STATE OF MARYLAND	*	**IN THE**
v.	*	**CIRCUIT COURT**
SIYYAHA CRAWFORD **CASE NO. 116224008;**	*	**FOR**
	*	**BALTIMORE CITY**
COREY CARROLL **CASE NOS. 115272027, 028;**	*	
WALTER RANDLE **CASE NO. 116140009;**	*	
	*	
TONY WARDLOW **CASE NOS 115281004-006;**	*	
RONALD MEDDINGS **CASE NO 117172005;**	*	
	*	
BRIAN JOHNS **CASE NOS. 116349013;**	*	
RONALD MERRIKEN **CASE NO. 117130018;**	*	
	*	
DARNELL HINES **CASE NO. 115050034;**	*	
LAMONT KNIGHT **CASE NO. 11713015;**	*	
	*	
ZIONNES SPENCER **CASE NO. 117061013;**	*	
and	*	
SANTEE TAYLOR **CASE NO. 117017026.**	*	

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ORDER OF CONSTRUCTIVE CIVIL CONTEMPT:
FINDINGS WITH PURGE PROVISIONS

This is a consolidated action involving three sets of show cause orders. The first was initiated by the Petitioners/defendants in the above referenced cases, excluding defendants Spencer

and Taylor. They petitioned this Court to order Respondent, the Maryland Department of Health and Mental Hygiene (hereinafter "the Department"), to show cause why it should not be held in constructive civil contempt of orders that directed the Department to admit these defendants whom the court had committed as incompetent to stand trial and dangerous under Md. Code Ann., Crim. Proc. § 3-106(b) (2017). On July 12, 2017, this Court issued show cause orders against the following individual officials and agents of the Department to show cause why they should not be held in contempt in connection with the same commitment orders: Dennis R. Schrader, Secretary of the Department; Barbara J. Bazron, Deputy Secretary of the Department; Erik Roskes, Director of Office of Forensic Services, Behavioral Health Administration of the Department, Kim Bright, Clinical Director, Behavioral Health Administration of the Department of Health; Inna Taller, Clinical Director, Clifton T. Perkins Hospital Center (hereinafter "Perkins"); Danielle Robinson, Clinical Director, Pretrial Services, Perkins; Elizabeth Tomar, Clinical Director, Spring Grove Hospital Center (hereinafter "Spring Grove"); and Bevin Merles, Forensic Office, Spring Grove. On July 25, 2017, this Court issued show cause orders against the same individuals, excluding Doctors Merles and Tomar, to show cause why they should not be held in constructive civil contempt in connection with their failure to comply with two additional commitment orders for competency evaluations for defendants Spencer and Taylor under Crim. Proc. § 3-105. Three individuals employed by the Department (Kim Bright, Elizabeth Tomar and Bevin Merles) were named in the July 12, 2017 show cause orders, but thereafter were dismissed from this action.

On July 13, 2017, this Court conducted a hearing on the Department's Motions, and denied its motion to dismiss and motion to quash a subpoena issued for Secretary Schrader. Since that date this Court has conducted hearings and taken testimony on July 25th and 26th, August 2nd, 4th, 15th, and 24th, and September 12th and 28th. On August 24, 2017, this Court found the Department in constructive civil contempt violation of commitment orders under Crim. Proc. § 3-106 involving the above-captioned defendants (excluding Spencer and Taylor) and deferred its determination of a purge provision. During the course of the hearings the defendants in the criminal cases were referred to as Petitioners since they petitioned for the original show cause orders, and the Department and individual officials and agents were referred to as Respondents, and shall be described as such herein. This Court adopts and incorporates its oral comments on August 24th as grounds for the decision herein.

I. CONSTRUCTIVE CIVIL CONTEMPT

Maryland Rule 15-206 provides that a proceeding for constructive civil contempt shall be included in the action in which the alleged contempt occurred. All of the show cause orders issued against the Department and the individual Respondents were filed in the criminal cases in which the Petitioners were charged in the Circuit Court for Baltimore City and in which the issue of competency to stand trial was raised. The court or a party to an action in which the alleged contempt occurred may initiate a proceeding. All show cause orders in this matter notified the Respondents that incarceration was not sought.

The issue for these contempt proceedings is whether the Department and the officials and agents violated this Court's orders to commit the Petitioners for inpatient competency evaluations under Crim. Proc. § 3-105 or violated this Court's orders to commit the Petitioners after a finding

that they were not competent and dangerous under Crim. Proc. § 3-106 in a manner that rises to the level of constructive civil contempt. Each order dictated a date for admission. There is no dispute regarding the dates of admission to Health Department hospitals. All admissions were after the dates ordered by the court, as evidenced by the procedural histories of the individual Petitioners/defendants. All of the defendants were held in pre-trial status in correctional facilities operated by the Department of Public Safety and Correctional Services. Whether the Health Department's acts and omissions and those of the individual Respondents constitute constructive civil contempt is discussed below.

II. RELEVANT STATUTES

A criminal defendant is "not competent to stand trial" if he or she is not able "(1) to understand the nature or object of the proceeding; or (2) assist in [his or her] defense as a result of a mental disorder or mental retardation." Crim. Proc. § 3-101(f). A competent individual possesses the "present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against him." *Thanos v. State*, 330 Md. 77, 85 (1993).

Section 3-105 states in pertinent part:

MD Code, Criminal Procedure, § 3-105

§ 3-105. Examination of defendant by Health Department

Conditions of examination

(a)(1) For good cause and after giving the defendant an opportunity to be heard, the court may order the Health Department to examine the defendant to determine whether the defendant is incompetent to stand trial.

(2) The court shall set and may change the conditions under which the examination is to be made.

Outpatient examination

(b) On consideration of the nature of the charge, the court:

(1) may require or allow the examination to be done on an outpatient basis; and

(2) if an outpatient examination is authorized, shall set bail for the defendant or authorize release of the defendant on recognizance.

Defendants held in custody

(c)(1) If a defendant is to be held in custody for examination under this section, the defendant may be confined in a correctional facility until the Health Department can conduct the examination. If the court finds it appropriate for the health or safety of the defendant, the court may order confinement in a medical wing or other isolated and secure unit of the correctional facility.

(2)(i) If the court finds that, because of the apparent severity of the mental disorder or mental retardation, a defendant in custody would be endangered by confinement in a correctional facility, the court

may order that the Health Department, in the Health Department's discretion:

1. confine the defendant, pending examination, in a medical facility that the Health Department designates as appropriate; or

2. immediately conduct a competency examination of the defendant by a community forensic screening program or other agency that the Health Department finds appropriate.

(ii) Unless the Health Department retains the defendant, the defendant shall be promptly returned to the court after the examination.

(3) A defendant who is held for examination under this section may question at any time the legality of the detention by petition for a writ of habeas corpus.

Duties of Health Department

(d)(1) If a court orders an examination under this section, the Health Department shall:

(i) examine the defendant; and

(ii) send a complete report of its findings to:

1. the court;

2. the State's Attorney; and

3. the defense counsel.

(2) Unless there is a plea that the defendant was not **criminally** responsible under § 3-109 of this title, the defendant is entitled to have the report within 7 days after the court orders the examination. However, failure of the Health Department to send the complete report within that time is not, of itself, grounds for dismissal of the charges. On good cause shown, the court may extend the time for examination.

(3) If the Health Department reports that, in its opinion, the defendant is incompetent to stand trial, the report shall state, in a complete supplementary opinion, whether, because of mental retardation or mental disorder, the defendant would be a danger to self or the person or property of another, if released.

Section 3-106 states in pertinent part:

MD Code, Criminal Procedure, § 3-106

§ 3-106. Finding of incompetency
Bail or release of defendant on recognizance

(a) If, after a hearing, the court finds that the defendant is incompetent to stand trial but is not dangerous, as a result of a mental disorder or mental retardation, to self or the person or property of others, the court may set bail for the defendant or authorize release of the defendant on recognizance.

Commitment of defendant to designated facility

(b)(1) If, after a hearing, the court finds that the defendant is incompetent to stand trial and, because of mental retardation or a mental disorder, is a danger to self or the person or property of another, the court may order the defendant committed to the facility that the Health Department designates until the court finds that:

(i) the defendant no longer is incompetent to stand trial;

(ii) the defendant no longer is, because of mental retardation or a mental disorder, a danger to self or the person or property of others; or

(iii) there is not a substantial likelihood that the defendant will become competent to stand trial in the foreseeable future.

(2) If a court commits the defendant because of mental retardation, the Health Department shall require the Developmental Disabilities Administration to provide the care or treatment that the defendant needs.

Hearings related to continued commitment of defendant

(c)(1) To determine whether the defendant continues to meet the criteria for commitment set forth in subsection (b) of this section, the court shall hold a hearing:

(i) every year from the date of commitment;

(ii) within 30 days after the filing of a motion by the State's Attorney or counsel for the defendant setting forth new facts or circumstances relevant to the determination; and

(iii) within 30 days after receiving a report from the Health Department stating opinions, facts, or circumstances that have not been previously presented to the court and are relevant to the determination.

(2) At any time, and on its own initiative, the court may hold a conference or a hearing on the record with the State's Attorney and the counsel of record for the defendant to review the status of the case.

Civil commitment of defendant

(d) At a competency hearing under subsection (c) of this section, if the court finds that the defendant is incompetent and is not likely to become competent in the foreseeable future, the court shall:

(1) civilly commit the defendant as an inpatient in a medical facility that the Health Department designates provided the court finds by clear and convincing evidence that:

(i) the defendant has a mental disorder;

(ii) inpatient care is necessary for the defendant;

(iii) the defendant presents a danger to the life or safety of self or others;

(iv) the defendant is unable or unwilling to be voluntarily committed to a medical facility; and

(v) there is no less restrictive form of intervention that is consistent with the welfare and safety of the defendant; or
(2) order the confinement of the defendant for 21 days as a resident in a Developmental Disabilities Administration facility for the initiation of admission proceedings under § 7-503 of the Health-General Article provided the court finds that the defendant, because of mental retardation, is a danger to self or others.

Application of Health-General Article to continued retention of defendant

(e) The provisions under Title 10 of the Health-General Article shall apply to the continued retention of a defendant civilly committed under subsection (d) of this section.

Defendants incompetent to stand trial but not dangerous

(f)(1) For a defendant who has been found incompetent to stand trial but not dangerous, as a result of a mental disorder or mental retardation, to self or the person or property of others, and released on bail or on recognizance, the court:
(i) shall hold a hearing annually from the date of release;
(ii) may hold a hearing, at any time, on its own initiative; or
(iii) shall hold a hearing, at any time, upon motion of the State's Attorney or the counsel for the defendant.
(2) At a hearing under paragraph (1) of this subsection, the court shall reconsider whether the defendant remains incompetent to stand trial or a danger to self or the person or property of another because of mental retardation or a mental disorder.
(3) At a hearing under paragraph (1) of this subsection, the court may modify or impose additional conditions of release on the defendant.
(4) If the court finds, at a hearing under paragraph (1) of this subsection, that the defendant is incompetent and is not likely to become competent in the foreseeable future and is a danger to self or the person or property of another because of mental retardation or a mental disorder, the court shall revoke the pretrial release of the defendant and:
(i) civilly commit the defendant in accordance with paragraph (1) of subsection (d) of this section; or
(ii) order confinement of the defendant in accordance with subsection (d)(2) of this section.

Section 6-103 states in pertinent part:

MD Code, Criminal Procedure, § 6-103

§ 6-103. Trial date

Time for trial

(a)(1) The date for trial of a criminal matter in the circuit court shall be set within 30 days after the earlier of:

(i) the appearance of counsel; or
(ii) the first appearance of the defendant before the circuit court, as provided in the Maryland Rules.
(2) The trial date may not be later than 180 days after the earlier of those events.

Change of trial date on motion of party or initiative of court

(b)(1) For good cause shown, the county administrative judge or a designee of the judge may grant a change of the trial date in a circuit court:
(i) on motion of a party; or
(ii) on the initiative of the circuit court.
(2) If a circuit court trial date is changed under paragraph (1) of this subsection, any subsequent changes of the trial date may only be made by the county administrative judge or that judge's designee for good cause shown.

III. PROCEDURAL HISTORY

All of the Petitioners/defendants in this matter were ordered by either a District Court Judge or a Circuit Court judge to receive an initial screening evaluation by the Circuit Court Medical Office (hereinafter "CCMO").[1] In some instances the original orders came from the District Court, and when the defendants were indicted, the consideration of competency was assigned to the Mental Health Court of the Circuit Court for Baltimore City. All orders for commitment as incompetent to stand trial and dangerous were issued by the Circuit Court for Baltimore City.

IV. HISTORY OF COMMITMENTS

Siyyaha Crawford: This Court signed the commitment for an initial competency evaluation on April 5, 2017. CCMO sent its transfer notes to DDA and Perkins on April 17, 2017, and requested that the Court sign an order for an extended evaluation by Perkins and DDA. The

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[1] The Community Forensic Screening Program was established, first in Baltimore City in 1979 and expanded to include all the counties by 1984. Trained mental health professionals, not necessarily psychiatrists, were organized throughout the State to screen out those who unquestionably were both competent and responsible. Anyone who, in the opinion of the screener, was "possibly not competent," was sent to Clifton T. Perkins Hospital for a full evaluation. Since its inception, the program has had the full support of the Chief Judge of the Court of Appeals in his capacity as administrative head of the judicial system, the Conference of Circuit Court Judges, and the Chief Judge of the District Court. *See generally,* Rappeport, Conti & Rudnick, *A New Pretrial Screening Program,* 11 Bulletin American Academy of Psychiatry and the Law 239 (1983), *Lewis v. State*, 79 Md. App. 1 (1988).

§ 3-105 Order for an extended evaluation was issued on April 19, 2017, with transportation to Perkins on April 24, 2017. Perkins failed to admit the defendant. Based upon the content of transfer notes from CCMO this Court committed the defendant as incompetent and dangerous to Perkins on April 26, 2017. The defendant was not admitted until June 29, 2017.

Corey Carroll: On February 3, 2016, this Court signed an Order for an examination for competency and criminal responsibility. CCMO recommended an extended evaluation and sent transfer notes on February 24, 2017. Perkins failed to admit the defendant for an evaluation, and this Court committed him as incompetent and dangerous on April 6, 2016. He was admitted on May 18, 2016. On September 29, 2016, an evaluator opined the defendant competent. The evaluation to determine criminal responsibility (hereinafter "NCR evaluation") then was conducted, and Perkins issued a report on January 1, 2017. On January 18, 2017, this Court returned the defendant to jail. Defense counsel raised the issue of competency anew, and on May 10, 2017, this Court issued an Order for an initial competency evaluation by CCMO. On May 19, 2017, an order for an extended evaluation was signed. Perkins failed to admit the defendant timely, and based upon CCMO transfer notes, this Court committed the defendant as incompetent and dangerous on May 31, 2017. The defendant was evaluated as an out-patient on July 6, 2017, and Perkins reported on July 7, 2017, that he was competent. Nevertheless on July 24, 2017, Perkins admitted the defendant under the May 31st § 3-106 Order. This Court found the defendant competent on July 26, 2017, and returned him to jail.

Brian Johns: On May 3, 2017, this Court ordered an initial competency evaluation. On May 16, 2017, CCMO issued transfer notes and requested an extended evaluation at Perkins. On May 17, 2017, this Court signed a § 3-105 Order for an extended evaluation, but Perkins failed to admit him timely. On May 31, 2016, this Court found the defendant incompetent and dangerous based upon the transfer notes and committed him under Crim Proc. § 3-106. Perkins admitted him on July 5, 2017. The defendant was held in custody at Patuxent while waiting for admission.

Tony Wardlaw: The defendant was found incompetent to stand trial and dangerous as a juvenile in 2014. In the above-referenced case he was evaluated for competency by CCMO, which requested an extended evaluation on March 28, 2016. An order was signed under Crim. Proc. § 3-105, but Perkins failed to comply with it. The defendant was committed as incompetent and dangerous and was admitted on May 13, 2016. On October 5, 2016, Perkins reported that the defendant was competent. On October 16, 2016, this Court found the defendant competent and returned him to jail. His competency was raised anew and on May 25, 2017, an order for an initial competency evaluation was signed. CCMO issued transfer notes and requested further evaluation at Perkins on June 5, 2017. On June 7, 2017, this Court signed an order under Crim. Proc. § 3-105. After Perkins failed to timely admit the defendant, this Court found the defendant incompetent and dangerous based upon the transfer notes and committed the defendant to Perkins under Crim. Proc. § 3-106. The defendant was admitted to Perkins on July 21, 2017.

