UNIFIED FAMILY COURT
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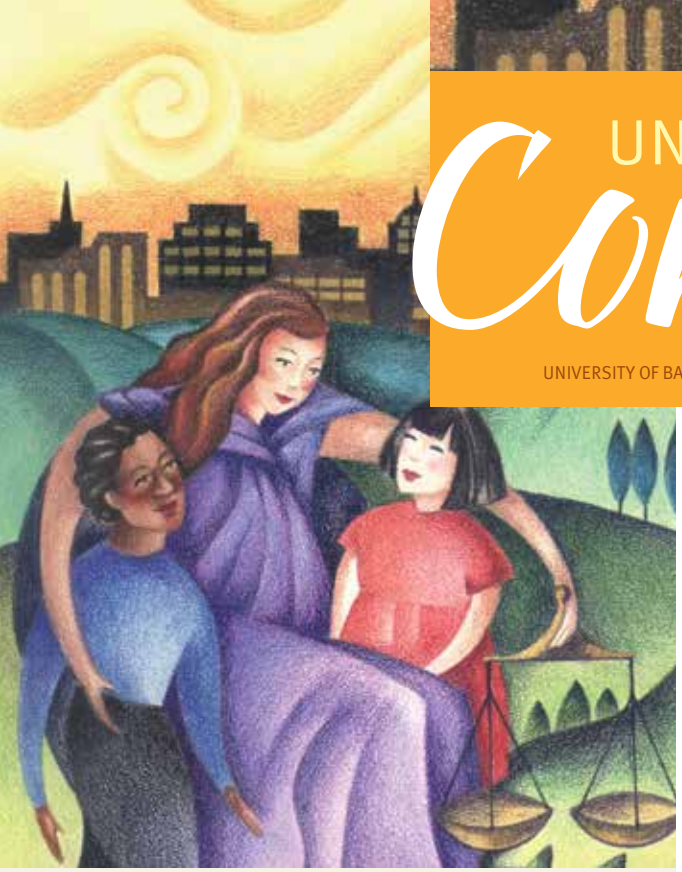

Overview

Mental Health is a Key Factor for Many Defendants in Courts Nationwide

The subject of mental health has become a key focal point of discussion throughout our nation – whether it is related to addiction issues, gun violence, homelessness or criminal recidivism.

Courts today are taking a more active role in addressing the mental health needs of families and children in court.

In this issue, you will find articles on mental health courts, trial competency and suicide prevention. Authors include:

- **John J. McCarthy**, the state's attorney for Montgomery County, Maryland, writes about the impact of a mental health court in the suburban Washington, D.C. county and how the court has diverted individuals who commit low-level crimes due to mental illness away from jail and into treatment.
- **Bhinna P. Park, M.D.**, a fourth-year psychiatry resident at the University of Maryland/Sheppard Pratt residency program, and **Christopher M. Wilk, M.D.**, a clinical assistant professor at the University of Maryland School of Medicine who provides court-ordered evaluations, write about a collaborative approach to outpatient competency restoration.
- **The Honorable Ginger Lerner-Wren,** who pioneered the first mental health court in the U.S. in Broward County, Florida, discusses the urgent need to elevate and prioritize suicide prevention in unified family courts.
- **The Honorable Gail E. Rasin,** who presides over the Baltimore City Circuit Court's Mental Health Court, discusses how mental health courts offer defendants a chance to change their lives.

Mental Health Courts Advance Justice

By John J. McCarthy

"The prosecutor has more control over life, liberty, and reputation than any other person in America. His discretion is tremendous. A prosecutor can have no better asset than to have his profession recognize that his attitude towards those who feel his power has been dispassionate, reasonable and just."

Those words of U.S. Supreme Court Justice Robert H. Jackson—which are framed on my desk—serve as my guide as a prosecutor. Applying his words requires tackling the issue of unjust or inappropriate incarceration – particularly of mentally ill offenders.

One year ago, at my urging and with strong leadership from the judiciary and from the political branches of government, mental health courts (MHCs) opened in the Montgomery County, Maryland, District and Circuit Courts.

These problem-solving courts were desperately needed. In fact, we have needed them in Montgomery County for years. Like the rest of the nation, Montgomery County, Maryland (a largely suburban county bordering Washington, D.C., and home to more than one million residents) has seen a steady increase in the number of people booked into our Central Processing Unit who require immediate mental health care.

