



CHANGING
Maryland
for the Better

Forensic Services Work Group:

Report of Recommendations

August 31, 2016

Prepared by Stephen B. Goldberg, MD, Forensic Services Work Group Facilitator
stephen.goldberg@yahoo.com

Abstract

The Forensic Services Workgroup was charged with developing concrete recommendations on how to reduce unnecessary congestion in Maryland's State Hospital System by providing improved efficiencies, maximizing appropriate throughput and providing for immediate system relief, as well as making longer-term recommendations that may require significant system-wide changes to prevent a similar backlog from occurring in the future. This reports captures the recommendations made by the Workgroup as a result of their deliberations.

Overview

The Forensic Services Workgroup was convened by Maryland’s Secretary of Health and Mental Hygiene, Van T. Mitchell, to address stakeholder concerns regarding significant delays associated with court involved individuals navigating through Maryland’s forensic system of care.¹ Community stakeholders were identified to include the Judiciary, Prosecutors, Public Defenders, community providers, consumers and advocates for the individuals with mental illness. The longstanding issues the Workgroup were asked to address included, but were not limited to, the lack of availability of State Hospital beds to complete court ordered forensic evaluations and honor court commitments within statutory time requirements²; the length of time it takes for individuals assessed as ready for release following their commitment by the courts to return to court for disposition; appropriate placement of incarcerated individuals ordered for evaluation and assessed, but not yet adjudicated as incompetent; and the impact on state facility staff from state hospital census’ consistently being at or above maximum capacity, managing a predominantly forensic (vs. civil) patient population and not being staffed nor compensated based on a “forensic” classification. Additionally, responsibility for aftercare if/when hospital level care is no longer necessary or appropriate, management in the least restrictive environment and a lack of a consistent and reliable policies on how to manage individuals throughout the continuum of care have also been areas of significant concern over recent years.

The reported problems associated with Maryland’s Forensic Services delivery system have been evolving over many years, thus several stakeholders have grown weary of the processes historically associated with trying to identify the root causes of the issues and the proposing of solutions to those problems. Understandably, some stakeholders have developed strong feelings about how these problems should have been addressed then and how they should be addressed now. Secretary Mitchell acknowledged, in a letter dated April 28, 2016 to the Honorable Mary Ellen Barbera that the Department was in the midst of a “crisis” in regards to the forensic mental health delivery system. Although multifactorial in nature with known and unknown consequences impacting numerous individuals and agencies, one of the most visible issues has been the inability for the Department to respond to court orders for commitment³ within statutory timeframe requirements due to a lack of available inpatient beds.

However, this “lack of space” has been attributed by many to be not just due to the absolute number of inpatient beds within the Department of Health and Mental Hygiene (DHMH), but also from the consequences of a disjointed system that, over many years, has created bottle necks at every point within the system; from initial evaluation to release to the community, and virtually every step in between.

Secretary Mitchell, recognizing the serious nature of the problem, convened the Forensic Services Workgroup to “develop a series of system-wide actions designed to manage the census while maintaining a high quality of care.” The Workgroup was charged with developing concrete

¹ “Forensic” for purposes of this report, includes adults committed to the Department for evaluation and /or treatment pursuant to competency to stand trial and criminal responsibility statutes, Title 3, Criminal Procedures, Ann. Code of Md, and pursuant to substance and alcohol abuse statutes, Health General §§ 8-505- 8-507, Ann. Code of Md

² See Maryland’s Criminal Procedure, Title 3 for details on and statutory time requirements

³ Includes commitments for *evaluations* as to criminal competency and criminal responsibility as well as commitments pursuant to *findings* of incompetence or not criminally responsible

recommendations on how to reduce unnecessary congestion in the system by way of improved efficiencies, maximizing appropriate throughput and providing for immediate system relief, as well as making longer-term recommendations that may require significant system-wide changes.

The Forensic Services Workgroup was made up of a diverse group of Secretarial Appointees and included representative from the Judiciary, Public Defender's Office, State's Attorney, community providers, consumers and advocates. All were identified leaders who are active within Maryland's mental and behavioral health community and who share the common goal of improving Maryland's Forensic Services delivery system.

