22	18	12	18
		Percentage admitted over 30 days	36.4%	29.4%	23.5%	29.0%
		Percentage admitted over 60 days	18.2%	2.9%	0.0%	4.8%

Note: The above table includes responses from all five state psychiatric hospitals (Clifton T. Perkins Hospital Center, Eastern Shore Hospital Center, Spring Grove Hospital Center,[2] Springfield Hospital Center, and Thomas B. Finan Center) as well as from DDA (inclusive of admissions both to the SETTs and to the Potomac Center).

Figure 2 presents the mean and median number of days from the date of a court order for residential placement in a State-run psychiatric facility or State intellectual disability center after an incompetent to stand trial and dangerous or a not criminally responsible finding.

[2] Note: Spring Grove did not have a database until the beginning of FY13 and was unable to manually gather data for FY12. In all cases, data from FY14 was slightly incomplete, generally missing the last two weeks of June 2014.

Figure 2[3]
Average Wait Time for Residential Placement
in a State Psychiatric Facility or State Intellectual Disability Center
Fiscal 2012 through 2014

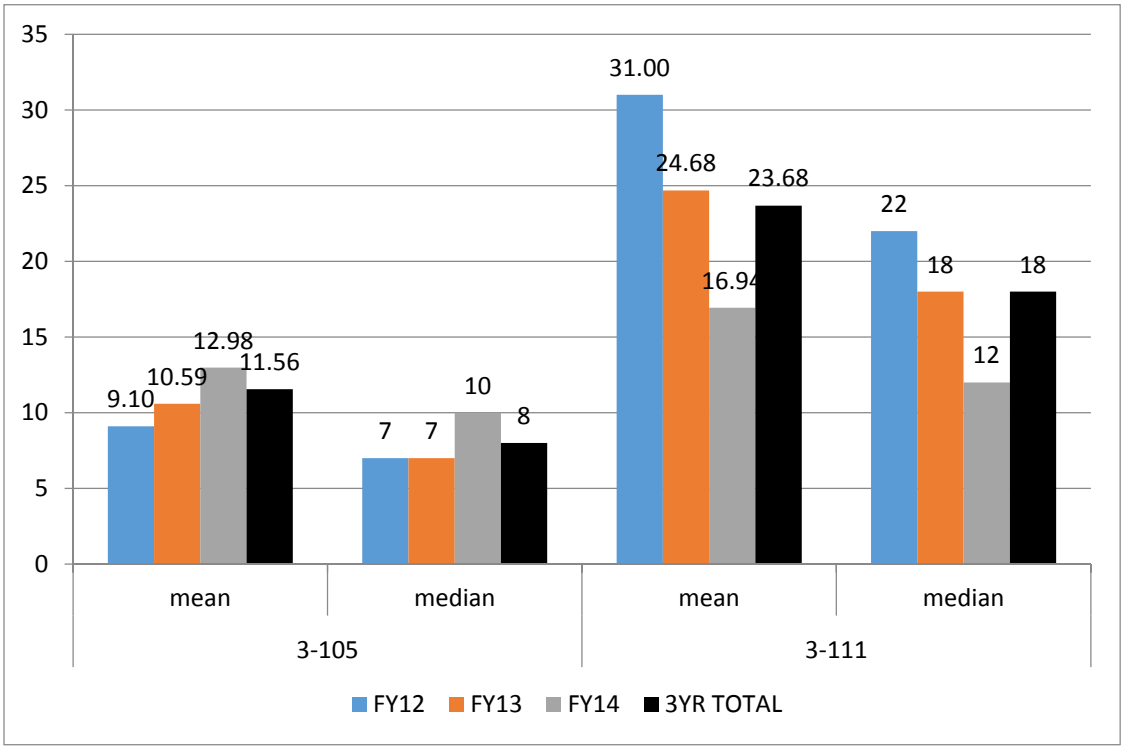


Note: The above table includes responses from all five state psychiatric hospitals (Clifton T. Perkins Hospital Center, Eastern Shore Hospital Center, Spring Grove Hospital Center,[4] Springfield Hospital Center, and Thomas B. Finan Center) as well as from DDA (inclusive of admissions both to the SETTs and to the Potomac Center).

Figure 3 presents the mean and median number of days from the date of a court order for evaluation for fiscal 2012 through 2014 and the average wait time for residential placement in a State-run psychiatric facility or State intellectual disability center after the signing of an inpatient evaluation order for a competency or not criminally responsible evaluation. It is important to note that because Spring Grove Hospital Center was unable to provide data for fiscal year 2012, and given the volume of cases committed to this hospital, it is difficult to interpret temporal changes across the three fiscal years, and especially to compare fiscal year 2012 to the other two years. Therefore, the aggregated 3 year total is the most informative.

[3] 3-106(b) is the statutory reference to incompetent to stand trial and dangerous, while 3-112 is the statutory reference to not criminally responsible.
[4] Note: Spring Grove did not have a database until the beginning of FY13 and was unable to manually gather data for FY12. In all cases, data from FY14 was slightly incomplete, generally missing the last two weeks of June 2014.

Figure 3[5]
Average Wait Time for Residential Placement
in a State Psychiatric Facility or State Intellectual Disability Center
After the Signing of an Inpatient Evaluation Order for a Competency or Not Criminally Responsible Evaluation Fiscal 2012 - 2014



Second, the median number of days (i.e. the point at which 50% of cases have been admitted) to admission is consistently shorter than the mean or average days to admission. This means that there are a small number of extreme outliers who took much longer to be admitted, while the bulk of the cases clustered around the median point. Percentage cutoffs are included in the Table 1 to further underscore this result.

Therefore, the most informative numbers are the median (the point at which half of the cases fall at or below the number) and the percentage cutoffs. For example, across the three years, 50% of incompetent to stand trial commitments (3-106(b)) occurred within 3 days or less from the date of the court order, and only 18.7% of these admissions occurred more than 7 days from the date of the order. While these outlier cases may reflect a problem with admission of certain cases, they do not indicate any sort of systemic failure on the part of either BHA or DDA. Thus, the fix is to further understand the outliers in order to devise a solution, not to impose an overall systemic change in how the Department responds to court orders which for the vast majority of cases happen very quickly. This issue is further discussed in the recommendations section of this report.

[5] 3-105 is the statutory reference to the competency to stand trial evaluation, and 3-111 is the statutory reference to the criminally responsible evaluation.

Demand for Residential Treatment Beds Generated From Drug Court and Section 8-507 of the Health - General Article

For fiscal 2012, 2013, and 2014, the Joint Chairmen's Report also required the Department to report on (1) the demand for residential treatment beds generated from drug courts and placements under Section 8-507 of the Health-General Article or any local equivalent; and (2) the average wait time for placement in a treatment slot after the signing of an order under Section 8-505 or 8-507 of the Health-General Article or any local equivalent. An 8-505 order requires the Department to conduct an evaluation as to a criminal defendant's need for substance use treatment, while an 8-507 order, upon the court's finding that a criminal defendant requires substance use treatment, requires the Department to facilitate the prompt treatment of that defendant.

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 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.

In addition, it is important to be aware that several steps take place after the §8-507 order is authorized by a court:

1. Once the order is authorized, the evaluation must take place. This typically occurs within **14 days**.
2. If a residential program is recommended on the basis of the defendant's addiction treatment needs, the defendant must be screened for other factors that might preclude placement in a community based program (the most prominent of which involves people with histories of sex offenses). Typically the Office of Forensic Services can do this in **15 days**. This requires collaboration with the Division of Corrections and local detention centers to gather the needed information.
3. The evaluation must be returned to the court. Typically this occurs within **14 days**.
4. The evaluation is completed and submitted to the court and to counsel. The defense attorney is then responsible for scheduling a hearing which can be done at any time after receipt of the 8-505 evaluation. This can take **days or weeks** to be scheduled, for a variety of procedural reasons.
5. If the person is suitable for community placement on both treatment and safety grounds, and the court agrees, the court then must so find and order an 8-507 placement. That placement typically can be implemented within **90 days**.