When our Mental Health Court Planning and Implementation Task Force met in the fall of 2015, the number needing help was more than double what it had been during the previous four years, rising from 1,011 in FY11 to 2,137 in FY15. This dramatic increase took place as our jail's average daily population decreased from 914 inmates to 621, the result of a lower crime rate and effective efforts by our correctional leaders to limit pre-trial incarceration to cases where there was no acceptable alternative.

Further evidence of the strain on Montgomery's criminal justice system from unmet mental health needs was the 37 percent increase in police calls related to mental illness, which rose from 4,440 in FY11 to 6,061 in FY15. Those numbers reflect the tragic impact of the wholesale deinstitutionalization of mentally ill individuals from U.S. psychiatric hospitals that began in earnest 50 years ago – a massive and well-intended social experiment that was never accompanied, despite promises, by adequate funding from the federal and state governments to help hundreds of thousands of deinstitutionalized people succeed in their new communities.

The streets, homeless shelters and jails became, and remain, the new residences for many individuals who were deinstitutionalized or for whom short- or long-term institutionalization was unavailable or no longer a realistic option. This is ironic because the movement that began in the mid-1800s to open psychiatric hospitals in the United States was driven by social reformers seeking appropriate care for mentally ill individuals who were warehoused and untreated in prisons.

Although U.S. jails and prisons, albeit to widely varying degrees, do a far better job than their predecessors decades ago in attempting to address the needs of men-

tally ill inmates, prison is not where mentally ill people belong. Yet, jails and prisons have become the largest mental health care facilities in our nation.

Thankfully, two decades ago, a few visionary judges established our nation's first MHCs. Now, there are more than 300 such problem-solving courts in the U.S. Maryland has six, including the two in Montgomery County. "Champion" judges in Baltimore City, Prince George's County and Harford County pioneered MHCs in Maryland. Montgomery County is in their debt because we benefited from their experiences and adopted their best practices.

The benefits of MHCs are many. National studies consistently have found that they improve the public's safety by reducing recidivism of participants by at least 20 to 25 percent and, in some cases, by much more (*See* "Long-term recidivism of mental health court defendants," published in *International Journal of Law and Psychiatry*, Volume 37, Issue 5, September-October 2014, and *Mental Health Courts: A Guide to Research-Informed Policy and Practice* by the MacArthur Foundation and the Council of State Governments Justice Center, 2009).

Another benefit of MHCs is that participants are connected to services, including appropriate housing, by mental health court social workers who help them lead more independent lives. Criminal justice system efficiency improves as fewer mentally ill individuals are re-arrested time and again for the same minor crimes, reducing jail time and other expensive encounters with the criminal justice system. In addition, MHCs can reduce costly emergency hospitalizations and emergency room visits.

Montgomery County's Mental Health Court program takes about 18 months to complete and entails many requirements for the defendant, including: living in court-approved housing; attending weekly court sessions; checking in frequently with his or her case manager; taking all prescribed medications; attending up to several Alcoholics Anonymous or Narcotics Anonymous meetings per week (if applicable, which is often); checking in with his or her probation officer (also often applicable); and securing and maintaining employment (this varies, depending on the participant's age and circumstances).

A strong incentive for defendants to participate in MHCs is the opportunity to have their charges dismissed or substantially reduced if they complete the program. Careful screening of prospective participants is crucial. They must be competent, motivated and not a danger to the public. My prosecutors will veto participants who pose a safety risk to the public.

Treatment plans are tailored to meet the unique needs of participants, but all plans are closely monitored. The ability of the presiding judge to engage and to relate to the participants, combined with careful screening of participants and an experienced, cohesive MHC team, consisting of the judge, court coordinator, prosecutor, public defender, case manager, clinical team and probation officer, are crucial for a successful MHC.

Montgomery County's MHC teams meet for one to three hours on the day of the weekly docket to discuss how each participant is doing and to problem solve. In between meetings and court sessions, considerable work is done through phone calls and emails. If a participant has a private defense attorney, he or she participates in that portion of the team meeting.