It is important to note that the issues facing the workgroup were not new problems for Maryland nor was this Maryland's first attempt to identify, quantify and/or seek recommendations to improve the forensic system. Most recently, a December 2014 report, the "Joint Chairman's Report, Page 78 – Treatment and Service Options for Certain Court-Involved Individuals," made specific recommendations to the State for court involved individuals. A Judicial Commentary echoed the primary recommendations of that report, with additional emphasis on the statutory requirements for admission to Department facilities and referenced another previous report, Cannon Design's "Independent Study on Future Demand for State-Operated Psychiatric Hospital Capacity," to further highlight the need for additional bed space within the Department. Other groups/taskforces, such as the HB 281 Workgroup, Maryland Continuity of Care Advisory Panel, the Outpatient Services Programs Stakeholder Workgroup and others, have attempted to address many issues that overlap with the concerns of this workgroup and some of their work product will be referenced below.

Meeting Schedule

The workgroup was to hold 4, two-hour public meetings, on the following schedule:

Meeting 1: June 23, 2016

Meeting 2: June 30, 2016

Meeting 3: July 7, 2016

Meeting 4: August 4, 2016

Meeting Location

Maryland Department of Transportation Building
7201 Corporate Center Drive
Hanover, MD 21076

Compliance with Maryland's Open Meeting Act

Meeting times and locations, as well as all meeting materials and public/member comments, were made available in compliance with Maryland's Open Meeting Act.

Attendees⁴

Workgroup Facilitator:

Stephen B. Goldberg, MD

Workgroup Members in Attendance:

Judge Sheila Tillerson Adams, Lynda Bonieskie (representing Pat Goins-Johnson), Laura Cain, Delegate Dumais, Lauren Grimes, Roger Harrell, Pat Goins-Johnson, Paula Langmead, Helen Lann, MD, Judge George Lipman (representing Judge John Morrissey), Kelley O'Connor (representing Judge Sheila Tillerman Adams), Daniel Malone, Dale Meyer, Captain Michael Merican, Judge John Morrissey, Mary Murphy, Randall Nero (representing Pat Goins-Johnson), Clarissa Netter, Mary Pizzo, John Robison, Rick Rock, Judge Ronald Silkworth (representing Judge Sheila Tillerson Adams), and Crista Taylor

DHMH Representatives in Attendance:

Barbara J. Bazron, PhD, Sarah Cherico, Shauna Donahue, Kathleen Ellis, Rachael Faulkner, Chris Garrett, Gayle Jordan-Randolph, MD, Christi Megna, Cathy Marshall, Secretary Van Mitchell, Erik Roskes, MD and Allison Taylor

⁴ Includes all individuals who attended as an officially appointed Workgroup Member (or as a designee of same) at one or more of the four meetings

Recommendations

The charge of the Forensic Services Workgroup was to develop concrete recommendations for immediate system relief that will reduce unnecessary congestion in the system by way of improved efficiencies, maximizing appropriate throughput and significant system-wide changes. However, in a group this size, addressing a decades-old problem from differing perspectives, with members from multiple professional disciplines, will elicit significant variability both in perspective and solution. And, although it is desirable and necessary to get input from multiple stakeholders, universal agreement on all recommendations is unlikely and unrealistic. Thus, although there was significant agreement on each of the recommendations that follow, it is important to note that not every group member fully endorsed every recommendation. There are some members who believe that the only relevant recommendation is for more bed space and others felt that the impact of some of the recommendations that address inefficiencies at other points in the continuum would have a negligible impact on movement within the system. Additionally, several group members expressed frustration about the scope of focus of the Forensic Services Workgroup and felt it not to be broad enough.

That being said, it would be difficult to proceed on to a discussion about any other recommendation without first acknowledging the need and expectation from 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.

Another critical issue that impacts the forensic population’s throughput through the forensic services system, referenced often during the course of the four meetings, but not discussed at any length was the issue of safe and affordable housing as it causally relates to entry into and exit from the State’s Hospital system. Although outside the scope of this Workgroup, the need for accessible housing has been shown to be a critical component of any successful program whose target population has significant homelessness issues and is worthy, in and of itself, of additional resources to explore solutions.

Despite these expressed concerns and upon the request of Secretary Mitchell at the outset of the Workgroup, the membership, in good faith, with professionalism and appropriate passion, utilized this opportunity to discuss the issues and make the following recommendations.