Table 2 provides data on the number of 8-505 and 8-507 orders received by BHA during the three years in question. It is important to note that for the reasons discussed above, a smaller number of defendants are actually admitted to 8-507 slots than may be ordered into those slots. It is also important

to note that more than three times as many defendants are ordered into treatment via drug court as compared with the 8-507 commitment process.

Table 2:
Total Number of Court-Ordered Substance Use Evaluations and Commitments
Fiscal 2012 – 2014

	2012	2013	2014[6]	2012-2014 Total
8-505 orders	1,222	1,205	1,051	3,478
8-507 orders	625	541	604	1,770
Orders from Drug Court	1,984	1,903	1,596	5,483

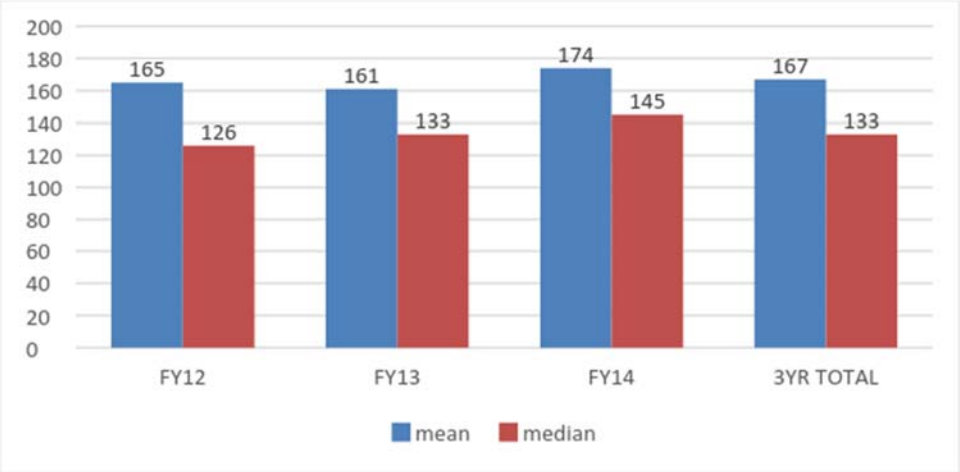
Table 3 and Figure 4 below provide data on the wait time to admit to an 8-507 mandated drug treatment slot beginning from the point of the initial 8-505 order in a case. The data demonstrates that, on average, it takes 167 days, or about 5½ months, for these individuals to be placed, and 50% of them are placed in 133 days, or about 4½ months.

Table 3:
Time to Placement in an 8-507 Residential Treatment Slot
Fiscal 2012 – 2014

	2012	2013	2014	2012 – 2014 Totals
Total number of cases	462	398	416	1,276
Range (days)	10-1,248	31-1,038	0-563	0-1,248
Mean number of days	165	161	174	167
Median number of days	126	133	145	133

[6] Projected based on data through May 2014.

Figure 4
Time to placement in an 8-507 Residential Slot
Fiscal 2012 - 2014



Other Relevant Outcomes for Court-involved Individuals

The Joint Chairmen's Report also required the Department to report on any other relevant outcomes for court-involved individuals with mental illness, intellectual disabilities, and substance use disorders. During the Joint Chairmen's Report stakeholder meetings, a variety of outcomes were discussed. These included consideration of the timeliness to admission data presented above, but also a number of other potential outcomes, including:

- timeliness of release from commitment;
- timeliness of availability of community resources once legal barriers to discharge are lifted;
- adequacy of community programs serving court-involved clients, including the number of returns from conditional release;
- a program's willingness to serve forensic clients;
- adequacy of aftercare plans prepared by facilities;
- additional consideration of "high utilizers" who disproportionately use both the criminal justice system and behavioral health resources; and
- the effectiveness of residential drug treatment placement's via 8-507 placements, including the number of absconders.

In order to supplement the workgroup's discussions, Judge Lipman conducted a preliminary survey of trial judges regarding the budget language that requested this report. While a number of responses to his survey were informal, judges in the following courts responded in writing to the survey: Kent County District Court; Baltimore County District Court; Washington County District Court; Anne Arundel County Circuit Court; and Prince George's County District Court. Among other things, this survey revealed:

- satisfaction with the responsiveness of the Eastern Shore Hospital Center, Springfield Hospital Center, and Thomas B. Finan Center;

- variable frustration with the responsiveness of Spring Grove Hospital Center, in part, this relates to some jurisdiction being prioritized over others[7]; and
- frustration with the responsiveness of Clifton T. Perkins Hospital Center

However, separate from the issues related to wait times for admission, the judges responding to the survey generally expressed dissatisfaction with the availability of certain types of community-based services, including housing, ready access to clinical services and case management, and, in some jurisdictions, transportation. There was a general consensus that delays at the "front door" to the hospital relate directly to delays at the "back door". In other words, where stable patients remain in a state facility only because the various pieces of a discharge plan are not available, or are not yet in place, they tie up resources that could better be used by people not yet in that facility, and they cause there to be a wait time for admission in some circumstances.

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. 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.

In addition to delays in admission to 8-507 placements, some judges expressed dissatisfaction with the quality of the service provided by the residential drug treatment provider(s) available to serve court-committed patients in their jurisdictions. There was some sentiment to having the option of more than one provider available for these placements. To the extent that additional resources were available, and providers were capable of expanding services, a reduction in wait times could most likely be facilitated.

Availability of Services by Jurisdiction

The second portion of the Joint Chairmen's Report required the Department to discuss the availability, by jurisdiction, of the following resources for court-involved individuals with mental illness, intellectual disabilities, and substance abuse disorders: on-site clinicians or other behavioral health assessment staff at court locations; the availability of case management and other wrap-around services, including transportation grants and subsidies; and the availability of intensive supervision (pre-trial, probation, and parole). **Appendix A** details Treatment and Service Options for Court Involved Individuals by county. **Appendix B** outlines Approved Mental Health Case Management Programs by jurisdiction. **Appendix C** summarizes diversion programs by Core Service Agency.

Recommendations

Based on an analysis of the data requested by the Joint Chairmen's Report the Department was required to develop recommendations to improve treatment and service options, including additional State-operated residential capacity that will facilitate lower detention, imprisonment and hospitalization

[7] The Judiciary in three jurisdictions that feed into Spring Grove Hospital Center (Baltimore City, Baltimore and Charles counties) provided a sample of cases from which admission wait times were calculated. The timeframes differ somewhat, so it is difficult to directly compare the jurisdictions, but the results were as follows: (1) Baltimore City's (N=80) median time to admit to Spring Grove was 7.5 days; (2) Baltimore County's (N=27) median time to admit to Spring Grove was 26 days; and for Charles County (N=8) the median time to admit to Spring Grove was 8 days.

rates, and emergency room visits, for court-involved individuals with mental illness, intellectual disabilities, and substance use disorders. Any recommendations are also required to include detailed cost estimates.

Wait Times in the Forensic Delivery System

The data and information collected in response to the Joint Chairmen's Report sheds light on only some of the issues inherent in this query. While the information discussed in this report is helpful in understanding aspects of the relationship of the courts to certain facilities and community-based programs, it does not address use of emergency services, risk factors for incarceration, or the quality or quantity of community-based treatment programs for court involved individuals with mental disorders or intellectual disabilities. Many of these issues are addressed in the Department's response to other legislation, specifically the Continuity of Care Workgroup that met in 2013 and the Outpatient Services Workgroup – established under House Bill 1267/Chapter 353 and Senate Bill 882/Chapter 352 of the Acts of 2014 – that also met a number of times during the summer of 2014.