Support for a problem-solving court and government funding to launch a MHC do not just happen. The blue-ribbon Mental Health Court Task Force in Montgomery County, chaired by a former long-time member of the County Council, included all stakeholders, helped strengthen judicial buy-in, and developed the blueprint for successfully launching and operating our MHC. Maryland's Office of Problem-Solving Courts was extremely helpful throughout the process, and has contributed funds for court administration. Crucially, the chief judicial officers in Maryland enthusiastically supported and authorized Montgomery County's newest problem-solving courts.

The primary cost of MHCs is the need to hire skilled mental health therapists. Approximately three licensed clinical social workers are needed for every 50 MHC participants. Generally, the other members of the MHC team already are working on the cases of the defendants who choose to become participants. Their workload, however, will increase because of the labor-intensiveness required by MHCs. My office has absorbed the cost of four prosecutors who devote more than 20 percent of their time to the MHC.

The experience of Montgomery County's MHC has been very positive. Only a handful of the 57 participants have been re-arrested since joining the program six months to a year ago. Based on past experience of the "revolving door" of defendants needing mental health care, there would be a far higher number of re-arrests. Many participants have complied with all requirements, have regained their independence, and have moved steadily from Phase 1 to (the final) Phase 4 of the program. Their potential is being realized and their criminal behavior, usually a result of not having or taking needed medication, has been stopped.

Although the benefits of MHCs with respect to recidivism are very clear, some of the challenges may not be. For example, when participants are preparing to undergo surgery for whatever reason, they must stop taking medication that may be critical to their mental health. Although unavoidable, this can stall their progress or cause them to need crisis care. In addition, securing employment can be very challenging for participants because of a pre-existing criminal record. Maintaining employment also may be difficult because the requirements of MHC may conflict with a supervisor's expectations or requirements. The greatest challenge, however, is finding appropriate supervised housing for participants because of short supply.

I am proud that my prosecutors are diverting dozens of individuals who commit low-level crimes due to a mental illness away from jail and into treatment. This is a win-win for the public and for the offender. I think Justice Jackson would agree that MHCs enable prosecutors to use their discretion to advance justice.

John J. McCarthy is the state's attorney for Montgomery County, Maryland. He joined that office in 1982. Prior to becoming the state's attorney in 2006, he served as deputy state's attorney in Montgomery County for 10 years and previously headed every major trial division in the office.

A Collaborative Approach to Competency Restoration Is Essential

By Bhinna P. Park, M.D., and Christopher M. Wilk, M.D.

People with serious mental illness intersect with the criminal justice system for a myriad of reasons, ranging from shoplifting or trespassing cases to more serious violent crimes.

In the pretrial setting, forensic psychiatrists are sometimes asked to opine about a person's mental state at the time of the offense. Did the person have symptoms of a mental illness that impaired his/her appreciation of the criminality of their conduct at the time of the offense? Did such symptoms impair their ability to conform their conduct to the requirements of the law? More commonly, the court asks about a person's competence to stand trial. The court focuses on their ability to understand the nature and object of the proceedings against them and their ability to assist in their defense.

As forensic psychiatrists, we are often asked to conduct evaluations for competence to stand trial, which are among the most common psychiatric evaluations ordered by criminal courts throughout the United States. When the U.S. Supreme Court set the standard for competency evaluations (*Dusky v. United States*, 362 U.S. 402 (1960)), state mental health hospitals were well-established sites of psychiatric evaluation and treatment. Since that time, deinstitutionalization has shifted patients with mental illness out of hospitals toward community treatment, but the hospitals have remained a cornerstone of competency evaluation and attainment services, and that remains the case in Maryland.

In Maryland, if the court raises the possibility that a defendant may not be competent to stand trial, that person is evaluated by a forensic psychiatrist or psychologist. If the evaluator asserts that the person was not competent to stand trial and the court adjudicated in kind, the defendant typically is admitted to one of the state psychiatric hospitals to receive competency attainment services. This is often consistent with clinical reasoning because, in many cases, the defendants may be dangerous to themselves, others or the property of others. But how is competency attained by defendants who are adjudicated as incompetent to stand trial, but not dangerous to themselves or the person or property of others?

According to a 2016 article in the journal, *Psychology, Public Policy and Law,* there are currently 36 states with statutes allowing outpatient competency attainment services, and 16 states operating formal outpatient competency attainment programs.

In Maryland, outpatient competency attainment is permitted, but as of now, the only extant outpatient competency attainment program serves only juveniles. For that population, competency attainment services can be conducted in either a home, an institution, a school setting or other public place, as determined to be appropriate. Such settings allow these respondents to benefit from their natural support systems. At this point in time, there are no equivalent adult services in Maryland.

