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WHEN TREATMENT IS PUNISHMENT:

THE EFFECTS OF MARYLAND'S INCOMPETENCY TO STAND TRIAL POLICIES AND PRACTICES

JUSTICE POLICY INSTITUTE | OCTOBER 2011

JUSTICE POLICY INSTITUTE

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FOREWORD

That people with a mental illness and other mental disabilities are being arrested in large numbers and incarcerated in our nation's jails and prisons is a subject of widespread concern and increasing attention. Another, less-examined issue involves treatment of persons arrested but subsequently found incompetent to stand trial: more specifically, where treatment attempting to restore competence takes place and for how long it can continue. Over the years, states have enacted laws addressing the constitutional standards and due process rights of people found incompetent to stand trial. While some have adopted reasonable maximum treatment periods and have shifted to greater use of outpatient treatment to attempt to restore competency, others require costly inpatient treatment for too many people and allow confinement for long periods of time.[1]

In this report, the Justice Policy Institute looked specifically at Maryland's "incompetent to stand trial" (IST) law as applied by the Baltimore City District Court. Maryland is among those states that do not have a maximum period for treatment to attempt to restore competency that is consistent with scientific research. Instead, state law provides for the dismissal of criminal charges against a person who cannot be restored to competence after set periods of time that are tied to whether the person is charged with a misdemeanor, felony or capital offense. Baltimore City District Court handles misdemeanor and nonviolent felony offenses that would not likely lead to significant, if any, incarceration for a person who is competent to stand trial.

The research included in this report shows that too many people found not competent to stand trial are unnecessarily locked in a secure setting for treatment and, on average, confined for longer periods than research demonstrates is clinically reasonable. In addition, the majority of people who are eventually found competent are not convicted and sentenced to incarceration, raising serious concerns about the state's interest in imposing lengthy periods of competency restoration treatment. In the first six months of 2011, none of the 24 people from Baltimore City whose IST cases were resolved were sentenced to spend any time behind bars, and most were not even convicted of the charge.[2] Eleven of 24 people had their cases dismissed, including one person who had their case dismissed after spending 147 days at Spring Grove for filing a false police report—the longest possible sentence for this offense.

As people's liberty is denied when they are involuntarily confined to an institution pretrial, and is severely curtailed when required to enroll in residential and outpatient programs, it is critical that they not be held in "competency limbo" beyond the time that research shows is reasonable to either restore competency or to determine that competency is not substantially likely to be restored. Failure to do so raises questions not only of civil liberties, but also of fiscal efficacy: it costs Maryland taxpayers $512 per person per day to hold someone in Spring Grove, where the majority of Baltimore City residents are placed; as the average length of stay of a person from Baltimore City for forensic IST is 414 days (nearly 14 months),[3] that means that Maryland is spending an average of $211,968 per person to house them in Spring Grove for competency restoration.[4]

Maryland's competency system is in need of reform. At a time when the state's mental health budget is in danger of even deeper cuts, it is imperative that Maryland stop wasting precious resources on inappropriate use of confinement for competency cases.

INTRODUCTION

The most recent U.S. estimates suggest that 50,000 to 60,000 people undergo competency evaluations every year,[5] and that in about a fifth of these cases the person was found incompetent to stand trial (IST).[6] In other words, around 12,000 people are found incompetent to stand trial in the U.S. every year, and around 4,000 of these people are hospitalized for treatment to restore competency at some point during a single incident of court involvement.[7]

In FY2010, the Maryland Mental Hygiene Administration provided 789 pretrial screenings and evaluations for incompetency to stand trial, 77 percent of which were for the District Courts. Baltimore City makes up the largest percentage of screenings and evaluations in the state: 23 percent come from Baltimore, 72 percent of which are for the Baltimore City District Courts.[8] In FY2011, 129 competency screenings were conducted in Baltimore City District Court, 70 percent of which were referred for further evaluation due to the possibility of incompetency to stand trial.[9]

The number of people on forensic IST status in state hospitals is increasing

	FY2006	FY2011	Percent Change
Maryland			
Forensic	586	663	+13%
Forensic IST	163	348	+113%
Spring Grove Hospital Center			
Forensic	242	261	+18%
Forensic IST	34	148	+335%

Source: Mental Hygiene Administration

At the end of FY2011, two out of every three people (68 percent) in state psychiatric hospitals in Maryland were on forensic status, meaning they were involved in the justice system, either as incompetent to stand trial (IST) or after a finding of "not criminally responsible."[10] While the total number of people treated in state hospitals in Maryland has decreased 18 percent since FY2006, the number committed as IST increased 113 percent since FY2006, from 163 people to 348 in FY2011.

For Spring Grove Hospital Center (Spring Grove), where the majority of IST patients are committed by the Baltimore City District Court, this percentage increase is even greater: the number of people committed as IST increased 335 percent since FY 2006, from 34 people to 148 at the end of FY2011.

This increase in the number of forensic IST commitments is happening at the same time that Maryland is diverting civil admissions* to

* A person is categorized as a "civil" admission if she voluntarily admits herself into the hospital or is involuntarily confined after an administrative hearing finding that she has a mental disorder, is in need of inpatient treatment and there is no less restrictive alternative, is a danger to herself or others, and is

private and community hospitals by purchasing beds in those settings, closing state hospitals and reducing beds in many facilities. The reasons for this shift include a belief that most people are more appropriately served in hospitals and outpatient settings located in their own communities, and for cost-containment purposes.[11] However, due to the increasing numbers of forensic patients, including IST patients, state hospitals are still operating at or above capacity.[12]

Increasing commitments by the courts and increasing lengths of stay for people who are committed puts intense pressure on Maryland to continue operating at current state hospital bed capacity, and perhaps even consider expanding. During the 2011 legislative session, the budget committee of the Maryland General Assembly reallocated $200,000 from the general fund appropriation made to support the operations of the state hospitals for Department of Health and Mental Hygiene (DHMH) to use for an independent study on (a) potential demand for state hospital capacity, including the maximum appropriate use of community-based alternatives; and (b) best practices for facility operations, including building size and configuration; and (c) appropriate site locations based on future demand.[13]

An accurate analysis of future need for state hospital beds cannot be made without close scrutiny of the legitimacy of current use of beds by the courts, particularly the rapidly increasing IST population. As Spring Grove alone saw a 335 percent increase in IST patients, examining court practices—especially those of the Baltimore City District Court, which makes up the majority of IST commitments to Spring Grove—is necessary to make sure courts are using IST commitments appropriately and effectively.

HISTORY AND CONTEXT: THE IMPACT OF THE 2006 AMENDMENTS TO THE IST STATUTE

When a person is brought into court to stand trial, it is legally imperative that they understand what is happening to them and to be able to assist in their defense. If it appears that they may be unable to do so, they are evaluated and may be found to be incompetent to stand trial and ordered to inpatient or outpatient treatment to restore competency.[14] A person cannot legally be tried for an offense if he or she is found to be incompetent to stand trial.

In 1972, the U.S. Supreme Court ruled in *Jackson v. Indiana* that people can only be held for a "reasonable period of time" to determine whether there is a substantial probability that they may soon be restored to competency to stand trial.[15] The Court did not set a maximum time limit on attempts to restore competency, leaving it up to the states to make this determination. A number of states base this time limit on research that shows that most people will be restored within six months to a year, and continued treatment and detention to restore competency beyond this time period is unnecessary.[16] Twenty states have a maximum treatment period of one year or less (**See APPENDIX**).[17] However, Maryland law is not in line with these findings and practices.

unwilling or unable to consent to voluntary treatment. Md. Code Ann., Health-General, §10-617.

INCOMPETENCY IN MARYLAND

In Maryland, "incompetent to stand trial" means that the person is not able to 1) understand the nature or object of the proceeding, or 2) assist in their own defense.

Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-101. Definitions.

For nearly 35 years, Maryland allowed for indefinite commitment to attempt to restore competency to stand trial, contrary to the *Jackson* decision. In 2006, the statute was amended to provide people with certain due process protections, including prohibiting continued confinement of individuals without a finding that there was a substantial probability of restorability in the foreseeable future and providing for annual review hearings. In addition, the statute was amended to say that DHMH include a plan for community services if the person either had their competency restored or was no longer a danger to themselves or others based on their mental disability,[†] and services were necessary to maintain competency or ensure that the person remained not dangerous.[18]

In this amendment, Maryland rejected adopting a maximum treatment period based on the research on competency restoration. Instead, it tied maximum treatment lengths to the maximum sentence that a person could have received if convicted of the charges against them or up to three years for a misdemeanor, five years for a felony and 10 years for a capital offense, whichever is shorter.[19] In other words, a person charged with a felony crime can be held in a state hospital for up to five years, at which time they "time-out" and must be released. For the people who are confined until their charges are required to be dismissed (or a substantial portion thereof), the use of forensic confinement in this way is de facto punishment for a crime in which the person was never tried and convicted.

For example, people committed to Spring Grove from the Baltimore City District Court who are ultimately found not restorable are spending an average of 19 months confined in a secure hospital, or more than half of their maximum "sentence" (three years) under the IST law. While de facto punishment for an offense that will never be tried may not be the District Court's intent, from the point of view of the person forced to stay in these secure hospitals, this is precisely what is happening.

"In reality, statutes tying treatment to the maximum sentence attempt to assure that incompetent defendants are punished sufficiently for their alleged crimes."
Grant H. Morris and J. Reid Meloy

[†] Throughout the report we will use the term "mental disability" to describe people with a mental disorder, developmental disorder, intellectual disorder or traumatic brain injury.

In addition to lengthy confinement periods, the requirement that DHMH develop a discharge plan that the court considers "adequate," is also driving up lengths of stay. Some of the services the court is demanding, such as residential treatment or housing, are not readily available and not always necessary, resulting in people remaining confined not because they need more inpatient competency treatment, but due to wait time for community services. Although people should have access to the community services that they need, using incompetency status to judicially appropriate such services is inappropriate. It is expensive to taxpayers because it increases the number of inpatient beds that are needed, may not be in line with best practices for mental health treatment, and is unfair to the person forced to stay in a secure hospital without ever being convicted of the offense.

"No credible social or rehabilitative purpose is achieved by punishing a defendant who cannot understand the nature and purpose of a legal proceeding, and who is unable to understand the reason for which a sentence has been imposed."
Daniel H. Swerdlow-Freed, *Michigan Criminal Law Annual Journal* (2003)

WHAT HAPPENS TO PEOPLE FOUND INCOMPETENT TO STAND TRIAL IN BALTIMORE CITY?

By statute, the issue of competency may be raised at any point in the criminal process prior to the conclusion of trial by the person charged with the offense, his or her defense counsel, the Assistant State's Attorney or the judge.[20]

Once an order for competency evaluation is issued by a judge, the person is screened at the Court Medical Office, and if the clinician performing the screening finds that the person may be incompetent to stand trial (IST), he or she is referred to the Mental Hygiene Administration (MHA) for further evaluation. Of the cases referred for competency evaluation, at least 90 percent are referred to MHA due to the presence of a mental disorder.[21]

The judge may order that the evaluation take place in jail, in the community or at an MHA facility. These full evaluations must be completed within seven days of the court ordering examination, but this time can be extended by the court.[22] When the evaluation is completed, the case moves to the Mental Health Court‡ for the competency hearing if the case is from District Court. The evaluation report must include an opinion as to whether the person is competent to stand trial and, if not, whether the person is "a danger to self or the person or property of another" due to a mental health disorder.[23] Finally, the report must be accompanied by a discharge plan for those persons determined to be not dangerous but incompetent to stand trial, if MHA determines such services are necessary to ensure that the person remains not dangerous.