However, the data collected for this Joint Chairmen's Report does suggest certain responses. First, the data collected on wait times for residential placement in a state psychiatric facility or a State intellectual disability center after finding of incompetent to stand trial and dangerous or not criminally responsible, and the data on the average wait time for a residential placement in a State psychiatric facility or State intellectual disability center after the signing of an inpatient evaluation order competent to stand trial or criminally responsible indicate that over the period studied, there were wait times to admissions across the state. In the majority of cases, these wait times were not very long. However, the data suggests that a minority of cases referred for admission waited a fairly long period of time before they could be admitted, and these outliers may highlight a potential resource limitation. In many instances, a part of the delay in admitting individuals ordered into Department facilities may stem from delays in accessing community-based programs that meet the needs of other individuals currently in facilities who could be discharged if such programs were more readily available. These issues were discussed in detail in both the Continuity of Care and the Outpatient Services workgroups discussed above. To the extent that delays in admissions relate to delays in other individuals' releases, the resource limitation is community-based, and not hospital-based. Consequently, the solution to this issue is community-based rather than hospital-based.

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.

Delays Regarding 8-505 and 8-507s

Similarly, the data collected regarding 8-505 and 8-507 wait times indicate that it takes several months before an individual court-mandated for an addiction evaluation, who is subsequently determined to require residential substance use care, is admitted to a residential program. 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 outcomes may be preferable. Many of the workgroup participants view the limitation as related to the number of available residential treatment slots, or alternatively, to the amount of money allotted to BHA to pay for residential treatment. To the extent that this is so, it suggests that there is a mismatch between the supply of and the demand for these treatment

slots, further suggesting that budgetary allocations could alleviate the wait times.

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.

Demand for Substance Use Treatment

While, additional funding for treatment beds may improve wait times for 8-505 and 8-507 orders, additional information is needed regarding where the Department should target resources. In 2008, as a result of a bill requiring ADAA to conduct a needs assessment "for prevention, diagnosis, and treatment of drug misuse and alcohol misuse in the State," a study entitled *Need for Substance Abuse Treatment in Maryland Final Report* was delivered to the legislature.[8] This assessment was expected to "identify the financial and treatment needs of each jurisdiction and of each drug treatment program operated by the State." This was intended to adjust funding allocations to the jurisdictions. However, the Secretary did not pursue re-allocation despite inequities in funding allocations. Data used was from 2001-2005 and looked at arrest rates, hospital discharges, mortality, and treatment admissions. It did not specifically focus on residential services but rather on treatment services as a whole.

While, the report does not provide a breakdown of the levels of care needed in each jurisdiction, a few of the findings of the report include:

- The areas of greatest unmet need were the suburban counties outside of the District of Columbia, Baltimore County and its surrounding counties (Anne Arundel, Harford, and Carroll), Baltimore City, the western counties, and Cecil County.[9]
- Treatment needs in Maryland were highest in Baltimore City by a wide margin.
- Among the seven counties with the largest treatment gaps, four of these counties (Prince George's, Montgomery, Howard, and Harford) had substance need index scores below the median, but they also had especially low levels of treatment admissions.
- The relative treatment gaps could be eliminated by a moderate, potentially achievable increase in statewide treatment admissions and targeting of the new admissions to counties with the greatest amount of unmet need.
- If all of the gaps were completely eliminated so that these counties had treatment admissions rates consistent with estimated need, an additional 13,807 admissions per year would be required.

[8] The ADAA contracted with the Center for Substance Abuse Research (CESAR) at the University of Maryland, College Park, to conduct the treatment needs assessment. Dr. William McAuliffe of the Department of Psychiatry at Harvard Medical School was funded by SAMHSA to direct the National Technical Center in order to advise all of the states as they conducted their needs assessments. CESAR engaged him to collaborate with its staff and to direct Maryland's treatment needs assessment. A copy of the report may be found here: http://www.cesar.umd.edu/cesar/pubs/20081215.mdtxneed.pdf.

[9] The largest relative treatment admissions gaps per 100,000 were in Allegany County (550), Prince George's County (493), Baltimore County (434), Howard County (397), Cecil County (259), Montgomery County (254), Harford County (249), Worcester County (160), Fredrick County (120), Baltimore City (116), Anne Arundel County (101), Carroll County (76), Garrett County (43), St. Mary's County (24) and Washington County (18).

Recommendation 3: The Department should update this study using data that reflects the demand for substance use services since the implementation of the Affordable Care Act. The study should identify the demand for various levels of care, including residential services, throughout the four regions of the state.

Additional Data Reporting

The Department is developing a new forensics database that will capture important data regarding the court-involved population within the Department. This database will be able to track individual cases from the point of initial contact with the Department through the evaluation and treatment processes and into community-based care under the Department's oversight. In addition to its utility for managing cases as they happen, the database, once complete and with populated data fields, will permit reporting on any number of questions that are of interest to internal and external stakeholders, including:

- the average and median wait times for admission pursuant to court orders of various kinds;
- the average and median length of stay tied to court orders of various kinds;
- the average and median time between court order for release and subsequent community placement;
- the number of cases in which the court rejects a plan for release proposed by a facility; and
- the number of cases under community release monitored by the Department who are returned to a facility, including voluntary admissions and admissions through a hospital warrant or another form of a court order.

All of these questions will be able to be assessed by jurisdiction, by court level, by facility, by evaluator, or by any of a number of selection criteria based on the questions of interest to any stakeholder. For this Joint Chairmen's Report, the answers to questions regarding wait times for not criminally responsible, incompetent to stand trial and dangerous, competency to stand trial, and criminally responsible admissions were answered using a prototype of the forensics database that has been in use at Springfield Hospital Center for the past decade and at Spring Grove Hospital Center for the past two years.

Recommendation 4: The Department should expedite the building of the forensics database in order to begin capturing data as soon as possible. The database process allows for the adding of modules based on future interests within the Department, and the Department will involve internal and external stakeholders in these future developments as needed.

Moreover, some of this information should be reported as part of DHMH's managing for Results (MFR) submission. BHAs current MFR submission does not include measures related to the Office of Forensic Services.

Recommendation 5: As a part of its budget submission, BHA should develop MFR outcomes to measure the performance of the Office of Forensic Services. Potential outcomes to measure the Office's performance may include (1) timeliness of evaluations; (2) timeliness of admissions; (3) timeliness of release; and (4) timeliness of aftercare planning.

Identification of High Utilizers

During the workgroup process, there was extensive discussion of "high-utilizer" individuals – that is, the small number of people who use disproportionately large amounts of resources, both in the criminal justice and in the behavioral health systems. These individuals often frustrate all of the partners in the workgroup, and they shine a light on the formal and the informal gaps in the system. Formal gaps include those which are defined in law or practice, including the legal, liberty-based limits on civil commitment. Informal gaps are those not defined by law or practice but which nonetheless are real and

which create often insurmountable barriers to the individual achieving stability, such as the lack of a ready supply of affordable, accessible housing for people with co-occurring mental and addictive disorders with criminal records.

Recommendation 6: A joint behavioral health and criminal justice system for the identification of high utilizers of services in both systems. This would then lead to the development of specialized approaches to managing high utilizers once they are identified.

Enhanced Forensic Services

As discussed in the background section of this document, the census of the State psychiatric hospitals has changed significantly since 2002. The number of forensic admissions to the hospitals has remained relatively unchanged over this time period, while non-forensic admissions have substantially decreased. Because of this, court-involved cases now account for about 90% of all state psychiatric hospital admissions. This change in patient population affects the mission of the Department's psychiatric facilities.