Walter Randle: The District Court ordered that the defendant be evaluated for competency and he was admitted to Perkins on May 22, 2015. Based on an evaluation he was committed as incompetent on June 11, 2015. Almost a year and a half later, on December 19, 2016, Perkins reported that the defendant was restored to competency. An NCR evaluation was performed and Perkins reported on February 26, 2017, that the defendant was competent and responsible. This

Court immediately returned the defendant to jail. On April 21, 2017, counsel requested another competency evaluation. On May 10, 2017, this Court ordered an initial competency evaluation by CCMO. Based upon the transfer notes, defendant's recent lengthy hospitalization, and the defendant's presentation in court, this Court committed the defendant as incompetent and dangerous under Crim. Proc. § 3-106 on May 24, 2017, with a transportation order for May 30, 1017. He was admitted to Perkins on June 28, 2017.

Ronald Meddings: The District Court ordered an initial competency evaluation by CCMO on June 7, 2017. At that time the defendant was charged with assault. CCMO issued transfer notes on June 9, 2017, and requested an extended evaluation at Spring Grove. The District Court ordered an extended evaluation on June 15, 2017. The defendant was indicted on June 21, 2017, for offenses including attempted murder, and Spring Grove required a Circuit Court Order for commitment and transferred the case to Perkins. On June 28, 2017, this Court committed the defendant to Perkins under Crim. Proc. § 3-106 based upon the transfer notes. On June 30 2017, Dr. Robinson sent this Court a letter stating that there would not be a bed for the defendant on the scheduled transportation date. On July 1, 2017, the defendant was admitted to Bon Secours Hospital. After discharge from the hospital eventually he was admitted to the medical unit of Spring Grove on July 18, 2017, and was transferred to Perkins on August 7, 2017.

Ronald Merriken: On April 25, 2017, the District Court issued an order for an initial competency evaluation. On May 1, 2017, CCMO issued transfer notes to Spring Grove and requested an extened evaluation. The defendant was indicted on May 11, 2017. On May 31, 2017, this Court committed the defendant as incompetent and dangerous based upon the transfer notes. On July 7, 2017, Dr. Merles sent this Court a letter stating that there seven people ahead of the defendant on the wait list at Spring Grove. The defendant was admitted to Spring Grove on August 2, 2017.

Darnell Hines: On May 10, 2017, an order for an initial competency evaluation was ordered by the Circuit Court judge with whom defendant is on probation. Based upon the opinion of CCMO this Court committed the defendant as incompetent and dangerous under Crim. Proc. § 3-106. According to the CCMO report the defendant had been in general population for five months and had been placed in single cell isolation in the crisis management room in the Inmate Medical Health Unit on several occasions due to his aggressiveness and suicidal statements. He was admitted to Spring Grove on July 30, 2017.

Lamont Knight: On May 11, 2017, defense counsel filed a motion for a competency evaluation and recited her concerns based upon a visit to defendant's cell at the mental health unit at Central Booking. On May 24, 2017, this Court ordered an initial evaluation and on May 30, 2017, committed the defendant as incompetent and dangerous under Crim. Proc. § 3-106 based upon a report by CCMO. On July 7, 2017, Dr. Merles of Spring Grove reported to this Court that there were nine people ahead of the defendant on the waiting list. The defendant was admitted to Spring Grove on July 30, 2017.

Zionnes Spencer: On June 21, 2017, this Court ordered an initial competency evaluation. On July 10, 2017, CCMO issued transfer notes and requested an extended evaluation at Perkins. On July 12, 2017, this Court ordered the extended evaluation under Crim. Proc. § 3-105 to be

admitted in five days, with a return to court on August 16, 2017. The defendant was admitted on August 4, 2017. Perkins requested a thirty-day extension to complete the evaluation. On September 20, 2017, the defendant returned to Court and was found competent to stand trial based upon the report from Perkins. The defendant returned to jail on that date.

Santee Taylor: This Court ordered an initial competence evaluation on June 21, 2017. On July 6, 2017, CCMO issued transfer notes and requested an extended evaluation at Perkins. On July 12, 2017, this Court signed an order for an extended evaluation at Perkins to be admitted in five days, with a return to court date of August 8, 2016. On July 14, 2017, Dr. Robinson of Perkins wrote a letter to the Court stating that no bed was available. The defendant was admitted to Perkins on August 8, 2017. On August 10, 2017, Dr. Robinson requested a thirty-day extension. The defendant returned to court on September 20, 2017, was found competent, and returned to jail.

V. MOOTNESS

Respondents repeatedly have urged this Court to dismiss the show cause orders because all Petitioners/defendants were admitted to the hospital as either incompetent and dangerous or for evaluation during the more than two months that it took to conduct contempt hearings. None of the defendants were admitted under Crim. Proc. § 3-106 at the time that the show cause orders were issued, and in at least one instance, there was a delay of three months from the date of commitment to the date of admission to the hospital.

This Court declined to stop the hearings and dismiss the show cause orders, drawing upon appellate cases that address the issue of mootness in judicial review. In *State v. Dixon*, 230 Md.App. 273 (2016), the Department appealed an order of this Court under Crim. Proc. § 3-105 for immediate in-patient admission of Larry Dixon to Perkins for evaluation of competency. Counsel for Mr. Dixon moved to dismiss the appeal on the grounds of mootness, since eventually Mr. Dixon was admitted to the hospital before briefs were due. The Department urged the Court of Special Appeals to render a decision, arguing that as a matter of public policy the court should rule on the issue of whether this Court had the authority to set a date when the defendant should be admitted for evaluation under Crim. Proc. § 3-105.

The Court of Special Appeals noted that a case is moot when there is "no longer an existing controversy when the case comes before the Court or when there is no longer an effective remedy the Court could grant." *Dixon*, 230 Md.App. at 275 (citing *Suter v. Stuckey*, 402 Md. 211, 219–20 (2007)).

> As a general rule, courts do not entertain moot controversies. There are, however, circumstances in which this Court will address the merits of a moot case. ***The first is where the controversy, even though moot at the time of judicial review, is capable of repetition but evading review. The second exception allows us to express our views on the merits of a moot case to prevent harm to the public interest.***

Dixon, 230 Md.App. at 275 (emphasis added) (internal citations omitted).

The *Dixon* Court ruled, "we are persuaded that the issue presented is capable of repetition yet evading review and is, therefore, not moot." *Id.* The Court of Special Appeals affirmed this Court's decision, finding that under Crim. Proc. § 3-105 this Court had the power to set a date for Dixon's admission and immediate transportation to Perkins.

It is important to note that the *Dixon* opinion was issued less than a month after the contempt hearings regarding the Department's failure to admit multiple defendants to Perkins were conducted by this Court during July and August of 2016. In oral argument on August 24, 2017, the Department's counsel conceded that *Dixon* is good law. The Department did not seek further review by the Court of Appeals.

Citing *Dixon*, the Court of Appeals recently declined to grant the Department's motion to dismiss on the ground of mootness in a case involving the interpretation of Crim. Proc. § 3-106. *Powell v. Maryland Dep't of Health*, No. 77, 2017 WL 3699338 (Md. August 28, 2017). In *Powell*, Judge McDonald expanded the analysis of the possibility of repetition, beyond the likelihood that identical cases would arise involving other defendants whose commitment orders are not obeyed, yet who are admitted before judicial action to enforce the orders is possible. He addressed the possibility that individuals before the Court may be restored to competence, but later lapse back into incompetence, or "decompensate," and their competence would need to be reconsidered by the court even *during the course of the prosecution* under Crim. Proc. § 3-104(c). *Id.* at 17 ("It is thus conceivable that one or more of the Appellants, having experienced that cycle, will again be the subject of a commitment order under Criminal Procedure Section 3-106(b) in connection with his or her criminal case.").

The *Powell* Court held that this is "a classic example of one of the limited exceptions to the mootness doctrine because the controversy between the parties is "capable of repetition, yet evading review." *Id.* (citing *State v. Parker*, 334 Md. 576 (1994).

> [This exception] applies when (1) the challenged action was too short in its duration to be fully litigated prior to its cessation or expiration; and (2) there was a reasonable expectation that the same complaining party would be subjected to the same action again. Even if it is unlikely that the same party will be subject to the same action, the exception may also apply if the issue is of public importance and affects an identifiable group for whom the complaining party is an appropriate surrogate (even if a class action is not certified.)

Powell, 2017 WL 3699338, at 17 – 18.

The *Powell* Court found that "the failure to admit the Appellant to Perkins – was too short in duration to be fully litigated prior to its cessation. It is also entirely possible that the complaining party – one of the Appellants – would be subject to the same circumstances again." *Id.* at 18. *It is significant that the Appellants in this appeal were the defendants who were the subjects of last year's contempt hearings.* The fact that one year later this Court is faced with another group of incompetent defendants who languished in jail awaiting admission to the Department's hospitals proves the point that this situation is not only capable of repetition. Indeed, it repeats itself with

additional defendants. Moreover, the possibility of a particular defendant being exposed to multiple delays of admission because of recurrent periods of incompetence exists among the defendants before this Court, particularly with those who have periods of medication non-compliance, such as Mr. Meddings.

More compelling, in two of the cases before this court in which there was significant delay in admissions, the defendants indeed in the past have been committed as incompetent and dangerous and restored to competency, and subsequently decompensated in the jail. They recently have returned to Perkins, after being adjudicated incompetent and dangerous. As recited in the History of Commitments, *supra*, and as proven by admission records introduced by Respondents, both Tony Wardlow and Walter Randle have been committed as incompetent to stand trial and dangerous and spent significant periods of time at Perkins.

In Mr. Randle's case, the date of charges was May 1, 2015. Competency was raised immediately, and Mr. Randle was evaluated at Perkins at the end of May 2015. The hospital evaluators opined him competent in December of 2016. They then performed an NCR evaluation and opined him criminally responsible at the time of the offence. Based upon those opinions Mr. Randle returned to court, was adjudicated as restored to competency, and was transported back to jail on February 26, 2017. His attorney raised the issue of competency again on April 21, 2017.

The May 19, 2017 CCMO transfer notes introduced by Respondents on August 24, 2017, state that Mr. Randle was a "poor historian due to his psychosis" and that:

> Mr. Randall was not quite sure why he was sent to the Medical Office. He said it was 'to see if I go to Perkins.' He has been there before and did well there. He said he had a long history of Schizophrenia with command hallucinations, telling him to hurt himself or others, as well as cursing at him.

The competency evaluation portion of the transfer notes describe the defendant's understanding of the roles of various participants in a trial such as a jury, State's Attorney, defense attorney, and judge. It concludes that:

> Mr. Randall appeared very confused about some of the facts of the case and about what he was experiencing at the time. He also had some memory problems, was actively psychotic, and was confused about some of the Court proceedings, though he seemed to be able to recite some of the above information by rote memory.

The letter from the evaluator to the Court concluded that Mr. Randle "seemed quite paranoid and actively psychotic. He was confused about some of the facts of the case and would have great difficulty assisting in his own defense." *Yet rather than opining him incompetent, CCMO requested further evaluation*, pursuant to a directive of the Office of Forensic Services, which will be described in full in the Findings of Fact, *infra*.

It is notable that the evaluation report from CCMO did not offer an opinion as to Mr. Randle's competency. Given the dictates of the Office of Forensic Services described below, which prohibit CCMO from providing an opinion to the Court that a defendant is incompetent in a "Perkins level case," given Mr. Randle's history of a lengthy hospitalization at Perkins lasting over a year and a half (evidencing the difficulty in achieving competency restoration), and given Mr. Randle's presentation in court, this Court declined to order a further evaluation at Perkins and committed him under Crim. Proc. § 3-106 on May 24, 2017. He languished in the jail for four weeks before he finally was admitted.

Petitioner/defendant, Tony Wardlow, was arrested on August 20, 2105. He was evaluated for competency by CCMO, with transfer notes dated March 28, 2016, contained in Respondent's admission file and introduced as evidence. In accordance with CCMO's request, this Court ordered further evaluation under Crim. Proc. § 3-105. Because Perkins failed to timely admit the defendant for evaluation, he was then committed under Crim. Proc. § 3-106 based on the evidence available to the Court from CCMO. The first report to the Court dated October 5, 2016, contained an opinion that the defendant was competent. On October 19, 2016, the defendant was adjudicated competent and was returned to jail with prescriptions for lithium for his mood and Seroquel for psychosis.

In May of 2017 the issue of Mr. Wardlaw's competence was raised again, and on May 30, 2017, this Court ordered an evaluation by CCMO. A report dated June 5, 2017, requested further evaluation at Perkins. The Mental Status Exam reports the following:

> He was minimally verbally expressive throughout the exam…When he spoke, he gave monosyllabic responses and often said, "I don't know." When he did speak, his volume was soft and he mumbled. Eye contact was minimal . . . . His affect was overall neutral with occasional inappropriate brightening. He laughed several times and smiled intermittently throughout the interview without apparent reason or cause. At times he appeared confused and slightly anxious and at other times appeared aloof and slightly irritated. Once during the interview, he suddenly looked behind him. Additionally, throughout the interview his eyes somewhat quickly shifted horizontally back and forth, while his gaze was diverted to the ground, as if responding to internal stimuli. However, he was not noted to be significantly internally pre-occupied and maintained good attention. He did not respond in any meaningful way to questions regarding vital sense, hallucinations, paranoia and delusions. It was difficult to ascertain his level of insight and judgment given his lack of verbal communication.

CCMO requested further evaluation at Perkins, which was ordered by this Court on June 7, 2017. When Perkins failed to admit the defendant in accordance with the § 3-105 Order, given that the only evidence before the Court was the CCMO report, the defendant was committed as incompetent and dangerous on June 21, 2017. He was admitted to Perkins on July 21, 2017, according to the Perkins admission sheet.

In addition to Mr. Wardlow's 2016 commitment to Perkins as incompetent and dangerous, he was adjudicated incompetent as a juvenile in 2014.

According to Dr. Robinson, there is no indication from the treatment team at Perkins that either Mr. Randle or Mr. Wardlow is now competent.

Thus, among this group of nine individuals who have been committed to the Department and not admitted timely, seven currently are hospitalized as incompetent to stand trial and dangerous. Two of those previously were hospitalized at Perkins, treated, restored to competency, and have been readmitted. These are precisely the circumstances envisioned by Judge McDonald in his *Powell* opinion.

The *Dixon* case describes the second exception to the mootness doctrine on appellate review as one that "allows us to express our views on the merits of a moot case to prevent harm to the public interest." *Dixon*, 230 Md.App. at 3 (citation omitted). Certainly there is a strong public interest in the timely admission and restoration of incompetent defendants. As evidenced by the procedural histories above, the wait for admission to Spring Grove was from two to three months for the defendants committed there under Crim. Proc. § 3-106. Ronald Merriken, who waited three months for admission, was arrested for a robbery that was committed on November 23, 2017. The State's case, based upon a review of the Statement of Charges, relies upon the testimony of the victim, a store clerk, who allegedly was hit and robbed of his watch while the defendant purchased a muffin from him, and perhaps another individual in the store who was acquainted with the defendant. Immediately upon his arrest, after unsuccessfully attempting to interview Mr. Merriken, the police took the defendant to the hospital for an emergency evaluation as he was mumbling and incoherent. As a result he was committed to the hospital and discharged to the jail.

This delay of two or more months can be fatal to a criminal prosecution, especially one involving civilian witnesses. Witnesses can move; victims lose interest over time. The State has a vital interest in the prompt admission of defendants who are incompetent to stand trial and in the restoration of their competence. The community has an interest in this in terms of public safety.

This Court finds that not only is the issue of delay in hospital admission capable of repetition but evading review, but that enforcing commitment orders under Crim. Proc. §§ 3-105 and 3-106 prevents harm to and serves the public interest. *Id.* at 3.

VI. MOOTNESS AND CONSTRUCTIVE CIVIL CONTEMPT

Respondent's counsel has taken the position that contempt actions are the only vehicle available to the courts to enforce commitment orders. *See* Md. Ct. of Appeals Archives of Oral Arg., *Powell v. State*, Arg'd March 31, 2017, and Appellee's Br. in the same case. This position contradicts the position of Principal Counsel for the Department in argument before this court at the conclusion of the show cause hearing in August of 2016. In that case officials and agents of the Department were called upon to show cause why they should not be held in constructive civil contempt for failure to timely admit defendant, Fredia Powell, and others under various § 3-106 Orders. As has happened in the current cases, Ms. Powell had been admitted to Perkins by the

date the show cause hearing concluded. The Department argued that the cases were moot. In response to the Court's suggestion that, because the problem of admission delay was likely to recur, a systemic remedy should be crafted and included in a contempt judgment with a remedial purge provision, counsel further argued that the pending Fredia Powell civil case requesting declaratory relief was the proper remedy. When a judge of the Circuit Court for Baltimore City granted the Department's motion to dismiss the contempt proceedings, and certiorari was granted to the Court of Appeals, the department changed tactics and argued that contempt is the only viable remedy for a defendant to pursue when he or she is not admitted timely to a hospital.

Of course that is a daunting and potentially frustrating pursuit for a criminal defendant who asks the Court to enforce a § 3-105 Order or § 3-106 Order. Both last year in the previous contempt cases and over the last two months in this consolidated action, this Court took testimony over multiple days, taking into account the schedules of lawyers, witnesses, and parties. If the court had not consolidated the cases and agreed to incorporate testimony taken in the original cases against the Department the hearings would have taken additional days.

