HB 406 Testimony.pdf
Uploaded by: Amy Petkovsek
Position: FAV

MARYLAND LEGAL AID

Advancing Human Rights *and* Justice for All

STATEWIDE ADVOCACY SUPPORT UNIT

Cornelia Bright Gordon, Esq.
Director of Advocacy
for Administrative Law
(410) 951-7728
cbgordon@mdlab.org

Gregory Countess, Esq.
Director of Advocacy
for Housing & Community
Economic Development
(410) 951-7687
gcountess@mdlab.org

Anthony H. Davis, II, Esq.
Director of Advocacy
for Consumer Law
(410) 951-7703
adavis@mdlab.org

Erica I. LeMon, Esq.
Director of Advocacy
for Children's Rights
(410) 951-7648
elemon@mdlab.org

February 11, 2022

The Honorable Maggie McIntosh
Chair of the Appropriations Committee
House Office Building, Room 121
Annapolis, Maryland 21401

RE: Maryland Legal Aid's Written Testimony in Support of HB 406 – Children in Out-of-Home Placements- Placements in Medical Facilities

Dear Chairperson McIntosh and Committee Members:

Thank you for the opportunity to present testimony in support of HB 406, a bill that seeks to relieve children in foster care of the pain, frustration, and trauma of calling a hospital their home. Maryland Legal Aid (MLA) is a private, non-profit law firm that provides free legal services to indigent Maryland residents. From 12 offices around the state, MLA helps individuals and families in every Maryland county with many civil legal issues, including housing, consumer, public benefits, and family law matters. MLA also represents abused and neglected children and provides legal assistance to senior citizens and nursing home residents. This letter serves as notice that Amy Petkovsek, Esq. will testify on behalf of Maryland Legal Aid at the request of Delegate Kirill Reznik.

Medical hospitals and psychiatric facilities are safe places to heal from physical and mental health conditions. They are not, and should not be repurposed as, housing units for children in foster care whom the state has run out of placement options for. A lack of appropriate placements for foster youth in Maryland was an emerging crisis pre-pandemic, which has now been exacerbated by the closure of congregate care homes across the state and a decrease in open foster home beds. HB 406 would take a significant step forward in addressing this escalating situation by setting clear guidelines for when a youth in foster care can

EXECUTIVE STAFF

Wilhelm H. Joseph, Jr., Esq.
Executive Director

Stuart O. Simms, Esq.
Chief Counsel

Gustava E. Taler, Esq.
Chief Operating Officer

Administrative Offices
500 East Lexington Street
Baltimore, MD 21202
(410) 951-7777
(800) 999-8904
(410) 951-7778 (Fax)

www.mdlab.org
04.2021

remain placed in a hospital setting, and also by establishing a support fund and task force to remedy the continued practice of placing children in medical and psychiatric facilities.

Currently, MLA represents dozens of youth across Maryland who are medically and psychiatrically cleared for discharge but live in hospital facilities due to a lack of appropriate placement options. One youth refers to the rotation of hospital nurses as "his new family." Another hospital became frustrated with the lack of movement on any other placement, needed the bed free, and dropped MLA's client off at a homeless shelter. Yet another youth sits at a facility with no television, no opportunity to attend appropriate schooling, and no access to activities outside the four white walls of her room- not because of any psychiatric or behavioral need, but because there is no place for her to go. Even worse- she knows that. Beyond having a hospital turn into a de facto home, these children are given the clear message- no one wants you, there is no place for you. This is traumatic, inappropriate, and cruel. And in Maryland, it is becoming the new normal, rather than the exception.

Opponents of HB 406 may contend that removing extended and needless hospital stays as a placement option will increase the placement of foster children in motel settings. It is true that in 2021 and continuing in 2022, many local Departments of Social Services are so placement resource-strapped that they are placing children in local motels, with a support worker checking in on them. Just last month, a 14-year-old MLA client placed in a motel took too much of his prescribed medication and was then thrust into a potentially life-threatening situation. Motels are not a safe, appropriate, or kind place to house a youth in care. And neither is a hospital. Maryland needs to do better, and soon. HB 406 takes steps in that direction.