While the mission of these facilities has changed, it is unclear if forensic staffing – staff that are solely dedicated to forensic work such as competency restoration services and preparation of aftercare plans – has adapted accordingly statewide. Moreover, feedback from the Workgroup members and the constituents they represent highlighted dissatisfaction with two facilities – Clifton T. Perkins Hospital Center and Spring Grove Hospital Center. Based on these concerns the Department conducted an assessment of forensic staffing in each of the regional state psychiatric facilities as the type of cases that they handle are comparable. However, Clifton T. Perkins was not included in this analysis because its mission and the population that it serves is different from those of the regional psychiatric facilities. Rather, the Department will conduct a further study of barriers to clinically appropriate movement within the forensic service delivery system at Clifton T. Perkins Hospital Center under Recommendation 1. As indicated in Table 4, the findings suggest a need for increased forensic staffing allocations at Spring Grove Hospital Center.

Table 4
Caseloads for Forensic Staff
State Psychiatric Regional Hospitals

State Psychiatric Facility	Cases per FTE
Eastern Shore Hospital Center	17.2
Spring Grove Hospital Center	41.5
Springfield Hospital Center	12.7
Thomas B. Finan Hospital Center	16.2

The import of these findings is clear: Spring Grove Hospital Center is badly understaffed and requires substantial additional personnel dedicated to the provision of forensic services. The Department estimates that approximately 10 additional FTE's dedicated to forensic work are needed to serve the needs of individuals committed to Spring Grove Hospital Center. With additional staff, the Department believes that it will be better able to provide competency restoration services, more frequent forensic evaluations and reviews, and the preparation of the comprehensive aftercare plans needed to provide courts with adequate assurances that individuals committed by and under the jurisdiction of criminal courts may safely be released into the community. By moving forensically committed patients more efficiently toward recovery, the hospitals will be able to move people into community settings more efficiently, directly resulting in improved availability of hospital resources when courts commit new cases to the hospitals.

Recommendation 7: The Department recommends budgeting for increased forensic staffing, particularly at Spring Grove Hospital Center.

Conclusion

The Department thanks all of those who provided data and information needed to prepare this response, including the numerous stakeholders who gathered information and who provided helpful feedback and discussion of the complex issues contained in this response to the 2014 Joint Chairmen's Report. In addition, the Department thanks DHMH's facility forensic coordinators, DDA Forensic Services, Justice Services, and the BHA Office of Special Needs Populations staff who assisted in the production of this report.

Appendix A
Treatment and Service Options For Court Involved Individuals

County	CSA Contact Information	On-site clinicians or other behavioral health assessment staff at court location	The availability of case management and other wrap-around services, including transportation grants and subsidies	The availability of intensive supervision (pre-trial, probation, and parole)
Alleghany	Lesa Diehl, Director Lesa.diehl@maryland.gov 1-301-759-5070 Kara Lankford, Adult Coordinator Kara.lankford@maryland.gov	No	The Western MD Health System has developed a short-term aftercare case management program staffed by LMHP to work with individuals in the community following discharge to ensure consumers link with appropriate services including cm, PRP and OPT.	N/A
Anne Arundel	Adrienne Mickler ajmickler@aol.com 410-222-7858	Substance Use screenings only-Circuit Court only	High users are identified through Value Options reports and working to set up crisis case management for all through Care Coordination. Continue to work with inpatient agencies to utilize the CC release to help expedite the intake process for cm and follow up services	N/A
Baltimore City	Bernard McBride Bernard.mcbride@bhsbaltimore.org 410-637-1900	FAST-Forensic Alternative Services Team-screening, assessment, treatment planning, diversion to the community if appropriate, tracking, consultation to court personnel and others, and technical assistance for providers in how to work better with the courts.	ACT-Assertive Community Treatment, The Capitation Project, The Care Management Entity	N/A

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County	CSA Contact Information	On-site clinicians or other behavioral health assessment staff at court location	The availability of case management and other wrap-around services, including transportation grants and subsidies	The availability of intensive supervision (pre-trial, probation, and parole)
Baltimore County	Dave Goldman dgoldman@baltimorecountymd.gov 410-887-3828 Mary Viggiani mviggiani@baltimorecountymd.gov	No	Assertive Community Treatment- matches high end/high risk users with in home clinical, medical and support services to avoid entering a higher level of care.	N/A
Calvert	Julie Ohman, Director Julie.ohman@maryland.gov 410-535-5400 ext 311 Nancy Porter, Adult Services Coordinator Nancy.porter@maryland.gov	The CSA maintains a Court Assessor/Diversion program to assist the judges in determining what is most appropriate for individuals appearing before the court who may have a mental illness.	The Calvert CSA maintains a collaborative relationship with Calvert Memorial. Together they work to create effective discharge plans and linkages to community based services. Residents are referred for services as appropriate.	N/A
Carroll	Sue Doyle, Director Sue.doyle@maryland.gov 410-876-4800 Jackie Mazurick, C & A and Adult Coordinator Jackie.mazurick@maryland.gov	Unit that conducts substance use screenings only.	Collaborative effort with Carroll Hospital Center for one Peer Recovery Support Specialist that provide community support services for individuals after discharge 5 days a week, 3 in the hospital and 2 in the local office.	N/A
Cecil	Shelly Gulledge, Director Shelly.gulledge@maryland.gov 410-996-5112	No	MCCJTP works with local court systems to assist individuals in accessing mental health services in the community.	N/A

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Charles	Karyn Black, Director Karynm.black@maryland.gov 301-609-5757 Constance Garner, Adult Coordinator Constance.garner@maryland.gov	No	Implementation of the expanded Forensic Liaison program to provide case management services to individuals identified as needing linkage to community MH services by the court system and local detention center.	N/A
Fredrick	Robert Pitcher, Director rap@mhma.net 301-682-6017 Joyceann Sundergill Schmid jss@mhma.net	New FY 15 contract for MCCJTP will include a mental health professional in the District Court with emphasis on post booking diversion.	ACT now providing services to 92 consumers reducing the need for ER services or hospitalizations. Intensive in-home intervention services provided by MHP to reduce need for out of home placements.	N/A
Garrett	Fred Polce, Director Fred.polce@maryland.gov 301-334-7440 Diana Boller, Adult Coordinator Diana.boller@maryland.gov 1-301-334-7442	No	No	N/A
Harford	Terence Farrell, Director tfarrell@harfordmentalhealth.org 410-803-8726 Jessica Kraus, Adult Coordinator jkraus@harfordmentalhealth.org	Diversion from jail: MHDP works with District Court Judge to assist individuals in accessing services and monitoring through the program. Alliance is contracted to provide a case manager.	Diversion programs from hospital-community programs for smooth access to services and resolutions of problems. Mobile Crisis Team and CIT are utilized also to avoid hospital placements.	N/A

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Howard	Donna Wells, Director wells@hcmha.org 410-313-7350	No	In FY 13, the county received a Transition from Jail to Community grant from the DOJ. The grant focuses on building better community partnerships and linkages to community services for those who are released from incarceration in the hopes of addressing recidivism for this population.	N/A
Mid Shore	Holly Ireland, Director hireland@msmhs.org 410-770-4801 Johanna Walter, Clinical Coordinator, Adult jwalter@msmhs.org	The Forensic Mental Health Program staff work closely with Judges, Masters, Parole and Probation Agents and local detention centers to assist in cases where the defendant has mental health and/or co-occurring issues.	A new mobile treatment team came online in July of FY 14 to serve the mid-shore five-county region in a continued effort to maintain individuals, non-compliant with traditional mental health treatment, in the community. Education of providers and stakeholders about community based resources is ongoing through the BHSN quarterly meetings and regular meetings of BHSN workgroups.	N/A

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Treatment and Service Options For Court Involved Individuals