Recommendation 1 – Increase bed capacity within DHMH

The 2014 Joint Chairman Report (the JCR of 2014) recommended a 10 percent increase over the then current level of beds (100 beds), but only if DHMH was unable to partner with private sector to use their beds and decrease their length of stay (emphasis added). This was a polarizing point of discussion throughout the meetings. It was argued by some members that the actual number of inpatient and Step-down Unit beds needed to run the system conscientiously and within statutory requirements cannot be determined without knowing the impact of the other efficiencies, while others cited the 2012 and 2014 reports as proof of the need.

Although the number of actual beds needed remained contentious, the overwhelming majority of the membership did agree about the need for “some” more beds. Furthermore, the Workgroup membership expressed universal agreement that if more beds were made available without concurrent changes to the system, the same inefficiencies and bottlenecks that contributed to the current bed shortage would ultimately result in future bed shortages. Therefore, any recommendation for an increase in bed capacity must also be accompanied by the recommendations that follow, which are intended to also address length of stay factors in a positive way. These include, but are not limited to the availability of Step-down Unit beds, efficient movement within the DHMH inpatient system, adequate outpatient forensic services so that release to the least restrictive setting is possible, crisis services to reduce the number of individuals entering into or returning to the system and adequate hospital staffing with appropriate training and compensation to maximize the effectiveness of the hospitalization itself.

1A. Immediate opening of 24 inpatient hospital beds (one unit), initially on a temporary basis, to address current backlog of court committed individuals

- DHMH to determine most appropriate location of unit
- Newly formed Forensic Steering Committee (see recommendation 5A, below) to:
 - Determine priority admissions from current back-log
 - Set realistic goals with each jurisdiction to “catch-up” on current backlog without falling further behind on new commitments
 - Duplicate what’s working well in successful jurisdictions

1B. Rapid creation of 24 “Step-down” beds within existing DHMH infrastructure thus allowing for the transfer of appropriate patients from the inpatient level of care

- Although this too will add additional costs, it will add more capacity and operate at a lower cost than another inpatient unit
- Adds to the number of inpatient beds immediately available for backlog of court committed individuals
- Eligibility for transfer to be determined by Forensic Steering Committee (5A below)

1C. Expedited contracting with community-based hospitals/systems to use private sector psychiatric beds

- Flexible contracting to allow for expansion and contraction of use based on need
- Forensic Steering Committee (5A below) to establish the patients for whom this type of setting would be most appropriate

- Eligibility for transfer to be determined by Forensic Steering Committee (5A below)

1D. Expedited re-assessment of actual bed needs

- Re-examine need for additional beds (both inpatient and Step-down) after the improvements associated with the beds added from 1A, 1B and 1C (above) and the gains in efficiency associated with Recommendations 2 – 6 (see below) have been realized

Recommendation 2 – Increase availability of Community Crisis Services

Throughout the discussions of the Forensic Services Workgroup, the importance, effectiveness and positive impact of community crisis services was a consistent theme. However, any discussion of community mental and behavioral health services in Maryland must include an acknowledgment of the role of the Maryland Association of Core Service Agencies (MACSA)⁵ to appreciate the intricacies of the system and to effectively integrate their involvement in operationalizing any mental and behavioral health recommendations that impact the communities they serve.

The membership of the Workgroup did agree that providing appropriate and timely care to individuals in crisis in the community reduces the risk of harm to self and others as well as reducing the risk of entry/re-entry into the criminal justice system. In fact, the Outpatient Services Programs Stakeholder Workgroup’s final recommendation is echoed by this Workgroup in regards to the need to enhance crisis services statewide.

2A. Immediate statewide assessment of currently available crisis services

- Define what is to be included in the spectrum of “crisis services”
- Mapping jurisdiction by jurisdiction crisis service needs has already been done by the Core Service Agencies and their work product should be updated, rather than starting the process de novo.
- Assess existing, active programs only to maximize speed of implementation of 2C, below

2B. Rapid determination of which active crisis services programs are most effective in responding to crises in a way that minimizes entry/re-entry into the criminal justice system

- Utilize existing data to make determinations
- Extrapolate when facing incomplete or missing data

⁵ The Maryland Association of Core Service Agencies (MACSA) is the non-profit organization comprised of Maryland’s Core Service Agencies (CSA), Local Addictions Authorities (LAA), and Local Behavioral Health Authorities (LBHA). Their agencies are responsible for planning, managing, and monitoring public behavioral health services at the county level.