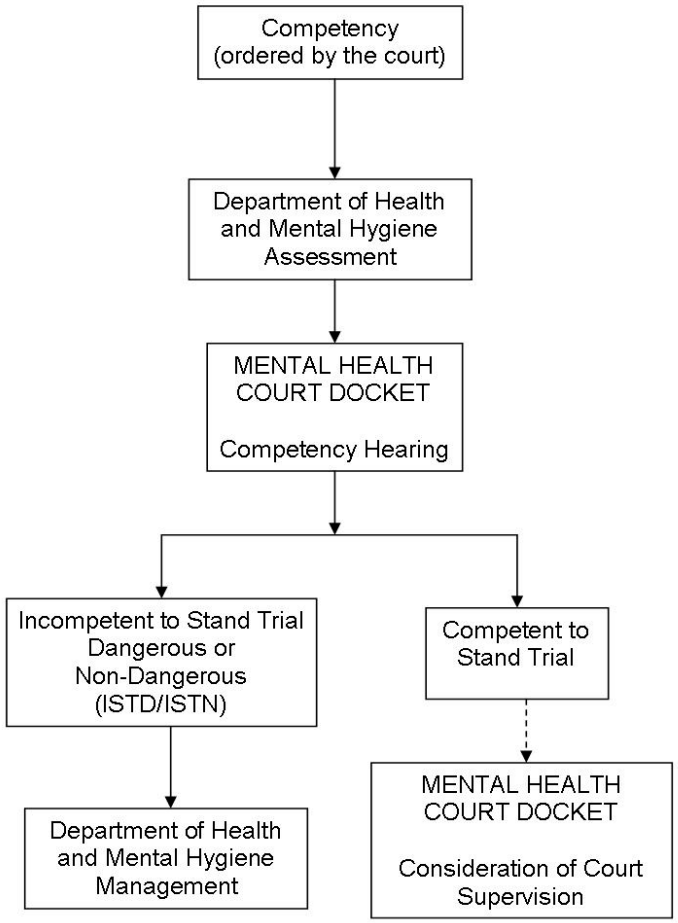
If a person is found to be IST and NOT a danger, she can be released to a community mental health program to receive treatment to restore competency and may face specific conditions of pretrial release and supervision by the Community Forensic Aftercare Program (CFAP). CFAP is a Department of Health and Mental Hygiene (DHMH) program that provides assessment and monitoring services to people with mental disabilities within the justice system,

‡ In 2002, the District Court in Baltimore City established a Mental Health Court that started by consolidating into one docket all cases where competency evaluations were ordered. Prior to this, competency cases were scattered among nine jurisdictions within the City. Today, the Baltimore City Mental Health Court can serve up to 250 people at a time and is broken up into two dockets: competency and voluntary diversion to community mental health treatment.

including people who are IST and those found not criminally responsible and put on a conditional release order. Conditions of release can include taking medications, attending meetings and treatment, abstaining from using drugs or alcohol, not possessing weapons and seeking voluntary admission to a hospital for treatment if needed. If the person "violates" – that is, fails to follow the required conditions – she is sometimes re-assigned as "dangerous" and returned to a state hospital. CFAP monitors report back to the court on their clients' condition.

If however, the person is found to be IST and dangerous, she is committed to a secure DHMH hospital to be restored. The criteria of being dangerous for the purposes of inpatient confinement does not relate to the nature of the charged offense (i.e., whether it was a crime of serious violence).§ Thus, a person charged with a nonviolent offense can be considered a danger for commitment purposes based on a current lack of services and supports, including housing, if the evaluator believes that lack of such services and supports makes the person a danger to self or to the person or property of others, and be confined in a state hospital for many months – and even years - until such services and supports are obtained.

Competency Pathway into Baltimore City Mental Health Court



Source: Process Evaluation of Baltimore City Mental Health Court (Maryland Judiciary Research Consortium, March 2010)
www.courts.state.md.us/opsc/mhc/pdfs/evalutations/bcmhcprocessevaluation3-11-10.pdf

§ The statute requires a finding that the person, "because of mental retardation or a mental disorder, is a danger to self or the person or property of another." Md. Code Ann., CrimProc §3-106, but does not define or place limitations on what is reasonably considered "dangerous." For civil commitment, the statute requires a finding that the person "presents a danger to the life or safety of the individual or others," which is narrower because it excludes property, and seems to more closely tie "danger" to the potential threat of actual physical violence or harm than does the criminal commitment criteria.

WHAT IS COMPETENCY TREATMENT?

People from Baltimore City District Court who are found incompetent to stand trial and dangerous are typically sent to Spring Grove Hospital Center (Spring Grove) and, as are all patients, assigned a treatment team that includes a social worker, psychiatrist and nurses. The treatment team meets every 60 days to discuss the patient's progress. Treatment is focused on restoring the person to competency, which for purposes of the court, primarily means that the person understands how the court operates.[24] The treatment team typically uses pharmaceutical treatment to try to improve mental functioning, and education to attempt to teach the person how a court works – for example, the roles of the judge, defense attorney and prosecutor. Other than this court process education, treatment of a person on IST status is essentially the same as for all other patients, with one striking exception - they are not permitted to leave the confines of the unit and its small, fenced-in courtyard.

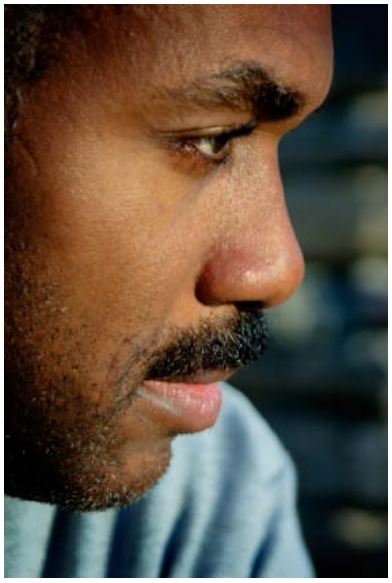
A TYPICAL DAY AT SPRING GROVE

Spring Grove Hospital Center was established in 1797 and is the second oldest operating psychiatric hospital in the country. The 200-acre campus is located just outside of Baltimore City in Catonsville, Maryland, and has the capacity for 425 beds. Units house approximately 25 men and women and are located in buildings throughout the campus. Each unit has a small fenced-in yard for recreation and a "comfort room" where people can go to be alone or meet with guests. Each unit also has a "day room," with chairs, a television set, and tables that patients can use to play games such as cards, checkers or chess. Social workers are scheduled to meet with their clients weekly. Medical doctors visit the units once a week to monitor the patients' physical health, and psychiatrists review the progress of their patients once a month.

Patients who are court-ordered for treatment to restore competency to stand trial are confined in locked units 24/7 and not permitted to earn grounds privileges, regardless of their behavior. As a result, they have access only to the activities/groups provided on the unit. On a typical day, patients are awakened and required to assemble in the day room at 5:00AM, four hours before breakfast is served in the dining room. After breakfast, patients typically again congregate in the day room. Depending on the unit and the day of the week, staff members, such as nurses, nurse techs, and other treatment professionals, may conduct one or more groups. Groups are held on topics such as the how the criminal justice system works (which is considered part of treatment for restoring competency to stand trial), or current events. Staff may also facilitate activities such as arts and crafts or trivia. On most units, people spend their days sleeping or watching TV, rousing only to take a noon and evening meal together in the dining room, to get in line for medication, or to return to the sleeping quarters between 8:00PM and 9:00PM.

HOW OFTEN ARE PEOPLE RE-EVALUATED?

American Bar Association standards recommend that a person be re-evaluated whenever a staff person feels that competency has been restored, if the person is not likely to have their competency restored, or at a minimum of every 90 days.[25] Under Maryland law, DHMH is required to report to the court every six months from the date of commitment of the person and whenever it determines that the person no longer meets the commitment criteria of incompetent to stand trial and dangerous.[26] However, the court is not required to hold a hearing more than once per year unless it determines that a report contains "opinions, facts or circumstances that have not been previously presented."[27] Thus, for example, if the court has previously made a finding of restorability or dangerousness contrary to the opinion of the DHMH forensic evaluator, it may be difficult to get a hearing before the next scheduled annual hearing date if the evaluation report contains the same opinion and is based upon the same or similar facts.



Although the treatment team has the most contact with the person and meets every 60 days to review progress towards achieving competency and whether the person remains dangerous, the practice at Spring Grove is to have a separate DHMH "forensic" psychiatrist conduct the evaluation and provide written reports to the court at the required six month period and at the annual hearing. The Maryland Disability Law Center, a nonprofit legal services organization that is the mandated Protection and Advocacy agency in Maryland, reviewed the cases of 20 people confined for at least one year as IST at Spring Grove in 2011. They found that the medical records did not indicate that any had been formally re-evaluated to determine whether they continued to meet commitment criteria more frequently than at the required six-month intervals.[**]

The lack of more frequent evaluations and the discretion of the court to hold hearings upon receiving reports can contribute to people staying longer—in some cases significantly longer—in a locked facility than is necessary or fair. Since the treatment team has daily access to the person, they should be making preliminary determinations and the formal forensic evaluation should take place promptly upon notice from a member of the team that the person's condition has changed and he or she may no longer meet the IST commitment criteria. If that is the opinion of the forensic evaluator, a report should be promptly forwarded to the court and a hearing should be scheduled.

[**] These individuals gave written authorization to review their medical records. None had been determined to lack the capacity to do so or to agree to psychiatric treatment, which they all consented to receive.

Mr. H: More than Two Years Confined in a Hospital While Waiting for Housing

Mr. H has a passion for bicycling and recycling and, for over 30 years, he rode his bike and collected scrap metal to sell. While he did not have permanent housing, he reports that he had enjoyed the freedom that his lifestyle provided. In May 2009, Mr. H allegedly threatened another individual with a large nail during an altercation while in line at a Baltimore City soup kitchen. He was charged with trespassing, second-degree assault, and concealment and possession of a dangerous weapon with intent to injure. Following his arrest, he lost his belongings, which included his bicycle and Permanent Residency Card (PRC). He was found incompetent to stand trial and dangerous, and sent to Spring Grove for treatment.

In April 2010, the forensic evaluator reported to the court that Mr. H was fit to stand trial. According to the medical record notes, despite the opinion that Mr. H was competent, the judge found that he remained incompetent and "mandated" that the hospital provide an aftercare plan, including housing, that he could order as conditions of Mr. H's pretrial release. Another year passed and, in April 2011, the forensic evaluator provided the court with his opinion that Mr. H would not be restored to competency "within the reasonably foreseeable future." The court dismissed the criminal charges and ordered him civilly committed to Spring Grove.

Several months later, a note in his records summarized why he then remained confined "[t]he patient has a desire to be discharged from this hospital and live on his own. Currently, the discharge plan is for the patient to be discharged to an assisted living placement in Baltimore City. A placement has not been identified . . . [t]he barrier to the patient's discharge is the lack of necessary paperwork to get identification and (subsequently) entitlements; all needed for community placement . . . [After] application [for green card/Permanent Resident Card] is submitted it usually takes approximately 6-8 months to obtain PRC. The patient has been made aware of this but has difficulty understanding why he cannot be discharged without his PRC." Despite the belief that the lack of a replacement card was a barrier to his discharge, no action was taken at any point during his lengthy confinement.

In September 2011, attorneys with the Maryland Disability Law Center (MDLC), the state's protection and advocacy system, intervened on his behalf. Within a few weeks, his application for the replacement PRC was filed and independent housing and support services were secured through a Baltimore City program for people who are homeless and have mental health needs. MDLC also obtained a donated bicycle for him and he was discharged from the hospital.

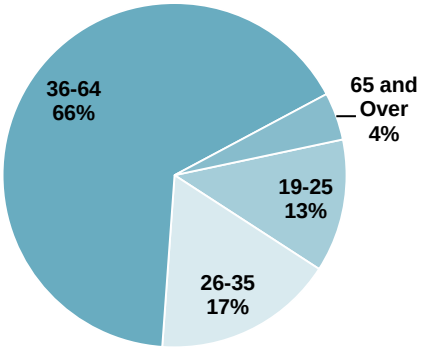
WHO IS HELD AT SPRING GROVE?

The Maryland Mental Hygiene Administration reports that Spring Grove housed 148 forensic IST people and 261 non-IST forensic patients at the end of FY2011.[28] This included 112 forensic IST people from Baltimore City—from both District and Circuit Courts.[29]

THE MAJORITY OF PEOPLE IN SPRING GROVE ARE OVER AGE 35.

Nearly two-thirds (66 percent) of the 112 forensic IST people in Spring Grove from Baltimore City in FY2011 were over age 35.[30] Five people were reported as age 65 and over.

The majority of forensic IST people from Baltimore City in Spring Grove are over age 35.



Source: Mental Hygiene Administration

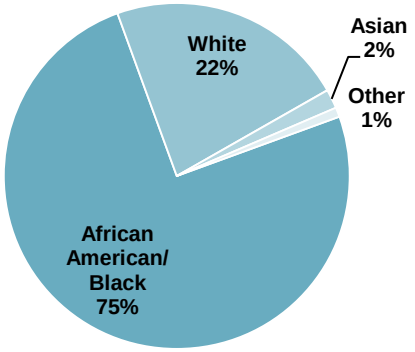
THE MAJORITY OF PEOPLE AT SPRING GROVE ARE MALE.

Three-quarters of forensic IST people from Baltimore City held at Spring Grove at the end of FY2011 were male.

THE MAJORITY OF PEOPLE HELD IN SPRING GROVE ARE AFRICAN AMERICAN.

African Americans make up 64 percent of people in Baltimore City,[31] but 89 percent of those held in the Baltimore City Detention Center (the jail)[32] and 75 percent of forensic IST people held at Spring Grove from

The majority of forensic IST people from Baltimore City in Spring Grove are African American.