County	CSA Contact Information	On-site clinicians or other behavioral health assessment staff at court location	The availability of case management and other wrap-around services, including transportation grants and subsidies	The availability of intensive supervision (pre-trial, probation, and parole)
Montgomery	Raymond Crowel, Director Raymond.crowel@montgomerycountymd.gov 1-240-777-1400 Ken Weston, Adult Coordinator Ken.weston@montgomerycontymd.gov	No	The CSA BHPM has also worked closely with Value Options and People Encouraging People Assertive Community Treatment team on diverting high end users from emergency rooms. PEP utilizes Value Options alert system so when a high end user shows up at an emergency room, PEP is called to pick the individual up and divert them into residential crisis services.	N/A
Prince George's	L. Christina Waddler, Division Manager lcwaddler@co.pg.md.us 1-301-985-3890 Margueritte Parker, Adult Coordinator mlparker@co.pg.md.us	Mental Health Court – Individuals with mental illnesses who are arrested for misdemeanors can go before the court.	ACT provides comprehensive, community based treatment, rehabilitation and support services to individuals with SMPI. Priority is given to individuals released from state hospitals, those with frequent psychiatric hospitalizations and/or incarcerations due to their MI, those who are homeless and are unable to meet their basic needs. Services are delivered by a multidisciplinary team utilizing evidence based practices. ACT team members are available 24/7 and 365 days a year.	N/A

Appendix A
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County	CSA Contact Information	On-site clinicians or other behavioral health assessment staff at court location	The availability of case management and other wrap-around services, including transportation grants and subsidies	The availability of intensive supervision (pre-trial, probation, and parole)
St. Mary's	Cynthia Brown, Division Manager Cynthia.brown@stmarysmd.com 1-301-475-4200	No	No	N/A
Washington	Rick Rock, Director rickr@wcmha.org 1-301-739-2490	No	No	N/A
Wicomico-Somerset	Heather Brown, Director Heatherl.brown@maryland.gov 410-543-6981 Lisa Renegar, Adult Coordinator Lisa.renegar@maryland.gov	No	ACT provides comprehensive, community based treatment, rehabilitation and support services to individuals with severe and persistent mental illness. Priority is given to individuals released from state hospitals, those with frequent psychiatric hospitalizations and/or incarcerations due to their MI, those who are homeless and are unable to meet their basic needs. Services are delivered by a multidisciplinary team utilizing evidence based practices.	N/A
Worcester	April Turner, Director April.turner@maryland.gov Jessica Sexauer, Adult and C & A Service Coordinator Jessica.sexauer@maryland.gov	No	Worcester County Crisis Response Team, Jail Reentry services jointly funded by MCCJTP and the DOJ.	N/A

Appendix B

Maryland Mental Hygiene Administration 2014
APPROVED MENTAL HEALTH CASE MANAGEMENT PROGRAMS

Allegany County
Lesa Diehl/Sarah Pinardi
Allegany County Mental Health Systems
Serving both adults and children
P.O. Box 1745
Cumberland MD 21501-1745
301-759-5070
Fax: 301-777-5621
lesa.diehl@maryland.gov
Sarah.Pinardi@maryland.gov

Anne Arundel County
Michelle Hammer
Community Residences, Inc.
Serving both adults and children
7477 Baltimore Annapolis Blvd.
Glen Burnie, MD 21061
410-760-2250
Fax: 410-760-6670
mhammer@comres.org

Sondra Tranen/Erin Gallagher/Amber Schmidt
Partnership Development Group PDG
Serving both adults and children
804 Landmark Drive, Suite 118
Glen Burnie, MD 21061
410-863-7213
Fax: 410-863-7205
stranen@pdgrehab.com
egallagher@pdgrehab.com
aschmidt@pdgrehab.com

Baltimore City
Adam Gomez/ Sequoia Alexander
Community Institute of Behavioral Services
Bon Secours Health System
Specialized Case Mgmt Program
Serving adults only
3101 Towanda Avenue
Baltimore MD 21215
(410) 627-3182
410-383-4942
Fax: 410-383-4513
Adam_Gomez@bshsi.org
sequoia_alexander@bshsi.org

Baltimore City
Annastasia Kezar
Johns Hopkins Bayview Medical Center
Child & Adolescent Case Mgmt Program
Serving children under 18 only
4940 Eastern Ave D-3 East 242
Baltimore MD 21224
410-955-1930/410-550-0067
Fax 410-550-1302
akezar@jhmi.edu

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John Hopkins Bayview Medical Center
Serving adults only
1821 B Portal Street
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410-284-5020
FAX: 410-550-1061
dcavey1@jhmi.edu
410-550-1930

Baltimore City
Larry Alessi, M. D.
Ursula Goldring-Neal
Harford-Belair CMHC, Inc.
Serving adults only
4308 Harford Road
Baltimore MD 21214
410-426-5650
443-451-3240
Fax: 410-426-5143
lalessi@harfordbelair.org
uneal@harfordbelair.org 667-205-1745

Baltimore City
Kathy Malloy
JHH Community Psychiatry Program
Serving adults only
600 N. Wolfe Street
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Fax: 410-955-6154
Kmalloy1@jhmi.edu

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Angela Robinson/ Timothy Allen
Mosaic Community Services, Inc.
Serving adults only
2225 N. Charles Street
Baltimore MD 21224
410-366-4360 x415
Fax: 410-308-8926
Angela.Robinson@mosaicinc.org
Timothy.allen@mosaicinc.org

Baltimore City
Barbara Wahl/Wayne Wood
University of MD Medical Center (UMMC)
Community Support Program
Serving adults only
701 W. Pratt Street, 2nd Floor
Baltimore MD 21201
410-328-1406
Fax: 410-328-1614
Bwahl@psych.umaryland.edu
Wwood@psych.umaryland.edu

Baltimore City
Shakena Mabrey
People Encouraging People
Serving adults only
2002 Clipper Park Road, Suite 105
Baltimore MD 21211
410-366-4299
Fax: 410-366-6277
ShakenaM@peponline.org

Baltimore City
Erin Moyer
Baltimore Crisis Response, Inc. – Case Management
Serving adults only
2041 E. Fayette Street
Baltimore, MD 21231
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Fax: 410-433-7653
emoyer@bcresponse.org

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Serving both adults and children
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Baltimore County
Malcom Williams
Alliance, Inc.
Serving both adults and children
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Calvert County
Karen Carloni/Janeen Collinson
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kcarloni@smcni.org
jcollinson@smcni.org

Carroll County
Michelle Stuckey/Meghan Edwards
Keystone Services of Maryland
Serving both adults and children
255 Clifton Boulevard, #309
Westminster MD 21157-3872
410-875-4694
Fax: 410-875-4699
mstuckey@keystonehumanservices.org
medwards@keystonehumanservices.org

Cecil County
Debbie Parker/Dana Brady
Upper Bay Counseling & Support Services
Serving both adults and children
200 Booth Street
Elkton, MD 21921
410-620-7161
Fax: 410-996-5197
dparker@upperbay.org
dbrady@upperbay.org

Charles County
Cathy Meyers/Lindsey Bragunier
Center for Children, Inc.
Serving children only
6100 Radio Station Rd.
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301-609-7284 (fax)
Meyers@center-for-children.org
Bragunier@center-for-children.org

Charles County
Burt Otts
Southern Maryland Community Network
Serving adults only
11865 Federal Square, Suite 203
Waldorf, MD 20602
301-932-9146
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Frederick County
Michelle Stuckey/ Meghan Edwards
Keystone Services of MD
Serving both adults and children
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Westminster MD 21157-3872
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Fax: 410-875-4699
mstuckey@keystonehumanservices.org
medwards@keystonehumanservices.org

Garrett County
Nancy Rotruck/Dawn Graves
Burlington United Methodist Family Services
Serving both adults and children
105 S. 2nd Street
Oakland MD 21550
301-334-1285
Fax: 301-334-0668
nrotruck@bumfs.org
dgraves@bumfs.org

Harford County
Renee L. Duzan
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Fax: 410-273-2085
rduzan@allianceinc.org

Howard County
Jennifer Corcoran, LCSW-C
Alliance, Inc.
Serving both adults and children
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jcorcoran@allianceinc.org

Mid-Shore Counties
John Plaskon/Lisa Brooks
Sherri Hitchcock
Crossroads Community, Inc.
Serving adults only
120 Banjo Lane
Centerville MD 21617
410-758-3050
Fax: 410-758-1223
plaskonj@ccinconline.com
brooksl@ccinconline.com