MLA appreciates the opportunity to provide testimony and urges this committee to dedicate the funds needed to give foster care residents a safe, appropriate place to live by giving HB 406 a favorable report.

Sincerely,

/s/ Amy Petkovsek

Amy Petkovsek, Esq.
Deputy Chief Counsel
Maryland Legal Aid
apetkovsek@mdlab.org
(410) 951-7813

HB406 - Hopkins - Support.pdf
Uploaded by: Annie Coble
Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

HB 406
Support

TO: The Honorable Maggie McIntosh, Chair
House Appropriations Committee

FROM: Annie Coble
Assistant Director, State Affairs, Johns Hopkins University and Medicine

DATE: February 15, 2022

Thank you for the opportunity to share our experiences leading Johns Hopkins to **support HB 406 Children in Out-of-Home Placement-Placement in Medical Facilities.** Johns Hopkins appreciates the sponsors attempt to put into motion procedures to protect the vulnerable children who are being harmed by unnecessary hospitalizations, prolonged hospitalizations, and prolonged emergency department stays due to insufficient community-based treatment and placement options.

Johns Hopkins has a long history of, and a substantial commitment to, providing care for persons who suffer from mental health and substance use disorders. Our nationally ranked department of psychiatry treats a higher percentage of medically compromised psychiatric patients than any other hospital in Maryland. Our Division of Child and Adolescent Psychiatry is an important part of this expert team, and is devoted to meeting the behavioral health needs of our young patients through a multidisciplinary approach to the assessment, treatment, and study of pediatric mental disorders.

Over the past several years, due to insufficient community-based treatment and placement options, our Child and Adolescent Psychiatry inpatient units and pediatric emergency department have experienced an alarming increase in the length of stay for our young patients. Citing testimony Johns Hopkins submitted in 2017, some children have been hospitalized for as long as 115 days beyond what is medically necessary. During such extended and unnecessary hospitalizations and emergency department stays, children have little to no access to ongoing education, outdoor recreational activities, or community and family engagement. Unnecessarily prolonged hospitalization is not only detrimental to the child, it is also a significant resource drain, limiting our ability to admit and treat the many vulnerable pediatric patients in mental health crisis who are increasingly presenting in emergency departments and other health care settings. Johns Hopkins Child and Adolescent Psychiatry inpatient services receives over 2,000 referrals and is only able to accept approximately 20% due to the unit being at capacity.

The cost to the hospital and the state is significant in both human and financial terms. Inpatient psychiatric services cost $2,109 per day. For the child hospitalized for 115 days beyond what is medically necessary, the calculated expense is $242,535. This is critical funding that could otherwise be dedicated to more efficient and appropriate treatment for multiple children. Our recent review suggests that this problem has only escalated since 2017.

Generally, these increases in the length of stay are attributed to a lack of both appropriate community and inpatient placements and sufficient state processes to address out-of-home placement when needed. In a retrospective review of three years of data looking at factors related to length of stay on the Child and Adolescent Inpatient Services, the most salient predictor of prolonged length of stay was need for out-of-home placement at the time of discharge. This troubling finding highlights the importance of inadequate out of home placement options as a driver of unnecessary days on pediatric psychiatry inpatient units and in emergency departments.

The relative lack of needed out of home placement options for Maryland youth has a profound ripple effect throughout an already overwhelmed system of acute psychiatric services for children and adolescents. Throughout the state there is a shortage of not only general acute inpatient psychiatric hospital beds, but also more specialized neurobehavioral inpatient beds that are designated to meet the increasing needs of children who are both developmentally disabled and behaviorally impaired. This lack of capacity often results in children languishing in hospital emergency departments without access to active interventions. An unfortunate consequence is that children who could have been successfully managed with prompt and appropriate acute psychiatric management may escalate to violence or self-harm, and may end up being placed out of state where they are separated from family and familiar surroundings.