The primary competency attainment strategies involve pharmacotherapy and the provision of education about the court system and the defendant's specific legal circumstances. Aside from the relatively rare instance in which a person requires a clinical review panel to facilitate the use of involuntary medications, it may be possible to avoid hospitalization in cases in which the person is not imminently dangerous.

One strategy to address this need is by providing competency attainment services in the detention center. In that setting, defendants already have access to psychiatrists who can prescribe the medications that can treat the illnesses that compromise their ability to understand the nature and object of the proceedings against them or their ability to assist in their defense. The missing component would be the provision of the educational component of competency attainment services, but this would be a relatively simple service to provide in the correctional setting.

Nine states (Arizona, California, Colorado, Florida, Georgia, Louisiana, Tennessee, Texas and Virginia) currently offer restoration services in select local jails. "Outpatient" mental health clinics at jails and prisons serve inmates who are safe enough to be in the general population of the detaining facility and can appear for their own appointments at detention center clinics.

According to a 2016 report from the American Psychological Association, jail-based competency attainment services often provided sufficient treatment so that the defendants no longer required an inpatient level of care by the time a hospital bed was available. In other cases, states with outpatient competency restoration programs used the jail-based restoration as a screening mechanism, allowing appropriate individuals to be released directly from jail and into the outpatient program, bypassing a potentially unnecessary hospital stay.

Another option that does not involve the correctional system is to provide outpatient competency attainment services through a public-private partnership. For example, an Assertive Community Treatment (ACT) program that provides intensive services to people with chronic and persistent mental illnesses certainly would be equipped to provide twice weekly clinical services. Currently, this is the frequency with which attainment services are provided in the state hospital system. The provision of didactic competency attainment services would be very simple to implement in such a setting.

ACT programs also provide access to psychiatrists who can prescribe medications to treat the illnesses that may impinge upon a person's competency. In addition, some of these programs have psychiatrists and other mental health professionals who are specifically trained to work with the courts and people who have legal entanglements.

A program offering outpatient competency attainment service has many advantages, including the following:

- Even if only a small percentage of defendants who are adjudicated as incompetent to stand trial would be eligible for such a program, it would offset the number of people that are admitted to state hospitals at a time when demand is high and supply is relatively low.
- A reduced number of admissions to the state hospitals would save the state and the taxpayers of Maryland a considerable amount of money, even after accounting for the costs of additional resources required for outpatient competency attainment services.
- Public-private partnerships offer an opportunity to use the existing infrastructure to efficiently address a major public health and criminal justice system concern.
- Programs offering outpatient competency attainment services may allow defendants to retain civil liberties in the pretrial phase for relatively minor crimes, such as trespassing.

As with most innovations, implementation of an outpatient competency attainment service program has some potential challenges. For example, there would have to be a thorough screening process and risk assessment to discern which defendants are at low-risk for violence and recidivism of the alleged offense. There also would have to be screening to determine whether a defendant is stable enough to be released into the community, with instructions to follow-up on an outpatient basis. In the absence of confinement to a hospital, a plan to enhance adherence to treatment would be beneficial. Such outpatient services may not be appropriate for all defendants, particularly those who are dangerous or who have serious charges.

In addition, a very pragmatic concern to consider is that outpatient competency restoration services would not automatically provide housing or meals, as does an inpatient setting. For many of the more vulnerable defendants who struggle with housing, financial concerns or active substance use, an inpatient setting may offer some advantages to an outpatient setting for competency attainment services.

As forensic psychiatrists, in addition to conducting forensic evaluations for the court, we also provide treatment services to many individuals who have been involved with the criminal justice system. There are many specific people we have treated for whom such outpatient competency attainment services would be effective. These services would allow them to remain in treatment with an outpatient provider whom they trust, and to continue living in their community among their natural support systems. From a clinical perspective, those two factors are significantly advantageous as compared to incarceration or long-term hospitalization. From an economic perspective, it saves money.

The state of Maryland, the courts, the detention centers and private non-profit mental health service providers should consider a novel and collaborative approach to outpatient competency attainment.