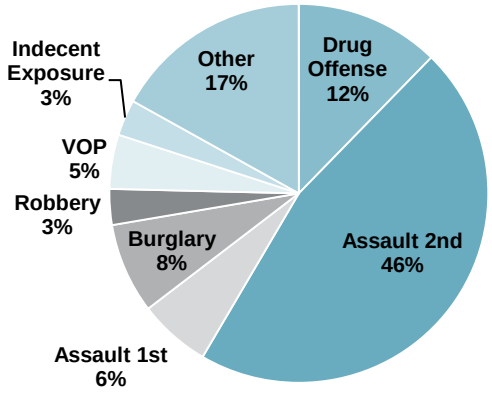
Source: Mental Hygiene Administration

Baltimore City at the end of FY2011.[33] The reasons for these disparities in criminal justice involvement are numerous. African Americans in Baltimore City disproportionately rely upon the public mental health system because of income disparities and lack access to employment opportunities that provide private insurance;[34] it may be that inadequate access to high quality, timely community-based health services contributes to the overrepresentation of African Americans in the population confined to secure facilities for restoration of competency treatment. It is likely that many of the same factors that lead to disparities in criminal arrest and incarceration rates generally are applicable to higher rates of confinement in a secure facility for African Americans found incompetent to stand trial.

THE MAJORITY OF PEOPLE IN SPRING GROVE ARE HELD FOR ASSAULT.

The Office of Forensic Services reports that as of June 2011, 65 people were being held at Spring Grove on IST cases from Baltimore City District and Circuit Courts.[35] For about half of these people, their most serious current charge was misdemeanor second degree assault[††] without a weapon, followed by a drug offense, mainly possession of a controlled substance other than marijuana. These are offenses that could generally be handled by community supervision programs.

The most serious charge of most IST people from Baltimore City being held in Spring Grove is 2nd degree assault.



Source: Office of Forensic Services

While many of these charges are relatively minor and may not illicit much if any jail time if convicted, findings of IST and dangerous can lead to their being held in secure state hospitals for long periods of time under the auspices of receiving treatment. People who are mentally ill generally spend more time in the criminal justice system under some form of incarceration both pretrial and post-conviction than the general public due to their unique cases.[36] The lack of community-based treatment options, training for police officers and crisis services[‡‡] leads to more people with mental illness being held in the justice system, including in prisons and jails as well as secure hospitals, often for minor offenses.

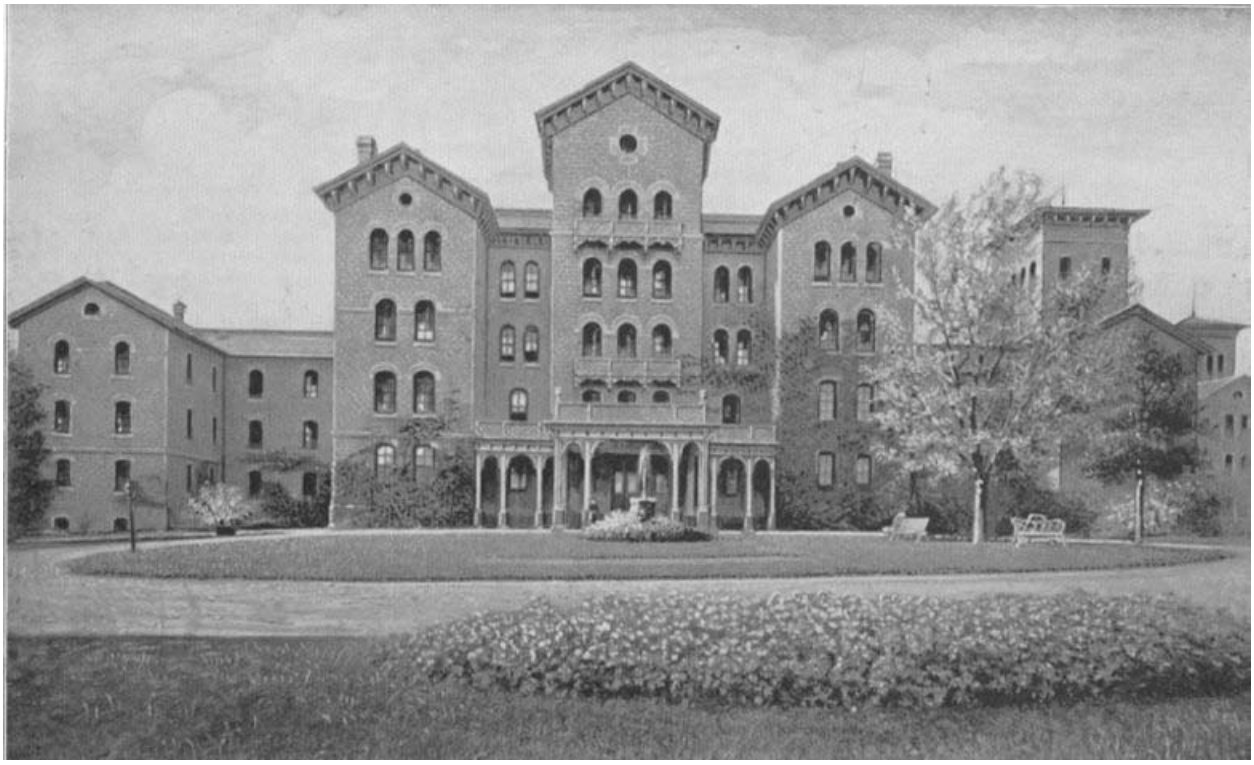
[††] Assault in the first degree requires intentional cause, or attempt to cause, serious physical injury, or assault with a firearm. Md. Code, Crim.Law §§ 3-201, 202 and 203. Assault in the second degree includes "assault", "battery" and "assault and battery", as defined by the Maryland appellate courts. Thus, a second degree assault charge may be filed against an individual where no physical contact with the alleged victim was made, or where the contact was slight and resulted in no physical injury.

[‡‡] Baltimore City Crisis Response, Inc., for example, can only operate its mobile crisis units between 7:00 a.m. and Midnight, due to lack of sufficient funds to have 24-hour availability.

Mr. E: More Than Two Years Confined Despite Existing Involvement in the Mental Health System

Mr. E was living in a group home and receiving outpatient mental health services when he was charged with assault for incidents involving arguments with peers that did not result in any injuries. He was found incompetent to stand trial and ordered to Spring Grove for competency treatment. The notes in his medical records state that his housing provider continued to stay in touch with Mr. E during his confinement and was willing to have him return.

Mr. E was not likely to be sentenced to jail or prison even if convicted of the minor charges against him and, because he had the opportunity to return to community mental health services, his criminal case should have been resolved quickly. Instead, he remained criminally committed in a costly state hospital.



Main Building of Maryland Hospital for the Insane at Spring Grove near Catonsville, MD, as it existed at the turn of the 20th-century. See www.springgrove.com for more pictures of Spring Grove Hospital Center.

HOW LONG DOES IT TAKE TO RESTORE A PERSON TO COMPETENCY?

A number of factors can determine whether a person will be restored to competency with specific treatment and within a given time period. But research shows that for the majority people who are likely to be restored, it usually happens within the first six months of starting treatment to restore competency.

RESEARCH SHOWS THAT IF PEOPLE ARE GOING TO BE RESTORED TO COMPETENCY, IT WILL HAPPEN IN A RELATIVELY SHORT PERIOD OF TIME.

Studies are inconclusive on the exact factors that will increase a person's likelihood of restoration. However, a number of studies report characteristics that may make a person more or less likely to be restored. A study out of Ohio, for example, found that people who are chronically psychotic with a history of lengthy inpatient hospitalization and people whose incompetence stems from irreparable cognitive disorders like an intellectual disability have a low probability of competency restoration.[37]

Studies also show that the majority of people who *are* restored to competency are restored within a certain timeframe. Research on competency restoration for people with mental illness shows that 70 percent or more become competent within six months of starting treatment;[38] nine out of 10 will be restored within a year. A very small percentage of people do take longer to be restored to competency, and if substantial progress is shown, and the state's interest in prosecution is great, it may be appropriate to attempt continued treatment for a brief additional period.

- A study of people in Oklahoma found that the average length of stay for people who were restored to competency was 63.7 days; less than 6 percent of the subjects had a length of stay greater than six months.[39]
- A study that reviewed 18 years of data in Indiana found that 72.3 percent of people admitted for incompetency to stand trial were restored within six months and 83.9 percent restored within one year.[40]
- A Florida study found that 40 percent of people were restored to competency in three months or less and 78 percent within six months.[41]

PEOPLE ARE CONFINED IN SPRING GROVE FOR LONGER PERIODS THAN RESEARCH SHOWS IS APPROPRIATE BEFORE BEING FOUND COMPETENT OR NOT RESTORABLE.

Based on the research, we would expect to find that three-quarters or more of all persons committed to Spring Grove who are restored to competency would be so restored within six months or less. However, the data shows that this is not happening.

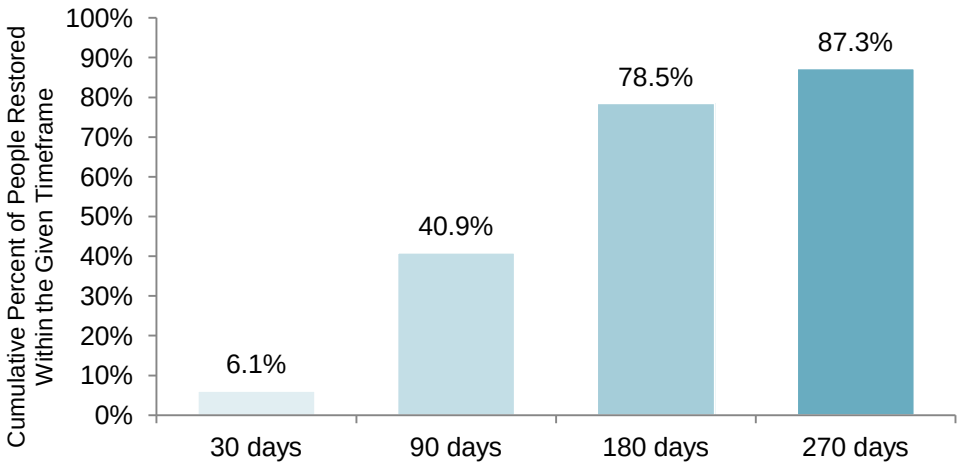
The 48 forensic IST people from Spring Grove whose cases were resolved—whether competent or unrestorable—in the first six months of 2011 spent an average of 354 days at Spring Grove from commitment to resolution.

Eleven of these people—almost a fourth—spent more than a year at Spring Grove; six of these spent two years or more. Those who were restored to competency spent an average of 232 days at Spring Grove, while those who were unrestorable spent an average of 591 days under IST status.

People from Baltimore City spent an average of 414 days in Spring Grove before their case was resolved.

Half of the forensic IST people who had their cases resolved were from Baltimore City. These 24 people—most of whom were from the District Court—spent an average of 414 days in the hospital before their case was resolved.[42] This does not include the time they spent in jail before someone noticed that they may be incompetent to stand trial, or the additional time spent at the hospital while

87 percent of people restored to competency in a Florida study were restored in 9 months or less.



Source: Data provided by Forensic Services Division, Florida Department of Children and Families cited in Gary B. Melton and others, *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers*, 3rd Edition (New York: The Guilford Press, 2007)

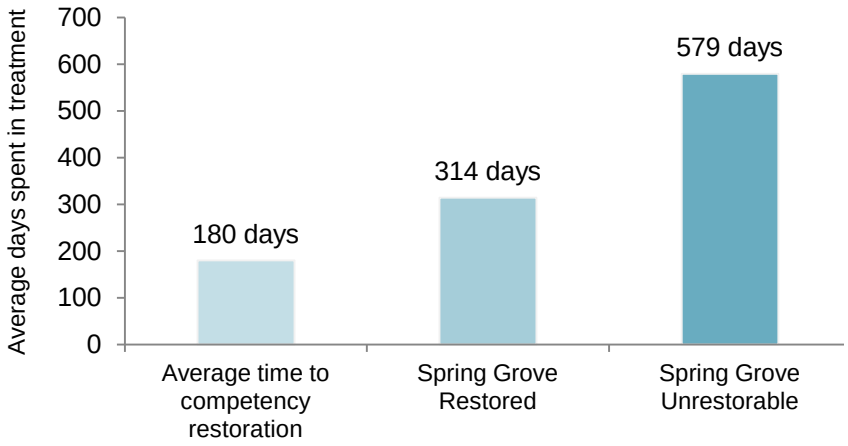
being evaluated for IST, which can be legally up to a week or more; this is only the time after they are officially committed for treatment for competency restoration. Those who were restored to competency spent an average of 314 days in Spring Grove before their case was resolved. And even after the case is resolved, they may continue to be confined, waiting for housing and other community services.