Montgomery County
Eugene Morris/ Jennifer Vidas
Community Case Management Services
Serving adults only
255 Rockville Pike, S145
Rockville MD 20850
240-777-3353
Fax: 240-777-4740
Eugene.morris@montgomerycountymd.gov
Jennifer.Vidas@montgomerycountymd.gov

Prince George's County
Nicola Davis/Sydney Bryson
Alek's House, LLC
Serving both adults and children
4200 Forbes Boulevard, Suite 122
Lanham, MD 20706
301-731-0383
Fax: 301-731-2835
alekandgabriel@hotmail.com
sbryson@alekshousemd.com

Prince George's County
Kyoko Queen/Victoria Karacheyeva
Volunteers of America
Serving both adults and children
4611 Assembly Dr., Suite D
Lanham, MD 20706
301-306-0904 x212
Fax: 301-306-5105
kqueen@voaches.org
vkarakcheyeva@voaches.org

St. Mary's County
Lori Bowes
Southern Maryland Community Network, Inc.
Serving both adults and children
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Leonardtown, MD 20650
301-475-9315
Fax: 301-475-9317
lbowes@smcni.org

Washington County
Dawn Johns
Potomac Case Management
Serving both adults and children
324 East Antietam, Suite 304
Hagerstown MD 21740
301-791-3087 x 203
Fax: 301-393-0730
djohns@pcmsinc.org

Wicomico & Somerset Counties (combined CSA)
Wicomico County Behavioral Health Authority and
Somerset County Core Service Agency

Wicomico County
Tasha Jamison/Jodi Holland
Wicomico County Targeted Case Mgmt
Serving both adults and children
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Tasha.Jamison@maryland.gov
Jodi.Holland@maryland.gov

Somerset County
Eric Gray/Jennifer Rodgers/Wendy Shirk
Worcester County Targeted Case Mgmt
Serving both adults and children
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Berlin MD 21811
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Appendix C

	Diversion Programs by CSA *May 2014*
Allegany County	• The Western MD Health System has developed a short-term aftercare case management program staffed by licensed mental health professionals to work with individuals in the community following discharge to insure consumers link with appropriate services including case management, PRP, and outpatient treatment. • In response to individuals who present in the ER in Opioid withdrawal, Western MD Health System has developed an Ambulatory Detox program. • The PATH Coordinator meets with consumers in the acute inpatient psychiatric unit at WMHS and at the Residential Crisis beds to complete PATH assessments and increase the likelihood individuals will follow-through with PATH services. (many are also homeless or at risk of being homeless)
Anne Arundel County	• Hired a crisis specialist who will meet with identified high cost users to see what barriers are stopping clients from being placed. This clinician will also visit Emergency Rooms to help with least restrictive placement of clients in crisis. • Continue to identify high utilizers through VO reports and working to set up crisis case management for all through Care Coordinator. Continue to work with inpatient agencies to utilize the care coordination release to help expedite the intake process for case management and follow up services. • Have increased our stabilization visits through use of Mobile Crisis to help provide support until linked with services or the crisis has diminished. • Our Crisis Response System is now working with 4 providers to help gain more access to urgent care appointments. • 6 high cost users have been placed in programs such as RRP and ACT. The Care Coordinator follows up with the staff of the respective RRP and ACT providers to assess client stability in these programs.
Baltimore City	Baltimore city has the following services that promote hospital and jail diversion: • 24/7 crisis hotline for adults and children • Mobile crisis response from 7am to midnight 365 days a year • In-home crisis intervention services • 21 residential crisis beds for adults • Short-term case management for adults leaving a residential crisis beds • Hospital-based urgent care for children, youth and families • Hospital-based crisis assessment for adults • Unplanned respite care for children and youth • Crisis intervention training for police officers • Critical incident debriefing

	• Substance use information and referral line • Substance abuse detox services with three providers serving approximately 230 adults • Jail diversion services through the Forensic Alternatives Services Team (FAST) that includes the following services to individuals with current involvement in the criminal justice system: screening, assessment, treatment planning, diversion to the community if appropriate, tracking, consultation to court personnel and others, and technical assistance for providers in how to work better with the courts • Problem solving courts including drug courts, mental health courts and a specialized homeless services docket There are additional programs in Baltimore City that provide targeted interventions to high users of psychiatric inpatient services: • 7 assertive community treatment (ACT) teams with one targeting homeless individuals and a second targeting individuals with forensic involvement. ACT is an evidence-based model providing wrap-around care at a client's home or other location by a multidisciplinary team including psychiatrists, therapists, addiction counselors, and peer support specialists. • The Capitation Project provides comprehensive mental health care for 354 individuals with serious mental illness and history of frequent ED visits or inpatient utilization. • The Care Management Entity (CME) provides wrap around community-based care to help children/youth avoid placement in a residential treatment setting. In addition BHS Baltimore as the CSA provides the following services in support of hospital and jail diversion: • Collaboration with hospitals, community-based service providers and the ASO to provide system-level care coordination for individuals identified by the ASO as high utilizers of psychiatric inpatient services. Baltimore City also has multiple problem solving courts including drug court, mental health court and a homeless services docket. • The DataLink Project captures individuals who are arrested and enter Baltimore's Central Booking and Intake Facility (CBIF) and have current or previous treatment through the public mental health system in an automated data sharing system. BHS Baltimore uses this information to notify providers of an individual's arrest and notify the jail of defendants in need of intensive planning prior to release.
Baltimore County	• Assertive Community Treatment (ACT)- matches high end/high risk users with in home clinical, medical and support services to avoid entering a higher level of care. Baltimore County has added 2 teams in the past two years for a capacity of 200 individuals. As of May 2014, there are two fully functioning ACT teams in Baltimore County. Each team has between 80 and 85 consumers currently enrolled as they reach full capacity. • Mobile Crisis teams, In Home intervention Teams (IHIT) and Urgent Care clinic as a response to crisis needs and then as step downs to community resources. There is a healthy communication and interplay between the Crisis programs and the ACT teams that has reduced the constant churn into institutional care.

Calvert County	• Currently, the Calvert Co. CSA maintains a cooperative agreement with Emergency Psychiatric Services at Calvert Memorial Hospital. When individuals present at the ER but do not meet the medical necessity criteria for admission or could be successfully served in the outpatient setting individuals are diverted to urgent care appointments maintained by the CSA within the local mental health clinic. The CSA also prioritizes referrals for community based services by recommendation of Calvert Memorial. • Calvert County also has an Adult Crisis House funded by the Five County Project. Individuals can be diverted at the ER and stepped down from inpatient care as appropriate. • The Calvert CSA maintains a collaborative relationship with Calvert Memorial. Together we work to create effective discharge plans and linkages to community based services. This is done by weekly review of census on the unit by CSA staff. Calvert County residents are reviewed and referred for services as appropriate. • The CSA maintains a Court Assessor/Diversion program to assist the judges in determining what is most appropriate for individuals appearing before the court who may have a mental illness. The Assessor completes evaluations and makes recommendation to the judges for diverting defendants from incarceration. • The CSA maintains an in-jail mental health program to assist with screening, assessment, therapy, short term crisis intervention, and referral and coordination of care for inmates approaching release.
Carroll County	• Carroll continues to work collaboratively with Carroll Hospital Center we have implanted one Peer Recovery Support Specialist who works three days a week. The Peer Specialist provides services in the Emergency Department, Behavioral Health Unit or a Medical Unit. He works three days a week at the hospital and two at our office following up on those in the community after discharge. The original intent was to target high use/high utilizes from the data supplied-by Value Options and Carroll Hospital Center. We were able to show a decrease in Emergency Department use of 41% as well as track return to Emergency Department for services six months of 10%. Carroll County Health Department and Carroll Hospital Center presented this initiative and the data in a webinar hosted by the Maryland Hospital Association. A copy can be made available if needed. • On May 12, 2014 our Urgent Care diversion services were reinstated after finally being able to secure staffing, tele-mental health provider and develop resources. This initiative was originally funded for six months as part of the LHIP and due to the compelling positive impact we decide to find a way to provide these essential services in Carroll. • Carroll County Government continues to fund four residential crisis beds strictly for the prevention of inpatient admission. This effort has diverted 40 + persons in FY14 with only one individual needing to go to the hospital. • Carroll County is also in the process of developing a Crisis Intervention Team we hope to implement in November. • We also continue to recruit for our Crisis Response Nurse.
Cecil County	• Diversion from Hospital- monthly meeting with Union hospital, Cecil County Drug Alcohol Recovery Center, and Mobile Crisis, to discuss noteworthy consumers to provide a smooth access to services.