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Unified Family Courts: Judges Become Champions for Zero Suicide

By Ginger Lerner-Wren

Across America, parents, teachers, health care providers, mental health practitioners and policy makers realign behavioral health resources and implement systemic public health initiatives to advance suicide prevention and awareness. Based upon the data, there is an urgent need to elevate and prioritize suicide prevention in unified family courts.

According to recent Center for Disease Control and Prevention (CDC) data, the suicide rate in the U.S. "has surged to the highest levels in nearly 30 years". (Sabrina Tavernise, "U.S. Suicide Rate Surges to a 30-Year High," The New York Times, April 22, 2016.) As Katherine Hempstead, senior adviser at Robert Wood Johnson Foundation, put it: "It's stunning to see a large increase in suicide rates affecting virtually every age group." (https://www.nytimes.com/2016/04/22/health/us-suicide-rate-surges-to-a-30-year-high.html). According to Hempstead, research shows a link between suicide rates for those 40-60 years of age and toxic stress related to job, financial and legal problems. (KA Hempstead, et al., "Rising Suicide among Adults Aged 40-64 years: the role of job, and financial circumstances" AM J Prev Med. 2015).

The American Foundation for Suicide Prevention and The Jed Foundation recently launched "Seize the Awkward," a powerful national advertisement campaign geared to teens and young adults between the ages of 16 and 24. (Gabriele Beltrone, "Embracing an Awkward Moment Can Save a Life, Say Droga5's Suicide Prevention Ads," ADWEEK January 17, 2018.) "Seize the Awkward" is intended to be light-hearted and encourage friends to check in with one another.

According to the AD Council, "an awkward silence among friends isn't just a moment to gloss past. It could be an opportunity to save the life of someone you care about." (Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report, "Suicide Trends among Persons Aged 10–24 Years, United States, 1994-2012," (March 2015)) .

According to the CDC, suicide is the second-leading cause of death among teenagers in the U.S. The data is alarming when one considers that suicide among teenagers ages 15–19 is the second-leading cause of death, surpassing homicide rates, which fell to third. (Alicia VanOman, et al. "Suicide Replaces Homicide as Second-leading Cause of Death among U.S. Teenagers," Population Reference Bureau (analysis of Centers for Disease Control and Prevention, National Center for Health Statistics, June 2016).)

The community of Perry Township, Ohio, recently reeled from six teen suicides in its school district within six months. According to

news reports, the deaths did not appear linked and the Perry Township Chief of Police emphasizes the need for parents to get involved with their children and have conversations about their emotional well-being, bullying and social media and for expanded resources in the community to help their children. (Steve Almasy, "6 Teen Suicides in 6 Months in 1 Ohio School District," CNN January 17, 2018).

INTEGRATION OF SUICIDE PREVENTION IN COURT PROCESS

As presiding judge of the Broward County Misdemeanor Mental Health Court, I write extensively about mental health, criminal justice and suicide prevention. There are many common threads between unified family courts and problem-solving mental health courts. The most notable goal to is help families overcome crisis and to act as "a problem-solver." (Babb, Barbara A. et al., "Introduction to Special Issue on Unified Family Courts," Family Court Review 224 (2008)). In furtherance of this goal, both solution-focused court models rely on a collaborative and restorative approach to court process through the applied principles of therapeutic jurisprudence (TJ) and procedural justice.

From a TJ perspective, court process and individualized psycho-social interventions are directed toward "root causes," whereas the court's therapeutic goals are enhanced by giving voice and validation to court participants to establish trust and perceptions of fairness. In this regard, many unified family court judges and staff possess the passion, skills and competencies to help break the silence and taboo surrounding suicide by affirmatively establishing a court culture of zero suicide.

It is fair to ask: how can one judge make a difference? It is a great question. In mental health court, for example, I lead heartfelt discussions aimed at understanding facts about suicide. I also educate myself on the research surrounding facts about suicide across the life span and among special populations and I provide written materials dedicated to safety plans and information on local suicide prevention crisis services (i.e., crisis hot lines, mental health crisis and walk-in centers). From a clinical perspective, in-court staff conduct private suicide risk assessments.

What is Zero Suicide?

Broward's Mental Health Court is a diversionary court dedicated to balancing the goals of decriminalization, individual legal rights and public safety. (Lerner-Wren, G. "Mental Health Courts: Serving Justice and Promoting Recovery," Annals of Health Law, Vol.19. Issue 3, Spring 2010.)

