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Patrick Moran – President

**HB 658 – Maryland Department of Health –
Community Forensic Aftercare Program – Established
February 24, 2026**

Position: FAVORABLE WITH AMENDMENT

AFSCME Maryland Council 3 represents 55,000 public employees in varying levels of Government across Maryland, including the frontline staff at the Community Forensic Aftercare Program (CFAP). Our members who do this work support HB 658 and codifying the program in statute. However, as drafted, this legislation significantly expands operational requirements without providing the staffing, infrastructure, or clinical safeguards necessary to sustain public safety and program effectiveness.

CFAP, within the Maryland Department of Health (MDH) plays a critical and highly specialized role in protecting public safety while supporting the successful community reintegration of individuals found Not Criminally Responsible (NCR) or adjudicated Incompetent to Stand Trial (IST). As of February 2026, CFAP monitors 547 individuals statewide, mostly on Conditional Release following an NCR finding, and approximately 20 on pretrial IST supervision. In 2025 alone, 106 individuals were discharged from state facilities into the community under CFAP oversight.

CFAP's mission is twofold: safeguard Maryland communities and ensure individuals receive appropriate, least restrictive, clinically sound care. The proposed bill alters clinical decision-making authority, mandates rigid meeting structures, accelerates record-production timelines beyond current regulatory standards, and restructures the Community Monitoring Board (CMB) in ways that risk shifting its purpose from clinical oversight to adversarial litigation. Without additional resources and statutory refinements, these changes will strain an already overextended workforce and undermine the very outcomes the legislation seeks to strengthen.

CFAP's Current Capacity and Operational Reality

CFAP currently operates with:

- 9 full-time LCSW-C monitors
- 1 Supervisor
- 1 Manager
- 2 administrative staff (with one reassigned since September 2025 due to staffing shortages)

Caseloads average 61 individuals per monitor, well above best-practice forensic supervision ratios. Monitors maintain daily communication with community providers, assess psychiatric stability, evaluate treatment compliance, respond to emerging risk factors, and coordinate crisis interventions.

They draft all hospital warrants and extension paperwork, while the administrative staff processes and files time-sensitive court documentation through MDEC.

CFAP monitors frequently possess the most comprehensive understanding of an individual's psychiatric history, criminal background, risk factors, and court conditions. In many community meetings, CFAP clinicians are the most experienced and sometimes the only licensed clinicians present. Community providers often rely on rehabilitation personnel who may be unlicensed or bachelor's level staff (COMAR10.21.21.09C(3)). CFAP's clinical judgment, therefore, serves as a critical safeguard, ensuring decisions reflect both therapeutic needs and public safety considerations.

CFAP's work is not administrative monitoring; it is high-level forensic clinical oversight. The program exists to identify destabilization early, intervene before crises escalate, and avoid unnecessary returns to state hospitals while preserving public safety.

Impact of Mandated 90-Day Meetings

The bill requires mandatory 90-day meetings during the first year of community supervision. While well intentioned, this requirement is redundant and operationally unworkable without significant staffing increases.

On average, more than 100 individuals are discharged annually from state hospitals, excluding discharges from the SETT and Potomac Center. Even under current practices, monitors meet frequently with newly discharged individuals and adjust meeting frequency based on clinical need. This graduated approach reflects best practice in forensic rehabilitation: higher contact during destabilization risk, tapering as stability is demonstrated.

Mandating rigid 90-day meetings creates:

- Over 300 additional meetings annually for nine monitors
- Increased scheduling burdens for already understaffed community providers
- Reduced flexibility to prioritize high-risk cases
- Diversion of time from crisis intervention and individualized care

The result would not be enhanced oversight but diluted attention across all cases.

Ensuring compliance with this mandate would require additional monitors, at least one additional supervisor, and increased administrative support for scheduling coordination. Without such staffing, the mandate risks becoming a box-checking exercise rather than meaningful clinical engagement.

Record Production Requirements

The bill requires records to be provided within 24 hours to four business days. CFAP receives an average of 18–20 record requests per month. Under current staffing, CFAP strives to deliver records within 10 days, consistent with Maryland regulatory standards (Md. Code Regs. § 14.09.16.09).