The various channels of state government that are responsible for addressing the needs of these children are challenging to navigate for the social workers and clinical teams responsible for arranging safe, appropriate, and timely placement prior to discharge. The responsible agency often varies based on diagnoses or age of the patient, with coordination needed, but often lacking when more than one agency or department is involved. Johns Hopkins has a number of pediatric patients with psychiatric conditions in state custody awaiting placements outside the hospital and who have been here beyond what is medically necessary. The development of a standard multi-agency approach to finding and securing appropriate community-based care and living arrangement would dramatically improve the lives of these children.

This issue is not unique to Johns Hopkins hospitals; hospitals across the state and country are experiencing the same problem. Children kept in medical facilities because of a lack of appropriate alternatives is a systemic problem and requires a comprehensive review by all the stakeholders.

HB406 is a huge step in the right direction by creating accountability for state agencies to find safe and timely placements for these children. Additionally, the creation of the Task Force to Examine the Placement of Foster Children in Emergency Departments is a crucial tool for creating long term successes. The issue of children being stuck in medical facilities has been a long-standing issue and will not see improvements until there is true investment in an integrated and forward-looking solution by the State, as seen by the creation of this task force. We would encourage the membership of the Task Force to be broadened to include clinical representation of hospital and community providers.

For these reasons, Johns Hopkins urges a favorable report of HB406.

HB406 OPD Position on Proposed Legislation
Uploaded by: Carroll McCabe
Position: FAV

PAUL DEWOLFE
PUBLIC DEFENDER
KEITH LOTRIDGE
DEPUTY PUBLIC DEFENDER
MELISSA ROTHSTEIN
DIRECTOR OF POLICY AND DEVELOPMENT
KRYSTAL WILLIAMS
DIRECTOR OF GOVERNMENT RELATIONS DIVISION
ELIZABETH HILLIARD
ASSISTANT DIRECTOR OF GOVERNMENT RELATIONS DIVISION

POSITION ON PROPOSED LEGISLATION

BILL: HB406, Children in Out–of–Home Placements – Placement in Medical Facilities

FROM: Maryland Office of the Public Defender

POSITION: Favorable

DATE: 02/15/2022

The Maryland Office of the Public Defender respectfully requests that the Committee issue a favorable report on HB406.

Today, there are multiple foster children being held in hospital emergency departments and inpatient psychiatric units without medical need due to DHS' failure to ensure appropriate placements. This practice is illegal and inhumane. This practice further traumatizes already traumatized and vulnerable children. The Mental Health Division of the Office of the Public Defender represents these children. The vast majority of the children we represent are in the custody of DSS. Since 2017, the OPD has worked with hospitals around the State to address the issue of children remaining in emergency departments after discharge and in involuntary inpatient psychiatric units after discharge or judicial release. After a number of unsuccessful attempts to resolve this issue in Maryland courts, the MHD sought the assistance of two law firms, Venable, and Brown, Goldstein and Levy, and Disability Rights Maryland.to pursue civil rights litigation on behalf of these foster children in Federal Court. We also worked with Maryland legislators to develop legislative solutions to this issue. We are now in 2022, and despite being aware of the problem for years, the adults who have the responsibility to care for the most vulnerable of our children are not doing their jobs and the children are still suffering.

"What's past is prologue." If the State agencies responsible for caring for these vulnerable foster children aren't forced to take action, they won't.

Maryland Office of the Public Defender, Government Relations Division, 45 Calvert St, Suite 108, Annapolis MD 21401
For further information please contact Krystal Williams, krystal.williams@maryland.gov 443-908-0241;
Elizabeth Hilliard, Elizabeth.hilliard@maryland.gov 443-507-8414.