The court works in partnership with a collaboration of mental health, substance use and social service community-based providers. The court clinically is guided by an in-court licensed clinical social worker and the values of dignity, person-centered care and recovery. The court process is devoted to public safety, individualized treatment planning, coordinating linkages of community-based care, system accountability, breaking arrest cycles and community integration.

The court process is humanistic and integrates educational discussions on mental health care and what happens when personal solutions, in response to adverse childhood experiences and trauma, lead to negative health and social consequences, which include incarceration and addiction, as noted in The Adverse Childhood Experience Study (The ACE Study). (Vincent J. Felitti, "The Origins of Addiction: Evidence of the Adverse Childhood Experiences Study," Department of Preventative Medicine, Kaiser Permanente Med. Care Program, 2003.)

In 2015, the New York Times reported on the alarming surge in the rate of suicide in the U.S., and I realized that courts needed to do more. Through my participation with the National Action Alliance (The Action Alliance) for Suicide Prevention, I understood that while a focus on trauma was essential, I had not effectively elevated suicide prevention as a core element of the court process.

According to The Action Alliance, Zero Suicide is an aspirational goal and key concept of the 2012 National Strategy for Suicide Prevention. (U.S. Surgeon General and National Action Alliance for Suicide Prevention, "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action," (2012)).

As noted by The Action Alliance, "Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and a specific set of tools and strategies. It is both a concept and a practice." ("What is Zero Suicide?" National Action Alliance for Suicide Prevention, February 10, 2015).

In 2016, I declared Broward's Mental Health Court a Zero Suicide Initiative Court as a means of communicating to court staff, lawyers and the community at-large that suicide prevention is a court priority.

Championing Suicide Prevention

Whether leading change one court at a time or working on a community or state level to promote suicide prevention, the perceived authority of judges to lead cultural change from a public health perspective is a historical cornerstone of behavioral health policy. From a national perspective, problem-solving courts, while not a substitute for a rational public health agenda, have revolutionized the legal system. They offer judges the opportunity to improve systems of justice for persons by expanding pathways to behavioral health care and saving lives.

For those interested in learning more about Suicide Prevention, see the National Action Alliance website and join me in the promotion of Zero Suicide. ("Need to Know: A Fact Sheet Series on Juvenile Suicide: Juvenile Court Judges and Staff," prepared by the Youth in Contact with the Juvenile Justice System Task Force of the National Action Alliance for Suicide Prevention," September 2013).

http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/JJ-2_Juv_Court_Fact_Sheet_508.pdf)

If you or someone you know is contemplating suicide, call the National Suicide Prevention Hotline at 1-800-273-8255 or text Crisis Text Line at 741-741.

Ginger Lerner-Wren is a county court judge in the Criminal Division of the 17th Judicial Circuit, Broward County, Florida. In 1997, Judge Lerner-Wren pioneered the first mental health court in the U.S., based on a human rights model dedicated to the decriminalization of mental illness. She speaks nationally and internationally on therapeutic jurisprudence, behavioral health and suicide prevent.

Mental Health Court Offers Defendants a Chance to Revamp their Lives

By Gail E. Rasin

Since June 2011, the Circuit Court for Baltimore City has dedicated a specialized docket to handle criminal cases involving defendants who suffer from serious mental illness. Every judge who hears criminal cases knows that a significant percentage of defendants suffer from mental illness, whether diagnosed or undiagnosed.

Frequently, a defense lawyer raises a client's mental illness as mitigation of criminal behavior and asks a judge to grant probation. Usually, a condition of probation for a mentally ill defendant is mental health treatment. That seems logical and appropriate, but can be a set-up for failure on probation. Access to treatment, insurance coverage, insecure housing and the difficulty of navigating the health care system present significant barriers to a mentally ill person successfully completing probation, without the benefit of assistance and intensive monitoring.

I. HISTORY

To break the cycle of failure on probation, the Baltimore City Circuit Court, with the assistance of the predecessor agency to Behavioral Health Systems Baltimore, received a three-year grant from the Association of Baltimore Area Grantmakers to fund a position for a mental health professional who could assess defendants for mental illness, develop treatment plans and obtain treatment services in the city's public mental health system. Along with this position of clinical coordinator, I obtained the agreement of the State's Attorney's Office, the Public Defender's Office, and the Division of Parole and Probation to dedicate lawyers and a probation agent to staff a specialized court. We developed a protocol for referring defendants, assessing them, and accepting them for a probation docket. The then-administrative judge created the Mental Health Case Management Docket for assigning all cases in which competency to stand trial was raised and criminal responsibility was an issue, including in specialized probation cases. The court was envisioned as a three-track operation – probation, competence and criminal responsibility.