A 24-hour turnaround, particularly for urgent requests, requires:

- Immediate record retrieval
- Clinical review for accuracy and appropriateness
- Administrative processing
- Secure electronic filing



With only two administrative staff (one reassigned), compliance would be unfeasible without additional personnel. Imposing unrealistic timelines risks errors, incomplete production, and diversion of clinical staff from direct safety functions.

Community Monitoring Board (CMB) Changes

The proposed restructuring of the Community Monitoring Board introduces significant operational and philosophical concerns.

Quorum and Membership Requirements

Mandating an odd number of members and a guaranteed quorum is impractical amid statewide clinical staffing shortages. Forensic clinicians are already in limited supply. Delays in convening boards due to quorum failures would disrupt time-sensitive decisions regarding conditional release modifications, hospital returns, or stabilization plans.

Authorized Agent Participation

Allowing an authorized agent or legal advocate to attend board and community intervention meetings risks transforming clinical intervention meetings into adversarial proceedings.

Community providers already maintain their own internal processes and ethical obligations for advocating for patients' rights and ensuring compliance with treatment standards. The insertion of legal advocates into routine clinical intervention meetings risks influencing or disrupting those established clinical advocacy processes in ways that are neither necessary or appropriate within a treatment-based setting.

In the community setting, intervention meetings are often urgent and time-sensitive. Delays caused by coordinating legal attendance could impede rapid response to destabilization—directly affecting public safety.

CMB meetings are designed as clinical review forums, not evidentiary hearings. Their purpose is therapeutic oversight and rehabilitation planning. The presence of legal advocates may:

- Shift the discussion from clinical stabilization to litigation positioning
- Inhibit open clinical dialogue
- Undermine therapeutic alliance
- Create scheduling delays as legal representatives coordinate availability
- Increase administrative complexity

Additional administrative staffing and scheduling infrastructure would be required to manage authorized-agent notifications, written meeting records, breakout sessions, and documentation compliance.

Clinical Decision-Making Authority

Perhaps most concerning, the bill reduces CFAP monitors' ability to exercise independent clinical judgment.

CFAP clinicians integrate:

- Comprehensive psychiatric history
- Criminal and forensic risk profile
- Community provider input
- Statutory and court requirements

Community providers may appropriately advocate for client-centered goals. However, CFAP's statutory role is broader: to balance rehabilitation with public safety. Limiting their discretion weakens the safety net that has historically prevented destabilization and recidivism. Clinical decisions in forensic contexts cannot be reduced to procedural mandates. They require professional judgment informed by experience and risk assessment expertise.

Fiscal and Public Safety Implications

Absent additional staffing, the bill will:

- Increase burnout and turnover among specialized forensic clinicians
- Delay crisis responses
- Reduce individualized oversight
- Increase hospital readmissions
- Heighten liability exposure
- Potentially compromise public safety

Conversely, targeted investment in staffing would allow the General Assembly to strengthen CFAP while preserving its clinical integrity.

Required resources include:

- Additional LCSW-C monitors
- At least one additional CFAP Supervisor
- 1 additional administrative staff
- Dedicated administrative support for board coordination
- Part-time forensic psychologist and psychiatrist support

Without these positions, statutory expansion becomes an unfunded mandate with foreseeable operational stain.

Recommendations for Legislative Action

1. Codify CFAP in statute with explicit recognition of its clinical discretion.
2. Condition implementation of 90-day meeting mandates on funded staffing increases.
3. Align record-production timelines with existing regulatory standards or provide funding for additional administrative personnel.
4. Clarify the clinical not adversarial purpose of Community Monitoring Board meetings.
5. Avoid quorum and structural requirements that exceed current staffing capacity.
6. Ensure cross-agency discharge communication requirements are codified for all state facilities.

Conclusion

CFAP is a cornerstone of Maryland's forensic mental health system. It protects communities while advancing recovery for individuals transitioning from secure facilities to community life. Its success rests on clinical expertise, flexible risk management, and rapid response capacity.

Legislation that expands procedural requirements without expanding resources risks weakening that foundation.

The General Assembly has an opportunity to strengthen CFAP to enhance both public safety and rehabilitation outcomes. Doing so requires aligning statutory mandates with operational realities and ensuring the workforce has the support necessary to carry out this complex, high-stakes work.

AFSCME Maryland Council 3 stands ready to work collaboratively with legislators to ensure this bill achieves its intended goals without unintended consequences for Maryland's communities or the frontline professionals entrusted with their safety.