Civil contempt proceedings are "generally remedial" and "intended to coerce future compliance," while sanctions for criminal contempt "may be purely punitive." *Royal Inv. Grp., LLC v. Wang*, 183 Md.App. 406, 447 (2008), *cert. dismissed*, 409 Md. 413 (2009). Ordinarily a civil award for compensatory damages without a purge provision is improper. *Dodson v. Dodson*, 380 Md. 438, 445 (2004). In that case the Court of Appeals repeated that:

> "remedial" in the context of civil contempt means to coerce compliance with court orders for the benefit of a private party or to issue ancillary orders for the purpose of facilitating compliance or encouraging a greater degree of compliance with court orders. We have not used the term 'remedial' to mean a sanction, such as a penalty or compensation, where compliance with a prior court order is no longer possible or feasible.

Id. at 448.

The Order issued by this Court herein does not constitute a penalty, fine, or a sanction. Instead its purge provision constitutes an "extraordinary remedy." *Gertz v. Md. Dep't of Env't*, 199 Md. App. 413, 423–24 (2011). It contemplates future compliance in order to prevent the otherwise predictable recurrence of violations of court commitment orders, to avoid deprivation of Petitioners'/defendants' liberty interests, to reduce delay in effective prosecution of crimes by the State, and to eliminate future harm to the public, thereby promoting public safety.

An "extraordinary remedy" is appropriate in these cases, given the lengthy history of delays in hospital admissions and noncompliance with court orders documented by the Court's Exhibits. The Forensic Services Work Group: Report of Recommendations, dated August 31, 2017, is a product of a group assembled by then-Secretary Van Mitchell that introduces its recommendations with the following summary:

> ...it would be difficult to proceed on to a discussion about any other recommendation without first acknowledging the need and

> expectation for some group members for immediate inpatient bed space. This need, as stated by multiple members, has been consistently identified for more than a decade. Cited studies included the increase in capacity that was specifically recommended in the "Independent Study on Future Demand for State-Operated Psychiatric Hospital Capacity" from July of 2012. This need was further articulated as the number one recommendation in the "Joint Chairman's Report, Page 78 – Treatment and Service Options for Certain Court-Involved Individuals," (JCR) from December of 2014 and was re-emphasized in the Judicial Commentary that followed. In fact, the need for additional bed space was the single most intensely discussed system need throughout the meetings of the Workgroup. Strong feelings from the membership about their perception that the State has not responded timely nor appropriately to previous recommendations fueled these discussions and added to some members' lack of faith in the State's intention to follow through with any current recommendations that come from this Forensic Services Workgroup.

(Ct.'s Ex. 3, p. 5)

The "Joint Chairman's Report" (Ct.'s Ex. 1) was prepared by the Department and presented to the Maryland legislature as a result of budget language in 2014 which orders the Department to study the issue of delays in admission to state hospitals under Crim. Proc. §§ 3-105 and 3-106. Recommendation One of the Department's report was for a ten percent (10%) increase in bed capacity in the five (5) state hospitals. That translates to over ninety (90) beds. However, the Department failed to follow its own recommendation to increase bed capacity.

Given the clear evidence that the Department has been aware of the problem of admissions delays, has been admonished about the problem (*See* Ct.'s Ex. 5), and recommended an increase in bed capacity in 2015 – then demurred, declared a "crisis" in April of 2016 due to lack of bed availability for admissions, promised through then-Secretary Mitchell to "fix" the problem by opening a twenty (20) bed unit at Perkins, then through its Workgroup recommended the immediate opening of an admissions unit to accept court-ordered individuals – which it failed to pursue- the time has come for an extraordinary remedy. And yet, the purge provisions ordered below do nothing more than order the Department and the Respondents to obey court orders, to not interfere with their execution, to follow its own recommendations, and as to the Secretary, to do that which he testified before this Court, erroneously, had already been accomplished.

VII. FINDINGS OF FACT

The Department maintains two hundred, fifty-five (255) budgeted beds for Clifton T. Perkins Hospital Center, the only officially designated forensics hospital in the State of Maryland, and six hundred, ninety-six (696) budgeted beds in the four regional hospitals – Spring Grove, Springfield, Finan Center, and Eastern Shore State Hospital. In fact the vast majority of patients in the regional hospitals are forensic patients, committed by the Courts in criminal cases as incompetent or not criminally responsible. According to Dr. Merles, Spring Grove's population

was eighty percent (80%) forensic as of May 5, 2017. There are three hundred, forty-three (343) budgeted beds at Spring Grove. At the time the hearings began there were no available beds at any of the five hospitals for admitting any patients. Perkins and Spring Grove typically operate over census.

Both Dr. Roskes and Secretary Schrader testified that the normal hospital operational goal is to run at eighty-five percent of capacity in order to meet exceptional demands and surges in admissions.

Eight of the Petitioners/defendants were committed to Perkins. Three were committed to Spring Grove. As of July 25, 2017, when the contempt hearings commenced, there were five people on the waiting list at Perkins and thirty-seven (37) on the list at Spring Grove. All individuals committed to Perkins and Spring Grove for evaluation or as incompetent and dangerous must be received initially in an admissions unit, unless directed to a medical unit for a somatic condition. Perkins maintains a female unit, which is used for both initial admissions and continued residential purposes. The one admissions unit for men holds nineteen (19) beds. The medical unit can, if appropriate, receive an admission, but normally and currently is full.

In April of 2016 then-Secretary of the Department, Van Mitchell, declared a "crisis" in admissions at the five hospitals. He appointed a work group to study the problem and report recommendations, which are contained in Court's. Exhibit 3. That report included a number of recommendations, but the very first (1A) was for the "immediate opening of twenty-four (24) inpatient hospital beds (one unit), initially on a temporary basis, to address current backlog of court committed individuals." The Department would determine the most appropriate location. The second recommendation (1B) was the "rapid creation of twenty-four (24) "step-down" beds within existing infrastructure within the Department, thus allowing for the transfer of appropriate patients from the inpatient level of care. The report noted that it would operate at a lower cost than other inpatient units. The next recommendation (1C) was "expedited contracting with community-based hospitals/systems to use private sector beds." Recommendation three was to "expand the Office of Forensic Services" (hereinafter "OFS"), which addressed the issue of enhanced data collection. The report noted that OFS "is the entity within [the Department] responsible for coordination of all court ordered evaluations, monitoring those committed as incompetent to stand trial, not criminally responsible, and individuals on conditional release and reporting back to the judiciary."

What actually occurred at Perkins after the issuance of these reports up until the present was most credibly and reliably testified to by John Robison, who became CEO of Perkins in the summer of 2016. According to him, Dr. Bazron made the decision to open a step-down unit, rather than to follow the first recommendation of the work group to immediately open an admissions unit to accommodate court-ordered individuals. He was not aware of any conversations regarding an admissions unit, and believed that such a consideration was not on the table. (Tr. July 25, 2017, p. 300) The step-down unit was intended for those patients preparing to be discharged from the hospital (on conditional release). Such a unit carries with it the lowest level of security. It finally opened on April 10, 2017.

In order to have any effect on opening up beds in the admissions unit, which requires the highest level of security, three or four moves within the hospital would have to occur. A patient

would move from minimum security to the step-down unit. Then a person from a medium security unit could take the bed in the minimum security unit. And so forth and so on. Dr. Bazron agreed in testimony on March 12, 2017, even before the unit opened, that it would have a "trickle down effect." Dr. Taller accepted the description that it was "a matter of happenstance contingent upon all these other people in the hospital either getting out or moving down, it is a matter of happenstance whether a defendant committed for either evaluation or incompetent can actually get in." (Tr. 7/25/17, p. 253) Mr. Robison agreed that there was not really any direct connection between moving somebody into the step-down unit and opening a bed in the admissions unit. He characterized it as "indirectly yes, patient flow," and agreed that it is correctly characterized as a "trickle down" effect.

The testimony regarding staffing for the unit was contradictory. Mr. Robison, again the most credible of witnesses, testified that he requested nineteen (19) PINS from Dr. Bazron for additional staffing and was given two. Staffing the unit actually relies on the use of overtime. Dr. Taller believes that the unit did not receive new staff. Dr. Bazron said that she gave the CEO nineteen (19) PINS and that twenty-one (21) people were hired to fully staff the unit. (Tr. 8/15/17, p. 35) This Court accepts the testimony of Mr. Robison.

Perkins relies heavily on the use of overtime. In the last fiscal year Perkins used one hundred, ninety-eight thousand (198,000) hours of overtime.

It appears that at most twelve (12) people at one time have occupied the beds in the step-down unit. As of July 25, 2017, according to Dr. Taller, there were no additional patients who qualified as being on the cusp of discharge and therefore appropriate for that unit. Plans have changed for it. Mr. Robison testified that currently the plan is to add medium security patients to fill the other eight beds. It will be staffed through the use of existing staff rather than hiring additional staff. That involves changing staffing patterns significantly to reassign staff, and these changes were described as going "over like an atom bomb in terms of staff- in terms of staff morale, but it is the only pathway that the leadership team at the hospital has identified to staff those eight additional beds." (Tr. 7/25/17, p. 273)

Various witnesses testified regarding discussions and plans to reopen a vacated SETT unit at Perkins. Dr. Taller testified that there are conversations, but nothing is definite. Mr. Robison said that he was given permission to order furniture from Dr. Bazron and had requested thirty-one (31) PINS to staff a twenty (20) bed medium security unit. He noted that it is very difficult to recruit new staff, especially nurses, because "the state wage base is very suppressed compared to the private sector by about forty-five percent (45%)." (Tr. 7/25/17, p. 271) In fact because Perkins is designated as a forensic hospital the staff salaries are higher than at the regional hospitals.

Dr. Bazron testified that no decision had been made as to the patient mix for the new twenty (20) bed unit. She also testified that PINS had been identified from other vacant positions in the Department to staff the planned unit.

The Court asked Mr. Robison the following question, "Why doesn't the hospital open up an evaluation unit for IST and NCR to take whoever's ordered for an evaluation at Perkins?" He responded, "I don't think that there's any reason we couldn't do that." But—he had not heard any

conversation about it. Dr. Bazron testified that it was feasible to make the new twenty (20) bed unit in the old SETT unit into an admissions unit. (Transcript 8/15/17).

Dr. Bazron's testimony regarding the type of patients who could be added to the "step-down" unit was confusing and required corrections. (Tr. 8/15/17) First she indicated that ten (10) beds in the newly opened unit would be used for patients ready to be discharged, and that ten (10) beds could be used for direct admission of court-ordered individuals. Then she corrected that to say that the other ten (10) beds would be used by already admitted patients moving from other units in the hospital.

She described the creation of the twenty (20) bed step-down unit as a first step, the conversion of ten (10) of those beds to non-step-down status as "Step Two." Then she said that "the third thing we've done is to have opened Potomac Center" with eighteen (18) beds. (Tr. 8/15/17, p. 104) She also testified to other actions being taken such as a project at Bon Secours Hospital that will permit four people to be admitted for pre-trial evaluation for Spring Grove cases. Thus far not one person has been admitted. A unit is scheduled to be opened at the Eastern Shore Hospital in one hundred, eighty (180) days. At Springfield a private operator has opened a step-down unit called "Segue" on the grounds of the hospital for short-term stays.

It is evident that no defendant committed under Crim. Proc. §§ 3-106 or 3-105 will go directly to the Potomac Center. According to Dr. Bazron those placements are intended for individuals with developmental disabilities who no longer need psychiatric care in the hospital – presumably NCR patients. The transfer of nine people from Perkins to Potomac Center, once again, can only have an indirect, "trickle down" effect on the availability of admissions beds.

Mr. Robison testified that the configuration of units and types of patient mixes were decided by Dr. Taller, himself, and the leadership team, and that he believed the Secretary and Deputy Secretary would defer to them.

Lawrence Brown, admissions coordinator at Perkins, testified on July 25, 2017, that Perkins had not admitted a single defendant for an in-patient evaluation under Crim. Proc. § 3-105 during the entire calendar year. Both he, Dr. Robinson, and Dr. Taller testified that a defendant who failed to be admitted for evaluation, and then was committed by a Court as incompetent and dangerous under Crim. Proc. § 3-106, did not receive a competency evaluation upon admission. The reasoning of Mr. Brown and Dr. Robinson seemed to be that because no report is due until the six month status conference with the Court that they should move on and satisfy their other Crim. Proc. § 3-105 order obligations, through out-patient evaluations that required reports within thirty (30) days. Thus a defendant like Cory Carroll, whose competency could not be definitively determined by CCMO, took up a bed from May 18, 2016, until January 18, 2017, when this Court returned him to jail. From a reading of the competency evaluation report that finally was prepared, it is apparent that the failure to evaluate him before the six month hearing cost Perkins the use of a bed for many months.

The "crisis" declared by Secretary Mitchell in April of 2016 and that summer's contempt hearing dealt primarily with Perkins. It is fair to say that Spring Grove is experiencing a crisis, with a thirty-seven (37) bed waiting list as of commencement of the contempt hearing, which

increased from thirty (30) at the end of May. Unlike Perkins, which limits admissions to nineteen (19) men and an indeterminate number of women, Spring Grove has more than eighty (80) admissions beds. Spring Grove has not been authorized to open any new beds to solve its crisis. The "fixes" testified to by Dr. Bazron and Secretary Schrader clearly will not solve the problem at Spring Grove, given the numbers. While the Bon Secours project, in the works for over a year, now is prepared to accept four pre-trial detainees for competency evaluations, thus far not one defendant has been admitted. The Segue project at Springfield will not relieve Spring Grove's admissions problem. It remains to be seen how the eighteen (18) beds at Potomac Center will reduce the waiting list at Spring Grove.

One source of Spring Grove's admissions problem can be traced back to 2012, when the Department eliminated its forty-eight (48) assisted living domiciliary care beds, commonly referred to as ALU's. The department also closed forty (40) such beds at Springfield Hospital. Legislative history regarding the FY 2013 budget for the Mental Hygiene Administration (hereinafter "MHA") is illuminating. "Assisted living beds are considered step-down placements for patients in the State-run psychiatric facilities who no longer need hospital-level care but either are not considered fully ready for community placements or are difficult to place. "Ironically, as shown in Exhibit 11, this comes after several years when MHA has increased the number of assisted living beds during various cost containment actions *i.e.*, closing hospital-level care beds in favor of assisted living beds which are cheaper to operate." (App. A) (quoting *M00L – DHMH-Mental Hygiene Administration, Analysis of the FY 2011 Maryland Executive Budget* 2010, p.18)

Dr, Roskes testified that it was his understanding that the ALU's were closed for budgetary reasons. The hope was that community providers would increase their capacity for accepting discharged patients from Spring Grove, and that Medicaid would pay for some of the services. As testimony from Dr. Bazron and Dr. Taller suggests, such hopes and expectations of community providers have proved disappointing. There has been no discussion about the possibility of reopening the ALU's.

The testimony of the CEO of Spring Grove, Andrea Braid, draws a picture of a hospital that is being deprived of resources and one that cannot meet its obligations, despite the conscientious efforts of its leadership. She testified that in FY 16 she lost eight positions, 29.5 in FY 17, and 11.7 in FY 18. Last year the hospital used five million dollars in staff overtime. She stated that this is not sustainable from a morale standpoint. Her budget has remained virtually the same for the last several years. She does not ask for more beds to solve the problem of the waiting list, appearing to be cowed by the expectations of the Department of Budget and Management, which gives her a budget "mark." "We've been operating under the presumption that we're given what we're given and that's all we can have. So no, I would not be asking for more beds." (Tr. 8/2/17)

Secretary Schrader's description of three actions taken at Perkins to open up additional beds is unsupported by any other witness or evidence, and is erroneous. While he defers to Dr. Bazron for details he clearly testified that:

> [B]asically we've made three actions to increase capacity both by adding beds as well – and different types of beds. So we've got step-

> down beds as well as direct care beds. Direct care beds. Yeah. So, you know, with the step-down beds we're trying to cycle people out and get them ready to go back into the community and then the other beds would be, you know, when we have an admission they'd go into those beds. So Barbara can give the exact numbers…Those are the three major things…Well, the step – there's – there were two efforts. One, we added beds last year, then we added another batch of beds this year and the step-down beds – so it's three efforts.

The Court inquired, "You added beds last year, a batch of beds this year and then the step-down unit?" The Secretary answered, "In addition, yeah. So there's three batches of beds that have been added." The testimony from every other witness in that regard was that a step-down unit was opened with limited staffing capacity in April, and thus far its maximum use has been for twelve (12) people at one time. His understanding or misunderstanding of the actions his staff are taking to reduce admissions delays will be discussed below.

Several policies and practices of the OFS and the Behavioral Health Administration play significant parts in the process of competency and NCR evaluation and admissions under Crim. Proc. §§ 3-105 and 3-106.