	• Emergency Room & Hospital Intervention Project provides care coordination to children under the age of 18, enrolled in the PMHS. The care coordinator will serve between 10 & 15 families on a rolling basis for up to one year. Develop crisis prevention plan & service plan with input from the family and outpatient therapist and school personnel when appropriate. • Diversion from jail: MCCJTP Works with local court system to assist individuals in accessing mental health services in the community.
Charles County	• Implementation of Urgent Psychiatric Care Program through a local OMHC. Individuals with MA or uninsured, not already linked with community MH Provider, are referred by local ED when Inpatient criteria is not met. • Implementation of the expanded Forensic Liaison program to provide case management services to individuals identified as needing linkage to community MH services by the court system and local detention center. • Grant funded Crisis Beds for adults, four bed program shared by Five County Project located in Calvert County.
Frederick County	• Assertive Community Treatment now providing services to 92 consumers. Very successful in reducing the number of persons needing the ER services and or hospitalization. • Recently began Walk-in Behavioral Health facility with goal to divert persons from the ER. • Mobile Crises team in close coordination with Law Enforcement reduces need for high cost hospital visits especially because of the extensive follow-up after the first visit. • TAMAR program very successful at reducing recidivism of female detainees. • Crisis beds resulting in decrease in use of ER and a possible step down that reduces hospital stays. • New FY 15 contract for MCCJTP will include a mental health professional in the District Court with emphasis on post booking diversion. • Close coordination between hospital and clinics in establishing timely appointments after discharge from hospital. Includes appropriate documentation to the clinic to quickly process new intakes. • Intensive in-home intervention services provided by Mental Health Professionals to reduce need for out of home placement. • RTC retooling grant providing intensive transition and aftercare for youth returning to the community from the RTC. Pre-discharge contact with services in the community to have in place upon discharge, especially smooth and timely transition to community school system. Intensive after-care management including each youth having a cell phone to be able to make contact with key person at the RTC.
Garrett County	• Garrett County has no official diversion programs. • We do have a Jail mental health program as well as a TAMAR program that is stationed with a Mental Health Professional in the Community Supervision office (Parole/Probation). • Both programs probably work with about 160 individuals, with an estimated 2% of those or (3) being served returning to Jail within the fiscal year being served. • Our Local Mental Health Advisory Committee has been discussing the most efficient and effective type of

	Behavioral Health Court that could be utilized in Garrett County.
Harford County	• Diversion from jail: MHDP (Mental Health Diversion Program) – Works with District Court Judge to assist individuals in accessing services and monitoring through the program. Alliance is contracted to provide a case manager. • Diversion from Hospital: Regular meetings with hospital social work staff and community programs for smooth access to services and resolution of problems. Mobile Crisis Team and CIT are utilized also to avoid hospital placement. • Contract with Upper Chesapeake Health System for psych evaluations referred by Mobile Crisis to alleviate potential hospitalizations. • Family Involvement Specialist (FIS) via DJJ funding provides in-home interventions with children in the DJJ system to decrease possibility of hospitalization or RTC placement. • Crisis Stabilization Program provides in-home assistance to families of children involved in DSS system to alleviate need for hospitalizations and placements. Originally for Foster Care involved children but expanded to any DSS involvement.
Howard County	• Howard County has a Mobile Crisis Team that works closely with the local Police Department that is then able to divert individuals from the Criminal Justice system to treatment options in the community. MCT is considered an "unofficial" diversion program. In FY 15, additional county and state funds will be available to expand to two MCT teams during the daytime hours • In FY14, Howard County received funding for a Mental Health Liaison position within the local police department to help identify individuals/families where patrol makes repeated visits to the home/family but the needs are not public safety but linkage to various community resources. Hopefully, this will allow early intervention and prevention of more costly services such as out of home placements for youth and in-patient/ED utilization. This staff position will also function as the CIT Coordinator within the HCPD. • In FY 13, the county received a Transition from Jail to Community (TJC) grant from the Department of Justice. This grant focuses on building better community partnerships and linkages to community services for those who are released from incarceration in the hopes of addressing recidivism for this population. • In FY 15, Howard County has funded a full time position to do an ED Follow-up Program with the local hospital, Howard County General, based on the SAMHSA model. Individuals who are EP'ed but not hospitalized for whatever reason, will be encouraged to consent to participate in this program, which will follow-up with the individual to link them to needed community services.
Mid-Shore Counties (Caroline, Dorchester, Kent, Queen Anne's, Talbot)	• Eastern Shore Operations Center (ESOC) is now operated by MSMHS rather than contracted out to ensure program is operating at an optimal level for hospital diversion effectively utilizing mobile crisis teams, crisis beds, and urgent care appointments. • Expansion of Mobile Crisis Teams from two (2) to four (4) serving eight counties of the nine eastern shore counties has allowed for closer follow-up until consumers are engaged with a treatment provider. • Urgent Care Services in Dorchester County were expanded in FY14 in response to an additional mobile crisis team located in Dorchester County and the increased demand for services evident through the SHIP data as

	well as historical data collected by MSMHS. • Mobile crisis support for Chester River Hospital Center Emergency Department and Shore Health Systems Queen Anne's Emergency Department for behavioral health specialty care evaluations has been provided since FY13. • Ongoing education of community providers on the shifting system culture and eliminating instructions to "proceed to the nearest emergency room" from voice mail messages and ensuring provider on-call crisis response as required by COMAR. • Educate 911 operators, emergency responders, and law enforcement on the shifting systemic culture. CIT efforts have included the development, approval and implementation of a four (4) hour Behavioral Health First Responder training for law enforcement, 911 operators, emergency responders, and other community partners. • Partner with local Substance Abuse Treatment programs/coordinators to address primary substance abuse and co-occurring alternatives to ED/INPT utilization. An Urgent Care appointment model for referrals to addiction providers is in the development phase for primary care physicians to access for their patients. • Partner with Crisis Bed providers to develop shared risk and responsibility with diversion efforts by working more collaboratively with the ESOC and mobile crisis teams. Continued collaboration has allowed for crisis beds to be utilized at the maximum level. • A new mobile treatment team came online in July of FY14 to serve the mid-shore five county region in a continued effort to maintain individuals, non-compliant with traditional mental health treatment, in the community. • Education of providers and stakeholders about community based resources is ongoing through the Behavioral Health Services Network (BHSN) quarterly meetings and regular meetings of BHSN workgroups.
Montgomery County	• For the past two decades HHS has been in close collaboration with Department of Corrections and Rehabilitation, initially with the Jail Addictions Services and later the Clinical Assessment and Triage Services programs. Both programs are physically located in the correctional facilities providing various services as follows: The Jail Addiction Services (JAS) program, is an ADAA certified (level II.5) substance abuse treatment program for inmates who self-diagnose and voluntarily opt to participate in treatment; DOCR has designated one of the housing pods at the Boyds facility (Montgomery County Correctional Facility) for the men's treatment unit and part of another housing unit for the female program. JAS serves an average of 260 inmates annually and is staffed by a supervisor, five (5) full time licensed therapists and a State Care Coordination specialist. JAS clients who are released receive Care Coordination through a newly created ADAA funded position. The Clinical Assessment and Transition Services (CATS) program deploys staff at both the Rockville (MCDC) and Boyds (MCCF) facilities. The Rockville team is responsible for assessment and management of suicide risk, comprehensive needs assessments, classification decisions and post-booking diversion. They are staffed by a supervisor, five (5) licensed therapists and a discharge specialist (CSAIII). CATS provides services to an average of 2200 assessments per year to incoming inmates presenting with behavioral health concerns. Staff coverage is 13 hours per day, seven days a week. The CATS team's diversion efforts are a

