Maryland Association of
Resources for Families & Youth

TO: The Honorable Maggie McIntosh, Chair
Members, House Appropriations Committee
The Honorable Brooke E. Lierman

FROM: Pamela Metz Kasemeyer
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DATE: February 27, 2020

RE: **SUPPORT WITH AMENDMENT** – House Bill 1382 – *Children in Out-of-Home Placement – Placement in Medical Facilities*

The Maryland Association of Resources for Families and Youth is a statewide network of private agencies serving at-risk children and youth and advocates for a system of care in Maryland that meets the needs of children and families. MARFY is a program of Maryland Nonprofits and **supports with amendment** the passage of House Bill 1382.

On behalf of the provider community in Maryland, we would like to thank you for your attention to the critical issue facing children and families in Maryland's child welfare system today. The system is seriously under-resourced as well as being complex, and these factors have led to a long-term degrading of the options available to provide appropriate services for children with significant mental health and behavioral needs.

The Maryland Association of Resources for Families and Youth brings together the provider community to have a collective voice in improving the child caring system in Maryland. Since the publication of the article in the *Baltimore Sun*, we have been working with our members to help to unbundle the many issues that contribute to the crisis of hospital overstays and other situations where critical needs are not being met. Attached please find our briefing paper with additional information on the issues and potential solutions. Fundamentally, the system needs more resources to function at a baseline level of adequacy that is not the case at this point. Still, the "system" spans many different departments, jurisdictions and public and private agencies, and additional resources need to be well coordinated with targeted systemic improvements.

Thank you again for your attention to this matter, and we look forward to working collaboratively with you, the Department of Human Services, the Maryland Department of Health and others to solve the problems in an expeditious manner.

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Legislative Briefing on Issues Related to Youth Hospitalization Over-Stays

All youth in Maryland should have access to appropriate services, regardless of their level of need. When a child is removed from their family, the removal itself is traumatic, compounding the traumas that led to that removal, such as abuse, neglect, trafficking victimization, and behavioral health challenges. The system of care is designed to have a graduated level of care, depending on the needs of the child, starting with community-based prevention services. The Family First Prevention Services Act was designed to create more programs for prevention. Once a placement needs to be made, foster care and treatment foster care are preferred because the best place for children to grow up is within a caring family environment. However, some children's mental health and behavioral needs are severe, and even well-trained and supported treatment foster care families are unable to keep them safe and meet their needs. In these cases, therapeutic group homes, diagnostic centers and residential treatment centers are utilized, and in some cases hospitalization is necessary.

Being removed from one's family is itself a traumatic event. Being removed from a particular placement such as a failed foster family placement, is also a traumatic event where a child feels rejected and further loses trust in themselves and in adults. These traumas inflicted *by our system* are part of the problem leading to dead-end hospitalization.

Over the past 10-12 years, Maryland has worked to reduce the number of children in care, and has reduced the number of children in care by about half. While the goals of these reductions were laudable, little attention was given to the unintended consequences, and the savings achieved were not reinvested back into prevention and ensuring the system had all the components it needed. We are now seeing the number of children in care increase again, partly due to the opioid crisis.

Providers know that if we provide clinically appropriate services on the front end for youth in care then we could significantly reduce the number of youth requiring hospitalization and hospitals being used as placement which results from the current lack of resources. Maryland needs substantial resource development (i.e. creation of new programs) and funding to match the growing needs of the youth in child welfare. One part of the system that is present in other states and is woefully lacking in Maryland is availability of 24/7 mobile crisis services that result in reducing the need for higher levels of services.

CURRENT CHALLENGES IN THE SYSTEM

Referral Process- Referrals are sent from the Department of Human Services to providers generally via email which include the reason for referral, request for a specific placement and when available, past clinical and educational documentation. If the youth is not placed in the appropriate placement from the beginning it will likely result in placement disruption, ejection or hospitalization. Some factors leading to failed placement include:

- Placement is often needed immediately and Departments of Social Services (DSS) at the local level report feeling desperate to find placement otherwise the youth may end up sleeping at the DSS office. This is particularly challenging going into the weekend and can lead to finding a "bed" versus a program that will benefit the youth.

- If a youth comes into care over the weekend there is no "shelter" available thus youth are placed wherever a bed can be located. Historically, DSS had shelter placement available for youth.
- The acuity of mental health issues has spiked significantly over the past few years and providers don't have adequate funding and resources to provide the services that the youths actually need.
- Youth are being referred to (less intensive) therapeutic levels of care despite a recommendation for residential treatment center (RTC), while they wait for a bed due to the shortage
- The referral does not always include the full clinical picture thus compromising the providers' ability to accurately assess the appropriateness of the youth in their program.

Suggestions:

- Address the shortage of RTC's and other more intensive programs, and enable youth who need those programs to be assigned to them immediately when the need is clear.
- Create a uniformed referral process that all Departments of Social Services use requiring specific information. This should be created in conjunction with the State and providers.
- Require oversight in the Department regarding how referrals are developed.

Hospitalizations- When a youth goes to the ER to be assessed for inpatient, these are issues we face collectively. Without adequate resources, the proposal in the bill of limiting the number of days a youth can remain in the hospital will not be feasible.

