January 13, 2009

The Honorable Ulysses Currie
Chairman, Senate Budget and Taxation Committee
3 West, Miller Senate Building
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman, House Committee on Appropriations
1312 Whittier Drive
Salisbury, Maryland 21801-3241

RE: Joint Chairmen’s Report on Alternate Plan for the Assessment of Inmates

Dear Chairmen Currie and Conway:

In accordance with the 2008 Joint Chairmen’s Report on page 137, the Department of Public Safety and Correctional Services (DPSCS) and the Mental Hygiene Administration (MHA) were directed to report on the implementation and results of the alternative plan for securing an appointment for a seriously mentally ill individual within two weeks of release. Specifically the Joint Chairmen’s Report states:

Alternate Plan for the Assessment of Inmates: Section 10-814 of the Health-General Article requires the Mental Hygiene Administration (MHA) to compensate case managers or other appropriate community mental health providers for conducting initial assessment of inmates who are (1) identified by the Department of Public Safety and Correctional Services (DPSCS) as having a serious mental illness; and (2) expected to be within three months of release. However, the committees are concerned that conducting initial assessments within DPSCS facilities have not proven feasible because resources for implementation are unavailable; and significant geographic challenges exist because inmates often return to a home community that is not in close proximity to the correctional institution they are leaving. The committees understand that MHA and DPSCS have developed an alternative plan to secure an appointment for a seriously mentally ill individual within two weeks of release. The committees request DPSCS and MHA report back to them on the implementation and results of this alternative plan.

An alternative plan was developed by the Mental Hygiene Administration (MHA), through the work of the Maryland Association of Core Service Agencies (MACSA), and the Department of Public Safety and Correctional Services (DPSCS) with the assistance of the Mental Health Association of Maryland and the Mental Health and Criminal Justice Partnership. The Partnership includes members of the two departments, the Mental Health Association, and other state, local, and private agencies. The success of the plan is dependent upon the agreement of the numerous agencies. Consequently, it took a number of meetings and conversations to put this plan together. A copy of the membership list of the Partnership is attached hereto as Exhibit A.
The parties developed a formalized process for referral of seriously mentally ill individuals to the local mental health authority, the Core Service Agency (CSA) in the jurisdiction to which the individual will return. The referral is made by DPSCS to the CSA at least 30 days prior to the date of the individual’s release from DPSCS. At the time the referral is made, DPSCS staff provide to the CSA information concerning the individual’s diagnosis, medication, incarceration information, entitlement application status, the release plan, the type of assistance needed, as well as other pertinent information. See a copy of the referral form attached hereto as Exhibit B.

The purpose of providing so much information to the CSA at time of referral is to obviate the need for the first appointment with the community provider to be an intake, information-gathering session. With the information provided to the community provider organization prior to the individual’s release, the first appointment can be with a clinician to ensure that continuity of medication treatment can occur without interruption.

The CSA’s responsibility in this process is to ensure that the individual is scheduled to receive the needed services in the community. Those services include an appointment with a provider organization within 30 days of the date of the individual’s release from prison, case management services (if necessary), assistance with finding housing, and follow-up work on acquiring entitlements. Upon scheduling the appointment, the CSA is also responsible for communicating the date of that appointment to DPSCS referring staff so that the DPSCS Division of Parole and Probation is aware of the plan and can enforce and follow up to ensure that the appointment is kept by the individual.

At the same time, DPSCS is making the referral for mental health services, DPSCS will be working with the Maryland Medicaid program, or its agent, in facilitating Medicaid and other entitlements for the individual. If the individual has not received Medicaid eligibility at the time of the appointment in the community, the Public Mental Health System will still cover the cost of the services.

Implementation of this plan began on September 19, 2008, with a cross-training session. Representatives from each of the CSAs, all DPSCS social workers and some correctional mental health clinicians met to be introduced to one another, to get a basic understanding of each agency’s operations and difficulties, and to learn their respective responsibilities in this new process. The referral form was reviewed, an instruction manual was provided, and terms contained on the form were defined. The attendees had the opportunity to ask questions, raise concerns, and present issues for discussion.