First one must understand that OFS designates certain offenses to be Spring Grove level offenses and others Perkins level offenses. The latter tend to be crimes of violence, including armed robbery, rape, certain arsons, carjacking, and murder. Assaults and unarmed robberies typically make up the former. In this connection, OFS established a practice, not reduced to a written policy, and in place for ten years according to Dr. Roskes, that limits the ability of evaluators at CCMO to render definitive evaluations as to competency. A definitive evaluation is one that answers the question: Is this defendant competent to stand trial? The obvious possible answers to that question are (1) yes; (2) no; (3) unsure – needs further evaluation. OFS has limited CCMO in the following manner: in evaluations performed pursuant to District Court Orders, CCMO may answer the question definitively yes whether the charges are Spring Grove level or Perkins level. On the other hand CCMO may not inform the Court that a defendant is incompetent for either Spring Grove or Perkins level cases. In either instance CCMO must request a further evaluation at either hospital, thereby requiring the Court to postpone the evaluation report for thirty (30) days, based upon the form orders provided by the judiciary. For Circuit Court orders CCMO may report that a defendant is incompetent in Spring Grove level cases, but even if the defendant clearly meets the test for incompetence the report must withhold that opinion and simply request a further evaluation by the hospital in Perkins level cases.

No witness was able to speak to the provenance of this directive. Dr. Bazron, who as the head of the Behavioral Health Administration supervises OFS, claimed that she was not aware of it. When Dr. Robinson was asked what possible good purpose it served, when a defendant clearly was incompetent, she was unable to supply one. It was Dr. Roskes who finally testified to the only reason that explained the driving force behind the directive. He said that "Perkins is a very valuable and limited resource. And we need to maintain as much flexibility as we can in how we use that resource. It's always full, it's always overfull, almost always overfull." (Tr. 8/2/17) The

Court asked the following question, with regard to a case in which it is clear to CCMO that the defendant is incompetent:

> Q: Why can't they offer the Court the opinion so that the Court commits that person right away and skips the thirty-day evaluation part?
> A: That's how we operate.
> Q: You don't have any reason or rationale?
> A: The rationale is to try to allow us as much flexibility on admission as possible.
> Q: So you can defer that person's admission?
> A: Correct.

(Tr. 8/4/17, p. 82)

Defer means to postpone, stall, impede, shelve, put on hold. The antonym is advance or expedite.

Dr. Roskes testified that it is within his purview as director of OFS to impose the directive on CCMO that limits them, in effect requiring them to withhold the answer to the question posed by the Court Order, because OFS has a contract with CCMO.

Dr. Heller testified that in May of 2017 he requested of OFS authority to provide dispositive IST opinions to the Court in cases where the defendant is clearly IST. He agreed that he had characterized theses as "no brainer" cases. He further testified that he had received that permission. Yet it is telling to this Court that he could not recall if CCMO had offered any definitive opinions of IST in Perkins level cases. This Court finds that CCMO continues to be constrained by an unwritten policy from OFS that limits ability to answer this Court's Orders. Dr. Heller further testified that evaluation of Spring Grove level cases are screening evaluations and CCMO is prohibited from opining a defendant IST. Nevertheless, Dr. Heller testified that there is no difference in quality between evaluations for Spring Grove level cases and Perkins level cases.

One of Dr. Roskes' other rationales for the restriction on CCMO that prevents doctors from opining defendants incompetent in Perkins Level cases is that those evaluations tend to be more complex because of their seriousness. The obvious question arises—if that is the case, why is it permitted to make a finding of competency? The consequences are at least as grave, and to err is perhaps of more lasting consequence. Moreover a review of the reports and transfer notes before this court belie this assertion. Clearly competency evaluations focus on the mental status of the defendant and not on the elements of the crime. The evaluation for a robbery is no different than an evaluation for an armed robbery. If previous medical records are important to review before opining a defendant incompetent, then they should be just as important in opining a defendant competent.

The Court pressed Dr. Robinson on this point in asking her whether there is any difference in evaluating a defendant who committed an attack with a knife, only nicked the defendant in the neck, is charged with assault, versus, a defendant who committed an attack with a knife, unfortunately hits the carotid artery causing the victim to bleed out, and is charged with murder.

The first case is a Spring Grove case and the second is a Perkins case. She suggested that the first case would be referred to Perkins, but never explained why the nature of the crime affects the complexity of the evaluation.

Two cases involved in these contempt proceedings contradict Dr. Robinson's testimony. Lamont Knight is charged with assault for stabbing his roommate multiple times with a knife; it is a Spring Grove level case. Ronald Meddings was charged in the District Court with assault for beating up a nurse. The State's Attorney's Office decided to charge him with attempted murder – upping the ante. Thus, his case became a Perkins level case. Both defendants are psychotic and caused problems in the jail mental health unit. Yet their evaluations do not reveal that one was more complex than the other. Meddings was referred for further evaluation; Knight was not. All of the available information establishes that Meddings was just as incompetent as Knight.

In support of the directive to CCMO regarding dispositive evaluations, Dr. Roskes offers a final reason why it is not necessarily deleterious to defer a finding of incompetency, and suggests it may be preferable for a defendant to remain in jail waiting for admission for further evaluation. He testified that an incompetency finding invites stigma, that it delays going to trial, and that it impinges on a defendant's liberty. When pressed on his assertion that a defendant has less liberty in a hospital than in a jail he averred, "They have less rights to refuse treatment in a hospital." (Tr. 8/2/17, p. 76)

Of course one benefit of hospitalization is that a medication non-compliant patient may be urged and persuaded to take medication in a therapeutic setting. As a matter of fact a patient at Perkins may refuse medication as much as a defendant in jail, and forced medication is permitted only under special circumstances.

Another policy created by the Behavioral Health Administration and overseen by OFS is their admissions policy, which controls access to hospitals by creating a priority list. The first category includes voluntary admissions by persons on conditional release and hospital warrants. The next category includes persons adjudicated not criminally responsible. Next is those committed as incompetent and dangerous under Crim. Proc. § 3-106. Those committed under Crim. Proc. § 3-105 for evaluation find themselves in the fourth of five categories of priorities. Since the last category includes admissions from the community, which occur rarely if ever, those awaiting evaluation are at the bottom of the list. The policy also provides for overriding the priorities based upon an individual defendant's acuity, that is, the severity of his symptoms. In order to discern acuity each hospital is called upon to gather information from the institution where the defendant is detained. Lawrence Brown, the admissions office coordinator, speaks to staff at the jails, and in the case of the mental health unit at Central Booking, he may speak to doctors or psychiatrists. In cases where the defendant is in general population, Mr. Brown may be unable to gather any information – as in the case of Darnell Hines, who was housed at MTC. The admissions coordinator at Spring Grove makes the same effort according to Dr. Bevin Merles, director of pre-trial services there. She is met with a complete lack of response from Baltimore City. Instead of regular updates, Dr. Merles relies on monthly records that are obtained with some difficulty. Therefore she may be relying on almost month-old information.

Lawrence Brown creates a "flow sheet," which in a few words purports to capture a defendant's acuity. Respondents introduced it, and it reveals little, but addresses whether the defendant is compliant, eating, taking medication – or not – for example. If this information raises a red flag for Lawrence Brown, he takes it to Dr. Robinson, who may then consult Dr. Taller. Dr. Robinson claimed that she might call the detention center to check on a defendant's status. If she and Dr. Taller conclude it is justified, they may decide to move a particular defendant up on the waiting list to advance his date of admission. In the event of a disagreement then Dr. Roskes is consulted, and occasionally, Dr. Bazron (who signed off on the policy). The hospitals are not required to report to OFS when they change an individual's position on the wait list.

Dr. Robinson testified to the following when asked what information she would ask for if she were considering whether someone on the waiting list needed to be moved up:

> A: I would ask for their current mental status.
> A: Their current mental status. I would ask for their compliance with treatment. I would ask whether or not they have had any attempts at self-harm, or if they had tried to harm anyone else. I would ask about their eating and sleeping habits. I would ask about showering, hygiene, about any other abnormal behavior. For example, smearing feces, sitting motionless in a cell for hours at a time. Things like walking around naked for no clear reason. Things of that nature. All of which would be included in the progress notes and the information that we receive from the detention center.

(Tr. 8/24/17, p. 159)

The evidence in these cases, including Perkins' actual admissions files, proves that actual monitoring of acuity by Dr. Robinson and decisions made based upon the available information is deficient. No evidence exists that she actually comports herself in the manner she described above in regard to asking about the defendant's medical status.

The case of Petitioner/defendant Ronald Meddings makes an unfortunate example. Because his case began with an assault charge, CCMO was precluded from opining him incompetent and dangerous. Instead it requested further evaluation at Spring Grove, which put him low (as a category four individual) on a very long waiting list. The CCMO transfer notes raised concerns, even for Dr. Robinson. The cover letter to the District Court Judge stating the "opinion that Mr. Meddings requires further evaluation," described him as follows:

> Mr. Meddings did not communicate very well. He was actively psychotic and seemed quite confused about the questions and his answers did not make sense. He had no idea why he was referred to the Circuit Court Medical Office and gave incoherent responses about half the time. He thinks he is being charged with 'Failure to Report to Jury Duty'. . . . He would have no idea on how to behave in Court though he said he would be 'mild mannered and calm,' he clearly would have trouble focusing on what was going on and

> understanding the Court process. He tended to answer questions in a tangential and psychotic way. He would have great difficulty addressing an adverse witness and great difficulty assisting his own defense.

The transfer notes, included in the Admission's Office records, notes that he was a very poor historian, and that:

> [he] appeared to be responding to internal stimuli and reported a history of psychosis as well as current psychotic symptoms. . . . he said that he hears voices telling him to keep the peace and that he sees an "octopus garden" in this evaluator's office. He could not clarify further. He was quite paranoid . . .when asked about his current bloody spots, one on his eyebrow and one in the back of his head he stated they were a "prototype." He could not clarify further. When asked about medication he stated, "hopefully none" . . . . He had a dried bloody eyebrow and a bloody spot on the back of his head. He could not say how he got it. Though he gave answers to most of the questions they had psychotic content and were tangential. He could not give much information. His speech also had psychotic content most of the time . . . he had a history of auditory and visual hallucinations as well as paranoia. He said that he has been suicidal in the past with six attempts, the last time "last night" when he got into a fight on airliner. He is obviously delusional. His cognitive functions were impaired...His long term, short term and rote memory were all significantly impaired...His insight and judgment were very poor. He was oriented to time and person, but not to place, thinking he was in Bel Air, Maryland.

The District Court signed the § 3-105 Order on June 15, 2017. Spring Grove was given a week to admit him, but he was low on their waiting list. In anticipation of his return to court on June 22, 2017, for a "bed check" and a hearing on competency, Cory Pollack, the Clinical Court Coordinator of the District Court Mental Health Court, sent an email on June 20, 2017. She reported to the judge, attorneys, and doctors at Spring Grove, Dr. Merles and Dr. Tomar, the content of a forty-five minute conference call that she had with people at the jail regarding Mr. Meddings. The email is in evidence as Petitioners' Exhibit 2. It states in part:

> Since his incarceration on/about 6/2/17, Mr. Meddings has moved between the IMHU, MTC hospital and recently, JHH, where he stayed for 3-4 days to rule out head injury (I think). He is currently at the MTC hospital where he is said to be disruptive to the milieu and difficult to manage (he has flooded the floor, bangs his head on the walls causing in jury to himself, and has a history of falls). But for his age, frailness, and vulnerability, the MTC hospital would like him back on the IMHU. Regardless of where he is housed he said to be refusing medications and has received PRN (as

needed) medications only, for agitation. While he has both medical and psychiatric conditions, the information today is that none of his medical issues are 'active' but his untreated psychosis is a major concern, second only to his propensity for hitting his head against the wall causing injury and the occasional fall. In sum – they don't know what to do for him or how to manage him at this time, especially since he is refusing most treatments. And, they are VERY hopeful that the court will find him IST and that his admission to SGHC will be prompt!!

Mr. Meddings was reportedly on an acute psychiatric unit at the VA when the alleged offense occurred....

If/when SGHC wants/needs more information on this defendant, Dr. Ali agreed to be the contact for medical issues...and Dr. Handel agreed to be the contact for mental health.

(Pet'r's Ex. 2)

Mr. Meddings was indicted on June 21, 2017, so the District Court lost jurisdiction of his case. On June 28, 2017, this Court committed Mr. Meddings as incompetent to stand trial and dangerous.

Dr. Taller testified that she discussed Mr. Meddings' status and he was under consideration for admission to the Spring Grove medical unit, but when he was indicted for attempted murder, his case became a Perkins level case, and her activity ceased. She testified that she read Cory Pollack's email and that the information was sent to Perkins. Dr. Merle affirmed that this information was sent to Perkins.

Dr. Robinson admitted that she read the transfer notes and discussed his acuity with Lawrence Brown, whose flow sheet stated only "Psychotic, Disorganized med non-compliant, Haldol & Depakote," as of June 30th. Neither Mr. Brown nor Dr. Robinson admitted that they received any information that Mr. Meddings had engaged in self-harming behavior that resulted in his outside medical hospitalization. This Court found the testimony of both Dr. Merles and Dr. Tomar to be entirely credible and reliable, and concludes that Cory Pollack's email and the information it contained was sent to Perkins. The clear inference is that it would have been directed to Dr. Robinson. Dr. Taller testified that she did not learn about Mr. Meddings until July.

Dr. Robinson was asked about whether she was concerned when she read the transfer notes about the wounds on the defendant's head.

A: "Sure. Concern , yeah. It's definitely unusual.
Q: And what did you do to find it, if anything, when you read that information?
A: I didn't do anything.
Q: And when you read in the transfer notes how he couldn't explain how it happened, did that give you more concerns?
A: More concern? No. He's psychotic, so that would be consistent.

Q: And so based on what you've read from the transfer notes, you determined that he really was psychotic?
A: Yes,
Q: Yes?
A: Yes, he sounded, yes he did.
Q: What reason did you have for not bumping him up the queue?
A: The reason being that there was nothing about Mr. Meddings' presentation that suggested that he was more clinically acute than anyone else on the list. Meaning everyone that was on the list at that time certainly warranted hospitalization. There was nothing about Mr. Meddings that suggested that he needed to be hospitalized earlier than anyone else.

Q: Did you call anybody to try to get more information about what was going on with him?
A: Not at that time, no.
Q: Did you ask Lawrence to call anybody to try to get more information about what was going on with him?
A: No.

(Tr. 8/24/17, pp. 180–181)

Dr. Robinson further testified about her decision not to move Meddings up on the waiting list, "Well, because I can't tell definitely that first presentation was a result of psychosis or was likely to result –indicated that he was in immediate danger, what I did was, I left him where he was on the waiting list." (Tr. 8/24/17, p. 195).

Mr. Meddings was taken from the mental health unit in the jail to Bon Secours Hospital because of suspected "Afib." He was diagnosed with a pneumothorax, hemothorax, and four broken ribs. He was admitted to the ICU. According to Lawrence Brown he was considered at risk of renal failure. When Dr. Robinson learned of this she communicated with Spring Grove. His medical condition caused Perkins to ask Spring Grove to admit Mr. Meddings to their medical unit upon discharge from Bon Secours and the MTC hospital. Dr. Roskes emailed Dr. Taller regarding whether Mr. Meddings should be advanced on the wait list. He was admitted to the medical unit at Spring Grove on July 21st and to Perkins on August 7, 2017. The following exchange between the Court and Dr. Robinson questioned her ability make decisions based on information received from detention centers:

Q: So do you feel confident that you're able to get the information that you need in order to make a determination as to whether a particular defendant in the detention center needs to be, for example, brought to the hospital for medical care?
A: Yes. I've never had a circumstance where I didn't feel comfortable with the decision I made in that regard based on the information I received from the detention center.

The doctors at Perkins as well as Dr. Roskes readily express their opinions that not all persons found incompetent to stand trial and dangerous require hospitalization. They believe that incompetent individuals can stay in jail and receive medications that may restore them to competency. Dr. Roskes says that he endorses restoration in jail with appropriate resources, although he has no information regarding how long Perkins patients adjudicated incompetent actually remain in the hospital until restored to competency. Ultimately, he concedes, Maryland law does not permit restoration in jail.