- Include criminal justice and consumer partners in determination of what is considered “effective”

2C. Expedited funding support through budget reallocation/additional budget allocations with additional resources going to support those community crisis services determined to be most effective

Recommendation 3 – Expand the capacity of the Office of Forensic Services

The Office of Forensic Services is the entity within DHMH 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. They must coordinate with the outpatient evaluators, detention center personnel (both officers and contracted medical providers), State Hospitals, community-based hospitals and courts from every jurisdiction to ensure statutory compliance with all court orders and reporting requirements.

Herein lies an opportunity for improved efficiency across the system as the Office of Forensic Services is in the unique position within the state to be able to track data related to the provision of all forensic services, across all jurisdictions. The collection of this data has been identified as critical to judicial determinations, defense strategies and prosecutorial approaches, as well as in the assessment of the effectiveness of forensic evaluators, timeliness of evaluations, response to hospitalization, time to court following re-evaluation, as well as many, many other data points that have a direct impact on budgetary allocations, policy decisions and assessments of programmatic effectiveness.

The JCR of 2014 identified the urgent need to capture this data electronically and recommended that DHMH “expedite the building of the forensics database as soon as possible.” Likewise, other statewide workgroups, including the HB 281 Workgroup and the Maryland Continuity of Care Advisory Panel have identified the importance of accurate and comprehensive electronic data collection. The JCR of 2014 also recommended outcome measures to assess the performance of the Office of Forensic Services. This too is accomplished through consistent, appropriately defined data collection followed by regular and meaningful review of that data.

3A. Immediate Increase in the number and efficiency of forensic services staff

- Increase the number of outpatient evaluators and/or increase the use of telehealth to ensure timely evaluations in all jurisdictions and settings (detention, hospitals, etc.)
- Increased capacity for case management of court involved individuals receiving community treatment (will have added benefit of providing support to outpatient providers – see Recommendation 4A below)
- Staff at sufficient numbers to allow for initiation of manual data collection and limited data analysis until electronic systems are in place
- Establish minimum training standards
 - Ensure consistent application of dangerousness standard

- Utilize standardized report formats to ensure delivery of a consistent product that can be objectively audited, evaluated and compared across jurisdictions for quality

3B. Rapid restructuring of DHMH chain of command to fully integrate the management, delivery of services and the reporting of findings to the court under the Office of Forensic Services

- Central coordination of all statewide forensic services is necessary to ensure adequate resources are available to jurisdictions as they are needed. This includes the capacity for redeployment of evaluators at times of increased demand in particular jurisdictions.
- Hospital bed space (over 90% of which is forensic) utilization to be determined by Forensic Steering Committee, chaired by Office of Forensic Services designee (see 5A below), utilizing standardized admission criteria to ensure appropriate and equitable availability of beds to all jurisdictions. To be based on:
 - Order of request
 - Individual patient needs
 - Judicial and statutory requirements and
 - Clinical acuity
- Requests of the court for time extensions to be standardized and reviewed prior to submission to ensure the extension requests are clinically driven rather than the result of inadequate resources
- Tracking of hospital-based aftercare planning for committed individuals to ensure
 - Aftercare planning is adequate and timely as to meet statutory requirements and
 - Individual rights for release to the least restrictive environment
- Return to court requests are tracked to ensure they are accomplished as quickly as possible, thus maximizing throughput out of the hospital
- Active participation in the newly formed weekly Forensic Steering Committee (see recommendation 5A, below).
 - Ensure that all cases nearing or already past statutory time requirements are tracked weekly to maximize efficient resolution
 - Follow outlying cases weekly
 - Resolution is coordinated with each individual jurisdiction
 - Maximizes compliance with statutory requirements
 - Cases deemed ready to return to detention can be assessed for individual needs, their jurisdiction's detention center's capacity to meet those needs and the potential, in limited situations, for resource sharing amongst local detention centers when the designated detention center is unable to meet those needs

3C. Expedited review of newly generated data to determine where to place existing resources and evaluate the need for additional resources, including inpatient and Step-down Unit bed space needs

Recommendation 4 – Increase outpatient provider capacity to meet the needs of forensic patients

One of the most significant “bottlenecks” identified in the discussions of the Workgroup centered on the need to improve access to outpatient services for justice involved individuals. These individuals tend to be high utilizers of service, but often struggle to get the services they need in the community. Ultimately, this puts them at greater risk of further decompensation and increases the likelihood that they will re-enter or remain longer in the forensic system.