Referrals from DPSCS to the CSAs began on October 15, 2008, for individuals to be released on December 1, 2008, or later. It is premature to provide specific results of this alternative plan; however, the Departments have a data collection strategy in place for tracking the results.

The following information will be collected to track the success of the plan:

1) Number of referrals made by jurisdiction;
2) Number of initial community appointments made; and
3) Number of initial community appointments kept.

The Mental Hygiene Administration and the Department of Public Safety and Correctional Services will continue to monitor the implementation of the above plan. In addition, the Mental Health and Criminal Justice Partnership will continue to meet in order to resolve
additional concerns regarding re-entry of inmates with a serious mental disorder into the community.

If you have any questions regarding this report, please feel free to contact Assistant Secretary Richard B. Rosenblatt at 410-339-5031 or W. Lawrence Fitch, Director, MHA Forensic Services, at 410-767-3171.

Sincerely,

Gary D. Maynard
Secretary

Attachments

c: Senator Edward J. Kasemeyer, Vice Chair, Senate Budget and Taxation Committee
Senator James E. DeGrange, Sr., Chair, Senate Public Safety, Transportation, and Environment Subcommittee
Delegate James E. Proctor, Jr., Vice Chair, House Committee on Appropriations
Delegate Charles Barkley, Chair, House Subcommittee on Public Safety and Administration
Members of the House Committee on Appropriations
Members of the Senate Budget and Taxation Committee
Mr. Matthew Gallagher, Deputy Chief of Staff, Governor’s Office
Mr. Joseph Bryce, Governor’s Chief Legislative Officer
Mr. Warren G. Deschenaux, Director, Office of Policy Analysis, DLS
Mr. David Treasure, Executive Director, Office of Budget Analysis, DBM
Ms. Rebecca Moore, Policy Analyst, DLS
Ms. Diane Lucas, Supervisor, Budget Analysis, DBM
Mr. Joshua Watters, Staff, House Committee on Appropriations
Mr. David Smulski, Staff, Senate Budget and Taxation Committee
Ms. Shirleen Pilgrim, Staff, Senate Judicial Proceedings Committee
Ms. Cathy Kramer, DLS
Ms. Sarah Albert, Mandated Reports, DLS
Director Anne H. Hubbard, Government Affairs, DHMH
Deputy Secretary G. Lawrence Franklin, DPSCS
Assistant Secretary/Chief of Staff Thomasina Hiers, DPSCS
Assistant Secretary Richard B. Rosenblatt, DPSCS
Assistant Secretary David Bezanson, DPSCS
Director Rhea L. Harris, Office of Legislative Affairs, DPSCS
Acting Director Bonita Cosgrove, Mental Health, DPSCS
Mental Health and Criminal Justice Partnership
as of September 3, 2008

Wonda Adams
Field Supervisor II
Division of Parole & Probation
Department of Public Safety and Correctional Services
301 North Gay Street, 3rd Floor
Baltimore, Maryland 21202
410-895-1199
Wadams@dpwcs.state.md.us

Tara Agnese
Research and Evaluation Coordinator
Office of Special Populations
Mental Hygiene Administration
8450 Dorsey Run Road
Jessup, Maryland 20794
410-724-3035
agneset@dhmh.state.md.us

Lynn H. Albizo
Executive Director
NAMI MD – National Alliance on Mental Illness of Maryland
804 Landmark Dr., Suite 122
Glen Burnie, Maryland 21061
410-863-0470
lalbizo@nami.org

Marian Bland
Director, Office of Special Needs Populations
Mental Hygiene Administration
8450 Dorsey Run Road
Jessup, Maryland 20794
410-724-3242
blandm@dhmh.state.md.us

