Forensic Services Workgroup
Minutes – Meeting 3
July 7, 2016

Workgroup Facilitator: Dr. Stephen Goldberg

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

DHMH Representatives in Attendance: Dr. Barbara Bazron, Sara Cherico, Shauna Donahue, Rachael Faulkner, Chris Garrett; Dr. Gayle Jordan-Randolph, Christi Megna, Cathy Marshall, Dr. Erik Roskes and Allison Taylor

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Meeting 2 Review

The meeting began with a welcome and a reminder by Dr. Barbara Bazron, Executive Director for the Behavioral Health Administration, of the Workgroup schedule, including that the final meeting was scheduled for August 4th.

Dr. Stephen Goldberg, Workgroup Facilitator, then began the meeting by requesting that the minutes from the June 30th meeting, along with the comments submitted by Delegate Dumais and the Judiciary, be reviewed and approved through email following the meeting. There were concerns raised regarding the recommendations that were included in the June 30th minutes. It was noted from the Judiciary and Delegate Dumais that:

- Delegate Dumais stated that the recommendations were identified through discussion by individual members, and did not represent a consensus of the Workgroup members. This will be clarified in revisions to the minutes when they are sent out with the additional comments submitted by Delegate Dumais and the Judiciary.
- Generalizations were misleading as to the nature of delays in returning defendants to court who are opined competent. Many factors relate to the timing of competency adjudicatory hearings. Much clearer data is needed before any broad generalizations should be made. Present case specific issues should be communicated promptly to administrative judges, designated mental health judges, or Chief Judge Morrissey.
- The Judiciary referenced a lengthy analysis by the Judiciary during the summer of 2014, showing significant delays in state hospital admission upon court ordered extended competency evaluations.
- In response to DHMH's AAG stating that the statute is unclear with regard to "return to court," the Judiciary referenced Criminal Procedure §3-105 (c)(2)(ii), which states: "Unless the Health Department retains the defendant, the defendant shall be promptly returned to the court after the examination."
- The Judiciary stated that they do not agree that a change in the "burden of persuasion" should be made and that the statute is unambiguous as to the language of "return to court."

Approval of the minutes was deferred.

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Potential Recommendations for Efficiencies within Current System

Dr. Goldberg began by reviewing the purpose of the Workgroup, which is charged with developing recommendations to reduce unnecessary congestion in the system. This was followed by a review and discussion of potential recommendations for efficiencies where all members appeared to agree during previous meetings and through comments submitted in between meetings. The potential recommendations and subsequent discussion included:

Potential Recommendation 1: Increase Community Crisis Services

- The State provide additional resources to support community crisis services that maximizes the likelihood of someone remaining in the community
- Include community education to decrease stigma, and thus decrease any resistance to community-based care

Discussion (comments made by individual members):

- There are capacity issues within treatment community
- The community provider stated that crisis services do not accept people on emergency petitions
- Agreement from the Workgroup that community education was needed to decrease stigma

Potential Recommendation 2: Expand the Outpatient Forensic Evaluator System

- Increase the number of evaluators
- Explore telehealth options to allow for local differences in availability of trained professionals
- Establish minimum training
- Standardized report formats
- Ongoing audits for quality and consistency (must meet minimum standards to continue in the evaluator role)

Discussion (comments made by individual members):

- There is not currently a problem with the seven day requirement for evaluation (stated by multiple members)
    - Problem is with the next steps needed after an evaluation
    - Survey done by Judiciary two years ago showed timeliness of local competency "screening" evaluations as a high point in system
- Other members clarified that evaluations are done in multiple settings, not just pre-trial, and there are gaps (i.e., competency evaluations in hospitals)
- Once committed, there is a problem with timeliness of evaluations
- One of the Judiciary commented "Even if the Judiciary does not have current problem with the seven day requirement, the recommendation is not bad."
- There are also issues with the application of the "dangerousness" standard
- Change recommendation to reflect the need to expand the forensic evaluation system

Potential Recommendation 3: Incentivize Community Providers to Accept Forensic Patients

- Training – make it available on-line to maximize utilization
- Increase reimbursement rate for time
- Include new codes to allow reimbursement for report preparation and/or court time

- Access to legal guidance from State when necessary

Discussion (comments made by individual members):

- Expand the recommendation from Forensics to all seriously mentally ill as these individuals have complex needs who end up as forensically involved – start prior to individuals becoming involved with the judicial system
- Reimbursement rate would be good, however costs associated may not be clinical, such as housing and other costs to ensure safety, but are still necessary
- Patients need to be more engaged in their own treatment
    - Forensic peer support should be considered
- Assertive engagement and outreach are not reimbursable services but they should be

Potential Recommendation 4: Centralize DHMH Forensic Processes

- Single admission, discharge and transfer policy (based on statute/Health-General and coordinated amongst all hospitals within the system to maximize efficiency)
- Single point of contact for all jurisdictions (for use by Courts, PD, SA; and identify contact in each jurisdiction for two-way communication with DHMH)
- Establish mechanism for weekly review of all cases approaching or that are already outside of statutory limits (competency orders for evaluation, conditional release for NCR, and medical necessity criteria, least restrictive criteria, appropriate placement as a function of resources)
- Centralize decision to request extensions, returns to detention, etc.
- Consider expungement and other special circumstances to maximize efficiency at time of release
- Identified DHMH representative with authority to make special allowances for unique case that have willing community providers
- Reliable data collection that is shared (discrepancies in data to be clarified in weekly meetings with use of specific cases)
- Set realistic goals with each jurisdiction to "catch-up" and then continue to meet all statutory requirements on an ongoing basis

