Forensic Services Workgroup
Minutes – Meeting 2
June 30, 2016

Workgroup Facilitator: Dr. Stephen Goldberg

Members in Attendance: Judge Sheila Tillerson Adams, Laura Cain, Delegate Dumais, Pat Goins-Johnson, Lauren Grimes, Roger Harrell, Paula Langmead, Dr. Helen Lann, Daniel Malone, Captain Michael Merican, Judge John Morrissey, Mary Murphy, Clarissa Netter, Mary Pizzo, John Robison, Rick Rock, and Crista Taylor

DHMH Representatives in Attendance: Dr. Barbara Bazron, Shauna Donahue, Kathleen Ellis, Rachael Faulkner, Dr. Gayle Jordan-Randolph, Christi Megna, Cathy Marshall, James Pyles, and Dr. Erik Roskes

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Introduction of New Members

Dr. Barbara Bazron, Executive Director for the Behavioral Health Administration, announced that there were new members added to the Workgroup since the previous meeting: Danial Malone, Assistant Attorney General for DHMH, and Mary Murphy, one of three individuals added to represent the Maryland State's Attorneys Association on a rotating basis. The other two members are Gina Cirincion and Scott Shellenberger.

Meeting 1 Review

Dr. Stephen Goldberg, Workgroup Facilitator, reviewed the meeting process and emphasized that due to time constraints, he would have to keep the discussion within the allotted time. Workgroup members and the general public in attendance were also reminded of the deadline and importance of using the online form to submit all comments and homework in between meetings. The deadline is COB the Monday prior to each session.

The members then proposed revisions to the minutes prior to being approved. Those modifications are included in the revised minutes which will post on the website.

There was a question raised regarding the availability of having the agenda prior to meetings. It was explained by Dr. Goldberg that the agenda would not be available prior to meetings due to the likelihood that last minute edits that may needed.

Forensic Flow Chart and identified "Bottle-necks" / Barriers to use of Community-based Resources/Programs/treatment

Dr. Goldberg provided a PowerPoint presentation that began with a review of the charge to the Workgroup that was presented at the first meeting. Several concerns were raised by participants regarding the omission of certain items on the agenda including: the availability of getting into a hospital on the agenda and the role of DHMH on the flow chart.

Dr. Goldberg asked the group to identify places within the forensic service flow where bottlenecks occur. During the bottle-neck discussion, several comments and issues were raised, including:

- Individuals are provided treatment in Emergency Departments and then discharged without follow up - "treated and streeted"
- There is inconsistency in the application of the "dangerousness" standard among hospitals
- Reliance on calling the police due to a lack of community resources
- Central booking is faster than the ER evaluation and commitment process
- Most, if not all, non-state hospitals can take forensically involved individuals
- Most police will only take an individual under arrest to the hospital if they have a somatic medical injury
    - Some diversion programs/initiatives such as CIT-trained law enforcement officers will take individuals with mental health conditions to the hospital as well
- Those arrested for committing a serious crime have to be taken to detention
- Some, but not all, hospitals have specialized psychiatric units or services to provide evaluations on site
- There are two groups of individuals that are arrested: those who commit serious crimes and those who commit minor crimes where a family member or friend may have been the one who notified police in order to assist the person with the mental illness
- Individuals not taking medication should not be arrested
- Timeliness of evaluations for competency
    - There is a requirement in statute that an evaluation for competency be done in seven days, and that the court hold a hearing within 30 days of either getting a motion from one of the parties or receiving an updated report from DHMH
    - Dr. Roskes stated his belief that Maryland is the only state that requires proof of competency beyond a reasonable doubt
- Dr. Roskes states that if a person is found competent, it may take a long time (days to weeks to, occasionally, months) to return the case to court for resolution of an incompetency commitment. In some cases, where the case is before a mental health court or designated mental health judge, the case may move more quickly. It may be more difficult to get people scheduled back into all circuit courts. (restated by multiple members throughout the discussion)
- A consumer advocate referenced a 2012 report, stating that patients at Spring Grove Hospital Center could not get timely court hearings
- The Department's AAG stated that the statute is unclear with regard to "return to court"
- There is a problem with people assessed by an evaluator as not competent who are then sent back to jail to wait for placement
- There was a difference of opinion by members on the length of time it took a patient to "return to court"
- A member of the Judiciary stated that the Workgroup may need to hear from smaller jurisdictions who may have trouble returning people to court
- Once assessed as competent, it is difficult to get patients out of the hospital (stated in different ways by multiple members, including DHMH representatives and consumer advocate, throughout the discussion)
- There are not enough aftercare community providers willing to take forensically involved patients
- There is little community support services available for forensic patients, in part due to stigma
    - Providers are reluctant to take forensic patients because neighborhoods where residential providers are located are opposed
    - Associate "forensic" with "violent"