Those from Baltimore City who DHMH determined were unrestorable spent an average of 579 days in the hospital. This is more than three times the typical amount of time studies show that it takes someone to have their competency restored—180 days. Thus, the majority of people who are unlikely to ever become competent can and are remaining in a secure state hospital for longer than the research shows is clinically necessary or probable for restoration.

As of June 30, 2011, 100 people were held at Spring Grove while receiving treatment to restore competency. On average, these people had already spent 244 days at the hospital by this time; 28 of them have already been held for over a year.[43] Sixty five of these men and women are from Baltimore City. Of the people from Baltimore City, the average number of days they have been confined thus far is 257. About a third (22 people) have already been confined for more than a year.

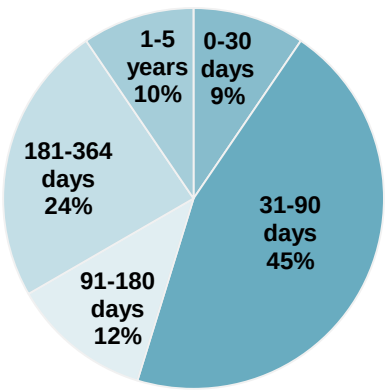
Likely as a result of the 2006 amendment tying length of treatment to sentence length, the length of time spent at Spring Grove has increased in the last five years. Of the 42 forensic IST people discharged from Spring

People from Baltimore City sent to Spring Grove spend more time in treatment for competency restoration than the average time it takes to restore someone.

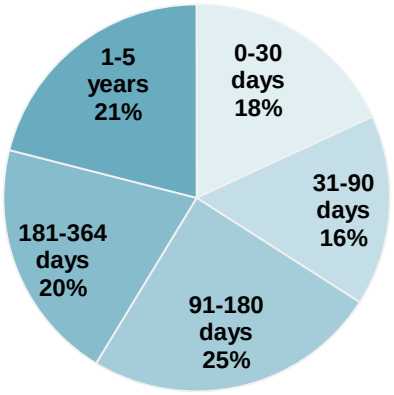


Source: Office of Forensic Services

Of the Forensic IST people discharged from Spring Grove in FY06, 34 percent spent more than six months in the hospital.



Of the Forensic IST people discharged from Spring Grove in FY11, 41 percent spent more than six months in the hospital.



Source: Mental Hygiene Administration. Notes: Length of stay based upon true discharge date.

Grove in FY06, 34 percent of people spent more than six months in the hospital for treatment to restore competency; of the 138 people discharged in FY11, 41 percent spent more than six months at Spring Grove.[44] In addition, there has been a dramatic decrease in the number of people discharged within 90 days, from 54 percent in 2006 to 34 percent in 2011, which may be connected to the amended statute's requirement that DHMH provide the court with a comprehensive discharge plan.

As the majority of people held in Spring Grove are charged with minor offenses, the practice of holding people for longer than necessary to restore competency is not necessary for public safety: the vast majority of charges are misdemeanor assaults, drug possession, indecent exposure and violations of probation. Given the nature of the offenses with which most people sent to Spring Grove are charged, the State's interest in keeping them locked up, and perhaps eventually prosecuting, is not nearly as great as their liberty interest.

Even after the forensic evaluator determines that the person is competent, unrestorable or no longer dangerous, unjustified delays often continue. People should have a hearing within 30 days of the hospital's filing a report with the court that the person no longer meets the IST commitment standard; however this is not always the case. Some people are waiting more than double or even triple that time for hearings.[45] Not only do these delays violate people's rights under the law, they can hamper discharge efforts as community programs often have waiting lists and cannot hold open slots pending the outcome of the hearing. In addition, any housing arrangement a person may have had prior to his arrest is frequently long gone by the time the charges are disposed. With nowhere to go after months or years locked in Spring Grove, some will agree to remain in the hospital to wait for housing – although this cannot truly be considered a voluntary decision.

Mr. F: Two Years Attempting to Restore Competency Despite the Progressive Deterioration of his Cognitive Functioning

In March 2009, Mr. F was charged with second-degree assault after alleging hitting a nurse at the University of Maryland Medical Center, where he had been admitted for psychiatric treatment. At the time of his arrest, he had been receiving mental health services and housing for the previous eight years through a Baltimore City agency, and had intermittently held a variety of jobs in the community. At Spring Grove, where he wound up for competency treatment, he was given the provisional diagnosis "rule out dementia." His psychiatrist documented that his cognition "has been worsening" in the four months since his commitment, and throughout his medical records he is noted to have dementia or, alternatively, a "cognitive disorder" of unknown origin. At the time of admission, he was ambulatory and did not need assistance with daily living activities such as eating, bathing or toileting. His strengths were noted to include an ability to care for self, history of compliance with treatment and having a place to return to in the community.

Over the course of his first year of treatment, Mr. F's physical and mental state deteriorated significantly. During the year, he lost approximately 35 pounds and staff observed that, most of the time, he was "virtually unresponsive." He also had begun to engage in self-injurious behavior (biting his hands). In his 2010 annual competency evaluation report, the evaluator describes that he was brought into the interview in a wheelchair because he could no longer walk independently and that he could not meaningfully participate due to his disoriented and confused condition. The evaluator further noted that Mr. F now needed nursing staff assistance to feed, toilet and dress him. Nevertheless, the evaluator determined that Mr. F was "potentially restorable to stand trial" because his psychiatrist had recently increased his psychiatric medication and because his "occasional clear thinking and reasonable responses to questions suggest the potential" for regaining competency. The court ordered continued commitment for treatment to restore competency to stand trial.

CHALLENGES IN RESTORING COMPETENCY TO STAND TRIAL FOR PEOPLE WITH OTHER TYPES OF DISABILITIES

People with intellectual disabilities and brain disorders such as dementia may face particular challenges in restoring competency to stand trial.

Dementia – Multiple studies have shown that people with dementia have lower chances of being restored to competency once deemed incompetent. A 2009 study found that people diagnosed with dementia, while able to be restored, were significantly less likely to be restored to competency within a year of treatment.[1] A 2002 study that focused on geriatric patients (over the age of 60) found that the major distinction between the group of people who were competent to stand trial and those who were incompetent was the higher prevalence of dementia in the latter group.[2]

Intellectual Disabilities – The issue of competency to stand trial for people with an intellectual disability is significant,[3] yet most programs designed to restore competency do not explicitly consider the needs of people with intellectual disabilities.[4] One study found that 60 percent of people with an intellectual disability who undergo competency hearings are found incompetent.[5] People with IQs ranging from 50 to 75 frequently do not understand legal terms and concepts, despite reporting familiarity with legal terminology.[6] Restoring competency can be a challenge for people with an intellectual disability; a study of 75 people with an intellectual disability who were incompetent to stand trial found that two-thirds failed to be restored.[7] In Maryland, if a person with an intellectual disability is committed for competency restoration, he or she will be confined in a secure unit operated by the Developmental Disabilities Administration.[8]

Sources:

[1] Douglas R. Morris and George F. Parker, "Effects of advanced age and dementia on restoration of competence to stand trial," *International Journal of Law and Psychiatry* 32 (2009): 156-160, p. 158.

[2] Richard L. Frierson and others, "Competence-to-Stand-Trial Evaluations of Geriatric Defendants," *The Journal of the American Academy of Psychiatry and the Law* 30 (2002): 252-256, p. 254.

[3] R. Bonnie, "The competence of criminal defendants: A theoretical reformulation," *Behavioral Sciences and the Law* 10 (1990): 291-316.

[4] Barry W. Wall and others, "Restoration of Competency to Stand Trial: A Training Program for Persons with Mental Retardation," *Journal of the American Academy of Psychiatric Law* 31, No. 3 (2003): 189-201, p. 189.

[5] C. Everington & C. Dunn, "A second validation study of the competence assessment for standing trial for defendants with mental retardation (CAST-MR)," *Criminal Justice and Behavior* 22 (1995): 44-59

[6] K. Ericson & N. Perlman, "Knowledge of legal terminology and court proceedings in adults with developmental disabilities," *Law and Human Behavior* 25 (2001): 529-545.

[7] Shawn D. Anderson and Jay Hewitt, "The Effect of Competency Restoration Training on Defendants with Mental Retardation Found Not Competent to Proceed," *Law and Human Behavior* 26, no. 3 (2002): 343-351, p. 348.

[8] Annotated Code of Maryland, Criminal Procedure Article §3-106, 2008.

SPECIAL CHALLENGES FACED BY PEOPLE WITH TRAUMATIC OR OTHER ACQUIRED BRAIN INJURY

A Traumatic Brain Injury (TBI) can occur following an intentional or accidental injury to the head. While this occurs in a number of ways including assaults, car accidents and sporting injuries, TBI is increasingly being found in military members who have been in combat.[1] TBI can affect a person's ability to perform normal, everyday activities, and can interrupt thought processes, including concentration, memory and attention. In turn, this can affect a person's ability to stand trial, resulting in an evaluation of incompetence to stand trial.

MHA data identified 6 people admitted to Spring Grove in FY 2011 as having a TBI diagnosis. However, a random sampling of 20 medical records reviewed by the Maryland Disability Law Center identified an additional 3 persons who were documented as having a self-reported history of brain injury, but no formal screening tool was used and none of the people were further evaluated. Experts note that informal screenings at intake in correctional facilities do not yield accurate prevalence rates and that a detailed and reliable screening tool is needed.[2] Based on recent studies, it is estimated that between 25 percent and 87 percent of people in jail and prison have reported some history of brain injury or traumatic head injury– three to ten times the prevalence rate of 8.5 percent in the general population.[3] Given the lack of reliable screening in Maryland it is impossible to know the true rate of TBI in persons found incompetent to stand trial, but it is reasonable to assume that it falls within the range of estimated rates among the jail and prison population.

The failure to identify TBI has profound negative consequences for the individual. Depending on the region of the brain that sustained injury, a person might exhibit a range of deficits and challenging behaviors, including attention and memory deficits, uninhibited or impulsive behavior, irritability or anger that is difficult to control, and slowed verbal or physical responses.[4] The use of standard medications targeted to psychiatric symptoms can compromise the person's medical condition and can actually cause an increase in challenging behaviors.[5] In addition, without understanding TBI, staff may grow frustrated with what they see as the person's failure to follow rules and impose sanctions that prevent them from progressing through the hospital's "level system." Uninhibited or impulsive behavior, including problems controlling anger and unacceptable sexual behavior, may result in high-risk restraint or seclusion incidents and/or may provoke other patients to retaliate, putting the person at risk of injury, including further head trauma. As the cycle of aggressive or unacceptable behavior followed by punishment continues, the person's chances of being deemed safe for return to the community diminishes.

While it is critical to accurately identify the presence of TBI, a state mental hospital is not the proper environment for most brain injury survivors and does not have the medical and psychiatric staff with training and expertise in the neuro-behavioral programming that is essential to properly treat them.[6] Further, the lack of funding and adequate community TBI programs presents a significant barrier to discharge. As a result, people with a TBI are either remaining stuck in an inappropriate and potentially harmful environment or, as with those with unidentified TBI, being discharged to traditional mental health programs and services that do not meet their needs.

Note: While we use the term TBI, many of the concerns also apply to those with other forms of ABI, including but not limited to stroke, near drowning, hypoxic or anoxic brain injury, tumor, neurotoxins, electric shock or lightening strike.
Sources:
[1] See, Maryland Traumatic Brain Injury Resources, www.dhmh.state.md.us/mha/TBI%20Fact%20Sheet%20military%2008.09.doc; Brain Injury Association of America, *About Brain Injury*, Accessed August 2011, www.biausa.org/_literature_81103/Military_Fact_Sheet_2011
[2] In a project in Minnesota to identify inmates with TBI, researchers found that only 1 percent reported a history of head injury during intake screening, as compared to 83 percent who reported at least one head injury through a more detailed screening questionnaire. See Marlena M. Wald, Sharyl R. Helgeson and Jean A. Laongois, *Traumatic Brain Injury Among Prisoners*, "Brain Injury Professional," www.brainline.org/content/2008/11/traumatic-brain-injury-among-prisoners.html.
[3] Webinar: *Traumatic Brain Injury and Competency to Stand Trial: Issues and Advocacy for the National Disability Rights Network,* February 2010. www.ndrn.org/images/Documents/Issues/TBI/NDRN2-8-10.pdf
[4] Department of Health and Human Services and Centers for Disease Control, *Traumatic Brain Injury in Prison and Jails: An Unrecognized Problem*. www.cdc.gov/traumaticbraininjury/pdf/Prisoner_TBI_Prof-a.pdf
[5] Interview with Diane Triplett, Former Executive Director of Brain Injury Association of Maryland and currently the Clinical Evaluator and Coordinator for NeuroRestorative, a national brain injury provider, and Suzanne Kantt, Assistant Director, Brain Injury Association of Maryland. September 2011.
[6] Ibid

Mr. A: No Treatment for His Brain Injury and Trauma Despite Two Years of Commitment for Competency Treatment

Mr. A suffered a brain injury as a child when he was involved in a serious auto accident that resulted in his being hospitalized. He received no rehabilitation services or follow-up care for his head injury and his family assumed that he had fully recovered. He was subsequently the victim of a violent attack, but did not receive psychological services related to this trauma. Over the years, he struggled to recover from these physical and emotional wounds as his family tried, unsuccessfully, to locate appropriate services for him. He was eventually arrested on minor charges, found incompetent to stand trial and committed to Spring Grove.