	complex and collaborative process with DOCR's Pre-Trial unit and the Courts. The annual percentage rate of diversion is 35% of all assessed inmates. Inmates are diverted to various community based programs depending on their clinical needs. • The MCCF CATS team is responsible for discharge planning for inmates with behavioral health issues that could not be diverted. Two full time licensed therapists serve an average of 160 inmates with re-entry plans. The transition team also conducts forensic evaluations (8-505), as the local ADAA designees. • The CSA BHPM has begun a pilot project with focus on consumers who are two high cost Assertive Community Treatment (ACT) clients. The CSA BHPM has met with a representative from each of the 5 hospitals in Montgomery County, (MedStar Montgomery, Suburban, Washington Adventist, Adventist Behavioral Health, and Holy Cross), a CSA BHPM staff person, the Crisis Center, Access Team , People Encouraging People (PEP) ACT team, and **most importantly the client**. In effect, the CSA BHPM will come up with a community treatment plan/behavior agreement while they are in the room with the client and the above named representatives. The client will have the opportunity to sign an authorization allowing the above mentioned parties to communicate with PEP if/when the client shows up in the Emergency Department or Crisis Center. The difference this project will make is to bring everyone together in one room and demonstrate to the client that the whole system is on board with the plan for the individual. The fact that all parties mentioned are with the client also demonstrates real integration/collaboration and should certainly help with diversion efforts and better client outcomes. The CSA BHPM hopes to expand this into the future. • The CSA BHPM has also worked closely with Value Options and People Encouraging People Assertive Community Treatment team on diverting high end users from emergency rooms. PEP utilizes Value Options alert system so when a high end user shows up at an emergency room, PEP is called to pick the individual up and divert them into residential crisis services. • The CSA has diverted several high cost utilizers into residential rehabilitation programs. • The CSA has been working with MHA and PEP on adding another ACT team to Montgomery County and received permission to do so. One of the prime missions of this new team will be to focus on diversion of high cost users.
Prince George's County	• Crisis Response System (CRS) – Responds to individuals experiencing mental health crises. Works to divert from inpatient through use of urgent care appointments, development of safety plans, providing linkage to community mental health resources, identifying and engaging support system. The CRS also responds to law enforcement requests for assistance with calls involving persons with mental illnesses and provides clinical expertise in those situations. In Fiscal Year 2013, the Crisis Response System has diverted 273 persons from inpatient hospitalization and 67 from jail. Total combined is 340 persons diverted. • Mental Health Court – Individuals with mental illnesses who are arrested for misdemeanors can go before the court. In Fiscal Year 2013, 95% of those served by the Mental Health Court case managers were diverted from incarceration. • Assertive Community Treatment provides comprehensive, community based treatment, rehabilitation and

	support services to individuals with severe and persistent mental illness. Priority is given to individuals released from state hospitals, those with frequent psychiatric hospitalizations and/or incarcerations due to their mental illness, those who are homeless and are unable to meet their basic needs. Services are delivered by a multidisciplinary team utilizing evidence based practices. ACT team members are available 24 hours a day, 7 days a week, and 365 days a year. This flexibility and availability of services contributes to the reduction of inpatient psychiatric hospitalizations. In Fiscal Year 2013, the Assertive Community Treatment team diverted 106 individuals from inpatient hospitalizations, six (6) of whom were identified as high utilizers of emergency department and inpatient hospital services.
St. Mary's County	• St. Mary's County has access to the Crisis House located in Calvert County. This is a four bed facility supported by grant funds through the Five County Project. • Providers operating in the district of the county with the highest percentage of homelessness and crime, offer tele-psychiatry services to expedite access to care and for crisis prevention. • St. Mary's Detention Center has dedicated a Correctional Officer to provide case management and coordination of services for inmates prior to their release. • St. Mary's Detention Center implements services under the MCCJTP. • Correctional Mental Health is provided to inmates.
Washington County	• Work with WCDSS to identify foster care youth who have repeated hospital admissions or ED visits. Identification of WCDSS youth has been problematic to this point but this task is still being pursued. • Continue partnership with local hospital to expand strategies already utilized around Total Patient Revenue. • Implement urgent appointments into daily schedules of local OMHCs to be used by ED staff for diversion of Hospital staff for discharge coordination to prevent rapid recycling related to medication/treatment issues. • CSA meets with the community providers' forum to process and share information re: identification of high service utilizers through ED, community mental health system providers, and City Police; and develop and implement alternative strategies to ED use. • IP and ED diversion continues to focus on working with the Law Enforcement and MH Task Force to construct community interventions prior to emergency use. • Continuing to work with Inpatient providers around more effective discharge planning and linkages.
Wicomico/Somerset Counties	• Hospital Diversion Committee: Meets monthly to discuss potential issues regarding ED and Jail diversion. Multiple providers which include the hospital and jail participate on the committee. • In development of implementing CIT. It is projected that the first CIT class will be held on 11/10/14. As to date 8 officers have been trained and one CRT staff. • CRT has been assisting police with high utilizers to attempt to link them to services. • Data Link as been implemented within Wicomico County. • Assertive Community Treatment provides comprehensive, community based treatment, rehabilitation and support services to individuals with severe and persistent mental illness. Priority is given to individuals released from state hospitals, those with frequent psychiatric hospitalizations and/or incarcerations due to

	their mental illness, those who are homeless and are unable to meet their basic needs. Services are delivered by a multidisciplinary team utilizing evidence based practices. • All coordinators within the CSA have been trained in mental health first aid. Will work with the police academy to train the majority of officers within Somerset and Wicomico Counties. • Implementing peer support within the ED of the hospital.
Worcester County	• Worcester County's Crisis Response Team has been functional for over twelve years. The team of licensed clinical Social Workers partner with local Law Enforcement. They are dispatched through 911. The team is skilled in hospital diversion and safety planning. For FY 2012 the CRT Team received 515 calls that resulted in 536 cases. The team completed 206 diversions for a diversion percentage rate of 38%. The Crisis Response Team is monitored through the CSA and is funded by MHA's Federal Block Grant. • Jail Re-entry Services: Referrals for Re-Entry services are made internally from the local detention centers mental health provider to the Re-Entry provider. A case manager with the Re-Entry program assesses needs with inmates using the *GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs*. This assessment tool identifies potential service needs post release, steps taken by staff to assist with meeting the identified needs, and contact information for referrals made. Re-Entry staff makes referrals identified and attempt to continue tracking inmates in the community for one year post release. During the first 3 quarters of FY13 there were 5 individuals who were re-arrested after release, out of 38 inmates referred for the Re-Entry program. Of these 38 individuals one was arrested in another jurisdiction for a charge obtained prior to his/her arrest in Worcester County. This has resulted in 89.5% of Re-Entry participants remaining in the community and out of the detention center. The Re-entry program is jointly funded by MCCJTP and the Department of Justice. • Crisis Intervention Team- The Worcester County Health Department has hired a CIT Coordinator as of May 2014, and is currently in the process of developing our County's CIT response through utilization of the "Memphis Model". The Worcester County CIT Coordinator in collaboration with other behavioral health clinicians, administrators, and law enforcements attended an CIT Forum in April 2014 for an overview of the guiding principles of the planning and implementation phase from National and local level experts.