Forensic Services Workgroup
Minutes – Meeting 4
August 4, 2016

Workgroup Facilitator: Dr. Stephen Goldberg

Members in Attendance: Laura Cain, Delegate Dumais, Roger Harrell, Paula Langmead, Dr. Helen Lann, Daniel Malone, Captain Michael Merican, Judge John Morrissey, Mary Murphy, Mary Pizzo, John Robison, Rick Rock, Judge Ronald Silkworth (representing Judge Sheila Tillerson Adams), and Crista Taylor

DHMH Representatives in Attendance: Dr. Barbara Bazron, Sarah Cherico, Shauna Donahue, Kathleen Ellis, Rachael Faulkner, Chris Garrett, Dr. Gayle Jordan-Randolph, Christi Megna, Cathy Marshall, Secretary Van Mitchell, and Allison Taylor

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Opening Remarks

Dr. Barbara Bazron, Executive Director for the Behavioral Health Administration, opened the meeting by thanking the members for their participation and welcoming back Secretary Van Mitchell.

Secretary Mitchell then providing additional remarks, beginning by thanking the Department's counsel for their support in recent court proceedings. Secretary Mitchell also thanked the Workgroup membership for their participation, particularly in providing information to the Department and coming together to develop solutions that address the current bed capacity issue. Since the Workgroup first convened, other states have reached out to the Department to inquire on our proceedings since they are facing similar issues.

Secretary Mitchell also announced new developments that will expand residential treatment services including a new 16 bed transitional unit on the grounds of Springfield Hospital Center.

- There are currently 4 beds filled
- Anticipating the unit will be at full capacity by September 30, 2016

There are also plans to relocate the SETT at Clifton T. Perkins Hospital Center to Springfield Hospital Center

- Administrative staff at Springfield are currently transitioning to other office space to make the unit fully available for bed space
- This option will result in substantial savings for the State and will increase availability at Perkins

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Intermeeting Communications

Rachael Faulkner with BHA referenced that an email was sent out on July 20th informing members that the minutes from the second and third meetings had been finalized and posted to the Workgroup's webpage. Since then no comments or questions have been received. Ms. Faulkner encouraged members who had not reviewed the final versions to review them and remark if there were any corrections needed.

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Review and Discussion of Draft Recommendations

Dr. Stephen Goldberg, Workgroup facilitator, began the review of the draft recommendations dated July 27, 2016. There were no objections to the preamble of the report, which captures the background and charge of the Workgroup. The members agreed that it captured the "tone" of the group's meetings.

Recommendation 1 – Increase Bed Capacity within DHMH

Dr. Goldberg began the review of the first recommendation by asking the representative from Disability Rights Maryland for comments regarding any objections to adding beds. A distinction was made to ensuring the availability of beds versus adding more beds; that more beds may not be needed if patients can be moved out of existing beds.

A member stated the need to address opening back door services, not just building bed capacity to previous levels. Another member remarked that, in her opinion, people are currently illegally detained in detention and that this is an immediate issue that needs to be addressed.

In addition, it was stated that the community hospitals needed to be included in any conversations regarding private sector beds (recommendation 1C). Secretary Mitchell informed the Workgroup that there would be a standing group following this process that would include additional parties, including the Maryland Hospital Association (MHA). He further stated that this recommendation may benefit hospitals, particularly rural hospital, under the new global budgeting requirements that have low bed census issues.

Recommendation 2 – Increase Availability of Community Crisis Services

The discussion began with a comment that there should be additional police training and/or coordination prior to involvement in the criminal justice system to prevent individuals with minor charges (i.e., trespassing) who are taken to the hospital and subsequently charged.

This was followed by a conversation of the existing training that law enforcement receives, including Crisis Intervention Team (CIT) training. A problem identified was that even when there is training, if there is not anywhere to take an individual, they go to detention. It was recommended by a member that crisis service needs have already been mapped out and should be referenced in the final report.

Additional comments related to this recommendation provided by individual members included:

- Community mental health centers (OMHCs) have no incentive to serve individuals with prior forensic involvement
- Need to build incentives for community providers to take individuals with more complex needs and potentially prevent individuals who previously could not find a provider from becoming forensically involved
- State Attorneys can play a role in diverting people from jail
- We already know what crisis services are needed; funding is also needed
- There is currently a process underway to develop a strategic plan for crisis services within the state

- Springfield and Spring Grove hospitals should be designated as forensic hospitals with the same benefits of those are who are performing similar jobs at Clifton T. Perkins Hospital Center

Secretary Mitchell stated that he is looking for solutions that can be included in the budget. Ultimately, the Secretary indicated he is looking for concrete things that can be done immediately as well as long term solutions.

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

Dr. Goldberg provided an overview of this recommendation. It was noted by a member that this was the role of the local core services agencies to provide services for this population, which requires staff and additional funding to provide case management as needed.

It was mentioned that a previous report included a recommendation to create a web-based electronic database (as stated in the draft report). Dr. Goldberg stated that the final document will reference this report and recommendation.