Although his medical records noted that he had a prior brain injury, he was given a mental illness diagnosis and only treated for that condition. In addition, although his medical records documented the traumatic event that he suffered, he was not offered trauma-specific services. During the years of his confinement, the forensic evaluator submitted conflicting reports regarding the probability of restoration, and submitted opinions about his dangerousness that conflicted with the treatment team's medical record notes.

After more than two years at Spring Grove, his legal case was resolved and he was discharged to traditional community mental health services. Shortly thereafter, a mental health provider conducted a TBI screen and concluded that many of his difficulties are likely related to brain injury. However, his family reports that, to date, he is still not receiving services targeted to either the brain injury or his trauma.

Mr. A's case illustrates that keeping people for unreasonably long periods of competency treatment on minor charges is not only a waste of resources and an unnecessary deprivation of liberty, it does not necessarily ensure that they receive all of the treatment and services that they may need to successfully recover.

WHY ARE SO MANY PEOPLE HELD AT SPRING GROVE ON IST STATUS, AND FOR LONGER THAN IS CLINICALLY NECESSARY?

A number of factors can affect how long someone remains on IST status, other than whether they are showing significant progress towards soon achieving competency—the only legal justification.

As noted earlier, using the maximum time for dismissing criminal charges as the outer limit on treatment can be perceived as punishment for a crime without trial and conviction. But in many cases, particularly those heard in the Baltimore City District Court, the motivation is often getting people services. While the various players in the system are undoubtedly operating with "good intentions" (i.e., out of a belief that getting a person mental health treatment is the best outcome for that person) using the IST statute for that purpose is inappropriate. Further, confinement in a secure facility, particularly lengthy confinement, can have a devastatingly *negative* impact on people. Trapped in a legal limbo that they may not understand, they can become frustrated and despondent, as they are isolated from family and friends and lose the social connections and confidence that they may have previously had to navigate life outside of the institution. For those who have a co-occurring brain disorder or injury, such as dementia or TBI, confinement in a mental hospital can lead to diminished mental and/or physical health.[§§]

JUDGES

One reason more people are not released to the community on a timely basis is that what judges consider "adequate treatment" is not readily available and may be more than what is necessary to attempt to obtain competency or to live safely in the community. Many judges require residential treatment[***] or

[§§] For example, for people with TBI, who often exhibit provoking behaviors, confinement in a mental hospital can put them at significant risk for physical injury. From a clinical perspective, this type of confinement can set the person's treatment prognosis back several months or even years. Interview with Diane Triplett, Former Executive Director of Brain Injury Association of Maryland and currently the Clinical Evaluator and Coordinator for NeuroRestorative, a national brain injury provider, and Suzanne Kantt, Assistant Director, Brain Injury Association of Maryland. September 2011.

[***] Residential treatment programs require people to live with other program participants in apartments or group homes and adhere to a variety of program

treatment that is accompanied by some form of housing and intensive case management, such as that provided by Baltimore City's Forensic After Care Treatment Team (FACTT), to discharge someone from a state hospital. Currently, there is a two-year waiting list for some residential rehabilitation programs (RRPs). But these intensive forms of treatment may not always be necessary and waiting for them to become available leads to keeping people locked up for longer than what is a clinically or legally appropriate period of time. Baltimore Mental Health Services (BMHS), which oversees public mental health services in Baltimore City, reports that while mental health treatment is available, not all of it involves residential treatment or intensive treatment. And not everybody needs this form of treatment—many people can live in the community with minimal care and supervision.[46] While housing, which the court frequently requires be included in a discharge plan, is certainly a critical issue for many persons with a mental illness, keeping people confined until it is obtained is the wrong approach, from both a fiscal and human rights perspective.

DEFENSE LAWYERS

Lawyers can also contribute to their clients remaining in state hospitals on IST status longer than necessary. Attorneys may contest findings of restored competency for a number of reasons. The most common is that they do not believe their client is competent and wish to have a second opinion to ensure that their client's due process rights are being protected. And while this does not occur often with people held at Spring Grove due to the low-level nature of their offenses, lawyers may also contest competency because they know that if their client is found competent and still dangerous, there is the possibility that they will be sent to jail to await trial, which can have a negative impact on their mental state, including competency. People with mental illness decompensate in jails[47] and may lose all of the progress they had made in restoring competency, in addition to the personal negative impacts on the person in jail. Upon release, community health professionals say they then have to work "twice as hard to get them back to where they were before they entered jail."[48]

"The ability to obtain community services is often a factor in a State's Attorney's decision to prosecute or nolle pross a charge, or a judge's decision as to whether incarceration or commitment to the Department [of Health and Mental Hygiene] is necessary. Without adequate funding and prompt availability of community services, it is likely even more individuals with mental illness will be incarcerated or court committed to the Department [of Health and Mental Hygiene]."
Forensic Populations and DHMH, 2008

Defense attorneys generally believe that it is in their client's best interest to keep them out of jail, and therefore may want to keep them from being found competent. However, this is not always what the client would prefer, and it is not necessarily true that he or she would end up in jail if found competent, particularly people confined to Spring Grove on low-level charges. The majority of people ultimately found competent to stand trial are released to

rules, which often include severe restrictions on freedom of movement, choice of recreational activities and employment. In addition, these programs provide intensive staff monitoring, which decreases over time as the person "progresses" through the program. If a person receives social security benefits, the program charges for "room and board," often leaving the individual with $40 per month – the legal minimum required under federal law.

the community or back to inpatient treatment on civil commitment by the judge, not to jail.

In addition, the data showing that people who are not restored are spending long periods of time confined in secure units at Spring Grove Hospital indicates that defense attorneys can, and should, be more aggressive in pushing for timely competency determinations and dispositions, particularly once the client has been held for six months.

PROSECUTORS

Prosecutors may also contribute to longer lengths of stay for people on incompetency status. Prosecutors may challenge DHMH's findings of unrestorability, especially when it is a more serious or high profile case, as a finding of unrestorability means that the person cannot be tried for the crime. Nevertheless, in accordance with the Supreme Court's ruling in *Jackson*, it violates the person's constitutional rights to keep him or her confined if restoration is not substantially probable. If the person is still dangerous, he can be civilly committed to a state hospital. Moreover, cases involving crimes of serious violence are relatively rare overall and certainly do not comprise the docket at Baltimore City District Court. The prosecutor's interest in bringing these cases to trial is diminished and it is improper to insist upon longer lengths of stay.

Prosecutors may also insist that people not receive treatment to restore competency in the community unless it includes receive residential treatment to ensure some level of monitoring. But, again, such a service is difficult to access and is frequently unnecessary from a public safety perspective.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH)

DHMH contributes to unnecessary ongoing confinement by failing to adhere to maximum treatment standards that are supported by clinical evidence, such as the studies contained in this report. The majority of people treated should be restored to competency within six months. At that point, if a person is still incompetent, there must be clearly documented evidence of significant progress toward competency to justify continued treatment. At the first annual hearing, very few people, if any, should be evaluated as having a substantial probability of soon becoming competent.

DHMH also contributes to delays whenever it fails to provide opinions to the court immediately upon a change in the person's condition that impacts his or her commitment status. As previously discussed, while the current law permits DHMH to file such reports, it only requires a report every six months. Data showing that the number of people released from Spring Grove prior to six months has decreased significantly suggests that, after the initial evaluation hearing and commitment for treatment, the hospital may be waiting for the required six-month interval before filing a report, thereby potentially prolonging a person's confinement.

In addition, DHMH appears to be making determinations that a person is "dangerous"

that are out of line with its opinions in civil cases. When a person is committed as dangerous in a civil case, DHMH may release him at any time it determines he is no longer a danger. Lengths of stay data show that as the civil admissions to state hospitals decreased, the average lengths of stay increased. In FY 2007, 60 percent of those admitted were discharged within 30 days. In FY 2010, that number dropped to 39 percent.[49] As discussed previously, there is often no marked difference in the behaviors that result in arrest for some and civil commitment for others. It is likely that people who can return to the community for treatment are remaining at Spring Grove for much longer periods than are reasonable or necessary for clinical or public safety purpose.

Finally, with DHMH keeping more people in state hospitals for longer, resulting in fewer available beds for people who may need ongoing treatment, some people who do not qualify for community placement are forced to stay in jails while awaiting bed space to open up so they can be transferred.[50] The law states that people can be evaluated in jails as well as state hospitals and community centers, but some judges require that evaluations take place in DHMH facilities. Currently, some people are waiting 14-21 days or more in jail awaiting competency evaluations after the Court Medical Office screening found that they were likely to be incompetent.[51]

HOW ARE INCOMPETENCY CASES IN BALTIMORE CITY DISTRICT COURT RESOLVED?

People committed to Spring Grove can have their cases resolved in a number of different ways, depending on whether they are restored to competency or not.

IF COMPETENCY IS RESTORED: TRADITIONAL COURT PROCESSING OR MENTAL HEALTH COURT

Traditional Court Processing

A person who becomes competent after treatment can go through traditional court processing either with a judge or jury trial. The court determines whether the person can be released on bail or on their own recognizance, or whether he is remanded to the Baltimore City Detention Center (jail). For those who were out in the community receiving treatment, they may continue to receive treatment and pretrial supervision in the community either through the Pretrial Release Services Program or Forensic Aftercare Services Team (FAST). In some cases, the court may order that the person remain at Spring Grove while awaiting trial, to ensure that he does not again become incompetent due to possible disruptions in treatment. If at any time any court personnel feels that the person is no longer competent, an evaluation can be ordered and the trial put on hold until the person again becomes competent.

The defense attorney may enter a plea of "not criminally responsible" and ask for an evaluation for that purpose.[†††] Often, this evaluation will have been already completed while the person remained at Spring Grove, but sometimes the person is again returned to the hospital to be evaluated for criminal responsibility.

Mental Health Court

People who become competent after treatment can, if approved, voluntarily enter the mental health court rather than go through traditional adjudication in District Court.[‡‡‡] People are eligible for the District

[†††] For the IST population confined at Spring Grove on minor charges, an NCR plea is not generally appropriate, as it would result in continued commitment for an indeterminate period – and likely be lengthy as the court frequently requires a residential community program with monitoring before approving release on conditions.

[‡‡‡] At this time the Baltimore City Circuit Court does not have a mental health court. Judge Gale Rasin at the Circuit Court is working with Baltimore Mental Health Systems, Inc. on three-year pilot program to work with people with mental illness who come into contact with the justice system on more serious offenses that are handled in Circuit Court.

NOT CRIMINALLY RESPONSIBLE

If a person pleads Not Criminally Responsible (NCR) and is found to qualify for this status after examination, he or she can be committed to DHMH for inpatient care, face conditional release (usually supervised by the Community Forensic Aftercare Program (CFAP)), or be released without conditions.[1] A person is considered not criminally responsible if, at the time of the offense, the person lacked the "substantial capacity" due to mental disorder or intellectual disability to appreciate the criminality of the offense or to conform to the law.[2] If the person is committed for inpatient care, he remains committed until the court finds that he would not, as a result of intellectual disability or mental disorder, be a danger to self or to the person or property of others if released, with or without conditions. The length of stay for people committed as NCR can be significantly longer than people civilly committed.[3]

Sources:
[1] Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-112. Not criminally responsible—Commitment.
[2] Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-109. Test for criminal responsibility.
[3] John Colmers, George Lipman and Charlotte Cooksey, *Report on Forensic Populations and the Department of Health and Mental Hygiene*, February 19, 2008.