I became the presiding judge and a protocol was issued to the entire bench, which allows judges and attorneys to refer cases pre-trial to the docket. The assistant state's attorney assigned to the docket screens the referrals and considers public safety issues. If the referral is approved by the assistant state's attorney, it comes to me and I decide whether to accept it. Participation by defendants is voluntary.

Once referred, a defendant is assessed by the clinical coordinator. She performs a complete psychosocial assessment, arrives at a diagnosis and considers the person's treatment needs. To participate in the docket, the person must be an adult, a Baltimore City resident, suffer from a serious mental illness and/or trauma disorder, be eligible for the public mental health system, agree to comply with the treatment plan and program requirement, and be amenable to treatment. If the assessor determines that the defendant meets the criteria, then she must explore whether appropriate treatment is available. Frequently, individuals suffer from multiple disorders, including mental illness, substance use, trauma, cognitive impairments and traumatic brain injury. Treatment plans must adequately address a person's needs; otherwise the outlook for success is diminished.

Unlike many mental health courts, we do not limit the eligibility for our court by including a criterion involving the nature of the offense. Some mental health courts only accept people charged with non-violent offenses. We will accept a person, regardless of the offense charged, if we are convinced that appropriate treatment is available in the community and the defendant does not pose an obvious threat to public safety if provided with treatment and intensive monitoring. As a result, we have accepted defendants charged with every manner of crime, including arson, armed robbery, rape, child abuse and murder.

Before agreeing to accept a defendant, the court team discusses the assessment report and the assessor's recommendation. Because a defendant must plead guilty under a plea agreement, if the prosecutor declines to recommend probation because of concerns for public safety, the case is not accepted. On occasion, a defendant who asked for the referral declines to accept the plea agreement because the treatment plan has elements that the defendant does not want to undertake, such as a requirement of supervised housing. Ultimately, the court decides whether the defendant may participate in the docket.

II. THE PROBLEM-SOLVING COURT MODEL

We follow the practices of a problem-solving court, ones with which I was familiar after having presided over both District and Circuit Drug Treatment Courts. Our clinical coordinator position became permanent in 2014 after the Circuit Court Medical Office funded the position. In 2017, our court's application to be designated an official problem-solving court was accepted by the Maryland Court of Appeals. We evolved from a docket to an official mental health court

We meet every week to discuss the cases that will appear on the docket that day and cases of defendants who are in the referral process. Every defendant who participates in the court appears in court regularly for status conferences, initially every few weeks. If progressing satisfactorily, the schedule for court appearances is extended to every month or even longer. Our two probation agents, who now supervise approximately 40 probationers, meet with their clients on a weekly basis and report to the court on the defendants' progress.

The individual treatment plan is the key to an individual's chances for success. Unlike a drug treatment court, which measures a defendant's success by periods of abstinence, a mental health court measures a defendant's success by his or her compliance with treatment and the terms of his or her agreement with the court. The clinical coordinator identifies and obtains treatment providers for every defendant. This means identifying a psychiatrist, therapist and, in many instances, a residential rehabilitation program where a defendant will live and be supervised. Because most defendants suffer from both serious mental illness and substance use disorder, they participate in substance use treatment. Indeed, because of the severity and duration of their sub-

stance use, many defendants are committed to the Department of Health under Maryland Code Ann. Health General § 8-507 for co-occurring residential treatment for substance use and mental illness before entering community-based treatment.

Some defendants require specialized treatment programs, such as trauma treatment or assistance with traumatic brain injury. In addition to treatment needs, the probation plan also addresses educational and vocational needs. Defendants attend General Education Development (GED) programs and job-training programs. Some pursue interrupted college plans.

The probationary term typically is three years. The purpose of a lengthy probation is to promote successful reentry in the community for individuals who may have spent lengthy periods incarcerated. Individuals with serious mental illness, such as schizophrenia or bipolar disorder, come to accept that treatment, including medication, is a permanent aspect of their lives and that substance use damages their health and wreaks havoc with their progress.