In addition to the general shortage of mental health professionals that limits access to care for all individuals with mental illness, there are additional barriers for the forensic population that further limits their access to outpatient providers. They include stigma towards this specific group, but also reasonably founded concerns about the additional workloads associated with this population, increased personal risk and/or increased liability treating those with a known history of violence, as well as the potential for negative impact on a clinic’s/provider’s reputation in the event there was a publicized negative outcome.

The need to address this gap in services has also been addressed by numerous statewide groups, including the JCR of 2014, in Recommendation 6, where it identified the need to develop specialized approaches to manage high utilizers. The Outpatient Services Programs Stakeholder Workgroup emphasized the need to enhance funding and support for Assertive Community Treatment (ACT) in their recommendations and the HB 281 Workgroup and Maryland Continuity of Care Advisory Panel also recognized this issue as a significant barrier to treatment. The Judiciary Commentary to the JCR of 2014 further highlighted the impact this lack of available services has on case dispositions.

Ultimately, this gap in services has a profound negative impact on individuals as well as upon the system that is in place to help them. It does not require further study to recognize this lack of available services has a direct impact on bed space within the system in two obvious ways. First, less available services in the community results in increased symptomatology, which leads to an increased chance of involvement with the criminal justice system, which then leads to increased utilization of forensic beds. In addition, it further criminalizes individuals with mental illness, places more strain on the local detention centers that must care for these individuals and causes unnecessary pain and suffering for those who get caught up in the system. Second, the gap in available outpatient services for the forensic population creates a bottleneck within the hospital, delaying release for those who no longer require that level of care; thus, preventing that bed from being utilized by someone with acute clinical and legal needs.

4A. Immediate increase in support to existing providers who already accept forensically involved patients

- Provide training specifically geared towards management and treatment of forensic patients in an outpatient or residential setting
 - Make the training available on-line to maximize utilization
 - Offer it at no cost to providers who are providing or wish to provide services to this population

- Make legal support services and guidance available, at no cost, to outpatient forensic providers in the form of:
 - Consultations for liability concerns
 - Advice on how to effectively document encounters with problematic patients
 - Legal steps necessary to properly discharge, legally charge or seek protection from a patient
 - Clarify reporting requirements
- Enhanced case management capacity from the Office of Forensic Services (Recommendation 3A, above) will also provide support for providers who must navigate through the forensic landscape.

4B. Rapid assessment of outpatient provider reimbursement structure

- Identify specific diagnostic codes not currently reimbursed (i.e. PTSD)
- Determine rate of reimbursement necessary to make treatment less costly and more attractive to providers by accounting for:
 - Longer appointments and/or higher no-show rates
 - Increased documentation and reporting requirements associated with their care
 - Increased liability concerns
- Additional coding to expand reimbursable services
 - Report writing
 - Court time
 - Pre-visits to detention/prison prior to release from confinement
 - Peer support programs
- Consider adding a “non-discrimination” clause to for those providers who receive any state funds
 - Cannot discriminate against this particular population by choosing not to serve them
 - Eligibility dependent upon “open door” policy
 - Exceptions possible

4C. Expedited increase of rates of reimbursement and the types of services that are reimbursable

Recommendation 5 – Centralize DHMH Forensic Processes

Maryland’s Department of Health and Mental Hygiene (DHMH) has undergone many changes over the last 30 years, as had mental health treatment in general across the entire United States. Although there have been positive advances in medication treatment, best clinical practices and public awareness, there has also been holistic system-wide changes such as deinstitutionalization from the 1980’s, the proliferation of managed care in the 1990’s, continued loss of state mental health hospital beds in the 2000’s and a dramatic change in the percentage of public mental health inpatient beds occupied by forensically involved persons⁶. And, although many administrations,

⁶ In Maryland, the ratio of beds occupied by forensic vs. civil patients has changed from 38% forensic to over 90% forensic in less than 15 years.

legislative bodies and workgroups have tried to limit the negative impact of these changes, there has still been resultant gaps in treatment services, particularly for the forensic population, which is highlighted by the current inpatient psychiatric bed crisis within DHMH.