Court's mental health court if they have a diagnosis of an Axis I serious mental illness[52] like schizophrenia, bipolar disorder or major depression and/or a trauma-related disorder and are eligible for public mental health services. The Mental Health Court accepts people charged with a misdemeanor or felony, but not those charged with domestic violence or who have any record of violent offenses.[53] The Court's Forensic Aftercare Services Team (FAST) determines if the person is eligible for the mental health court and whether they can supervise them while under mental health court. The FAST program screens about 800-900 cases a year for mental health court eligibility.[54]

If a person decides to enter the mental health court, he must plead guilty to his offense— he will not have a trial—and will receive a treatment and supervision plan mandated by the court and supervised by the Division of Parole and Probation, the Pretrial Release Services Program or FAST, depending on what agency is deemed most appropriate by the judge, and these agencies' willingness to supervise.[55] He will be required to periodically attend mental health court and follow his tailored conditions of release, which may include treatment, housing and other requirements. If he is not able to follow the conditions of the mental health court or wishes to opt out of the program, he will be traditionally processed under the guilty plea he accepted.[56]

IF A PERSON IS UNRESTORABLE: RELEASE TO COMMUNITY OR CIVIL COMMITMENT

Release to Community

If a person is found to be unrestorable and no longer dangerous to himself or others due to the nature of his mental illness, he can be released from the DHMH hospital with a discharge plan that may include plans for housing and/or treatment.

Civil Commitment

But if a person is found to be unrestorable and still dangerous, he can be civilly committed to a DHMH hospital. Commitments can only be made if the court finds by clear and convincing evidence that:

1. the person has a mental disorder;

2. inpatient care is necessary for the person;
3. the person presents a danger to the life or safety of self or others;
4. the person is unable or unwilling to be voluntarily committed to a medical facility; and
5. there is no less restrictive form of intervention that is consistent with the welfare and safety of the person.[57]

IF A PERSON "TIMES OUT": RELEASE

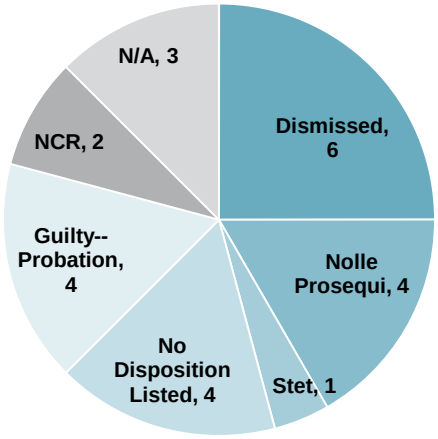
If a person remains in the facility until their "time-out" date, they must be released from the facility. Time-outs occur when a person has been held in a secure state hospital awaiting competency restoration for the maximum amount of time they could have been sentenced if found guilty of the offense.[58] At this time, the person must be released to the community or civilly committed to a mental health facility.

WHERE DO PEOPLE GO WHEN THEIR IST STATUS IS RESOLVED?

In the first six months of 2011, none of the 24 people from Baltimore City whose IST cases were resolved were sentenced to spend any time behind bars, and most were not even convicted of the charge.[59] Eleven of 24 people had their cases dismissed, including one person who "timed-out" and had their case dismissed after spending 147 days at Spring Grove for filing a false police report—the longest possible sentence for this offense. Four of these 24 people pled guilty (three of whom were sentenced to probation), two were found not criminally responsible (NCR) after spending two years—more than 700 days—on IST status at Spring Grove,[§§§] and four people had no disposition noted on their public record.[60]

Of this sample, people who had their cases dismissed spent an average of 450 days in Spring Grove before their case was resolved. This is equal to 15 months of their life that they spent in this hospital only to have their charges dropped—never being convicted or sentenced. If the courts had no interest in convicting these people, it is unclear why they wait so long to drop the charges. The use of competency commitments in this way is as good as punishment for a crime for which these people were never tried. Not only is this a deprivation of liberty, but it is wasteful policy. Rather than force people to receive treatment for competency restoration, Baltimore should be looking for ways to keep people in the community and get them access to the types of treatment they need or want.

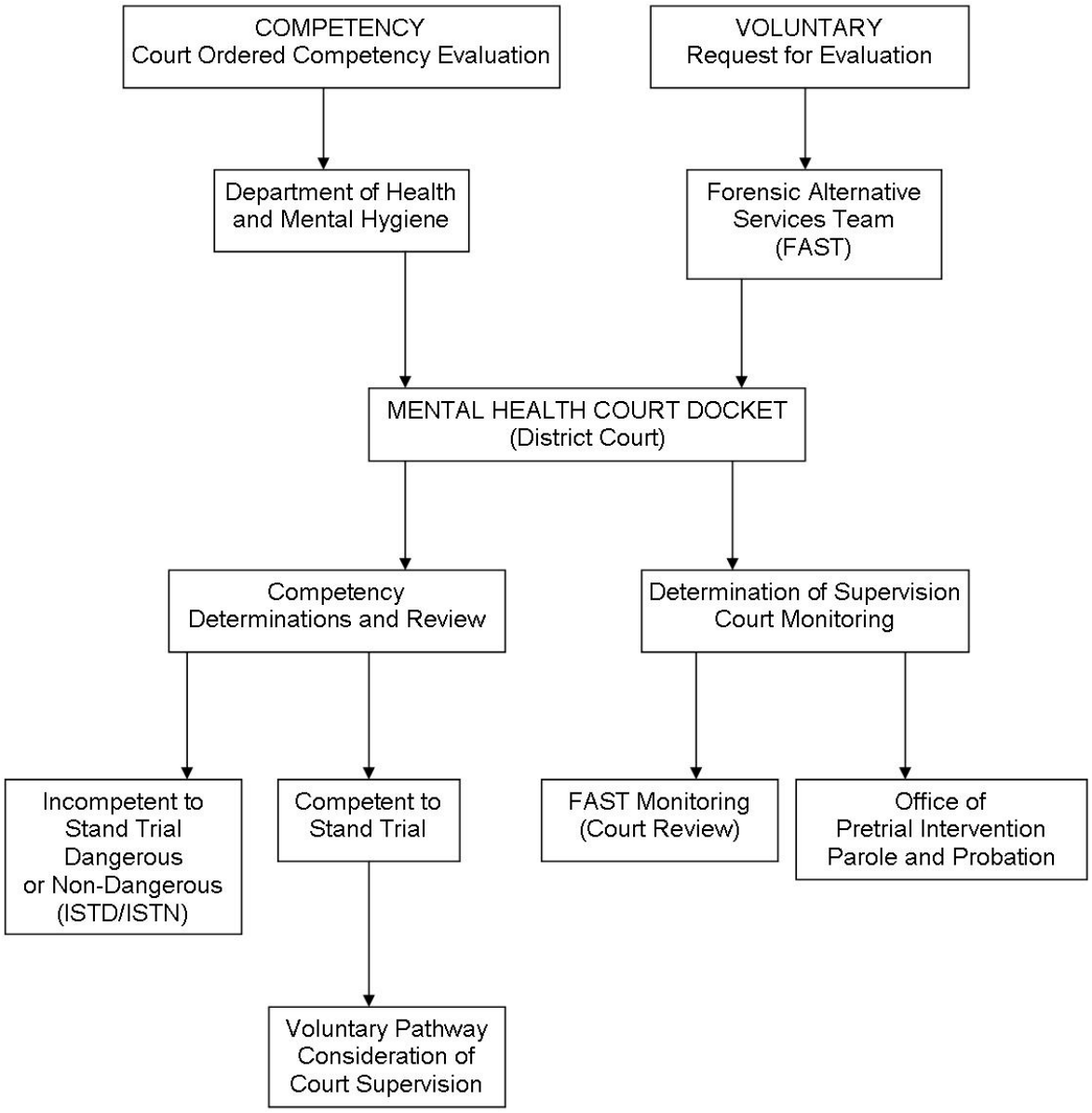
None of the 24 people whose IST cases were resolved from January to June 2011 received a sentence of incarceration.



Source: Office of Forensic Services Data

[§§§] As previously mentioned, the strategy of pleading NCR for people with relatively minor charges may not be the best outcome for the person who will then be confined for an unspecified additional time period and continue to be subject to court jurisdiction and monitoring.

Operating model of Baltimore City Mental Health Court



Source: Process Evaluation of Baltimore City Mental Health Court (Maryland Judiciary Research Consortium, March 2010)
www.courts.state.md.us/opsc/mhc/pdfs/evalutations/bcmhcprocessevaluation3-11-10.pdf

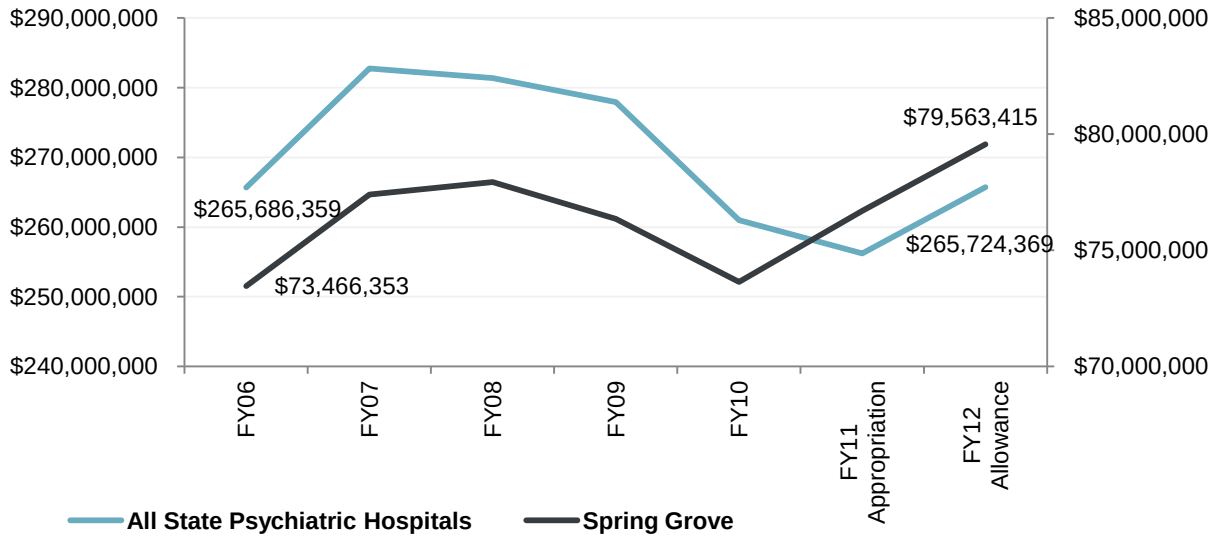
WHAT IS THE IMPACT OF THE CURRENT IST LAW AND THE PRACTICES OF THE BALTIMORE CITY DISTRICT COURT ON MENTAL HEALTH RESOURCES?

SPENDING ON SPRING GROVE HOSPITAL CENTER HAS BEEN INCREASING

Maryland appropriated $256 million for state psychiatric hospitals in FY2011, including $76.7 million for Spring Grove Hospital Center (Spring Grove). Spending on Spring Grove increased 4.4 percent from FY2006 to FY2011, while spending on all other psychiatric hospitals (excluding Spring Grove) decreased 6.6 percent.[61]

It costs Maryland taxpayers $512 per person per day to hold someone in Spring Grove—about $186,880 per year.[62] As the average length of stay of a person from Baltimore City for forensic IST is 414 days (nearly 14 months),[63] that means that Maryland is spending an average of $211,968 per person to house them in Spring

Spring Grove expenditures are growing faster than the total for all state hospitals.



Grove for competency restoration. Furthermore, for people who are found to be unrestorable—which the research shows should be determined within six months to a year of starting treatment—the average length of stay is 579 days (approximately 19 months). At this rate, people who may be unlikely to be restored to competency are costing an average of $296,448 per person for treatment at Spring Grove.

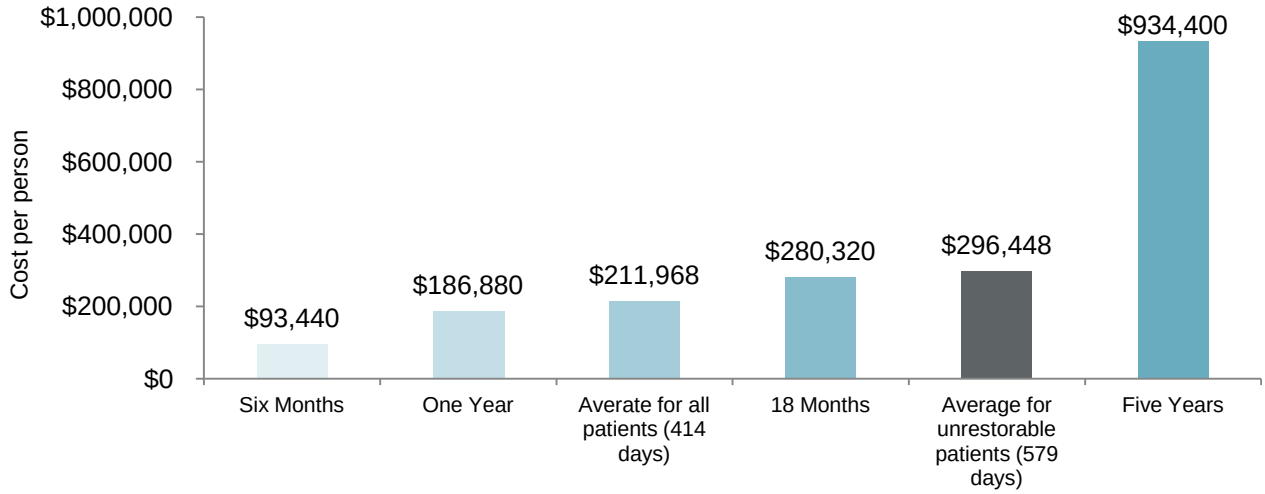
In order for the state to realize cost savings, the number of beds utilized for treatment to restore competency to stand trial needs to be reduced. A small number of beds for those who truly need it clinically, and for a short period of time, is all that is needed if Maryland reforms its IST system and provides an adequate community-based system of care, including an array of housing options.