- Youth often sit in the ER for days on end waiting for an assessment.
- If it is determined they need inpatient, it can often take 72 hours up to a week to locate a bed and then get an acceptance from the inpatient unit.
- The youth have to be supervised until they are admitted which requires provider agency staff to remain at the ER 24/7 with little to no relief from the Department of Social Services. This incurs extensive overtime and contributes to staff burnout.
- Often youth are not admitted despite the extensive clinical information we have provided because they are not presenting an imminent risk at the ER.
- One jurisdiction that does have a mobile crisis team is Montgomery County. However, if the crisis team is called, it can take hours. When the police accompany the crisis team and the youth has to be transported, the police use force so they are being treated as a criminal versus mental health issue, thus compounding trauma. There are limited mobile crisis services throughout the state.
- Once a youth is admitted to the inpatient unit, the communication from the hospital to the provider is extremely limited, if at all, until we are contacted in regards to the youth being discharged. This means the hospital is making medication adjustments and clinical decisions with little to no history about the youth except their presenting behaviors.
- If the hospital is having team meetings, providers are not contacted.
- If a youth is inpatient and does not have placement available upon discharge, the local DSS team sends out the referral request and frequently the presenting symptoms are too acute to accommodate.
- Regarding children with complex medical conditions, discharges are often complicated and held up due to lack of approval for nursing coverage. Without Medical Assistance/DHMH approval of home health care nursing services for the most complex, the risk can be life or death so the child remains in the hospital due to lack of nursing coverage. These arrangements must be in place before discharge.

- Providers rarely get recommendations in writing from the hospital unless we pursue them. When received, they are for the most part brief and of little help.
- When we are able to meet or discuss with the inpatient staff it is a social work or nurse speaking for the team with no thought to discharge unless we address it. One social work staff at a hospital stated "we have no time to do discharge planning". Discharge dates are set quickly without confirming the child has a place to go, and providers are not involved or able to prepare appropriately for a child-specific safety plan. If providers refuse to take the child back due to safety concerns, this puts us at odds with DSS if they chose to accept the child's discharge.
- When youth are in diagnostic placement they frequently overstay the maximum amount of days because there is no available placement.

Suggestions:

- Increase beds available in the state to meet needs of the youth and their increasing mental health needs to include: therapeutic group homes, respite services, diagnostic services, and consider creating a "shelter" short term placement.
- Institute universal mobile crisis response teams throughout the state.
- Departments of Social Services should be more involved when youth are hospitalized.
- Create a workgroup with hospitals, providers, the Department of Health and the Department of Human Services to address concerns collectively.
- A Family Involvement Meeting (FIM) should be facilitated prior to hospital discharge

Staffing issues- The entire system is experiencing severe staffing shortages across the board from social workers to direct care staff to foster parents:

- Most critically there is a social work crisis nationwide which has significantly impacted our ability to fill vacant positions. We are competing with the state that has access to the Title 4-E program and offer a more competitive salary.
- DSS workers often report being overworked and have caseloads that are not manageable which is often evident in their involvement.
- Direct care staff are not making a livable wage, so care is at risk of being compromised because of burn out due to having to work multiple jobs. There is a high turnover rate.
- Recruitment of foster parents is extremely difficult. When they do onboard we are often at risk of losing them due to the acuity of the youth in their homes. Social workers have to respond to crisis situations more frequently to attempt to prevent placement disruption which also contributes to burnout.
- There are numerous vacancies at DHS/ SSA and high turnover which impedes our ability to make progress on identified issues. There is also a disconnect in information being shared with the local DSS staff. Local DSS teams all operate differently which causes confusion.
- A significant amount of money is spent on providing 1:1 staff for the youth as a stop-gap measure when an appropriate placement is not available. This money should be reallocated to prevent the problem versus being reactive and ineffective.

Suggestions:

- Extend incentives for social work recruitment and retention to private providers (currently Title IV-E funds are used to cover tuition and other incentives only for social workers going into government positions).
- Increase per diem rates to pay staff competitively and train properly.
- Expand the requirements to allow agencies to hire other mental health professionals aside from social workers.
- Departments of Social Services should be required to attend state level meetings with SSA/DHS/Providers to decrease the break down in information sharing

Resources to Implement Family First Prevention Services Act: While the concept is critical in regards to preventing youth from entering care, there is concern that the fiscal note required to meet the standards in the Act will not be approved by the Interagency Rates Committee.

- The new law requires residential programs to be Qualified Residential Treatment Providers (QRTP). Funding is not available to cover obtaining accreditation, implement evidence based programming, have access to a nurse 24/7, and provide 6 months of aftercare services as required by the Act. There is a significant fiscal note that will be required to implement. If the IRC does not approve this then there is substantial risk of programs closing thus reducing the amount of beds available
- The RFP issued in November for RCC has stringent requirements that also require a significant rate increase to allow providers to continue to operate.
- There could be an increase in the need for foster homes and we are collectively struggling to recruit and retain qualified parents.

Suggestions:

- Ensure adequate funding is allocated to prevent further reduction in beds.