There were questions about to the weekly meetings proposed in the recommendation. It was recommended that these meetings review the status of individuals hospitalized for competency restoration who have been in the hospital for more than 90 days with a six month limit on the future length of stay. There is no time limit in statute for restoring competency even though some research suggests that if competency is to be restored, that it happens rather quickly.

The Judiciary commented that they are unable to make recommendations for other branches of government. In addition, they are concerned with recommendation 3B which includes considerations of clinical acuity as admission criteria. Admission should be limited to the requirements in the statute.

There was discussion of whether patients should be transferred between detention centers in the state and a recommendation by a member that the Maryland Association of Counties (MACo) be brought into this conversation. Secretary Mitchell expressed the need for some flexibility in rare cases to transfer patients.

Another recommendation by a member included possibly having different units within facilities designated for competency evaluations and restoration. This option should be explored to determine if it would be useful.

Finally, Dr. Goldberg stated that the proposed Forensic Services Steering committee would operate similar to other state efforts (i.e., City Stat, State Stat, etc.) where individual cases could be tracked and addressed by all parties involved.

Recommendation 4 – Increase Outpatient Provider Capacity to Meet the Needs of Forensic Patients

Dr. Goldberg provided an overview of the recommendation. He remarked that Maryland has established a provider system where providers have the ability to either accept or refuse to provide treatment to patients. This results in some patients not being able to find a provider. Forensic patients

are often refused admission, which results in stigmatization and creating a situation in which no one in the community will serve them.

It was stated that there may be legitimate reasons why a provider may refuse a patient, including financial reasons. If this recommendation goes forward, it must be in combination with other recommendations that support providers. Dr. Goldberg replied that the intent was for the recommendations to be a package and that this would be clarified in the preamble of the final report.

Members stated that additional resources and a different financial model are required to support the community service needs of forensic patients. One example provided was the Developmental Disabilities Administration (DDA) plans to submit in the next six months an amendment to their Medicaid Waiver to provide an enhanced rate for supervision to their DDA providers.

Additional comments for this recommendation provided by individual members included:

- Housing is needed
- Immigration status is an issue that is a barrier to discharge

With regard to housing, Dr. Goldberg will be including this barrier in the preamble and at the end of the report as it impacts services across the system, not just within one specific recommendation.

Recommendation 5 – Centralize DHMH Forensic Processes

Dr. Goldberg provided an overview of this recommendation. He stated that the number of forensic patients has been fairly consistent at around 1,100 annually, but the length of stay has tripled. Data related to this change will be presented in the final report.

Additional discussion included reviewing the forensic screening process, which, at times, may be done quickly and lead to subsequent system problems. Dr. Jordan-Randolph stated that a new web-based data system would assist in informing the Department, including providing data that would allow DHMH to review both evaluations and evaluators.

A member recommended that non-binding utilization be considered instead of a State-run centralized process. This could also be a possible solution to addressing the flow of patients.

Dr. Jordan-Randolph replied that a standard forensic restoration program was needed to effectively move people through the system. Dr. Goldberg referenced the existence of national best practices in this area.

A member remarked that there is a vast difference in the quality of evaluations and that centralization, including the creation of uniformed standards, are necessary. Due to the current differences in the quality of evaluations the Public Defender's Office often gets their evaluations completed.

A member requested that that Dr. Goldberg rethink the catchment area recommendation. Currently, hospitals have good relationships with the local jurisdictions in their catchment areas which are essential when discharge planning. Dr. Goldberg agreed that geographic consideration be given when admitting a patient, but that patients should not have to wait for a bed in the hospital closest to them if

there were openings elsewhere. One solution identified was to develop a transfer policy to allow a patient to be moved to a hospital closer to their home jurisdiction once a bed becomes available. This would prevent patients from waiting for a bed, transfer them from detention sooner, and assist in discharge planning back to their home community. It was stated that Virginia just did something similar and that Maryland may be able to model after their program.

Finally, the Judiciary remarked that they are unable to sit on a steering committee that would review cases, but would be available to answer questions and communicate scheduling issues back to the relevant jurisdiction.

Recommendation 6 – Increase Education to Reduce Stigma in Both the General Public and the Mental Health Treatment Community

There were no objections to this recommendation.

Acknowledgments and Wrap-up by Secretary Mitchell

In closing, Dr. Goldberg began by thanking the membership for their participation, Dr. Bazron for chairing, and Rachael Faulkner for staffing. Finally, Dr. Goldberg remarked that his intent was for the final report to capture the work and the spirit of the group.

Dr. Bazron then thanked the workgroup members for their terrific attendance throughout the summer and for the membership's commitment in getting the charge of the group completed in the allotted time.

Finally, Secretary Mitchell thanked everyone for their participation and that he would continue to work towards fixing this problem over the next six months in preparation for next year's budget; and ensuring that we create a system as best as possible. He then thanked Deputy Secretary Jordan-Randolph for her tenure and recent efforts in creating the Behavioral Health Administration.