During the last legislative session, the Maryland General Assembly ordered DHMH to conduct an independent analysis of the future need for beds.[64] At the same time, the General Assembly appropriated funds for a "Redevelopment Plan for Spring Grove Hospital Center" by the Maryland Economic Development Corporation (MEDCO). This plan must include detail on the construction of a new hospital (to replace the aging, inefficient and costly institution) and evaluate how to utilize proceeds from the sale of a parcel of land sought by a developer to "benefit the Community Mental Health System." By diverting people found IST to community treatment and moving people found NCR out more quickly it is possible to construct a small hospital that will better serve those who need inpatient care, and use the savings to expand community services and supports. As most of the people held in Spring Grove currently are held on low-level charges, this should have minimal impact on public safety and can have a positive impact on people with mental illness.[65]

TREATMENT IN THE COMMUNITY IS LESS EXPENSIVE THAN STATE HOSPITALS.

Spring Grove is one of the most costly methods of treating people for incompetency to stand trial, without the coinciding benefits.

Maryland could save an average of $109,568 per person who is unrestorable by reducing the length of time they spend at Spring Grove to one year from the current average.



Source: **Per diem cost of Spring Grove:** Mental Hygiene Administration**; Average Length of Stay:** Office of Forensic Services.

For people with more extensive needs, the Capitation Project, for example, provides a comprehensive range of coordinated services for people in Baltimore City with serious mental illness who are able to live in the community but have difficulty managing certain treatment aspects independently. According to Baltimore Mental Health Systems, Inc., the core service agency that directly manages public mental health system services in Baltimore City, "The Capitation Project, in its 13th year, provides 354 consumers with histories of long or recurring inpatient admissions a viable community alternative. The average cost per year for a Capitation Project consumer is $28,920."[66] If people were moved to the community, they may access a variety of different services at a lower cost and to the same effect of either restoring competency or working with people who are not able to be restored to competency. Moving people from Spring Grove in a reasonable amount of time could potentially save Maryland millions of dollars a year, even when accounting for the costs of community treatment.

However, while community treatment while attempting to restore competency is less expensive and less restrictive, it is important that same reasonable maximum treatment periods should apply. Frequent re-evaluations should be conducted and people should only be required to continue competency treatment after six months if there evidence of substantial progress. Once it is determined that there is not a substantial probability of restoration, the person's charges should be dropped and he should be offered the opportunity to access those mental health services and supports that he needs.

Currently, because judges in the District Court are reluctant to release a person from the hospital without a discharge plan that they believe is "adequate," the most intensive community resources, such as residential beds, may be unnecessarily over-utilized by the IST population instead of what may otherwise be recommended by MHA as necessary for competency treatment or to ensure that the person remains safely in the community. In FY2008, Baltimore City spent $178,388,747 on public mental health services (PMHS), 35 percent of Maryland's PMHS expenditures.[67] Over the past three years, Baltimore City spending on PMHS increased faster than total Maryland expenditures (24. 7 percent increase versus 10.1 percent).[****] While the number of persons who receive community mental health services and related supports as a result of their IST status is low relative to the total number of Baltimore City recipients, it is imperative that resources are allocated based on sound clinical judgment, not what judges or lawyers believe is sufficient.

It costs Maryland taxpayers

$512

per person per day to hold someone in Spring Grove—about $186,880 per year.

[****] Starting in FY 08 case management services became a contract-funded service, and thus not included in City expenditures.

RECOMMENDATIONS

Too many people are unnecessarily confined in secure settings and placed under orders for outpatient treatment for longer than necessary, for purposes of attempting to restore competency to stand trial. Not only is this a civil rights issue, but a waste of increasingly scarce resources. The following recommendations are designed to create a fairer and more efficient system, while allowing Maryland to continue to downsize and close its aging institutions and reallocate those resources to the community, so that all who need them will have timely access.

1. **Establish policies and practices in Department of Health and Mental Hygiene (DHMH) facilities to ensure IST cases are resolved and people are either found not dangerous, restored to competency or determined not restorable, more quickly and consistent with research.** DHMH policies and practices should include:
    a. targets for restoring competency within six months;
    b. Mental Hygiene Administration (MHA) administration-level reviews of people determined "dangerous" every 30 days to ensure that evaluators are appropriately applying the legal standard;
    c. Ensure that treatment teams are making frequent assessments on competency, restorability or dangerousness and notifying the forensic evaluators as soon as there is a change of status to ensure that evaluations take place within a short period of time following such notice by the team;
    d. MHA administration-level reviews of forensic evaluation recommendations for continuing treatment beyond six months;
    e. MHA administration-level approval for treatment beyond one year; and
    f. periodic independent system review to ensure that timely and appropriate determinations are made and reported to the court.
2. **Establish policies and practices for the Judiciary governing the proper use of the incompetency law.** Such policies and practices should include a clear expectation that courts follow the narrow purpose of the incompetency statute – to provide a reasonable period to attempt to restore competency to stand trial; provide guidelines with respect to making findings of competency, restorability and dangerousness consistent with the clinical evidence in the record; and provide guidelines on the proper role of the court in reviewing discharge plans presented by DHMH.

3. **Establish policies and practices for the Office of the Public Defender for representing persons found incompetent to stand trial.** Such policies and practices should be developed with input from mental health consumers, and should:
    a. be trauma-informed;

   b. include guidelines on case management for people charged with misdemeanors and felonies and found incompetent to stand trial that would not be expected to result in a significant period of criminal incarceration if the person were competent;
   c. provide guidelines for appealing court findings on competency, restorability or dangerousness; and
   d. ensure periodic internal review so that clients are returned to the community as quickly as possible and that treatment for competency restoration is ended within a reasonable period of time consistent with scientific and legal studies.

4. **Develop training for DHMH, judiciary, defense attorneys, prosecutors and other relevant court personnel, based upon available best or evidence-based practices and standards on treatment to restore competency to stand trial, including outpatient treatment, and appropriate limits on treatment periods.** Currently, Maryland law does not have a limit on treatment, other than a de-facto limit based on required dismissal of charges at set time periods. This legal flaw in the statute should not operate to extend treatment beyond a reasonable period of six months to a year, as demonstrated in various studies. Criminal justice and DHMH forensic treatment personnel must be aware of, and adhere to, standards based on sound clinical practice rather than extraneous improper motives such as "punishment" or a person's "need" for mental health treatment and housing. While consideration should be given to amending the law to provide treatment limits, it is not necessary if system players adhere to the purpose and narrow intent of incompetency laws. Twenty states have maximum treatment limits of one year or less. There is no reason why Maryland should not follow their progressive lead.

5. **Develop processes for streamlining competency evaluations for people confined while awaiting evaluations.** Currently, DHMH must conduct competency evaluations within seven days of court orders. People who are confined during this time—especially those confined in jails—can experience negative consequences during this time, including decompensation and loss of liberty. Streamlining the process will reduce these negative impacts and ensure that people are moved to the appropriate status quickly and fairly.

6. **Develop better policies and practices for people with TBI or other acquired brain injuries.** The impact of TBI on behaviors is not widely understood among people working in the justice system. Training is essential so that more-informed decisions can be made when a person demonstrating TBI-based behavior is arrested and brought before the court for processing. Based on estimates of prevalence rates in jails and prisons, it is imperative to accurately identify and meet the needs of persons with TBI who are arrested and found incompetent to stand trial. The need to expand community-based TBI services is acute in Maryland and the lack of community capacity contributes to individuals getting arrested for behavior related to their TBI.
   a. Use valid and reliable measures for TBI screening, including structured interviews to identify TBI in persons screened for possible incompetency, evaluations for competency in-patient or outpatient, and orders for competency restoration treatment.
   b. Develop training for DHMH, judiciary, defense attorneys and prosecutors, on the impact of TBI on people in the criminal justice system; and
   c. Develop and fund appropriate community-based programs, to ensure that people with TBI receive treatment to attempt to restore competency to stand trial in an appropriate setting.

7. **Ensure that effective community-based mental health resources are available and properly utilized**. A number of community-based mental health centers and programs that include housing—Forensic Assertive Community Treatment Team (FACTT) program and the Capitation pilot program, for example—are available in Baltimore, and are shown to be effective in working with people with mental health problems. Investing in more community mental health resources—especially for people with co-occurring mental health and substance abuse problems—can ensure that people have access to community services that use the most currently effective methods available.

8. **Invest in quality, affordable and supportive housing for people who need it**. A primary reason for the high incidence of people with mental illness in the justice system—and in turn, the high number of people in state hospitals receiving mental health treatment—is the lack of housing available. The availability of housing has been associated with reduced criminal justice involvement and can have a positive impact on people who are living with a mental illness and need the stability of a home.

9. **Eliminate quality of life policing sweeps that bring more people with mental illness and other mental disabilities, including TBI, into the justice system**. Many of the people who are held on incompetency status are charged with low-level offenses such as misdemeanor assault, disorderly conduct or public urination. Police sweeps that target people in certain neighborhoods or of certain social status only work to bring more people into the justice system, disrupting lives and stealing precious resources from more effective public safety strategies.

10. **Expand Baltimore's current special police team to a model based on Memphis' Crisis Intervention Teams**.[68] Baltimore City has the Behavioral Emergency Services Team (BEST), which provides training to police on how to deal with crises involving people with mental illness. But this program may not be enough. Baltimore should look to programs like the Crisis Intervention Teams (CIT) in Memphis, Tennessee for effective police programs that can work with agencies to improve outcomes for people with mental illness.[69] An adopted model should include training on other mental disabilities, including TBI, intellectual disability, and brain disorders such as dementia, and coordination with appropriate service agencies. People should not be arrested just for exhibiting signs of a behavioral disorder—the police should have other options, and know of these options, for getting people the treatment and services they need in the community.

11. **Ensure that the current studies on future state hospital bed needs and redevelopment plans for Spring Grove Hospital Center take into account the findings in this report that people are being unnecessarily confined for treatment to restore competency and for too long.** To get an accurate estimate of future needs, it is imperative not to base assumptions on current use and the rapid expansion of IST commitments since the 2006 amendments to the statute. As detailed in this report, the failure to have reasonable maximum treatment periods, together with the practice of confining people to get them community services and housing, are the root causes. By implementing these recommendations for reform, Maryland can plan to downsize Spring Grove and replace it with a much smaller facility that will better serve patients, and use the savings to expand community services and provide housing opportunities.

APPENDIX

State	Maximum Defined Competency Treatment Periods
Alabama	No max treatment
Alaska	180 days for crimes not involving force; 1 year crime of force against another
Arizona	21 months
Arkansas	1 year
California	Misdemeanor charges – lesser of 1 year or maximum sentence; felony – lesser of 3 years or maximum sentence.
Colorado	max sentence
Connecticut	Lesser of max sentence or 18 months.
Delaware	No max
D.C.	180 days total if charge did not involve crime of violence; If crime of violence max is required dismissal of charges at 5 years (except murder or 1st degree sex abuse and 1st degree sex abuse of child, in which case, no requirement to dismiss charges).
Florida	No max treatment limit. Criminal charges dismissed after 1 year for misdemeanors and 5 years for felonies.
Georgia	1 year.
Hawaii	No treatment maximum; no required dismissal of charges.
Idaho	270 days.
Illinois	At the end of 1 year, state either asks to dismiss charges or there is a "discharge hearing" in which there must be a finding of guilt "beyond a reasonable doubt," or person released or civilly committed. If found "guilty" can have treatment for an additional 15 months to 5 years, depending on criminal charge.
Indiana	6 months
Iowa	Lesser of 18 months or maximum sentence of charged offense
Kansas	6 months.
Kentucky	60 days.
Louisiana	maximum sentence
Maine	1 year.
Massachusetts	40 days (plus possible 6 month civil commitment).
Michigan	Lessor of 1/3 of max sentence or 15 months.
Minnesota	Cannot be ordered for treatment on misdemeanors (charges dismissed); felonies, excluding murder = 3 years.
Mississippi	No max either treatment or criminal charges.
Missouri	12 months.
Montana	No max treatment or criminal charges.
Nebraska	No max treatment or criminal charges.