The Mental Health Division (MHD) of the Office of the Public Defender (OPD) supports this bill for the following reasons:

1. Since at least 2017, children in local DSS custody are languishing in inpatient psychiatric units after discharge or judicial release because DSS, citing lack of available placement options, refuses to remove them.
2. Prolonged hospital stays are very destructive to children who already are highly traumatized due to physical abuse, sexual abuse, or neglect.
3. Foster children who needlessly occupy scarce inpatient psychiatric beds cause other children and adults to suffer longer stays in emergency departments waiting for scarce beds to open.
4. DHS has been aware of this problem since at least 2017, but has done little to resolve the issue.
5. Neither the hospitals nor the courts have been able to solve this issue.
6. Current federal and State laws require DSS to remove a child from an inpatient psychiatric unit or emergency room when the child no longer requires inpatient medical intervention or care. DSS flagrantly violates these laws. HB 406 sanctions DSS if they fail to follow current law.
7. DSS is currently keeping children in the most restrictive environment with the highest cost. HB 406 incentivizes DSS to locate outpatient placements.
8. This bill clarifies that no overlapping jurisdiction exists which would allow various county DSS agencies or courts to sidestep the Maryland Health-General Article requirements for receiving involuntary inpatient care.
9. This bill protects the constitutional rights of foster children.

Children are Languishing in Inpatient Psychiatric Units

Since 2018, the MHD has represented over 100 children who were either bounced from emergency department to inpatient psychiatric unit to emergency department or who remained hospitalized in hospital emergency departments or inpatient psychiatric units after discharge or judicial release because DSS refused to remove them. That number is not the total number of all foster children who remain hospitalized beyond medical need. Maryland law currently requires that OPD receive notice of a subset of those children - children who have been certified for involuntary civil commitment. This bill requires that OPD received notice of all foster children who are detained in emergency departments and inpatient psychiatric units beyond medical necessity.

Maryland Office of the Public Defender, Government Relations Division, 45 Calvert St, Suite 108, Annapolis MD 21401
For further information please contact Krystal Williams, krystal.williams@maryland.gov 443-908-0241;
Elizabeth Hilliard, Elizabeth.hilliard@maryland.gov 443-507-8414.

This Bill Protects the Constitutional Rights of Hospitalized Children

The Supreme Court in several cases, including, *O'Connor v. Donaldson, Addington v. Texas, Olmstead V. L.C. and Vitek v. Jones,* defined the due process rights of individuals facing involuntary civil commitment in a psychiatric facility. These Supreme Court cases provide that an individual cannot be involuntarily detained in a psychiatric facility or emergency department if they do not meet criteria for involuntary civil commitment. Maryland law currently provides that emergency evaluees may not be kept in an emergency department for more than 30 hours. (Md. Code Health-General, 10-624) These Supreme Court cases, The Americans with Disabilities Act, and Maryland law also require that individuals with disabilities, including mental illness, be treated in the least restrictive setting. Detaining foster children in emergency departments and inpatient psychiatric units when they do not meet criteria for involuntary civil commitment or beyond medical necessity, regardless of the reason, violates their constitutional rights, and these children have actionable claims in federal court.

Prolonged Hospital Stays are Destructive to Children

Prolonged hospital stays are very destructive to children. Foster children have already been traumatized by abuse and neglect. Many of them have been abandoned by their biological parents. Many foster children have behavioral difficulties derivative of the trauma they suffered. These children, who feel abandoned yet again, begin to deteriorate emotionally and behaviorally when DSS refuses to remove them from the hospital after they have been discharged or judicially released. Children who have been unnecessarily hospitalized can become angry and act out impulsively. The lack of schooling and the isolation from friends, siblings, and other family can cause children to lag behind peers when they return to school, and can impact their social development. Inpatient psychiatric units and hospital emergency departments are acute care units and are not designed to provide long term care. Accordingly, these units typically do not provide educational programs or other age appropriate therapeutic activities that would be available to foster children in appropriate long term placements. The State is failing these vulnerable children.