III. MEASURING SUCCESS

The primary goal of any probationary sentence is to insure compliance with the conditions of probation. Such conditions concern "showing up" to appointments with probation officers and to status conferences with the court. Another requires probationers to obey all laws. The special condition of mental health court probation is to follow the treatment plan established by the court. The entire mental health court team is devoted to promoting compliance with those conditions. Ultimately, evaluations using evidence-based practices will gauge the success of our mental health court's probation track. Comparing my 20 years of experience with routine probation and the probation of this specialty court, I can say that recidivism is rare and success is the norm. While the trend in criminal justice is to use instruments to predict recidivism and dangerousness, my own experience is that, regardless of a mentally ill person's history, if you give that person the treatment he or she needs, a stable residence, active monitoring and a positive relationship with the actors in the system – probation agent, clinical assessor, defense attorney, prosecutor and judge – the prospects for compliance and success are bright. When a defendant comes to court for a status conference and offers thanks to "The Team," he or she expresses the core value of our mental health court.

IV. COMPETENCY AND CRIMINAL RESPONSIBILITY

In addition to the probation track, the Baltimore City Circuit Court Mental Health Court also hears all cases in which there are suggestions by lawyers or judges that a defendant is incompetent to stand trial as well as cases in which defendants have entered pleas of not criminally responsible.

A defendant is incompetent to stand trial if, whether due to a mental disorder or intellectual disability, he or she is unable to understand the proceedings against him or her, or unable to assist counsel in his or her own defense. The focus is on the defendant's mental status in the moment. In contrast, a defendant is not criminally responsible if, at the time of the commission of the offense, the defendant did not comprehend the criminality of his or her conduct or could not comply with the requirements of the law due to a mental disorder or intellectual disability. An incompetent defendant must be restored to competency before proceeding to trial. After an evaluation by the Circuit Court Medical Office, if competency is not established, the court commits the defendant to a hospital where he or she receives treatment to restore him or her to competency. A defendant who is not criminally responsible can be convicted but not subjected to punishment. Instead, he or she is committed to a state hospital for treatment. The court may order a "conditional release," with treatment and monitoring requirements, after a finding that the defendant is not dangerous to himself or herself or others due to his or her disorder.

The Baltimore City Circuit Court Mental Health Court has devoted much time and effort to ensure that incompetent defendants do not languish in jail after having been committed to the Department of Health. For years, there have been delays in hospital admissions, resulting in contempt proceedings against the Department of Health in 2016 and 2017. In September of 2017, I held the Department of Health secretary, deputy secretary and three psychiatrists in contempt of the court's commitment orders in the cases of incompetent defendants, and ordered the department to add treatment beds and staff. As of the writing of this article, the contempt order is on appeal.

In terms of criminal responsibility, I have noticed over the years that some defendants who committed acts of violence, including murder, did so almost immediately after they were released from brief hospitalizations at psychiatric units of local hospitals. Those terrible instances underscore the need for continuity of care in the community as well as a rethinking of our system of mental health treatment, both inpatient and outpatient.

V. CONCLUSION

In my opinion, the Baltimore City Mental Health Court, after seven years of operations, is an oasis in our criminal justice system. It is a place where people who have suffered for years and, in many instances, have caused others to suffer can finally secure the treatment they need, avoid incarceration, put their lives back together and ultimately be their best selves. It is the greatest example of justice reinvestment.

As a judge who has been on the bench for over 25 years, in senior status for the last five, I can say that presiding over the mental health court, working with my team, and witnessing the changes in our people's lives has been the most rewarding experience of my judicial career.

Judge Gale E. Rasin served on Baltimore City's District and Circuit trial courts for more than 25 years, presiding over civil, family and criminal cases. She created a felony mental health court in the Circuit Court that supervises criminal defendants who suffer from serious mental illness. Since her retirement in 2012, she continues to preside over the Mental Health Case Management Docket in the Circuit Court for Baltimore City.

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FEEDBACK: We value your opinions and your comments! We look forward to hearing from you at *cfcc@ubalt.edu*.

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VOICE BOX

"CFCC has been a key partner in promoting family court reform in our state. Its work helps courts and their community partners remain focused on how our work can benefit families."

Pamela Cardullo Ortiz
Director
Access to Justice Department
Administrative Office of the Courts
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