Terry Bohrer
Consultant to Mental Hygiene Administration
Past-President, Mental Health Association of Maryland
16304 Bawtry Court
Bowie, Maryland 20715
301-262-2772
tbbohrer@yahoo.com

Laura Cain
Maryland Disability Law Center
1800 North Charles St., Ste. 400
Baltimore, Maryland 21201
410-727-6352
laurac@mdlclaw.org
Judge Charlotte M. Cooksey
District Court of Maryland
Baltimore City
700 East Patapsco Avenue
Baltimore, Maryland 21225
410-878-8316
Charlotte.cooksey@courts.state.md.us

Bonnie Cosgrove
Department of Public Safety and Correctional Services
Office of the Secretary
300 East Joppa Road, Suite 1000
Towson, Maryland 21286
410-339-5051
bcosgrove@dpscs.state.md.us

Herbert S. Cromwell
Community Behavioral Health Association of Maryland
18 Egges Lane
Catonsville, Maryland 21228
410-788-1865
mdcbh@verizon.net

Lisa M. Cuozzo
Director of Public Policy
Mental Health Association of Maryland
711 W. 40th Street, Ste. 460
Baltimore, Maryland 21211
410-235-1178 Ext. 208
lcuozzo@mhamd.org

Douglas C. Devenyns
President, Maryland Correctional Administrators Association
Director of Corrections
Wicomico County Department of Corrections
411 Naylor Mill Road
Salisbury, Maryland 21801
410-548-4859 Ext. 303
ddevenyns@wicomicocounty.org

M. Sue Diehl
Consultant to Mental Hygiene Administration
6005 Lake Manor Drive
Baltimore, Maryland 21210
443-797-2564
suediehlmsw@comcast.net

Barbara Y. DiPietro
Special Assistant to Deputy Secretary for Public Health
Department of Health & Mental Hygiene
201 W. Preston Street, 5th Floor
Baltimore, Maryland 21201
410-767-6575
bdipietro@dhmh.state.md.us
Lori Doyle  
Chief of Operations  
Mosaic Community Services  
76 Cranbrook Road, Ste. 110  
Cockeysville, Maryland 21030  
410-453-9553 x184  
Lori.doyle@mosaicinc.org

Kate Farinholt, Executive Director  
NAMI-Metropolitan Baltimore, Inc.  
410-435-2600  
kfarinholt@nami.org

Lois Fisher  
Office of Public Defender  
201 East Baltimore Street, Suite 1230  
Baltimore, Maryland 21202  
Phone: 410-347-1068  
lifisher@opd.state.md.us

W. Lawrence Fitch  
Director, Office of Forensic Services  
Mental Hygiene Administration  
8450 Dorsey Run Road  
Jessup, Maryland 20794  
410-724-3171  
fitchl@dhmh.state.md.us

Melvin Freeman  
Family Investment Administration  
Maryland Department of Human Resources  
311 W. Saratoga Street  
Baltimore, Maryland 21201  
410-767-7977  
Mfreema2@dhr.state.md.us

Stephen B. Goldberg, MD  
Medical Director/CEO  
Correctional Mental Health Services, LLC  
Cell number (443) 286-1439  
cmhs@comcast.net

Debra Hammen  
Chief, Systems Operation  
Mental Hygiene Administration  
Office of Forensic Services  
8450 Dorsey Run Road  
Jessup, Maryland 20794  
410-724-3178  
hammend@dhmh.state.md.us
Stephanie Hawkins  
FIA Program Analyst  
Family Investment Administration  
Maryland Department of Human Resources  
311 W. Saratoga Street  
Baltimore, Maryland 21201  
410-767-8121  
shawkins@dhr.state.md.us

James Hedrick  
Treatment Liaison  
CSAFE Program  
1623 Forest Drive, Suite 203  
Annapolis, Maryland, 21403  
410-978-3253  
jrhedrick@dpacs.state.md.us