DSS is Keeping Children in the Most Restrictive and Costly Placement

In a Letter of Information to the Legislature in 2020, Johns Hopkins hospital advised that each day that a child is hospitalized in an inpatient psychiatric unit costs $2,109.00. Medical insurance does not pay the cost of hospital stays beyond medical necessity. When children remain

Maryland Office of the Public Defender, Government Relations Division, 45 Calvert St, Suite 108, Annapolis MD 21401
For further information please contact Krystal Williams, krystal.williams@maryland.gov 443-908-0241;
Elizabeth Hilliard, Elizabeth.hilliard@maryland.gov 443-507-8414.

hospitalized beyond medical necessity, hospitals obtain reimbursement of their costs from the Department of Health - not DSS. OPD was recently made aware of 1 patient who remained hospitalized for a year after medical necessity because DSS refused to pick up the child when the child was ready for discharge. Using the 2020 rate, the cost for keeping that child in an inpatient psychiatric hospital was approximately $764,000.00. Another child at the same hospital remained for 6 months after medical necessity, costing approximately $380,000.00. The total cost of providing unnecessary inpatient treatment in a setting found to be harmful for those two children was over **One Million Dollars**. It is inconceivable that Maryland State agencies have not found the money to provide other appropriate, less expensive, less restrictive placements.

Inpatient Psychiatric Bed Shortage

There is currently a severe shortage of inpatient psychiatric beds for children in Maryland. Children may stay for days or weeks in emergency departments waiting for beds in inpatient units. This shortage is even more acute for children with autism spectrum disorder or other neurocognitive disorders. Warehousing children who do not meet the criteria for involuntary commitment in inpatient psychiatric units exacerbates this shortage. Just by way of example, since October of 2021, the OPD represented a client who remained in a hospital emergency department for 95 days waiting for an inpatient bed, a client who remained in an emergency department for 36 days waiting for a bed, and another client who has been in an emergency department for 90 days and is still waiting for a bed. Many more individuals spent days or weeks in emergency rooms waiting for inpatient beds to open. Multiple studies have shown that emergency department boarding is harmful to child and adult patients.

Courts and Hospitals Alone Cannot Fix This Issue

The use of hospitals to warehouse children is illegal, but hospitals cannot safely discharge minor foster children to the streets. Hospitals have worked with the OPD to file Petitions for Writs of Habeas Corpus seeking the release of these children in Circuit Courts around the State. Circuit Court judges have been reluctant to act on these Petitions. Most courts have been unwilling to order DSS to remove the illegally held child, frequently relying on the existence of a concurrent CINA case to avoid hearing the merits of the Habeas Petition. This bill clarifies that no overlapping jurisdiction exists which would allow various county DSS agencies or courts to sidestep the Health General

Maryland Office of the Public Defender, Government Relations Division, 45 Calvert St, Suite 108, Annapolis MD 21401
For further information please contact Krystal Williams, krystal.williams@maryland.gov 443-908-0241; Elizabeth Hilliard, Elizabeth.hilliard@maryland.gov 443-507-8414.

requirements for receiving involuntary patient care, and gives hospitals a statute to rely on when DSS abandons their wards despite a physician ordering discharge or a judge ordering release.

DSS is Aware of this Issue

DSS has been aware of this issue since at least 2017, and has seemingly done little to resolve this issue. DSS continues to warehouse foster children in emergency departments, sometimes moving children from emergency department to emergency department, and in inpatient psychiatric units simply because they have no other placements available. Despite the current publicity surrounding this issue and the interest shown by legislators and child welfare organizations, DSS continues (as recently as today) to unnecessarily hospitalize these children. This bill sanctions DSS directly if they leave children in emergency departments and inpatient hospital settings beyond medical necessity.

