Submitted for the House Judiciary's consideration in support of HB 1058 by Miriam Doyle

Why do people wind up being referred to a maximum security state hospital such as Perkins?

A lack of mental health interventions can result in individuals with SMIs (Serious Mental Illnesses) becoming extremely symptomatic and committing violent crimes before they ever get any sort of stabilizing care. A Perkins referral for intensive care in a maximum security environment comes after criminal charges are applied and a need for competency evaluation/restoration is identified.

Lack of substance abuse treatment is also a precipitating factor. Many individuals with SMIs have co-occurring disorders and their symptoms can be intensified as a result of substance abuse.

Lack of access to timely care in the community: We have many cases where patients sought out help but been told there were no openings. While waiting three months to see a psychiatrist, they've gotten into trouble and racked up criminal charges. In some cases, they've gotten charged in an emergency room or doctor's office while seeking care or wound up walking out a psychiatric evaluation and committing an assault.

Families need to be educated on mental health: One factor in being able to get timely interventions for an SMI is when loved ones are able to recognize warning signs.

Lack of mental health centers in low-income areas: Some individuals may face a barrier of lack of transportation to services outside of their community.

Schools not trained or given resources to identify these problems earlier on: There is a noted lack of school psychologists and school social workers throughout. Resources in schools can also be instrumental in reducing stigma, which is another barrier to recognizing treatment needs and accessing care.

Access to medications: There are numerous obstacles to accessing needed medications. Transportation to a pharmacy, understanding procedures for refills, education about medications are just a few. There are patients with SMIs who have gotten tripped up because they were prescribed a medication, but didn't understand that they needed to keep seeing a psychiatrist to continue getting refills. Other patients report that they were prescribed medications when younger, but were non-compliant because no one educated them on the importance of the medication.

Why do people have to wait for a bed to open up after being referred to Perkins?

Lack of discharge planners slows discharges from being carried out, which prevents beds from opening up.

Inappropriate screenings and referrals will also create a longer waitlist – if there are ten patients in admissions who have been inadequately screened and do not have SMIs that require care, that will keep an individual who needs treatment waiting in detention longer.

Insufficient number of community evaluators: If there aren't enough people to perform mental health screenings, evaluators with too much on their plate will produce lower quality evaluations. An individual who is uncooperative with an evaluation will quickly be pronounced IST (incompetent to stand trial) and will wind up occupying a bed at Perkins whether they need it or not.

Delays in court scheduling: If an individual has been assessed as competent and ready to be discharged to detention, but they can't get a court hearing scheduled for multiple months in the future, that will also delay beds from being opened up.

When an individual needs to be restored to competency, what impedes the process?

Lack of educational resources for non-English speakers.

Lack of competency evaluators in the hospital: A treatment team may assess that a patient is ready, but the patient will still have to wait three months or more for an evaluation. There are a limited number of doctors in the hospital to perform evaluations, and they are already overburdened with other responsibilities in addition to evaluations.

Delays in court hearings as noted above.

Delays in treatment resources, and a lack of programming.

Lack of varied competency resources for different needs: Admissions and maximum security hospital units may have the resources to run weekly competency education groups, but they don't have the resources to provide multiple groups for a population with a wide span of needs. Competency education may need to take on different forms for patients with developmental disabilities, patients with severe behavioral instability which often results in violent behavior, or patients with cognitive deficits.

When an individual has been declared NCR (Not Criminally Responsible), resolved their legal charges, and is legally eligible to advance through the hospital system, what are the deficits that slow their progress?

Lack of openings in less restrictive units – the whole system is clogged up!

Lack of therapists – if the patient waitlist is dozens of patients long for individual therapy, and a patient needs therapy to move forward, their hospitalization will be prolonged.

Lack of staffing in Rehabilitative Services. These include anger management strategies, coping skills, and mindfulness groups. Access and opportunities to engage in these services are limited.

DDA or services designed for cognitive impairments.

Community reintegration on maximum security.

Lack of regular trauma informed care training for staff.

Lack of educational opportunities for direct care staff.

When a patient is clinically ready for discharge, what slows the process?

Lack of competent community resources in all areas of the state: Some counties only have 1 or 2 RRPs (Residential Rehabilitation Programs). A patient who wishes to go to a certain area of the state where they have family or other ties may have to wait for limited program beds to become available.

Lack of Coverage for services: Intensive services for an RRP are typically reimbursed by Medicaid. A huge obstacle is created when a patient is clinically recommended for RRP but does not qualify for Medicaid. This obstacle occurs on a frequent and regular basis, shutting out needed services.

Reasons why a patient in need of RRP may not qualify for Medicaid: Veteran's benefits, Social Security Disability benefits that are too high, retirement funds, pensions, other assets that effectively disqualify access, yet an individual's resources are too limited to access RRP.

A spouse has insurance/assets that can prevent Medicaid coverage.

If a patient is not a US citizen, they may be court mandated to receive services in the community that they cannot get coverage for.

Change in practice: In the past, when a patient met criteria for an RRP and had SSDI due to a mental disability - but was over the financial limit for Medicaid - the State would pay for RRP. This is no longer happening.

What deficits in the community cause discharges to fail?

Some IST patients cannot be restored to competency: Their charges are dropped, but they are still clinically unstable – there is a lack of community resources for the level of care they need, and limitations on ways to ensure compliance with recommended treatment.

Lack of vital services for patients are ineligible for RRP coverage: Patients who are clinically recommended for RRP, but cannot obtain coverage for RRP services, may be discharged elsewhere without the same mental health resources. Unfortunately, sometimes discharge plans are structured around the patient's

healthcare and financial situations instead of being solely based on clinical recommendations that would favor an RRP. RRPs are supposed to restore independence – when a person has the ability to improve, RRP is desirable.

These patients who are lacking in healthcare coverage may wind up in a different program or residential setting where they do not receive the stimulation, oversight, and structured pathway towards greater independence that RRPs are designed to provide. This deficit in services can lead to reductions in successful community reentry and reductions in public safety.

Lack of insight building treatment to ensure compliance. As noted above, there is a shortage of therapists – if someone hasn't gotten the care they need to build insight about their mental illness and need for medications and treatment, they may be at risk for not remaining treatment adherent, which can jeopardize their wellbeing and public safety

Lack of relapse prevention supports: Substance use after discharge is a huge issue for a patient going through community re-entry.

When people decompensate in community, it's difficult to address: There are cases where an individual is checked into a community hospital but discharged within 48 hours because their situation was not acute enough to stay – but they were still unstable.

Quick access to appropriate treatment is needed when a patient decompensates in the community: All too often the length of time to appropriate treatment exacerbates the issue.

Programs may need to be educated on working with forensic patients on conditional release.

What are the deficits that we can anticipate with the privatization and closures in the MDH master plan?

Loss of gradual step down for sickest people in Maryland, loss of individual therapy to build insight: That lost service will not be provided at regional/community hospitals or community programs. Less care will lead to reduced success, higher recidivism, and risk to public safety.

Loss of Long-term Relationships: Some patients with a history of violent crimes lose their support networks, leading to further instability. Long-term intensive care provides them with an opportunity to form long-term relationships which can be a protective factor for maintaining their wellbeing.

Fewer discharge or transfer options with hospitals closing: With a system already at the breaking point due to under-resourcing and neglect, where are patients to go?