Discussion (comments made by individual members):

- How do we determine who should be admitted to Perkins compared to the other hospitals?
    - Lots of variability but shows the need for a single admissions, discharge, transfer policies, especially spelling out transfers between hospitals
    - Admission policy does exist and there was consensus at the June 30th meeting for the need of a single discharge policy
- Admission and discharge requirements also in statute, not just DHMH policy
    - There is some flexibility in statute
- Allows for the reallocation of resources across counties to address issues as they arise (i.e., an evaluator from another area can come into small county that has sudden influx of evaluation requests)
- Need to be able to track and discuss individual cases through centralized tracking system
- Tracking is already done well in Baltimore City and Prince George's County
- How do we duplicate what's working well in Baltimore City and Prince George's County to other areas of the state

  - One member cautioned the group not to mess up processes that are currently in place that work. For example, Prince George's County and Baltimore City have developed a system over 15 years that works well. The Facilitator asked whether we can expand what works in these locations in other parts of the state by using this as a "pocket of excellence."
- Should work from one set of numbers/data
- Tracking system would help with identifying people who are stuck in system
- Need an understanding of the rules that the Court and DHMH must follow
  - what is "clinical" and what is "statutory"
- Other states do non-binding utilization management to determine medical necessity and to identify gaps in services
- Advanced directives are underutilized – have peers work with individuals to develop advanced directives when they are well, which can be used when they are not well and possibly prevent re-traumatization

Following the review of the four recommendations, a comparison was done with the 2014 Joint Chairman's Report (JCR) addressing treatment services for court involved individuals. Recommendations 1, 4, 5, 6, and 7 from the 2014 JCR were similar to the recommendations discussed by the Workgroup. Judge Lipman referenced a corresponding report with commentary to the 2014 JCR from the Judiciary. DHMH agreed to post the report and the Judiciary's commentary to the Workgroup website.

Additional Potential Recommendations

Dr. Goldberg began this discussion with three other potential recommendations, which included:

<u>Medication Over Objection</u>
Comments made by individual members included:

- It is unconstitutional (stated by multiple members)
- There is currently a Court of Appeals case regarding medicating in hospitals
- It is needed in detention
- People do not take medications in detention and it would be helpful if there was a way they could receive their medication since if they choose not to they decompensate
- It is a personal decision to take medication; force in general is a problem
- Medication can be as big a problem for someone as a solution
- Should give the "systems change" recommendations a chance to work before recommendation forced medication which is a violation of rights
- People should not be in jail since jails are not set up to provide treatment; they should be in a hospital
- Judiciary wants the best aftercare plan possible to keep people in the community and out of jail
- Does aftercare plan include wellness/recovery centers, peer support, advanced directives, anti-stigma training?
  - Items are not in statute but are typically listed in the individual plan

Privatization

Comments made by individual members included:

- Privatization is useful if services can be accessed
- Need to assess services (public and private) if person is on No Bond status
- Need other people at table to discuss this issue including private hospitals and additional providers
- "In reach" from the private sector could be helpful when developing discharge plans
- The view of providers and hospitals is different when looking at discharge and who is appropriate for community placement
- Need to also be looking at co-occurring issues, particularly individuals who self-medicate with marijuana and then are rearrested
- Hospitals do discuss cases at monthly meetings
- Need subacute unit that an individual can go to while they are waiting aftercare services and supports to be put in place

Other Potential Recommendations (made by individual members)

- Need more beds (stated by multiple members)
    - 2014 report recommended 10 percent over current level
    - The recommendation for 100 beds has been consistent since 2003
    - If you open more beds you will end up with the same inefficiencies, which will require even more beds
    - With other components in place, more of the currently available beds will become open
- Need ACT services for forensics
- Housing through block grants
- Forensic "academy" is needed to prepare community providers regarding the needs of this population
- Need trauma informed treatment, not just trauma informed care (there is an existing gap in skills regarding trauma)
- Medicaid should be at the table as PTSD is not a covered service but should be (stated by multiple members)
- There are unique issues to treating the Transition Age Youth population
- Need step down (stated by multiple members)
    - Even when conditional release is agreeable to all parties, there can be a lack of community services (i.e., RRP); ALUs addressed this in the past
    - Need step down to get people out of "secure" environment they no longer need
    - Step down should be run by community providers, not the State
    - Need payment incentives with benchmarks
- Need beds for people ready to leave detention
- Mimic somatic health care with care management where we think of community based over hospitalization
- Designate a third of the beds as overflow for competency and orient patients to forensics
- Not sure more beds solves problem for individuals who have to go back to jail; need to prevent segregation in jails for those with long term limits
- Need community providers in hospitals/jails prior to release to transition and prepare individuals for community placement

- There is a need for ALU beds
- Need re-entry courts
- Need to acknowledge immigration issues

Wrap-up/Questions/Assignments

Dr. Goldberg encouraged members to post all additional comments and suggestions for the report through the public comment process.

It was agreed that the PowerPoint presentation would be sent out to members and that a draft report would be done within 10 to 15 days.

Dr. Bazron reminded the Workgroup that Secretary Van Mitchell would be attending the last meeting scheduled for August 4th and that the final report would be submitted to the Secretary by the end of August so the Department could begin implementation as soon as possible.