Maryland permits release of an incompetent defendant on conditions, including treatment in the community, if performance of those conditions would support a finding that the defendant is not a threat to himself or the person or property of others. If the Department evaluator offers an opinion that the defendant will not be dangerous if released with treatment conditions, the Department must prepare a treatment plan and arrange for treatment. Such a treatment plan typically includes psychiatric care, therapy, and a residential rehabilitation program. Dr. Roskes endorsed the use of such community treatment programs with competency restoration services, but testified that "right now we are not funded for that." (Tr. 8/2/17, p. 92)

VIII. CONTEMPT FINDINGS

Civil contempt must be proven by a preponderance of the evidence. *Bahena v. Foster*, 164 Md. App. 275, 276 (2005). If a "court order has been violated, a party with standing, or the court itself, may institute contempt proceeds for that violation." *Powell v. Maryland Dep't of Health*, No. 77, 2017 WL 3699338, at 2 (Md. August 28, 2017)

In a contempt proceeding, "willful conduct is action that is voluntary, and intentional, but not necessarily malicious." *Royal Inv. Grp., LLC v. Wang*, 183 Md.App. 406, 451 (2008), *cert. dismissed*, 409 Md. 413 (2009) (internal citations omitted). In that case, in the context of an environmental enforcement action, the willfulness of a violation of an order is considered in terms of the extent to which the existence of the violation was known but uncorrected by the violator, and the extent to which the violator exercised reasonable care. *Id.* at 443–46. "[E]vidence of an ability to comply, or evidence of a defendant's conduct purposefully rendering himself unable to comply, may, depending on the circumstances, give rise to a legitimate inference that the defendant acted with the requisite willfulness and knowledge. *Dorsey v. State*, 356 Md. 324, 352 (1999). Furthermore, "willfulness may be established merely by proof of a voluntary, intentional violation of a known legal duty.". *Att'y Grievance Comm'n v. Boyd*, 333 Md. 298, 309 (1994).

On August 24, 2017, this Court found the Department in contempt in connection with the Court's Show Cause Orders issued in June as a result of petitions for show cause orders filed by the Office of the Public Defender and reserved on the issue of a purge Order. Today this Court finds the five individual officers and agents of the Department in constructive civil contempt in connection with this Court's commitment orders for defendants Wardlow, Meddings, Carroll, Hines, Knight, Merriken, Spencer, and Taylor. The evidence supports these findings by a preponderance of the evidence. This Court finds that the department and its officials and agents had actual notice of the orders and willfully, intentionally, and voluntarily violated them. While it may be the case that there was no available bed for any of the Petitioners/defendants at the time the show cause orders were issued and the contempt hearings commenced, the lack of beds is

directly attributable to the actions, inactions, and omissions of the Department. The failure to admit these individuals was entirely predictable and foreseeable. The sources of the Department's inability to comply with the Court's Orders during the summer of 2017 may be traced to 2010. The legislative history is instructive in this regard. *See* App. A (providing analyses by the Department of Legislative Services of the MHA budget for fiscal years 2011 through 2018). The report of the Department's 2016 Workgroup, quoted, *supra*, proves that the Department's own consultant recommended a very significant increase in hospital beds in 2012. After the insertion of budget language by the legislature in 2014 forced the Department to study the issue of admission delays, its 2015 Joint Chairman's Report in 2015 included, as its first recommendation, the addition of one hundred (100) beds to the five psychiatric hospitals. Yet the Department failed to actually request funding for the beds or to take any actions to add them. That report included data by Dr. Roskes relating to length of delays in hospital admission which served to minimize the problem.

During the next legislative session in 2016, the Department's FY 2017 budget shows decreases for the psychiatric hospitals. In March of 2016 the then-Secretary recognized the crisis in terms of length of delays for admission, and in April, by letter to the Administrative Judges of the Circuit Courts, declared the crisis and his intention to establish a work group and receive recommendations on how to solve it. During contempt hearings before this Court in the summer of 2016 Secretary Mitchell asserted that he "owned" the problem and would "fix" it. He represented to the court that part of the solution was to open a twenty (20) bed unit at Perkins, with an estimated date for opening of December 15, 2016. That promise comports with Recommendation One of his work group. Counsel for Respondents has conceded that the commitments made by the then-Secretary are binding.

In August of 2011, this Court considered issuing contempt orders with a purge provision calling for a systemic remedy to solve the problem of admissions. Finding that the Secretary was acting in good faith in making a promise to open a twenty (20) bed admission unit to solve the problem at Perkins, this Court dismissed the show cause orders.

Almost immediately, apparently without the participation of Secretary Mitchell, Dr. Bazron decided to change the plan from opening an admission unit to opening a step-down unit. The testimony establishes the likely motivation. A step-down unit, with the lowest level of security, requires much less staffing than an admissions unit which carries with it the cost of maximum security and the additional nursing and professional staff who are tasked with treating patients of the highest acuity.

The CEO of Perkins, Mr. Robison, explained the difference between a low security step-down unit for patients who are standing in line at the door to be discharged from Perkins into the community and an admissions unit for defendants coming from jail in pre-trial status for competency restoration, who will be returning to jail. He characterized the patients in the admission unit as posing more of a clinical risk, even in comparison with medium security patients, requiring the expenditure of greater resources. He discussed the decision to transform the step-down unit opened in April to a mixed unit of step-down beds with medium security beds, in contrast with the possibility of opening a twenty (20) bed admissions unit. "That is, the resources

would be very different on a maximum security unit. The needs would be different. I mean, they'd be more. So this seems easier, less complicated, less risky to do." (Tr. 7/25/17, pp. 295–96).

On the other hand, Mr. Robison, who is responsible for risk management at Perkins, acknowledged that a real risk management problem exists in connection with allowing individuals, that are committed to the Department for treatment as incompetent and dangerous, to remain in jail rather than admitting them as required by court orders.[2]

Dr. Robinson described the patients admitted to admission units as incompetent as follows:

> Typically they're more acute than people who have been there for a period of time, and who are on our residential units for the simple fact a lot of times they haven't been taking medications. A lot of times, they have more severe symptoms. We have a lower patient-to-staff ration . . . .[b]ecause, again, a lot of times, these people are more acute than the residential patients . . . what I mean is whether or not their presentation is more severe, more active.

(Tr. 7/25/17, pp. 114–15)

Doctors Merles and Tomar characterized the high level of acuity of the patients being admitted to Spring Grove. Dr. Merles, in striking testimony, explained why she did not move IST-adjudicated defendant, Lamont Knight, up the waiting list, even though he was so acute that a CCMO psychiatrist had to travel to his cell at IMHU in order to interview. He was standing in urine and feces were smeared on the walls. He was highly psychotic. The psychiatrist at IMHU had described him as the sickest patient in the mental health unit. Nevertheless, Dr. Merles saw from her review of his jail records that he was taking medication, had improved as of the date of the cell-side evaluation, and he was looking forward to coming to Spring Grove. She concluded that he was no more acute or in need of hospitalization than the other people on her waiting list. So he stayed where he as, and waited two months for admission to Spring Grove.

Dr. Tomar eloquently explained the complexity involved in evaluating a psychiatric patient:

> You know, the patients we get now are very complicated. You know, they generally have—it's generally not are they malingering, are they not, are they sick are they not? It's never that simple or life

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[2] The issue of risk management seems to be a genuine concern in cases of admission delays, given that the defendant has been committed to the custody of the Department to be restored to competency through hospital treatment. That responsibility was acknowledged during the contempt hearing. Doctor Roskes testified at great length about the difference between the handling, literally, of a mentally ill individual in jail and the approach of a hospital treatment team. The description of the use of restraints in jail versus their use at Perkins is illustrative.

> would be so much easier. You know, there are always shades of gray. They always have had some kind of traumatic past, you know? They didn't have a stable beginning. They definitely have had some substance use. Often they have had some head trauma because of their lifestyle. You know, things are always a little foggy, what's what. And it's not always easy to tease out and the thing we can offer is watching them 24 hours a day to see if there are times when they look clearer than others.

(Tr. 7/26/17, p. 155)

The Department and the Respondents herein clearly were on notice of the problem of delays in admissions to the five psychiatric hospitals. They ignored their own consultants, their recommendation to the Joint Chairman, and the primary recommendation of the Department's workgroup, made over one year ago. Even the commitment of the Department's Secretary was ignored and transformed into a very different undertaking – one that failed to solve the problem of admissions delays. The Secretary testified that the Department has opened or shortly will have opened three batches of beds, including beds that receive court-ordered incompetent individuals. In fact the Department opened half of a step-down unit in mid-April. In terms of relief for Spring Grove, where the delay situation is more dire, all that has been put in place, after a year and a half of planning, is a memorandum of understanding with Bon Secours Hospital, which has not accepted any patient. The maximum capability for pre-trial evaluations is four. After evaluation an incompetent individual will return to the jail if no bed is available.

Failure to act, as well as omissions, have consequences as great as affirmative acts. Both can cause harm. Neglect and failure to act can wreak as much harm as abuse or affirmative wrongful acts. In the case of the eleven (11) defendants, nine (9) who were committed as incompetent nine and two (2) for further evaluation, all have suffered deprivations or injury, both tangible and intangible. In Mr. Meddings' case, which truly is awful, he was denied a meaningful competency evaluation because of the OFS directive that CCMO not render a definitive opinion – when he clearly was incompetent. The doctors and staff at IMHU urged, if not begged, the Court to commit the defendant so that he could go to Spring Grove. *See* Pet'r's Ex. 2. When his case was transferred to Perkins, and the transfer notes went to Dr. Robinson (and the email from Cory Pollack went to Perkins as well, according to the Spring Grove doctors), Dr. Robinson considered moving Mr. Meddings up to the list, but decided not to. In terms of obtaining more information, she "didn't do anything." The next day Mr. Meddings was admitted to Bon Secours and intensive care, and was treated for injuries that went unnoticed or untreated at the jail (four broken ribs, causing pneumothorax and hemothorax).

All defendants, by virtue of detentions in violation of their commitment orders and lengthy delays in admissions, from over one to three months, also suffered a deprivation of their liberty interests. All of the Petitioners/defendants, as pretrial detainees who have not been convicted of any crimes, have a fundamental liberty interest under the Due Process Clause of the Fourteen Amendment to the United State Constitution. *Trueblood v. Washington State Dep't of Soc. & Health Serv.*, 73 F.Supp.3d 1311, 1315 (W.D. Wash. 2014) (citing *Oregon Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1112 (9th Cir. 2003). "Incapacitated criminal defendants have liberty interests in freedom from incarceration and [also] in restorative treatment." *Mink*, 322 F.3d at 1121; *see also*

Goodman v. Utah Dep't of Human Serv., 180 F.Supp.3d 998 (D. Utah 2016), *In re Loveton*, 224 Cal.App. 4th 1025 (2016), *In re Williams*, 228 Cal.App.4th 989 (2014), *Advocacy Ctr. For Elderly & Disabled v. Louisiana Dep't of Health & Hosps.*, 731 F.Supp.2d 603 (E.D. La. 2010). The *Mink* Court listed the harms posed by incarceration of an incompetent defendant:

> Although jails can sometimes provide treatment to stabilize a patient, they cannot restore a patient to competency. Thus, incarceration in a county jail delays an incapacitated criminal defendant's possible return to competency. The disciplinary system that jails use to control inmates is ineffective for, and possibly harmful to, incapacitated criminal defendants . . . . Incapacitated criminal defendants have a high risk of suicide, and the longer they are deprived of treatment, the greater the likelihood they will decompensate and suffer unduly.

Mink, 322 F.3d at 1121.

The *Trueblood* Court enumerated the harms caused by prolonged incarceration as follows:

> [W]hile they are detained in jail, incapacitated criminal defendants do not receive care giving them a realistic opportunity of becoming competent to stand trial." In other words, because jails are inherently punitive and not therapeutic institutions, the mental health of detainees further erodes with each additional day of wait time, especially when those detainees are held in solitary confinement. Because delays lengthen incarceration, worsening the mental health conditions of detainees, and because continued commitment must be justified by progress toward the goal of restoration of competency so that the detainee is able to stand trial, there is no legitimate independent interest in delays.

Trueblood, 73 F.Supp.3d at 1316 (internal citations omitted).

Ironically, Dr. Roskes has described such harms in chapters of a psychiatry textbook to which he has contributed. In particular he wrote a chapter on correctional psychiatry. He agreed that "the increased likelihood of being injured in a fight for prisons, of mentally ill versus non-mentally is twenty percent versus ten percent and in jails is nine percent versus three percent." He acknowledged that the refusal of medication in a correctional setting may adversely affect other inmates and detainees. He admitted believing that ". . . in correctional settings the use of seclusions and restraint for individuals with psychiatric disorders is confounded by routine use of nontherapeutic restraints by corrections and law enforcement staff for security reasons."

Dr. Roskes explained further:

> [In hospitals] we use less and less seclusion and restraint over time. Some hospitals have been able to completely eliminate the use of seclusion or restraint by treating people through other means. In corrections, of course, they don't have a therapeutic mindset. I'm

> not critical of that, it just is what it is. And so their use of seclusion, of restraints can be difficult for patients to tolerate or for inmates to tolerate.

(Tr. 8/4/17, pp. 19–24)

Nevertheless Dr. Roskes has testified that, "contingent on proper resourcing," that he "would endorse having some people stay in jail while they're incompetent to stand trial and dangerous, until they're restored, and receive treatment in jail." Yet he is not acquainted with and has no data regarding how long it actually takes to restore defendants to competency, even in hospitals. When asked if he was aware that all but one of the defendants in last year's contempt hearings, all of whom had been admitted as incompetent over a year ago, were still committed as incompetent, he responded that "I haven't given it the level of detail that you're asking about. I haven't given it that kind of thought because it's not possible right now." He agreed that it's not possible because Maryland law does not permit it; instead Maryland law calls for the commitment of people adjudicated incompetent and dangerous due to mental illness or mental retardation to facilities run by the Department. Dr. Roskes is part of a group, including Dr. Bazron, some of her staff, medical directors, and the Attorney General's office, that is talking about and circulating proposals for Departmental legislation to change the competency statute, presumably by asking for fewer admissions for hospital restorations by virtue of departmental control over them and/or jail restoration. (Tr. 8/4/17, pp. 102–05).

As mentioned earlier, in addition to an individual's liberty interest that is entitled to protection, the *Trueblood* Court recognized the State's interest in prompt evaluation and treatment so that the individual may be brought to trial. *Trueblood*, 73 F.Supp.3d at 1316. The *Trueblood* Court recognized that the deterioration of defendants sustained in jail settings conflicts with the State's "primary governmental interest." *Trueblood*, 73 F.Supp.3d at 1315

> [T]he State's primary governmental interest in regard to [defendants charged with crimes] is to bring those accused of a crime to trial. In furtherance of that goal, the state has legitimate interest in evaluating a potentially incompetent defendant's competency so as to determine whether he or she may stand trial, and in restoring the competency of those found incompetent so that they may be bought to trial. The state has a corresponding interest in an efficient and organized competency evaluation and restoration system, the administration of which uses public resources appropriately.

Id.

This Court concludes, based upon the testimony of many of the witnesses, that the Department's conduct in failing to solve the problem of admissions delay is driven by budgetary concerns. As is often the case, it seems to be all about the money.

Secretary Schrader made it clear that he considers himself a steward of the funds made available to the Department in its budget, and seemed to pride himself on not having submitted a request for a supplemental budget. While the Department may be saving money for the Department, by delaying admission of defendants held in county detention centers, it is shifting

the cost of care to local jurisdictions. The Department of Public Safety and Correctional Services (hereinafter "DPCS") bears the cost in the case of Baltimore City defendants who are detained in jails operated by DPCS.

Unnecessary delay in the pursuit of a criminal prosecution can prejudice the State as much as or more than a defendant if the State loses witnesses. It is no secret that witness cooperation is a particular problem for prosecutors in Baltimore City. Witnesses move and cannot be located, victims lose interest; in some instances they feel or are intimidated. Regardless of who pays, the public bears the cost, and, therefore, has an interest in the prompt and efficient admission of defendants committed to the Department.

This Court finds the Department and Respondents in constructive civil contempt based upon years of notice regarding the problem, internal recommendations to increase bed size, admonitions by the Judiciary, oversight of the legislature (i.e. 2014 budget language), civil charges of contempt of court, and commitments by its own Secretary. The actions and omissions of the Department and the respondent officers and agents have been knowing, intentional, and voluntary. In some instances they are downright contumacious.

The Department's policies and practices in regard to evaluation and admission of mentally ill defendants have contributed to admission delays. The CCMO practice of withholding opinions of incompetent to stand trial for seriously ill defendants such as Mr. Meddings results in those individuals being treated as the lowest priority. OFS carries out this policy in a technical, and even cynical manner. Dr. Robinson testified that if Perkins conducts an out-patient competency evaluation of a defendant, and opines and reports to the court that issued the § 3-105 Order that the defendant is incompetent and dangerous, and should be committed to the hospital under Crim. Proc. § 3-106, it nevertheless sends the defendant back to jail, rather than admit him to the hospital in anticipation of the forthcoming § 3-106 Commitment.

When asked to justify this, the rationalization was entirely disingenuous. Because the defendant must go to court to be committed as incompetent, he remains in a priority four category – still lowest priority. Once he is committed under Crim. Proc. § 3-106, he moves up to category two (b) – incompetent to stand trial, where he may take a new place on the waiting list. In a system designed to restore an incompetent defendant to trial as soon as possible, and dare we say – in a humane system- the defendant would not leave the hospital. His treatment and restoration services would begin immediately, based upon the evaluation, and would not rely upon a return to court, a new order, and an upgrade on the wait list. Further delay is unreasonable and continued detention impinges on the defendants' liberty interests.