Nevada	Lessor of max sentence or 10 years.
New Hampshire	12 months.
New Jersey	No max treatment or required dismissal of charges.
New Mexico	9 months, except if felony involving "infliction of great bodily harm on another person," use of firearm, aggravated arson, criminal sexual penetration or sexual contact of a minor, in which case (unless charges dropped) court may order hearing on "factual guilt" and if found "guilty and dangerous may order continued treatment for period not to exceed max sentence.
New York	90 days misdemeanor; felonies 2/3 of max sentence.
North Carolina	60 days.
North Dakota	No maximum treatment; charges dismissed at max sentence.
Ohio	1 year maximum through tiered system: 3rd or 4th degree misdemeanor = 30 days; 1st or 2nd degree misdemeanor = 60 days; Non-violent felonies = 6 months; Violent felonies = 1 year
Oklahoma	Lesser of max sentence or 2 years.
Oregon	Lesser of 3 years or max sentence.
Pennsylvania	No maximum; criminal charges dismissed after lesser of maximum or 10 years except 1st or 2nd degree murder can remain indefinitely.
Rhode Island	2/3 of maximum term of imprisonment for most serious charged offense.
South Carolina	90 days total.
South Dakota	1 year for other than Class A or B felony; in those cases, maximum sentence could have received.
Tennessee	no maximum treatment; no requirement for charges dismissed.
Texas	180 days maximum.
Utah	36 months if charged with aggravated murder; 18 months serious felony; 1 year all other charges (not to exceed maximum penalty).
Vermont	No commitment
Virginia	Misdemeanors max 45 days (except for "peeping into dwelling/enclosure or disorderly conduct in public places); for all other charges – lesser of max penalty or 5 years, except murder charge, no limit.
Washington	Non-felony & no history of violence or previous findings of IST or NGRI = no commitment Non-felony and history of one or more violence acts or previously been found IST or NGRI = 120 days
West Virginia	9 months
Wisconsin	Lesser of 12 months or max sentence
Wyoming	No maximum.

[1] See Grant H. Morris and J. Reid Meloy, "Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants," *U.C. Davis Law Review* 1, no. 27 (1993).
[2] Office of Forensic Services data
[3] Office of Forensic Services data
[4] Based on FY10. Data supplied through Maryland Office of Reimbursement.
[5] JL Skeem, SL Golding, G Berge, et al, "Logic and reliability of evaluations of competence to stand trial," *Law of Human Behavior* 22 (1998): 519–47; RJ Bonnie and T Grisso, "Adjudicative competence and youthful offenders, in Youth on Trial: A Developmental Perspective on Juvenile Justice," Edited by T Grisso and RG Schwartz. Chicago: University of Chicago Press, 2000, pp 73–103
[6] GB Melton, J Petrila, NG Poythress, et al, *Competency to stand trial, in Psychological Evaluations for the Courts* (ed 2). New York: Guilford Press, 1997; JI Warren, WL Fitch, PE Dietz, et al, "Criminal offense, psychiatric diagnosis, and psycholegal opinion: an analysis of 894 pretrial referrals," *Bulletin of the American Academy of Psychiatry & Law* 19 (1991):63–9, Cited in Douglass Mossman, et al, "AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial," *The Journal of the American Academy of Psychiatry and the Law* 35, no. 4 (2007) www.forensic-experts.net/files/Forensic%20Psychiatry%20CTST%20evals.pdf
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[8] Office of Forensic Services, FY10 Pretrial Evaluations and Screenings
[9] Office of Forensic Services, MHA Community Forensic Evaluation Program FY2011 (Jessup, MD: Mental Hygiene Administration, 2011)
[10] *Funding and Characteristics of State Mental Health Agencies, 2007* (Rockville, MD: U.S. Department of Health and Human Services, 2010) Table 13. http://store.samhsa.gov/shin/content//SMA09-4424/SMA09-4424.pdf
[11] Forensic Populations and the Department of Health and Mental Hygiene, Report to the General Assembly, February 2008.
[12] Personal Interview with Susan Steinberg, Department of Health and Mental Hygiene, August 2011.
[13] Chapter 395, pp 87-88, Budget Bill, Fiscal Year 2012. The report is due December 1, 2011.
[14] RD Miller, "Hospitalization of criminal defendants for evaluation of competence to stand trial or for restoration of competence: clinical and legal issues," *Behavioral Science in the Law* 21 (2003):369 –91; DA Pinals, "Where two roads meet: restoration of competence to stand trial from a clinical perspective," *New England Journal of Criminal Civil Confinement* 31 (2005): 81–108.
[15] 406 U.S. 715 (1972).
[16] See Grant H. Morris and J. Reid Meloy, 1993
[17] Based on a 2005 review of the 50 state statutes and District of Columbia, conducted by the Maryland Disability Law Center.
[18] Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-108. Reports on incompetent persons.
[19] Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-107. Dismissal of charges.
[20] *Process Evaluation of Baltimore City Mental Health Court* (Maryland Judiciary Research Consortium, March 2010) www.courts.state.md.us/opsc/mhc/pdfs/evalutations/bcmhcprocessevaluation3-11-10.pdf
[21] *Process Evaluation of Baltimore City Mental Health Court* 2010
[22] Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-105. Examination of defendant by Health Department.
[23] Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-106. Finding of incompetency.
[24] Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-101. Definitions.
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[28] Mental Hygiene Administration
[29] Mental Hygiene Administration
[30] Mental Hygiene Administration. Age calculated based on age at admission.
[31] U.S. Census, Quick Facts, Baltimore City, Maryland. http://quickfacts.census.gov/qfd/states/24/24510.html
[32] See Nastassia Walsh, *Baltimore Behind Bars: How to Reduce the Jail Population, Save Money and Improve Public Safety* (Washington, D.C.: Justice Policy Institute, 2010) www.justicepolicy.org/reseach/1917
[33] Mental Hygiene Administration.
[34] *Mental Health: Culture, Race, Ethnicity Supplement*, a Report of the Surgeon General, 2001. www.surgeongeneral.gov/library/mentalhealth/
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[37] D. Mossman, "Predicting restorability of incompetent criminal defendants," *Journal of the American Academy of Psychiatry & Law* 35 (2007): 34–43
[38] See, G. Bennett and G. Kish, "Incompetency to stand trial: Treatment unaffected by demographic variables," *Journal of Forensic Sciences* 35 (1990): 403-412; S. L. Golding, D. Eaves, and A. Kowaz, "The assessment, treatment and community outcome of insanity acquittees: Forensic history and response to treatment," *International Journal of Law and Psychiatry* 12 (1989): 149-179; D. R. Morris and G. F. Parker, "Jackson's Indiana: State hospital competence restoration in Indiana," *Journal of the American Academy of Psychiatry and Law* 36 (2008): 522-534, www.jaapl.org/cgi/reprint/36/4/522; R. Nicholson and J. McNulty, "Outcome of hospitalization for defendants found incompetent to stand trial," *Behavioral Sciences and the Law* 10 (1998): 371-383.
[39] RA Nicholson and JL McNulty, 1992
[40] D. R. Morris and G.F. Parker, 2008
[41] Data provided by Forensic Services Division, Florida Department of Children and Families cited in Gary B. Melton and others, *Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers*, 3rd Edition (New York: The Guilford Press, 2007)
[42] Office of Forensic Services
[43] Office of Forensic Services
[44] Mental Hygiene Administration. Notes: Length of stay based upon true discharge date. Includes all discharges regardless of origination.
[45] Office of Forensic Services data
[46] Personal Interview with Crista Taylor and Steve Johnson, Baltimore Mental Health Systems, Inc. August 2011.
[47] Louden, Dickinger, and Skeem, "Parolees with mental disorder: Toward evidence based practice," In press; Cited in Seth Jacob Prins and Laura Draper, *Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice* (New York: Council of State Governments Justice Center, 2009) http://consensusproject.org/downloads/community.corrections.research.guide.pdf
[48] Ed Rosado, *Diverting the Mentally Ill From Jail* (Washington, D.C.: National Association of Counties Legislative Department, 2002) www.naco.org
[49] Maryland Mental Hygiene Administration, Annual Report Fiscal Year 2010. Lengths of stay data include both persons committed as IST and persons committed as Not Criminally Responsible (NCR). Delays in discharging the NCR population are even greater and should also be addressed.
[50] Personal Interview with Judge Gale Rasin, August 2011.
[51] Personal Interview with Sharon Bogins, Office of the Public Defender, August 2011.
[52] See *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) IV.
[53] Judge Charlotte Cooksey and Judge Mimi Cooper, *Mental Health Programs* www.courts.state.md.us/district/archive/mental%20health.pdf
[54] Rochelle Banta, "Mental Health Courts," NAMI Montgomery County, *NAMI News* 28, no. 7 (July/August 2006) www.namimc.org/PDF/News/NAMI%20News%20-%20Jul-Aug%202006.pdf

[55] *Process Evaluation of Baltimore City Mental Health Court* 2010
[56] For more information on the negative impact of being kicked out of specialty courts please see, Nastassia Walsh, *Addicted to Courts: How a Growing Dependence on Drug Courts Impacts People and Communities* (Washington, D.C.: Justice Policy Institute, 2011) www.justicepolicy.org/drugcourts
[57] Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. § 3-106. Finding of incompetency.; § 3-112. Not Criminally Responsible—Commitment.
[58] Time out dates for Capital Crimes (Murder 1) are 10 years; Felonies and crimes of violence (as defined in the Criminal Law Article § 14-101) are 5 years; Other crimes are 3 years or the maximum sentence, whichever is less. Annotated Code of Maryland, Criminal Procedure Article. Title 3. Incompetency and Criminal Responsibility in Criminal Cases. §3-107. Dismissal of charges.
[59] Office of Forensic Services data
[60] Three people's records were unavailable. Source: Public Court Records.
[61] Maryland Operating Budget Books, http://dbm.maryland.gov/agencies/operbudget/Pages/operatingbudget.aspx
[62] Based on FY10. Data supplied through Office of Reimbursement.
[63] Office of Forensic Services data
[64] Chapter 395, Budget Bill, pp 88-89, Fiscal Year 2012.
[65] Many of the people at Spring Grove as NCR have been committed on the same type of low-level, nonviolent offenses as those committed as IST. Those who were found guilty of more serious crimes are at Spring Grove after being transferred from Clifton T. Perkins Hospital Center, the maximum-security facility, as a "step-down" prior to release to the community.
[66] Jane D. Plapinger, *Mental Health Plan FY2010-2011* (Baltimore, MD: Baltimore Mental Health Services, 2009) Page 55. www.bmhsi.org/admin/upload/Microsoft%20Word%20-%20FY%202010-11%20FINAL%20MENTAL%20HEALTH%20PLAN%20052209.pdf
[67] Jane D. Plapinger, 2009
[68] See also, Melissa Reuland, Laura Draper, and Blake Norton, *Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions* (Washington, D.C.: Council of State Governments Justice Center and the Police Executive Research Forum, 2010) http://consensusproject.org/jc_publications/tailoring_le_responses/Tailoring_LE_Initiatives.pdf
[69] For more information, please contact Memphis Police Department's Major Sam Cochran, or visit http://cit.memphis.edu/TechAssistance.php

Justice Policy Institute (JPI) is a national nonprofit organization that changes the conversation around justice reform and advances policies that promote well-being and justice for all people and communities.

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ACKNOWLEDGEMENTS

This report would not have been possible without the generous support of the Maryland Disability Law Center. The work of the Justice Policy Institute is also made possible in part by grants from the Open Society Foundation and the Public Welfare Foundation.

This report is the culmination of interviews with many people in Baltimore, including stakeholders and people affected by the mental health and criminal justice system; research and data analysis; and visits to different parts of the system.

JPI greatly appreciates the input and expertise of the staff of the Maryland Office of the Public Defender; Susan Steinberg, Department of Health and Mental Hygiene; Judge Gale Rasin, Baltimore City Circuit Court; Judge George Lipman and staff, Baltimore City Mental Health Court; Larry Fitch and staff, Maryland Office of Forensic Services; Susan Bradley, Mental Hygiene Administration; Crista Taylor and Steve Johnson, Baltimore Mental Health Systems, Inc.; and JoAnne Dudek, Community Forensic Aftercare Program. And to the men and women currently in Spring Grove Hospital who we were willing to share their stories, we thank you.

Finally, the author would like to thank Laura Cain, Sarah Rhine and the staff of the Maryland Disability Law Center for their input and careful review of the report.

JPI staff includes Paul Ashton, Jason Fenster, Zerline Hughes, Amanda Petteruti, Kellie Shaw, Tracy Velázquez, Keith Wallington and Nastassia Walsh.

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