Delgracia Hendricks  
Department of Social Work Services  
Department of Public Safety & Correctional Services  
6776 Reisterstown Road, Suite 210  
Baltimore, Maryland 21215  
DBHendricks@dpacs.state.md.us

Jenny Howes, LCSW-C  
Forensic Programs Coordinator  
Office of Forensic Services  
8450 Dorsey Run Road,  
Jessup, Maryland 20794-1000  
410-724-3180  
Howesj@dhmh.state.md.us

Julia Jerscheid  
Consumer Advocate  
201 Federal Street #33  
Easton, Maryland 21601  
410-822-4917 home  
410-708-2516 cell

Steve Johnson  
FACTT Program Manager  
People Encouraging People, Inc.  
4201 Primrose Avenue  
Baltimore, Maryland 21215  
410.358.9570  
StephenJ@peponline.org

Sharon Lipford  
Executive Director  
Core Service Agency of Harford County  
206 South Hays Street, Suite 201  
Bel Air, Maryland 21014  
410-803-8726  
slipfordcsa@covad.net
Phyllis McCann  
Maryland States Attorneys Association  
Director, Forensic Prosecution Services  
Baltimore City States Attorney  
700 East Patapsco Avenue  
Baltimore, Maryland 21225  
410-878-8462  
PMcCann@stattorney.org

Darren McGregor, MS, MHS, LCMFT  
Director, Trauma and Jail Based Mental Health Programs  
Mental Hygiene Administration  
Office of Special Needs Populations  
8450 Dorsey Run Road  
Jessup, Maryland 20794  
410-724-3170  
mcgregord@dhmh.state.md.us

Indrani Mookerjee, LCSW-C., DSW  
Adult Services Coordinator  
Baltimore Mental Health Systems, Inc.  
201 E. Baltimore Street, Suite 1340  
Baltimore, Maryland 21202  
410-837-2647 x306  
imookerjee@bmhsi.org

Vickie Piontkowski, LGSW  
Neighborhood Defenders - Northwest  
Office of the Public Defender  
201 Saint Paul Place, 2nd floor  
Baltimore, Maryland 21202  
410-333-4900 x270  
VPiontkowski@opd.state.md.us

Daryl Plevy  
Project Director, Mental Health Transformation Grant  
55 Wade Avenue, Dix Building  
Baltimore, Maryland 21228  
410-767-0909  
Dplevy@dhmh.state.md.us

Linda Raines  
Executive Director  
Mental Health Association of Maryland  
711 W. 40th Street, Ste. 460  
Baltimore, Maryland 21211  
410-235-1178 Ext. 204  
lraines@mhamd.org

Richard Rosenblatt  
Assistant Secretary – Treatment Services  
Department of Public Safety & Correctional Services  
300 East Joppa Road  
Suite 1000  
Baltimore, Maryland 21286  
410-339-5031  
rrosenblatt@dpscs.state.md.us
Susan Steinberg  
Director, DHMH Office of Forensic Services  
201 W. Preston Street  
Baltimore, Maryland 21201  
410-767-0136  
ssteinberg@dhmh.state.md.us

Keisha Tatum, M.S.  
Adult/Older Adult, Health Policy Analyst  
Mental Health Transformation Mental Hygiene Administration  
55 Wade Avenue-Dix Building  
Catonsville, Maryland 21228  
410-402-8343  
ktatum@dhmh.state.md.us

Crista Taylor  
Director of Adult Services  
Baltimore Mental Health Systems  
201 E. Baltimore Street, Suite 1340  
Baltimore, Maryland 21202  
410-837-2647  
cctaylor@bmhsi.org

Sharon Tyler  
Baltimore County Department of Corrections  
Program Manager  
720 Bosley Avenue  
Towson, Maryland 21204  
410-512-3404  
stylern@co.ba.md.us