As Director of OFS Dr. Roskes has enforced the CCMO directive, continues to require CCMO to withhold definitive opinions regarding incompetency, thereby failing to answer the question posed by the court order for evaluation, and defends the policy with rationalizations that reveal his lack of acquaintance with the criminal justice system, and surprisingly, a lack of familiarity with, or worse, disdain for the quality of evaluations and reports (excellent) by CCMO. Worse, he admits that the policy serves a beneficial purpose in the forensic system – it "defers" commitments of defendants as incompetent. Of course the result is delay in restoration treatment, further incarceration and deprivation of liberty, and sometimes worse. No other witness could

testify to a good reason for the practice and directive. This Court finds that it is followed solely for the purpose of delay.

Unfortunately, Dr. Bazron lacks a full acquaintance with the practices of OFS: she testified she does not know about this practice, heretofore not expressed in a written policy. As the Order below provides, this Court expects her to address it.

Other than Dr. Bazron not knowing every detail about hospital units and OFS practices, it has been demonstrated through the testimony that over the period of her tenure as head of the Behavioral Health Administration, and since a year ago, Deputy Secretary, that she possesses sufficient knowledge of the problems with competency delay to be on notice regarding the nature and extent of the problem. After all, she was a Respondent in last year's contempt hearing and sat through the testimony. Unfortunately, again perhaps because of budgetary constraints imposed upon her, she has not honored the commitment of Secretary Mitchell, not even in spirit. Her step-down unit alternative, even she admitted before it opened, held only the possibility of a "trickle-down" effect. She participated in the 2016 Workgroup and in creating its recommendations, yet failed to follow them. There were four recommendations included in the primary one, "Increase bed capacity within [the Department]." More than one year after the report was issued, the Department has half of the twenty-four (24) bed step-down beds. There is no twenty-four (24) bed unit open to address current backlog of court committed individuals. No "Expedited re-assessment of actual bed needs" has surfaced. And there is no credible explanation for either. A lack of will and perhaps willful ignorance are the most obvious.

The issue of data has raised its ugly head over the last three years. Dr. Roskes admitted that he prepared the data for the Joint Chairman's Report. It served to minimize the problem of admission delay and perhaps was used as a reason the Department did not follow its own recommendation of opening one hundred beds. That data described days of delay before admission, rather than the number of people on the waiting lists.

Approximately one year later Secretary Mitchell declared a crisis, and explained that the Department was just beginning to collect data. During the contempt hearings in the summer of 2016 Dr. Roskes testified and produced charts similar to the ones the Respondents introduced in the current hearings, which report numbers on wait lists on a weekly basis. Since that time Dr. Bazron has claimed that the situation was much better because the Department had good data. Yet during the current contempt hearings, the specter of inadequate data has been summoned to explain away the Department's failure to act. This year it was pointed out that Dr. Roskes's data does not reveal the length of time defendants are waiting for beds. This contempt hearing perhaps would not have taken place if defendants did not appear on the wait list more than once - regardless of the raw numbers of defendants waiting. The response from Dr. Bazron is that recently we have asked Dr. Roskes to gather it, and he has been gathering it since June of 2017. (*See* Tr. 8/15/17, p. 150)

The Court engaged in the following exchange with Secretary Schrader regarding data that Dr. Roskes provides on a weekly basis, of which the Secretary receives only a summary:

> Q: That number doesn't tell you how long those people have been on the waiting list, does it?

A: No. I assume Dr. Bazron is paying attention to that.
Q: You assume that somebody's collecting data for her –
A: Right, that..
Q: –that has the number of days somebody's been waiting?
A Right.
Q: In your view, should somebody be collecting that data?
A: I would think, yeah.
Q: All right. Is it important to know how long people have been waiting on the waiting list in terms of measuring progress?
A: I think that –that's fair, yes.

The obvious question is – if data regarding lengths of delay for defendants on waiting lists was relevant in 2015 for the Joint Chairman's report, why did Dr. Roskes discontinue gathering it? Valid data about the nature and extent of the problem is of course the starting point of re-assessing actual bed needs – recommendation (1D) of the workgroup.

Dr. Roskes testified that he has been collecting and reporting "data sets" since September of 2016. His chart was introduced into evidence by Respondents. Here is his testimony on August 2, 2017 after explaining that "Well, since we only started gathering data in March of 2016, we don't know what's typical."

Q: What have you learned, if anything, from keeping track of all of this information?
A: How important it is to have data is lesson number one. . . If we have not had system wide data, so we have not historically, in my opinion, really known how to manage our system as a system. It gives insight into these trends and allows us to ask a lot of questions. The data is very useful for that in terms of hypothesis generation, trying to figure out why do we see an influx. You know, prior to March of 2016, each hospital had its own data in some form, although generally they didn't keep very good data. So the hospital may have known its own story, but we never knew the system's story. Now we have a sense of what the system story is.
Q: And would this system story, would that translate to the census number?
A: It might. I mean, anybody can look at this data and ask questions; should we have more beds, should we have less beds, should we have different beds, should we do more diversion, should we have other alternatives. There's lots of ways to approach data like this. The data is much more valuable in terms of the questions it allows you to ask than in terms of any specific answer.

(Tr. 8/2/17, pp. 48–49)

It appears to this Court that the use of and reporting of data has become a sort of shell game engaged in by Dr. Roskes, accompanied by dissembling and obfuscatory explanations. If the Department lacks important data, it has been a conscious and intentional choice not to gather it. It does not excuse the Department's failure to comply with court orders. If anything it supports a finding that the failure to obtain what now is claimed is important casts the acts and omissions of the Department and the Respondents in a contumacious light.

The administration of the pre-trial evaluation and commitment program at Perkins is the focus of this contempt case. Dr. Taller has contributed to, and is responsible for, the failure to provide sufficient beds to admit defendants for evaluation under Crim. Proc. § 3-105 and restoration services under Crim. Proc. § 3-106. According to Lawrence Brown, admissions coordinator at Perkins, Dr. Taller decides what beds are available to admit committed defendants. The CEO endorsed the idea that Dr. Taller participates in the decision as to how to configure the units and to decide which individuals are admitted to them for particular purposes. No satisfactory explanation was offered to justify the restriction of the male admissions unit to nineteen (19) beds. The number is striking when compared with the eighty (80) –plus beds in the admissions units at Spring Grove—a hospital that has three hundred, forty-three (343) beds compared to Perkins' two hundred, fifty-five (255) beds. This Court finds that limiting the male admissions unit to nineteen (19) beds has contributed in a significant manner to competency delays. Perkins is licensed for two hundred, ninety-eight (298) beds. The Petitioners/defendants, along with many other individuals, have languished in jails because a decision was made to restrict access to admission. The CCMO directive and the BHA admissions priority policy delay admission by slowing down the process. Maintaining such a small male admissions unit effectively closes the door. This decision clearly is an intentional one. The justification, as with many departmental decisions may be budgetary. Admissions units consume more resources, but the intentional and artificial limit of admissions to nineteen (19) male beds results in failure to timely admit and violations of this Court's orders.

Dr. Robinson's testimony as well as other evidence proves a rather flagrant willingness to disregard court orders. While she superficially acknowledges an obligation to obey court orders, she acts as if compliance with them is optional. This history goes back years, as evidenced by the Court's Exhibit 5, and its email to Dr. Robinson in 2014. It was made clear that 3-105 orders calling for in-patient evaluations were to be honored. Yet even this summer, in the case of Cory Carroll, one was ignored, with the authorization of Dr. Taller (according to Lawrence Brown). If Dr. Taller wished to modify the commitment order, she could have requested one and stated her reasons. She testified to another instance in which she contacted the Court and asked permission to send a committed defendant back to jail pending an NCR evaluation, and the Court agreed.

When asked about the 2014 email from the Court regarding her basis for doing out-patient evaluations and returning incompetent defendants to jail, when the orders explicitly required in-patient evaluations, Dr. Robinson's explanation lacked credibility. In contrast Dr. Tomar testified with conviction that if an evaluation order required an in-patient evaluation she was compelled to follow it. She was clear that in Baltimore City District Court cases in-patient evaluations were not allowed.

The Court's power to order in-patient evaluations and to set a deadline for admission, depending upon the Court's findings regarding a particular defendant, was made explicit in the *Dixon* case decided in September of 2016. That case affirmed an order that called for a next-day admission. This Court's § 3-105 Orders in the current calendar year have allowed Perkins five days for admission. Yet not one was complied with, and no individual was admitted under a § 3-105 order for an in-patient admission until August 4, 2017 – notably after the show cause orders for contempt were issued.

Doctors Robinson, Taller, and Roskes have been working in the forensic world for many years. The expectations of the Judiciary and this Court, in particular, are well known to them. Yet each of them has engaged in a course of conduct that resulted in the violation of the court orders involving defendants Meddings, Carroll, Wardlow, Spencer, and Taylor. The CCMO directive, which Dr. Roskes believes is within his purview to enforce under the OFS contract with CCMO, contributed to the delays for admission to Perkins for defendants Meddings and Wardlow, as well as Mr. Merriken's admission to Spring Grove.

The evidence establishes by a preponderance of the evidence that Erik Roses, Ina Taller and Danielle Robinson have committed constructive civil contempt.

Dr. Bazron does not deal directly with commitment orders, but receives weekly reports on the numbers of defendants on hospital waiting lists. She was a Respondent in last year's contempt hearings and participated in the 2016 DHMH Workgroup. She has made decisions that have caused the persistence and recurrence of the admissions delay problem, in particular, the decision to change the twenty bed unit promised by Secretary Mitchell into a step-down unit.

This Court acknowledges her dedication to her job and her persistent efforts to enhance the available services in the community so more people can be discharged on conditional release and on court-ordered treatment plans. But her testimony has revealed her own recognition of how daunting this task is. She testified that the "stakeholders," meaning community providers, after often reluctant to take on the treatment of court-involved individuals, particularly when they are being discharged from Perkins after being found guilty of serious crimes of violence. Initially her discharge initiative met with some success, with seventy some people being discharged. As Dr. Tomar testified, those individuals left the hospital with financial inducements for the providers who accepted them. Once again – it's all about the money. That effort has flagged.

Dr. Bazron has also been exposed to the fact that "trickle down" does not necessarily work. She envisioned a step-down unit for twenty. It was staffed for ten. At most twelve people occupied it, and according to Dr. Taller, nobody is ready to be transferred there.

This dedicated public servant has worked hard for the Department and for her Secretary, but she has made some bad decisions, some based upon bad information and perhaps because of bad advice from others. But because she has been and will continue to be the point person in the Department's response to admission delay, she too must be held accountable, along with those less well-intentioned. With regret, this Court finds that she too is in constructive civil contempt of the Court's commitment orders for defendants Meddings, Carroll, Wardlow, Spencer, and Taylor.

Secretary Schrader agreed with the Court that "the buck" stops with him. Yet his responses considering his obligation to comply with Court orders were less than convincing or reassuring. He acknowledged only his obligation to comply with the statute, as opposed to the court orders. The recent Powell decision made clear that there is a distinction, but also made clear that Crim. Proc. § 3-105 gives this Court the right to order an in-patient evaluation, and in the case of Larry Dixon, order admission on a date certain, even just one day after the commitment order. The Powell decision also made it clear that in connection with § 3-106 Orders that the Court or a party may pursue contempt for failure to comply with an order. The following exchange between the Court and Secretary Schrader is of particular concern:

> Q: Are you acquainted with whether there is any—within BHA or under the Deputy Secretary—anyone responsible for determining compliance with court orders?
> A: I kind of have to think about that for a minute. It—it's my expectation that we're following the statute and that we're –on a daily basis the process should drive an outcome that –
> Q: Well, what does that mean, you're following the statute?
> A: The statute—
> Q: What do you mean by that?
> A: The statute requires us to place people when asked by the court.
> Q: All right. So do you understand that an order is not an ask? Do you understand the difference between asking you to admit someone and ordering you?
> A: I'd have to think about that for a minute.

(Tr. 8/15/17, pp. 64–65)

This Court finds this testimony disturbing. Not one court order in this contempt proceeding was appealed, nor did the Department seek any modification of any order. Yet there was serious and extended failure to comply, with Siyyaha Crawford waiting two months for admission, apparently in part because Dr. Roskes failed to respond to multiple entreaties from Lawrence Brown to refer Mr. Crawford to the Development Disabilities Administration for an evaluation of his autism. The Department has been found in contempt for failure to comply with the court's commitment order, rather than any individual officer or agent (because Mr. Crawford was admitted before the Court issued any show cause orders). But it is important for the Secretary to understand that the order that committed the defendant under Crim. Proc. § 3-105 to Perkins for a joint evaluation with DDA, at the suggestion of CCMO, was not a request. He needs to understand that a two month delay in jail, even after Mr. Crawford was committed under Crim. Proc. § 3-106, was unnecessary and unjustifiable.

Based upon his testimony on August 15, 2017, the Secretary seems to believe that the problem has been fixed based upon the actions of his staff. But as it developed, the actions to which he testified have not actually taken place. There are not three units; there is half of a unit at Perkins. This Court does not suggest that Secretary Schrader is knowingly offering false testimony. But his testimony was in error, when compared with that of Mr. Robison, who seems to know best what actually is happening at Perkins, or even the confused and ultimately corrected testimony of Dr. Bazron. But the implications of this factually flawed testimony are serious. Either someone told the Secretary that "three batches of beds," including admission beds, had

opened, or he was briefed with accurate information and misunderstood it, or he was briefed with accurate information and forgot it. What is clear is that Secretary Schrader, in contrast with Secretary Mitchell, makes no pretense of "owning" this problem with competency delays. He was not even aware of the issue of hospital admission delay, he claims, until the spring of 2017, when "the present crisis, surge overload," as characterized by Ms. Bogins , was brought to his attention. He perceives his responsibility to be to direct staff to solve the problems. He characterized himself as impatient to get things done and full of questions for staff. But the overall impression is that he is disconnected from the process. He testified that he gets involved in policy. He seems to have delegated almost exclusively to Dr. Bazron, while lacking fundamental understanding of the forensic system and the major players in it such as Dr Roskes. Indeed, he testified that Dr. Roskes does not work for him; he works for Dr. Bazron.

This Court acknowledges the breadth and seriousness of the Secretary's responsibilities, particularly this year when access to health care is in jeopardy for many Marylanders. One expects him to delegate the execution of actions. But any public official who must delegate responsibility must know enough to make critical judgments about the actions of those to whom he delegates. Mr. Schrader seems to lack a basic grounding in the issues, and clearly misapprehends whatever has been reported to him. This Court calls upon him to genuinely accept the responsibility for solving a problem that is not an acute crisis in terms of being an emergent crisis. Instead it is chronic, having been predicted by legislators and declared by judges for years. Untold individuals suffering from acute and painful mental illness have languished in jails for months at a time. Prosecutors have lost witnesses and abandoned cases in the meantime. Local jurisdictions have expended thousands and thousands of dollars providing treatment in jail for individuals who are committed to the department's care. This Court finds by a preponderance of the evidence that Secretary Schrader, by virtue of willful ignorance and indifference, as well as willful failures to act, has been part of the chain of participants who have violated the Court's Orders along with the other four Respondents. This is not vicarious liability. The Secretary had the necessary knowledge.

The requisite element of intent is established when one charged with responsibility chooses not to be responsible. Those orders were issued to the department that he heads. Indeed the buck stops with him.

This Court finds Dennis Schrader in constructive civil contempt of this Court's Commitment Orders for defendants Meddings, Carroll, Wardlow, Spencer and Taylor.

IX. PURGE PROVISIONS

As previously stated, this Court is ordering the Department and the five individual Respondents to take remedial actions, and thus hereby issues purge provisions with which they are ordered to comply.

The purge provision orders are intended to eliminate the unjustifiable delay in admissions of defendants to the Department's hospitals, which has deprived them of legitimate liberty interests under the due process clause. The intentional delays attributable to the Respondents' intentional acts and omissions have been unnecessary, avoidable, and unreasonable. The due process principle that the Supreme Court articulated in *Jackson v. Indiana*, 406 U.S. 715, 738 (1972) applies here

as well: "[D]ue process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."

These require provisions require the Respondents to obey the commitment orders under Crim. Proc. §§ 3-105 and 3-106 and to complete undertakings that have been promised, recommended by the Department's 2016 Workgroup, and represented to the Court as having already been completed. Because this Court has found that in fact three "batches of beds" have not been opened, it hereby orders that the Department's contempt be purged by adding fully staffed beds to Spring Grove Hospital in addition to those at Perkins. Spring Grove has been ignored by the Department witnesses in describing actions already taken and planned for the future to solve the admissions delays. The Bon Secours contract will at best result in four pre-trial evaluations—a meager offering—when so much more is needed to remedy the crisis at Spring Grove and its lengthy wait list.

Therefore, it is hereby ORDERED this _____ day of September, 2017, that the Maryland Department of Health, having been found to be in constructive civil contempt of orders of commitment for admission of the Petitioners under Crim. Proc. § 3-106, shall purge the contempt by completing the actions that are described in the purge provisions below for Respondents Dennis Schrader, Barbara Bazron, Erik Roskes, Ina Taller, and Danielle Robinson. Satisfaction of those purge provisions shall constitute a purge of the Department's contempt.