  - Includes stigma in employment, not just housing, when an individual has an arrest record
  - Providers may have trouble maintaining insurance if they serve forensic patients (i.e., fire setting, etc.)
  - Providers concerned that if something happens, it will by posted/aired by press, which could ruin the provider's reputation
- There are additional costs associated with having a forensically-involved patient and there is not an enhanced rate structure to support it
- If a provider has a problem with a forensic patient, there is not a mechanism to get them back into a higher level of care or receive diversion services
- The existing crisis response is not comprehensive enough
- Adjudication is tied to the availability of services with judges determining what is an appropriate aftercare plan
  - This was followed by a discussion on how aftercare plans are determined and the necessity of having one prior to adjudication
- DHMH is not accepting people ordered by the judiciary for immediate hospital placement in a timely manner
- Problem identifying housing for individuals with co-occurring conditions

During this discussion, both Dr. Gayle Jordan-Randolph and Dr. Barbara Bazron stated that it is essential that data be collected and analyzed to determine outcomes. They both asked the Workgroup to identify what data elements should be used to assess system performance. It was also stated that DHMH began a focused effort to review in-patient data to determine which current patients were ready for discharge. As a result, 20 patients have been discharged from the hospitals since March. However, the Department has had trouble transitioning patients who have serious convictions and those with complex physical health care needs.

<u>Individual recommendations raised during this discussion included (recommendations were from individuals, not group recommendations)</u>:

- Telehealth resources could improve efficiencies in providing evaluations, etc.
- Having additional evaluators may have an impact and be a less expensive component in the service continuum
- Standard of proof for competency beyond a reasonable doubt should be changed to preponderance of the evidence or reasonable certainly
- Requests for extensions to the seven day competency evaluation requirement should be granted by the judiciary to the Department
- For those deemed competent, there is a need for supervised placement; the recommendation was that DHMH should stepdown beds for those with acute treatment needs (i.e., ALUs)
- Expungement: remove minor crimes from record (it was noted that this may have already been addressed through previous legislative efforts)
- Need additional resources to include forensic component to the existing Anti-Stigma Project operated by On Our Own of Maryland
- Hospitals need utilization reviews to determine medical necessity of patients

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Policies – Which Exist, What do They Say and Who Knows about Them

DHMH:

- There is a new admission policy
- There is no statewide discharge policy, as every hospital has its own, and this is guided by regulations and statutes
- The communication process State hospitals use to inform the Court of the admissions and discharge status of patients need to be formalized

Courts:

- Judges follow the statute, not policies developed by Executive Departments
- Each court has its own policy for scheduling
- Every district court has its own mental health judge
- Circuit courts all operate differently with some having mental health courts or an identified judge who handles mental health cases; other courts have just one judge to handle all cases
- The 30 day requirements in statute are not always followed
    - This was followed by a discussion on where this is happening as not everyone agreed that the 30 day requirements were not being met; Dr. Goldberg asked members to bring in information to support the delay (Note: Judge Morrissey volunteered to work with Judge Adams to develop quality assurance procedures for the Courts)

Public Defender / State's Attorney:

- State's Attorney:
    - The process in creating policies is different among counties but there is a process in Maryland for creating best practices for State's Attorneys. It was suggested that a Best Practice be developed. There is a State's Attorneys organization that has a committee that can address this issue.
    - Suggest a best practice in having at least one person identified in each locality to handle mental health cases
    - There are release planning difficulties
- Public Defender:
    - The policy for public defenders is to represent clients to the best of their abilities
    - Policies must consider each person's individual treatment needs
    - Public defenders operate independently
    - The Public Defenders' Mental Health Division, which oversees NCRs and mental health commitments just completed a five year strategic plan
    - There is a problem communicating with hospital staff

Other comments:

- There is a lack of a continuum of care for individuals transferred to corrections (i.e., found competent) whereby patients are transferred with little or no medication, treatment plan, etc.

Individual recommendations raised during this discussion included (recommendations were from individuals, not group recommendations):

- Admissions policy should be posted on DHMH's website
- DHMH should have a statewide discharge policy
- It would be helpful to have a statewide policy on when people return to court
- There should be a policy on how to have a hearing before an Administrative Law Judge
- Should there be a policy or mechanism to track the 30 day rule?

Wrap-up/Questions/Assignments

The next meeting is scheduled for Thursday, July 7, 2016 in the same conference room. In addition, there were several comments regarding the submission of comments, including technical difficulties with the website links. It was requested that DHMH send out the link to all members and allow everyone to see all comments posted on the website. DHMH representatives stated that the link will be resent and comments will be available for everyone to see.