One characteristic of a successful treatment system is the ability to maximize the use of available resources by employing effective processes that ensure consistent delivery of services in the face of dynamic and often unpredictable demands. This can only be accomplished through centralized proactive management. DHMH can address many of the issues discussed throughout the Workgroup's meetings and within this report by centralizing its management of both the forensic and hospital system, to include centralized admission, discharge and transfer policies; regular and coordinated communications with the Judiciary, Public Defenders and the Office of the State's Attorney for justice involved patients; and consistent channels of communication and support for community providers that accept forensically involved persons.

5A. Immediate centralization of all processes related to the delivery of forensic services

- Establish a Forensic Steering Committee
 - Chaired by the Office of Forensic Services
 - Membership to include a state hospital representative as well as representatives and/or liaisons from the Judiciary, Office of the Public Defenders and State's Attorney
 - Attendance from various jurisdictions dependent upon jurisdictional need
 - Those jurisdictions with active cases beyond statutory limits will be more likely to participate
 - Weekly review of all cases approaching or that are already outside of statutory time limits
 - Orders for evaluation and/or commitment
 - Pending releases
 - i. Returns to court
 - ii. Conditional releases
 - iii. Discharges
 - Consider medical necessity and least restrictive environment
 - Reallocation of resources across counties to address issues as they arise (i.e., redeploy evaluators to counties/hospitals that have evaluation requests that exceed capacity)
 - Consider expungement and other special circumstances, when possible, to maximize likelihood of a timely release for those deemed appropriate
 - Maintain a consistent schedule to maximize effectiveness
 - Same day of week, time of day and call-in number
- Develop unified admission, discharge and transfer policies that apply to all hospitals within DHMH
 - Consistent with statute⁷

⁷ See Maryland's Health General and Criminal Procedure for details on statutory requirements

- Promote coordination amongst all hospitals within the State Hospital system to maximize efficiency
- Do away with hospital “catchment” areas
 - An open bed is an open bed
 - Do not duplicate specialty units in each facility (i.e. a designated geriatric or medical unit that serves the entire state, rather than a similar unit in each hospital)
- Expand admission policy to include specific criteria to be considered for Clifton T. Perkins Hospital Center
- Develop a transfer policy to include all movement
 - Within a hospital, from one level of security to another
 - Between hospitals
 - To a “step-down unit” and
 - To and from detention/prison
- Single point of contact for all jurisdictions (for use by Courts, PD, SA; and DHMH to identify contact in each jurisdiction for two-way communication with DHMH)
- Identify a DHMH/BHA representative with authority to make special financial allowances for individual cases that have a willing community provider(s), but which may require creative funding to achieve rapid discharge, when appropriate
- Consider “non-binding” Utilization Review as a way to have objective, outside input into process

5B. Rapid reassessment and reclassification of staff at all State Hospitals to a “forensic” classification

- Recognize that, due to the overwhelming percentage of forensic patients in all of the regional hospitals, all State Hospitals are forensic in nature
- Staffing levels to be adjusted as to be appropriate to manage a forensic population
- Compensation consistent amongst all forensic staff, regardless of which hospital at which they work (currently higher rates for CTPHC)
- In-service training provided that is consistent with the forensic mission

5C. Expedited implementation of salary and staffing changes

Recommendation 6 – Increased education to reduce stigma in both the general public and the mental health treatment community

The impact of stigma cannot be overstated and its insidious consequences can only be overcome through education. Stigma, however, is not just limited to the general public. Unfortunately, stigma also impacts mental health professionals in both direct and indirect ways. Workgroup members were unanimous in their agreement that increased education would be helpful to reduce stigma in all settings.

6A. Immediate inclusion of anti-stigma education for providers who receive training as per Recommendation 4A, above

6B. Rapid development/expansion of public anti-stigma educational programs, including use of Crisis Intervention Training (CIT) for police and first responders.

6C. Expedited inclusion of anti-stigma educational funding in next budget cycle and state support to pursue grant funding

Other Potential Recommendations discussed, but for which no clear consensus could be reached, include:

- Medication over objection in settings other than a hospital
- Increased use of Psychiatric Advanced Directives
- Privatization
 - Outpatient court ordered evaluations
 - Inpatient hospitalization
 - Step-down unit management and oversight
 - Outpatient competency restoration