It is FURTHER ORDERED that Dennis Schrader shall purge his constructive civil contempt of this Court's Orders for Commitment under Crim. Proc. §§ 3-105 and 3-106 by completing the actions that he testified on August 15, 2017, have already been accomplished. By December 31, 2017, the Respondent shall take all actions necessary to fully staff and admit patients to the twenty bed unit opened at Clifton T. Perkins Hospital Center on April 10, 2017, with a patient mix to be determined by the CEO; by December 31, 2017, the Respondent shall take all actions necessary to fully staff, open beds, and admit patients to a new twenty bed admissions unit at Clifton T. Perkins Hospital Center for individuals committed to the Department under Crim. Proc. §§ 3-105 and 3-106; by December 31, 2017, the Respondent shall fully staff beds and admit patients to a new twenty (20) bed admission unit at a location to be determined by Dr. Tomar in consultation with John Robison, Director of Hospitals, to admit patients committed to Spring Grove under Crim. Proc. §§ 3-105 and 3-106; the Respondent shall obey Commitment Orders issued by this Court by admitting defendants committed to Department facilities in accordance with the terms of the Orders, including dates of admission.

It is FURTHER ORDERED that Barbara Bazron, as Deputy Secretary of the Department, shall purge her constructive civil contempt of this Court's Orders for Commitment under Crim. Proc. §§ 3-105 and 3-106 by taking all actions necessary to assist Dennis Schrader in the satisfaction of his purge order, to complete actions that he testified on August 15, 2017, have already been accomplished. By December 31, 2017, the Respondent shall take all actions necessary to fully staff and admit patients to the twenty (20) bed unit opened at Clifton T. Perkins Hospital Center with a patient mix to be determined by the CEO; by December 31, 2017, the Respondent shall take all actions necessary to fully staff, open beds, and admit patients to a new twenty (20) bed admissions unit at Clifton T. Perkins Hospital Center for individuals committed to the Department under Crim. Proc. §§ 3-105 and 3-106; by December 31, 2017, shall fully staff

beds and admit patients to a new twenty (20) bed admission unit at a location to be determined by Dr. Tomar in consultation with John Robison, Director of Hospitals, to admit patients committed to Spring Grove under Crim. Proc. §§ 3-105 and 3-106; the Respondent shall obey commitment Orders issued by this Court by admitting defendants committed to Department facilities in accordance with the terms of the Orders, including dates of admission; the Respondent shall oversee the Office of Forensic Services and direct Erik Roskes to satisfy his purge provision.

It is FURTHER ORDERED that Erik Roskes shall purge his constructive civil contempt of this Court's Orders for Commitment under Crim. Proc. §§ 3-105 and 3-106 by ceasing his practice of causing delay in commitments under Crim. Proc. § 3-106 by virtue of an OFS directive to CCMO which prohibits CCMO from providing this Court with definitive opinions in certain cases; the Respondent shall purge his contempt by directing CCMO to fully answer the Court's Orders for Initial Competency by reporting to the court, if possible, based on a reasonable degree of medical or psychological certainty, whether a defendant is competent or incompetent; the Respondent shall not interfere with the performance of CCMO's obligation to fully answer the Court's order for evaluations.

It is FURTHER ORDERED that Ina Taller, Clinical Director of Clifton T. Perkins Hospital Center, shall purge her constructive civil contempt by opening by December 31, 2017, a twenty (20) bed unit admissions unit, fully staffing it, and admitting patients committed for evaluation under Crim. Proc. § 3-105 or as incompetent under Crim. Proc. § 3-106; the Respondent shall obey Commitment Orders issued by this Court by admitting defendants committed to Department facilities in accordance with the terms of the Orders, including dates of admission; the Respondent shall monitor Dr. Danielle Robinson's compliance with Court Orders.

It is FURTHER ORDERED that Danielle Robinson, Director of Pre-trial Services at Clifton T. Perkins Hospital Center, shall purge her constructive civil contempt by obeying Commitment Orders issued by this Court under Crim. Proc. §§ 3-105 and CP 3-106 by admitting defendants in accordance with the terms of the Orders, including dates of admission.

GALE RASIN - PART 87
RETIRED JUDGE
THE JUDGES SIGNATURE APPEARS
ON THE ORIGINAL DOCUMENT
Baltimore City Circuit Court

APPENDIX A

LEGISLATIVE HISTORY

Mindful of the different resource and patient factors that apply to different facilities when making comparisons, two points can be made from these exhibits.

- The long-term trend in readmissions within 30 days continues to show readmission rates higher in fiscal 2009 than 2005, although all facilities except for the Eastern Shore Hospital remain below the latest available national benchmark for readmission rates (9%). However, for the most part, short-term readmission rates (again with the exception of the Eastern Shore Hospital) show improvement.

- Trends in the use of seclusion remain favorable. Elopement data is more mixed but tends to represent minimal change

One area of potential concern that bears watching concerns the number of staff hours lost due to injury. The largest three hospitals, Spring Grove, Springfield, and Perkins, all experienced an increase in the number and rate of staff hours lost due to injury. This may be a reflection of the more difficult population being served in these facilities with limited staff. Interestingly, as shown in the most recent staffing study, Spring Grove and Perkins face the largest deficit of staff, and all three facilities have high levels of overtime.

Summary

Although the recent changes in State-run psychiatric hospital capacity are being made at a pace not previously seen, they are consistent with the policy direction that MHA has been pointing the State-run psychiatric hospitals in recent years. Specifically, these hospitals have moved away from the treatment of civil and acute care admissions, toward that of serving patients with more difficult and complex conditions often requiring longer-term hospital care and forensic admissions.

However, this changing capacity will require MHA:

- To continue to manage the population at its State-run psychiatric hospitals through diversion projects (which have proved successful in diverting individuals from emergency departments and subsequent potential placement in a State-run psychiatric bed) as well as maintaining the policy of purchasing psychiatric bed capacity in private psychiatric hospitals and acute general hospitals. This, in turn, means that MHA must ensure that this mix of public and private psychiatric beds remains available.

- To manage the forensic population. This is a population for which control over admissions lies primarily with the judicial branch.

- To address, at some point, staffing issues. In addition to vacancy issues, the staffing study pointed to the fact that the hospitals' workforce tend to be longer-service employees. Even in the current economic climate, hiring, especially for skilled positions, has been problematic. There is nothing to indicate that the demand for the types of skilled health care staff that the State-run psychiatric hospitals need will change to the State's benefit in the near future.

Where It Goes:		
Inpatient utilization review		-20,000
Grants and Contracts	-$1,239	
Housing assistance initiative		1,000
Identification assistance		500
Administrative Services Organization contractual fee		252
Various federal grants		-448
Community alternatives to RTC placements (reimbursable funds)		-1,105
Grants and contracts to CSAs (after adjustments for ID assistance, ASO fee, and rate adjustment)		-1,438
Facilities (Nonpersonnel)	-$2,339	
Various health care services (across all facilities)		193
Utilities		-266
Food costs (includes savings from assisted living unit closures)		-266
Contractual employment		-471
Food services at Upper Shore Community Mental Health Center (food service contract transferred to building tenants)		-541
Drug costs (includes savings from assisted living unit closures, recent changes that have seen several brand-name drugs go generic, and efforts to reduce medication costs)		-988
Executive Direction	$497	
Increased oversight of community forensic compliance		497
Other		-13
Total		**-$1,593**

ASO: Administrative Services Organization
CSA: Core Service Agency
FTE: full-time equivalent
HSCRC: Health Services Cost Review Commission
RTC: Residential treatment Center

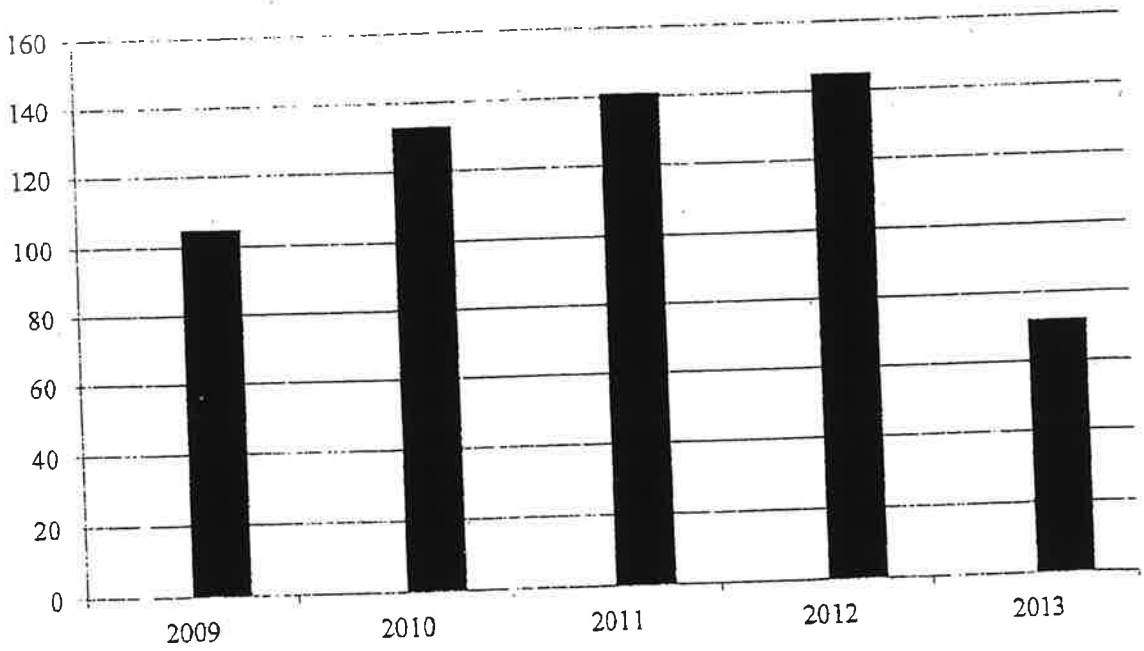
Note: Numbers may not sum to total due to rounding.

Personnel and Facilities Spending

The budget includes 93 new regular positions at Perkins at a cost of almost $4.3 million. As noted above, MHA is already adding new staff and plans to have 65 of these positions filled in fiscal 2012. The proposed changes at this hospital are discussed in greater detail in Issue 1. There are additional significant increases in retirement (almost $2.8 million) and health insurance (just over $2.2 million) costs. These increases are somewhat offset by several large reductions including just over $2.2 million from the removal of the one-time fiscal 2012 $750 bonus and almost $2.9 million in increased turnover adjustment.

The increase in turnover adjustment relates to the proposal in the budget to close 88 assisted living or domiciliary care beds: 48 at Spring Grove Hospital Center (leaving 24 beds for court-involved patients) and 40 beds at Springfield Hospital. Assisted living beds are considered step-down placements for patients in the State-run psychiatric facilities who no longer need hospital-level care but either are not considered fully ready for community placements or are difficult to place. Ironically, as shown in **Exhibit 11**, this comes after several years when MHA has increased the number of assisted living beds during various cost containment actions *i.e.*, closing hospital-level of care beds in favor of assisted living beds which are cheaper to operate. MHA proposes to close this capacity effective September 1, 2012, effectively eliminating 61 regular positions, although MHA has indicated that it will place all affected staff in vacant positions at the same facility where they are currently employed. Community FFS funding for psychiatric rehabilitation services goes up by $1.9 million for additional community services to serve this population. Additionally, a portion of the funding for housing assistance will also benefit the population transitioning from the assisted living units (ALU).

Exhibit 11
State-operated Psychiatric Facilities
Assisted Living Beds
Fiscal 2009-2013



Source: Department of Legislative Services; Mental Hygiene Administration

Two additional points should be noted about MHA's ALU proposal:

- In the past, there has been some talk of simply privatizing ALUs, allowing a private vendor to operate the same programming at the same location and also claiming Medicaid funds for services provided. However, according to MHA, CMS has become increasingly intolerant about private facilities operating on State hospital grounds and at the same time claiming Medicaid funding and this is not an option.

- To the extent that many of the individuals in the ALUs (like the State-run psychiatric hospitals in general) are court-involved, MHA will need to work closely with the Judiciary to ensure that patients in the ALUs can move into community-based settings (although it should be noted that these patients already have more latitude than patients in other wards to go on- and off-campus).

Finally, in addition to personnel savings, the closure of the ALUs also generates savings in such things as food and drugs. These savings contribute to a significant drop in nonpersonnel operating expenditures at the State-run Psychiatric Facilities.

Community Mental Health Services: Fee-for-service Expenditures

As shown in Exhibit 10, total expenditures in the FFS community mental health system are budgeted to fall between fiscal 2012 and 2013. However, that small decline reflects a combination of increases and offsets through cost containment.

Funding for enrollment growth and utilization is budgeted to increase $26 million, most of which is in the Medicaid-eligible program. In that program, the underlying rate of budget growth over fiscal 2012 (before adjusting for cost containment, psychiatric rehabilitation services for individuals transitioning for State-operated assisted living beds, and the 0.88% provider rate adjustment) is 3.7%. This assumes a continued decline in the use of RTC capacity in favor of community alternatives. The increases in the Medicaid-eligible program are largely offset by significant cost containment actions:

- $20.0 million in savings from diverting patients from expensive inpatient care. The intent is to better coordinate care between CSAs, ASO, and community providers to place people in crisis beds and otherwise serve them in less expensive settings. There is little doubt that it appears more could be done to reduce the utilization of inpatient care. **Exhibit 12**, for example, shows that the rate of Medicaid individuals presenting at emergency rooms with psychiatric symptoms and the rate of Medicaid individuals who are subsequently admitted for inpatient care with psychiatric symptoms is significantly higher than the comparable rates for other payers.

  Similarly, **Exhibit 13** shows that, among Medicaid recipients, the percentage of emergency room visits that result in an inpatient admission is significantly higher for individuals presenting with psychiatric symptoms than for somatic care.

The agency should comment on how it plans to combat heroin use and overdose deaths going forward, and what further options may be necessary for treatment and prevention of heroin use in both the near and long-term future.

3. Treatment and Service Options for Court-involved Individuals

BHA operates an Office of Forensic Services (OFS), which is the entity within DHMH that interacts with the criminal courts of Maryland to respond to certain statutorily defined forensic questions. These specific questions are defined in the Criminal Procedure Article, Title 3, Sections 3-105, 106, 108, 111, 112, and 114-120, as well as in the Health-General Article, Sections 8-505 and 507. These questions break down into two major categories.

Subject to Criminal Procedure Article, Sections 3-105 and 3-111, OFS is responsible for evaluating a defendant's competency to stand trial and/or their criminal responsibility for the crimes with which they are charged. OFS contracts with forensic evaluators in every jurisdiction to conduct these evaluations. While a majority of the cases require no further evaluation, a minority may either require further assessment, in which case the defendant is referred to one of the State facilities, or result in a commitment to a State facility for treatment pursuant to Criminal Procedure Article, Section 3 106(b) or 3-112.

Under Health-General Article, Section 8-505, OFS is responsible for the evaluation of a criminal defendant's need for and amenability to substance abuse treatment. If the court then orders services pursuant to Section 8-507, OFS has the responsibility to facilitate the defendant's prompt placement into services.

Based upon concerns that there were unacceptable wait times for both the evaluation and treatment for individuals in both of these court-involved categories, the 2014 budget bill included language withholding funds and requesting that a workgroup be convened by the department that included various stakeholders in order to review the average wait times for residential placement in State-run psychiatric facilities as well as for treatment under the 8-507 orders, to review and report on the availability of staff and services for court-involved individuals, and to report on any recommendations based on an analysis of this data. This report was submitted to the relevant committees on December 12, 2014.

Data on Forensic Populations

The workgroup examined the average and median wait times for the various populations for fiscal 2012 through 2014. This data is presented in **Exhibit 16**. According to the workgroup's report, while average wait times were above the standards that would be required, the median wait times were within the expected limits. Thus, they felt that the data demonstrated that there were not systemic issues with the forensic treatment system, but rather that there were various outlier cases that needed to be examined in order to make smaller improvements. However, it should be noted that for the initial evaluations, including § 3-105 and § 3-111, the statute provides a date by which these evaluations

Exhibit 16
Treatment and Service Options for Court-involved Individuals
Wait Times for Treatment (in Days)
Fiscal 2012-2014

Statutory Orders	Statutory Wait Time	Mean 2012	Mean 2013	Mean 2014	Median 2012	Median 2013	Median 2014
3-105	7	9.10	10.59	12.98	7	7	10
3-106(b)	n/a	3.11	6.00	5.88	1	3	3
3-111	60	31.00	24.68	16.94	22	18	12
3-112	n/a	3.14	6.77	3.05	1	3	1
8-507 Placement	"Prompt"	165	161	174	126	133	145

Source: Department of Health and Mental Hygiene

should be done, which is 7 and 60 days, respectively. While § 3-111 evaluations are in line with statutory guidance, the fact that the median measure for § 3-105 evaluations is 7 days means that half of all of these evaluations are taking place beyond the statutory guidelines.