Deborah Weathers  
Program Analyst  
MD Dept. of Human Resources  
Family Investment Administration  
Office of Programs  
311 W. Saratoga Street  
6th Floor, Room 645  
Baltimore, Maryland 21201  
410-767-7994  
dweather@dhr.state.md.us

Donna Wells  
Howard County Mental Health Authority  
9151 Rumsey Road, Suite 150  
Columbia, MD 21045  
410-313-7350  
wells@hcmha.org

Beverly Wise  
Forensic Alternative Services Team  
100 Courthouse East  
111 N. Calvert St.  
Baltimore, Maryland 21202  
410-396-5013  
beverly.wise@courts.state.md.us
Community Mental Health Referral Form

Date of Referral:______________

Referral from:__________________________________ Phone:______________________ Fax:______________________
(Name of DPSCS Staff)

Referral to:______________________________________County/City:__________________Fax:______________________
(Name of CSA Staff)

---

Demographics

Inmate:                                                                                           Emergency Contact:

(Name)                                             (Name)
(Identification #)                                             
(DOB)                                                 (Relationship)
(age)                                                
(SS #)                                                

(Permanent address upon discharge)                                                
(City/State/Zip code)                                                

(City/State/Zip code)                                                
(Telephone)

If to be released to a temporary arrangement, please indicate where inmate will be referred:

- [ ] shelter___________________________________________
- [ ] crisis bed_________________________________________
- [ ] halfway house______________________________________
- [ ] family/friend______________________________________
- [ ] streets
- [ ] unknown

Gender: □ male □ female

Veteran: □ yes □ no

Military Discharge Date:__________________________

- [ ] Honorable
- [ ] Dishonorable
- [ ] Medical
- [ ] Other

If yes, name of program:__________________________

Previously received community mental health services:

- [ ] yes □ no

If yes, name of program:__________________________

---

Application for Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Yes</th>
<th>No</th>
<th>Date of Application</th>
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</thead>
<tbody>
<tr>
<td>Medicaid</td>
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<tr>
<td>Primary Adult Care</td>
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<td>SSDI</td>
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<td>SSI</td>
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<tr>
<td>Food stamps</td>
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<tr>
<td>Reason for no application, if applicable:</td>
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Incarceration Information

<table>
<thead>
<tr>
<th>Offense/Charge</th>
<th>Date</th>
<th>Length of Incarceration</th>
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<tbody>
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Expected date of release__________________________

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Inmate Name:________________________________________ ID # ________ DOB:______________

<table>
<thead>
<tr>
<th>Mental Health History</th>
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<tbody>
<tr>
<td>Current Psychiatric Diagnosis:</td>
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<tr>
<td>Axis I:</td>
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<td>Axis II:</td>
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<tr>
<td>Axis III:</td>
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<tr>
<td>Axis IV:</td>
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<tr>
<td>Axis V Current GAF:</td>
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<tr>
<th>Somatic Issues:</th>
<th>Somatic Medications:</th>
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<thead>
<tr>
<th>Community Mental Health Referral Needs</th>
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</thead>
<tbody>
<tr>
<td>Inmate Needs Referrals to:</td>
</tr>
<tr>
<td>- Outpatient Mental Health Clinic</td>
</tr>
<tr>
<td>- Residential Rehabilitation</td>
</tr>
<tr>
<td>- Mental Health Case management</td>
</tr>
<tr>
<td>- Medications</td>
</tr>
<tr>
<td>In order to process the referrals, all items checked below are included as supporting documentation with this referral form:</td>
</tr>
<tr>
<td>- Psychosocial assessment</td>
</tr>
<tr>
<td>- Psychiatric history including symptoms, response to treatment</td>
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<tr>
<td>- Psychological testing</td>
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<tr>
<td>- Current treatment plan and recommendation</td>
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<tr>
<td>- Physical health history</td>
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<tr>
<td>- Substance abuse history</td>
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<tr>
<td>- Recommended Service plan</td>
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<tr>
<td>- Admission summary</td>
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<tr>
<td>- Discharge summary</td>
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<tr>
<td>- Institutional Adjustment/Risk Assessment</td>
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<tr>
<td>- Current prescribed medications</td>
</tr>
<tr>
<td>- Medication lab work</td>
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</tbody>
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<thead>
<tr>
<th>Authorization of Disclosure for Mental Health Services*</th>
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</thead>
<tbody>
<tr>
<td>I, ________________________________, give my consent for the release of this form and the written Information checked above from ________________________________ to the ________________________________ (Name of DPSCS facility) (Name of Core Service Agency) for the purpose of arranging mental health referrals upon release. I further give my consent for the release of information from my community treatment provider to my DPSCS Parole and Probation Agent. This disclosure is effective for one year unless revoked by the applicant.</td>
</tr>
<tr>
<td>Signature of applicant:______________________________ Date:_________________________</td>
</tr>
<tr>
<td>Witness:________________________ Relationship to Applicant:________________________ Date:_________________________</td>
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</table>

