NASW MARYLAND CHAPTER
National Association of Social Workers

House Appropriations Committee
February 15, 2022

RESPONSE TO HB 406: OUT OF HOME PLACEMENTS – PLACEMENT IN MEDICAL FACILITY

Support with Amendments

'Stuck children' are those with high intensity behavioral health needs and/or developmental disabilities on overstay in psychiatric facilities or in hospital emergency rooms. Despite the Children's Cabinet claim that increasing placement options for specialized youth remains a top priority, existing resources and policies have failed to help children get un-stuck. We appreciate that HB 406 is shining a light on this troubling issue which is the end result of decades of neglect by our State government.

The solution HB 406 proposes is to impose more prescriptive mandates on local departments of social services (DSSs) and their caseworkers, along with fines for noncompliance. But these children are not stuck because caseworkers aren't doing their jobs.

A deeper dive to understand the real driver of 'stuck children' would readily uncover a crumbling placement system only worsened by COVID-related staffing shortages. In recent years, roughly 450 beds for children with complex needs have closed. There are no plans for replacement. As a reminder, DSSs are reliant on private providers for youth with high intensity and complex needs. Private providers have limited bed spaces, the right to say no to admission, and the right to require a child be removed from a program. Local DSSs are now so desperate that staff are hoteling children for lack of alternatives.

What is hoteling? Youth with high intensity needs for whom ***all placement options have been exhausted*** (typically 40 to 60 rejections) are housed in hotels as an act of desperation. The DSS purchases 1:1 supervision, and provides the 1:1 aide with gift cards to purchase the child's food, and laundry is done at the laundromat. The caseworkers aren't lazy, uncaring, or otherwise shirking their responsibilities – they simply have no alternative. This is not the sort of parent Maryland intends to be.

What is needed to solve this crisis is leadership and funding from the Governor to create the services needed to meet these children's needs.

Fining the Department of Human Services $2,000 a day presumes that DHS has authority for licensing behavioral health treatment programs to meet the needs of those 'stuck' in the hospital, when that responsibility rests with the Maryland Department of Health. Moreover, the Children's Cabinet, to whom the Interagency Placement Committee reports, claims to be the entity with responsibility for identifying in-state placement needs.

In short, the root cause of "stuck children" is not the failure of DSSs to adequately do their job but the failure of **ALL** our Maryland child-serving agencies to sustain an array of placements that can meet the children's needs. DSSs are forced to spend an inordinate amount of time searching for placements that just don't exist and trying creatively to work a deal with providers by offering extra 1:1 or even 2:1 supervision. We have spent over $10 million dollars paying for that additional staff. Passage of HB 406 as is will result in much more hoteling of children, and that cannot be the answer.

NASW therefore offers amendments to strike the language related to timelines and penalties and instead, insert the following recommendations:

1. Mandate that the Governor appropriate $100 million to create a full continuum of care for children with behavioral health needs, including additional Residential Treatment Centers and other residential settings to assure these valuable resources exist and are financially sound.

2. Pending access to these beds, require MDH to develop 20 psychiatric respite beds for RTC bound youth.

3. Create a Task Force as proposed and add social work professionals with expertise in child welfare and placements. While attorneys are experts in the law, social workers are experts in the delivery of Child Welfare services.

4. The Interagency Placement Committee, who reports to the Children's Cabinet, claims responsibility for developing in-state placement resources. The Children's Cabinet has indicated that increasing placement options is its top priority. Until a more comprehensive report can be completed, request an update from the Children's Cabinet on the status of overall capacity and the plan for a meaningful expansion of resources that can provide immediate and long-term relief.

5. We understand there was an early February deadline for an RFP issued by DHS to create 35 new "Diagnostic, Evaluation Treatment" beds and 25 psychiatric respite beds. Ensure these beds add rather than replace capacity. Require the process for selecting providers be expedited so services can be in place by May 1st.

6. Support the Behavioral Health System Modernization Act (SB 637/HB 935) to develop a more robust continuum of behavioral health services for children and prevent the need for Out of Home Placement.

7. Review data related to emergency room 'boarders' to determine demographics of long-stayers and distinguish between children waiting for a foster care placement and those certified for placement and awaiting a hospital bed. The solutions for these children are entirely different and data will help identify what's needed.

8. Rate reform for providers has been many years in the making. Until that work is complete, add funding to the budget for providers to expand services and eliminate the need to purchase outside 1:1 or 2:1 services.

9. After the many changes in Child Welfare over the past two decades, mandating a holistic review of children's needs and available options like that completed in Oregon, "Identifying Capacity Needs for Children within the Oregon Child Welfare System," could be illuminating and offer a roadmap forward.

NASW Maryland is committed to Maryland's children and child welfare system and stands ready to facilitate discussions that lead to action to address this long-standing crisis.

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ADDITIONAL BACKGROUND

- The issue of hospital overstays and shortage of placements for high intensity youth with complex needs dates back decades but became especially acute in recent years, after we lost roughly 450 placement beds in residential treatment centers, therapeutic group homes, and DDA approved programs. The high intensity psychiatric respite beds developed during the last acute placement crisis also closed.

- No plan was made to replace any of these beds, in part because group homes have fallen into disfavor and also because of the optimistic claim of well-intended child welfare advocates that every child could be successfully served in family homes.

- What triggers an overstay? The answer is simple - not having a placement for a youth on discharge from the hospital. As many as 40 to 50 referrals may have been sent out, and no provider had space or all have said “no” to admission. Child Welfare relies on private providers to care for children with complex needs, who have the right to refuse admission or to require removal from a program.

- Data indicates that roughly 25% of entries into Out of Home Placement each year are the result not of maltreatment but because parents are unwilling or unable to provide care to their children – largely older youth – because of the intensity of behavioral health needs and/or developmental disability.

- These needs are characterized by self-injurious behaviors that may include swallowing glass and other objects; self-mutilation; and multiple suicide attempts as well as incidents of aggression and threatening behavior towards others and against property. These are also the youth who sexually offend against others in the family, including siblings and caregivers as well as family pets. Finally, behaviors may also have resulted in legal charges for gun possession, assault, car theft, robbery, breaking and entering, and other delinquent behaviors.

- The reduction in placement beds didn’t obviate the need for highly structured programs with 24/7 supervision. Fewer Residential Treatment Center beds, for example, now means an average 73 day wait for admission, which has varied from 4 days to 419. Where is a safe place for the children to wait?

- Child Welfare is reliant on a partnership with private placement providers; a business environment and rate setting process that attracts and supports quality providers who can meet the needs of children with complex needs is imperative.

- For the local departments, the scarcity means long, tense hours pleading with placement providers for a bed, including offering funding for additional staffing. Roughly ten million dollars ($10,000,000) are being spent to buy outside 1:1 or sometimes even 2:1 staffing for youth in placements that can't meet their needs. These staff are typically untrained and purchased simply for the purpose of additional supervision.

- While the Local Care Team is well-intended, by the time a family comes to the attention of the local department, caregivers are drained and desperate. Rarely do LCT partners have resources to recommend that weren't exhausted long ago.

- The Interagency Placement Committee, which reports to the Children's Cabinet, claims responsibility for developing in-state placement needs. However, the "Interagency Plan: Developing Resources to Meet the Complex Needs of Children in Care" relies heavily on new policies and procedures - more bureaucracy – and its progress developing residential resources has not been responsive to the urgency of the need.

- Finally, despite having responsibility for the children, the voice of public child welfare social work professionals is notably absent. A peculiarity of large public service bureaucracies is that those administrators with the least contact with children and families have the greatest access to shaping policy. We can change that.