Further, it was noted that for § 8-507 placement, the statute calls for prompt placement of a defendant into treatment by the department. While the issue as to whether or not these wait times are prompt is debatable, what came up in the workgroup discussion was the fact that these times are not conducive to the timeframes in which the Maryland District Court normally operates. According to the members of the Judiciary who served on the workgroup, this has led to many judges at the District Court level not utilizing this treatment option for individuals for whom it may be more beneficial than incarceration.

Recommendations

The final report from the workgroup contained seven recommendations, summarized as follows:

- add 100 beds to the State-supported psychiatric system;
- conduct an additional assessment of § 8-505 and § 8-507 order wait times;
- update the most recent study on the demand for substance abuse treatment services since the implementation of the federal ACA;

- expedite the building of the forensics database to better capture the information provided in this report;

- develop Managing for Results outcomes to measure the performance of OFS;

- develop a joint behavioral health and criminal justice system for the identification of high utilizers of services of both systems; and

- increase staffing for psychiatric evaluations, especially at Spring Grove Hospital Center, by approximately 10 FTEs.

One thing that BHA did not comment on during various early presentations to the budget committees on this subject is what it would cost to implement these recommendations. While they have said that they do not intend to pursue the addition of 100 beds at this time due the fiscal condition of the State, other recommendations, including the increase in staffing for forensic evaluations, could also have a large fiscal impact.

The agency should comment on what the potential fiscal impact of the workgroup's recommendations could be in the future. DLS also recommends that the withheld allotment in the fiscal 2015 budget be released.

Fiscal 2016 Actions

Cost Containment

The fiscal 2016 budget contained an across-the-board reduction for all State agencies, which resulted in a 0.6% across-the-board general fund reduction for the Department of Health and Mental Hygiene (DHMH) totaling $27,215,000. Of this total amount, BHA was assigned a cost containment decrease of $2,639,890 in general funds. Actions undertaken to make up this cut include utilizing additional federal fund attainment in lieu of general funds ($1,375,000), decreasing funds for services for the uninsured ($450,000), and a 2% operating expenses reduction at all of the State psychiatric institutions ($814,890).

Further, there is a specified reversion in the Governor's fiscal 2017 budget plan of $11,500,000 from Medicaid behavioral health in fiscal 2016. These funds are available due to lower than anticipated spending on the traditional Medicaid population, due to declining enrollment within that population.

Proposed Budget

As shown in **Exhibit 9**, after adjusting for the fiscal 2016 specified reversion as well as fiscal 2017 back of the bill reductions, the fiscal 2017 allowance for BHA grows by $13.7 million (0.8%) over the fiscal 2016 working appropriation. Not included in these numbers is $2.3 million from Supplemental Budget No. 2. Including this amount, expenditures increase by $16.0 million, or 1.0%.

Exhibit 9
Proposed Budget
Department of Health and Mental Hygiene
Behavioral Health Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2015 Actual	$839,520	$50,035	$649,268	$8,284	$1,547,108
Fiscal 2016 Working Appropriation	856,743	60,462	738,564	10,744	1,666,513
Fiscal 2017 Allowance	885,437	53,805	733,183	7,796	1,680,220
Fiscal 2016-2017 Amount Change	$28,693	-$6,657	-$5,381	-$2,948	$13,708
Fiscal 2016-2017 Percent Change	3.3%	-11.0%	-0.7%	-27.4%	0.8%

Across-the-board Reductions

The fiscal 2017 budget bill includes an across-the-board reduction for employee health insurance, based on a revised estimate of the amount of funding needed. For DHMH, the amount of these reductions is $1,424,451 in general funds, $132,440 in special funds, and $251,138 in federal funds across the entire department, of which $832,865 is in the BHA budget ($819,526 general funds, $1,266 special funds, $12,073 federal funds). There is an additional across-the-board reduction to abolish positions statewide, but the amounts have not been allocated by agency.

Personnel

Personnel expenditures net of back of the bill reductions increase by $3.6 million. The largest increases, consistent with other State agencies, are for employee and retiree health insurance contributions as well as retirement contributions at $4.3 million and $3.9 million, respectively. One new position within Program Direction also adds $76,936. This position is a contractual conversion of a program administrator position which assists homeless and mentally ill individuals with accessing entitlements and other supportive programs.

There is also an increase of $730,986 in overtime expenses. However, it should be noted that the current allowance for overtime is still below the most recent actual from fiscal 2015. During that year, overtime expenses across the agency totaled $13.7 million, which is in line with other recent historical trends. However, the current allowance only allots $9.6 million. This is problematic, both because the State hospital centers continue to be over capacity and because vacancy rates within the hospitals continue to be quite high. According to the most recent vacancy data, vacancy rates at the two largest hospital centers, Springfield and Spring Grove, are 13.8% and 11.9%, respectively.

The largest change in personnel expenditures is the decrease of $5.8 million for abolished positions. There are 100.7 positions abolished within BHA for a variety of reasons. A total of 77.0 positions are being abolished at Springfield Hospital Center due to the privatization of the dietary and housekeeping functions at the hospital. The position abolitions due to these privatizations are 56.0 and 21.0, respectively, with the majority of these positions being currently filled. However, due to an error in the calculations for the cost of the outsourced housekeeping contract, DHMH is no longer pursuing this specific privatization. The 21.0 position reduction, however, will still be made up with vacancies from throughout the department. More information on this is provided under the discussion of changes within the facilities.

There is also a decrease of 14.0 positions at the John L. Gildner Regional Institute for Children and Adolescents (RICA) due to the privatization of the dietary function at that facility as well. Personnel savings from all of the privatizations totals $5.5 million. A further 8.5 positions are being reduced at RICA – Baltimore due to a residential bed reduction from 38 to 34 beds, and 1.0 position is being transferred to the Department of Information Technology as part of the centralization of information technology functions across the State. The remaining 0.2 position is a reduction of a partial position for dental services at Spring Grove Hospital Center.

In contrast, homelessness continues to be especially acute for those with a co-occurring disorder at 9.5%. Further, those with a mental health diagnosis are the most likely to be unemployed at 59.5%.

Exhibit 7
Outcome Measurement System Data
Fiscal 2016

Adult Behavioral Health Outcomes	All	MH	SUD	Co-occurring
Net Improvement in Functioning (Percent of Total Observations)	7.7%	8.1%	3.7%	16.9%
Increase in Employment Between Observations	-0.2%	-0.6%	7.3%	3.2%
Persons Unemployed in Both Observations	58.3%	59.5%	42.2%	53.5%
Homelessness in Both Observations	3.8%	3.7%	5.0%	9.5%

MH: mental health
SUD: substance use disorder

Source: Behavioral Health Administration; Department of Legislative Services

Fiscal 2017 Actions

Proposed Deficiency

There are five different deficiencies for BHA, totaling $17,971,397 in general funds and $173,693,400 in total funds. The first two deficiencies are for community services within BHA, beginning with $2.0 million in general funds to augment the State's effort to address the heroin and opioid epidemic. These funds are going to be used to cover the cost of Health – General Article 8-507 treatment placements ($1.5 million) as well as the Opioid Operational Command Center ($0.5 million). The second community services deficiency is $7.0 million to cover the cost of inpatient psychiatric services for the Medicaid-eligible population.

Two additional deficiencies concern BHA institutions. The first is $500,000 to provide funds needed to establish a new 20-bed unit at the Clifton T. Perkins Hospital Center. The second deficiency is $471,397 in general funds and $122,003 in special funds, for a total of $593,400, to provide for operational expenses at the Crownsville Hospital Center. These funds were not provided for last year, because the Department of Health and Mental Hygiene (DHMH) believed that it would be able to dispose of the property during fiscal 2017.

The other large increases in personnel costs concern various salary adjustments throughout the administration. Of note, there is an increase of almost $900,000 in salaries for psychiatry positions at the Eastern Shore Hospital Center. These positions have been historically difficult to fill, and the hospital had to contract for psychiatry services. However, at this increased salary level, 3 of the 5 positions have now been filled, with the last 2 positions in active recruitment. There is also an increase of $268,000 for reclassifications at the Clifton T. Perkins Hospital Center in order to staff a new 20-bed unit at the center. This increase is net of the deficiency appropriation provided for this purpose. Further, there is an additional $1.2 million in salary increases due to a combination of hiring various positions above base, as well as the annualization of increment payments from fiscal 2017.

Some large personnel decreases help offset increases in salaries and overtime, in particular an increase in the turnover expectancy from 6.86% to 7.68%, resulting in a decrease of $1.6 million. As stated previously, however, BHA currently has more than enough vacancies to meet this turnover target presently. There are also large decreases for pension payments ($1.4 million), inclusive of the contingent reduction noted above, as well as health insurance payments ($0.8 million).

Community Behavioral Health Services

Fee-for-service Expenditures

Overall, spending on FFS expenditures for behavioral health treatment, including services for those within the Medicaid program, as well as the uninsured and State-funded services for the Medicaid-eligible, increases the fiscal 2018 allowance above the current working appropriation by approximately $111.6 million, accounting for the majority of the change within the overall BHA allowance. The largest change is $49.6 million to account for enrollment and utilization trends, which follows the trends previously discussed. There is also an increase of $31.1 million due to the transfer and annualization of reimbursement for Applied Behavioral Analysis services to ensure compliance with recent federal guidance on the provision of services for children with Autism Spectrum Disorder. Other large increases include $16.2 million for a 2% community provider rate increase, as well as $11.4 million for regulated rate assumptions.

The Department of Legislative Services (DLS) estimate of the adequacy of State-supported funds to meet demand for FFS community behavioral health services is provided in **Exhibit 9**. Overall, State funding for Medicaid-eligible spending looks to be inadequate in both 2017 and 2018, even after including the fiscal 2017 deficiency of $8.0 million in general funds for Medicaid behavioral health provider reimbursements. Based on recent spending projections for fiscal 2016 and 2017 and using projected enrollment growth, current utilization trends and projected provider rate increases, it appears that the fiscal 2016 budget for behavioral health Medicaid services is slightly overfunded, while both the fiscal 2017 and 2018 budgets appear to be underfunded by $8.5 million in terms of State-support in each fiscal year. This deficit represents a variance from the total amount of State support of 2.2% and 2.1%, respectively.

3. Forensic Services – Improving the Throughput of the System

BHA operates an Office of Forensic Services (OFS) that interacts with criminal courts in the State to respond to certain forensic issues set forth in various sections of Title 3 of the Criminal Procedure Article and Title 8 of the Health – General Article.

Subject to Sections 3-105 and 3-111 of the Criminal Procedure Article, OFS is responsible for evaluating defendants' competency to stand trial and their criminal responsibility for the crimes with which they are charged. OFS contracts with forensic evaluators in every jurisdiction to conduct these evaluations. While a majority of the cases require no further evaluation, some cases require further assessment, in which the defendant is referred to a State facility, or result in a commitment to a State facility for treatment pursuant to Sections 3-106(b) or 3-112 of the Criminal Procedure Article. In addition, Sections 8-505, 8-506, and 8-507 of the Health – General Article require DHMH to conduct certain court-ordered evaluations to determine whether a defendant is in need of and may benefit from certain substance use treatments and authorize a court to commit a defendant to DHMH for inpatient evaluation or treatment for substance use under certain circumstances.

In 2016, it became clear that DHMH lacked the adequate bed space or other additional capacity to receive people committed to DHMH under the Criminal Procedure Article. Numerous contempt hearings were held in Baltimore City and Prince George's County where officials from DHMH and OFS, including the Secretary of Health and Mental Hygiene, were asked why State hospitals were too full to accept any new patients and why the hospitals were turning away patients and forcing them to remain incarcerated in violation of the law. In a letter to the Judiciary in April 2016, the Secretary of Health and Mental Hygiene identified the bed shortage and inability of DHMH to admit patients in a timely manner as a crisis for DHMH, and the Secretary committed to resolve the issue as quickly as possible.

Forensic Services Workgroup

In order to begin resolving the issue, and to address stakeholder concerns regarding significant delays associated with court-involved individuals navigating the State's forensic system of care, the Secretary of Health and Mental Hygiene convened a Forensic Services Workgroup. The workgroup, composed of community stakeholders (including representatives from the Judiciary, prosecutors, public defenders, community providers, consumers, and advocates for individuals with mental illness), was asked to address various longstanding issues with the forensic system of care, including (1) the lack of availability of State hospital beds to complete court-ordered forensic evaluations as well as to honor court commitments within statutory time requirements; (2) the length of time that it takes for individuals assessed as ready for release following their commitment by the courts to return to court for disposition; (3) appropriate placement of incarcerated individuals ordered for evaluation and assessed, but not yet adjudicated as incompetent; and (4) the impact on State facility staff from State hospitals' census consistently being at or above maximum capacity, managing a predominately forensic patient population, and not being staffed or compensated based on a "forensic" classification.

The workgroup met on four occasions and issued a final report on August 31, 2016, which contained numerous recommendations, including:

- increasing bed capacity within DHMH, including the immediate opening of 24 inpatient hospital beds to address the current backlog of court-committed individuals, the rapid creation of 24 "step-down" beds within the existing DHMH infrastructure, expedited contracting with community-based hospitals to use private-sector psychiatric beds, and an expedited reassessment of actual bed needs;

- increasing availability of community crisis services, including an immediate statewide assessment of currently available crisis services, a rapid determination of which active crisis services programs are most effective in responding to crises in a way that minimizes entry and reentry into the criminal justice system, and expedited funding support through budget reallocation as well as additional budget allocations to the most effective programs;

- expanding the capacity of OFS, including an immediate increase in the number and efficiency of forensic services staff, a rapid restructuring of DHMH chain of command to fully integrate the management, delivery of services, and reporting of findings to the court under OFS, and an expedited review of newly generated data to determine where to place existing resources and evaluate the need for additional resources;

- increasing outpatient provider capacity to meet the needs of forensic patients, including an immediate increase in support to existing providers who already accept forensically involved patients, the rapid assessment of outpatient provider reimbursement structure, and the expedited increase of rates of reimbursement and the types of services that are reimbursable;

- centralizing DHMH's forensic processes, including the immediate centralization of all processes related to the delivery of forensic services, the rapid reassessment and reclassification of staff at all State hospitals to a forensic classification, and the expedited implementation of salary and staffing changes; and

- increasing education to reduce stigma in both the general public and the mental health treatment community, including the immediate inclusion of anti-stigma education for providers who receive training to treat forensically involved patients, the rapid development and expansion of public anti-stigma educational programs, including the use of crisis intervention training for police and first responders, and the expedited inclusion of anti-stigma educational funding in the next budget cycle.

DHMH, BHA, and OFS have taken numerous steps to address some of the recommendations, which were presented to several legislative committees at a hearing on September 13, 2016. Specifically, DHMH will contract with the Bon Secours Hospital to operate a pretrial diversion program, which will divert patients to the Bon Secours Hospital prior to their entry into the formal forensic system of care. The State has also partnered with a community provider at the Springfield Hospital Center to run a program, known as Segue, which will provide 16 transitional beds onsite at

the Springfield Hospital Center. Finally, the Secretary of Health and Mental Hygiene has begun the process of appointing a new advisory council, which will track DHMH's progress on the recommendations on an ongoing basis.

During the workgroup process, DHMH identified numerous patients who were still residing within State hospitals but who no longer met the medical criteria for inpatient care. After identifying these patients, BHA and OFS were able to secure sufficient wraparound services and other treatment options to enable the release of these patients from the hospital. This has allowed the State hospitals to not only reduce census numbers to below 100%, but as of the September 13 legislative hearing, to reduce the number of individuals waiting in jails throughout the State for a State hospital placement from 84 to 12.

Following these efforts, the average populations of each State hospital has been brought down below the staffed and budgeted level, with the exception of the Clifton T. Perkins Hospital Center. However, as previously mentioned, there is a deficiency appropriation to open an additional 20-bed unit at the Clifton T. Perkins Hospital Center. This should partially alleviate the pressure at this institution, but at this time, it is unclear how BHA intends to focus on getting people out of this hospital.

Security Concerns Remain at the Institutions

Beyond the work of the workgroup, language included in the 2016 JCR requested a report on security recommendations at BHA facilities in response to concerns about staff security and the ability of the current employees to deal with an ever increasing forensic population. This report identified a number of recommendations, mainly by surveying the various facilities on what their own respective security needs are. While almost all of the surveyed recommendations were included as final recommendations in the report, the one response that is not addressed is the need for more staff. Six of the seven institutions surveyed requested additional staff for their hospitals, but the final report submitted by DHMH, other than noting this request, is silent on the issue. **The department should comment on the implementation of the Forensic Services Workgroup recommendations, the number of individuals currently waiting for placement at State hospitals, as well as how the department intends to improve security staffing levels without the addition of more positions for this purpose.**