*Information disclosed will be used only to arrange for mental health services upon your release and for no other reason. You do not need to sign to be referred for services; however your signature will help us to arrange for the services that are appropriate for you and that you need. The information may be re-disclosed to the agency where your services will be provided. This authorization for disclosure may be revoked by you in writing at any time. The agencies receiving information are bound by State and federal confidentiality laws. |

Updated: 9/5/08
# Mental Health Referral Confirmation

(Completed by CSA)

<table>
<thead>
<tr>
<th>Date: ______________________</th>
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<table>
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<tr>
<th>Inmate Name: ___________________  ID# _______  DOB: __________</th>
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<table>
<thead>
<tr>
<th>Referral Confirmation from: ___________________________  Jurisdiction: ___________________________</th>
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<tr>
<th>(Name of CSA Staff)  Telephone: __________________  Fax: __________________</th>
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<tr>
<th>Referral to: ___________________________  Telephone: __________________  Fax: __________________</th>
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<tr>
<th>(Name of DPSCS Staff)</th>
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## Outpatient Mental Health

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<thead>
<tr>
<th>Outpatient Mental Health Clinic: ___________________________  Contact Person: ___________________________</th>
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<table>
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<tr>
<th>Address: ___________________________  Telephone: __________________</th>
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<table>
<thead>
<tr>
<th>Date and Time of Appointment with Physician: ___________________________  Name of Physician: ___________________________</th>
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<th>(if known)</th>
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<table>
<thead>
<tr>
<th>Date and Time of Appointment with Therapist: ___________________________  Name of Therapist: ___________________________</th>
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<tr>
<th>(if known)</th>
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## Case Management

<table>
<thead>
<tr>
<th>Case Management Provider Name: ___________________________</th>
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<table>
<thead>
<tr>
<th>Contact Person: ___________________________</th>
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<table>
<thead>
<tr>
<th>Address: ___________________________  Telephone: __________________</th>
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<table>
<thead>
<tr>
<th>Date and Time of Appointment with Intake: ___________________________</th>
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## Residential Rehabilitation Placement

<table>
<thead>
<tr>
<th>Application Status:</th>
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<table>
<thead>
<tr>
<th>Accepted</th>
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<table>
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<tr>
<th>Status: ___________________________</th>
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<tr>
<th>Denied- Reason: ___________________________</th>
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## Appointment Confirmation

(Completed by: Maryland Department of Public Safety and Correctional Services)

<table>
<thead>
<tr>
<th>Inmate:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>□ Attended initial outpatient mental health/physician appointment: ___________________________  (Name of Clinic Staff)</th>
</tr>
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<table>
<thead>
<tr>
<th>□ Did not attend initial outpatient appointment</th>
</tr>
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<table>
<thead>
<tr>
<th>(Name of DPSCS Staff)  Date</th>
</tr>
</thead>
</table>

*Updated: 9/5/2008*