We understand and acknowledge the concerns that various stakeholders have raised about this bill further overwhelming the child welfare system. To that end, we recommend that DHS, and MDH, along with other family serving agencies work together to materialize the recommendations from the 2019 Post Acute Discharge Planning Workgroup Report. The report details the barriers related to hospital discharge for adults and children with complex mental health needs and provides recommendations to address the shortage of robust community based services.

For example, it was recommended that BHA and DHS take the lead on evaluating the effectiveness of available in-home/respite care services to determine an effective model to consider to address inappropriate hospitalization while also providing relief to caregivers. HB 406 requires that a task force be convened to further study these issues and develop a plan to address them.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue a favorable report on HB 406.

Submitted by: Government Relations Division of the Maryland Office of the Public Defender.

Authored by: Carroll McCabe
Chief Attorney, Mental Health Division
Maryland Office of the Public Defender
200 Washington Avenue, Suite 300
Towson, Maryland 21204
Office: 410-494-8130

Testimony for HB406 (2).pdf
Uploaded by: Denise Wheeler
Position: FAV

APPROPRIATIONS
HB 406 – Children in Out-of-Home Placements
– Placement in Medical Facilities
Position: Support
February 15, 2022

On behalf of the Citizens Review Board for Children, an organization that seeks to advocate for all Maryland's children, we strongly urge you to support HB 6 – Maryland Medical Assistance Program – Dental Coverage for Adults.

The Citizens Review Board for Children (CRBC) is a federally mandated citizens panel that provides oversight for child welfare. The CRBC is composed of over 150 Governor appointed citizens on local out-of-home placement review boards in Maryland's 23 counties and Baltimore City.

Child welfare-involved children and youth with complex behavioral, developmental and/or psychiatric challenges have been routinely forced to endure unnecessary or extended hospitalizations with little or no access to education, outdoor recreation opportunities, or community and family engagement. This circumstance is commonly referred to as hospitals "overstays" or "psychiatric boarding." Due to the acute shortage of appropriate therapeutic residential options, out-of-home placements for these children frequently are limited to psychiatric boarding or one-on-one supervision in a motel. Overstays are detrimental to children, in violation of their civil rights, and limits the ability of our medical facilities to admit and treat other Maryland citizens in need of psychiatric care. Housing children in motels is also unacceptable.

The CRBC supports HB 406 as an unfortunately necessary first step towards addressing a long-term systemic shortage of clinically preventative and wraparound services as well as appropriate in-state placements options for child welfare-involved youth with complex behavioral, developmental and psychiatric needs. To date the detriment of affected children, wasting scarce human and financial resources on unnecessary psychiatric overstays, lawsuits, and media coverage have not motivated the Department of Human Services (DHS), the Maryland General Assembly, the judiciary and local jurisdictions to work collaboratively to resolve this crisis.

Enactment of HB 406 will: 1) alter the circumstances under which the court may commit a child for inpatient care in a psychiatric facility; 2) establish requirements and procedures for placement by local departments of social services; 3) authorize affected health care facilities to petition the court to compel the local department to remove a child from its care; 4) require the DHS to make a $2,000 per day payment for violations; 5) establish a foster child support fund; 6) prohibit an emergency facility from admitting or keeping certain minors, under certain circumstances, beyond a specified time period; and 7) creates a task force to examine the placement of foster children in emergency departments.

This legislative prescription fails to adequately address the complexities of psychiatric

boarding and the lack of appropriate in-state therapeutic residential placement alternatives. However, it is hoped that this legislation will force the stakeholders to engage in discharge planning early in the hospital stay, develop back-up plans, and most importantly, force the government entities (e.g., local jurisdictions, the Developmental Disabilities Administration, and Behavioral Health Administration) involved to break stalemates over who will accept responsibility for finding and funding the least restrictive appropriate therapeutic placement. While is it hoped that greater government collaboration, reducing judicial complicity, and the more efficient use of existing resources may provide immediate short-term relief, it will not solve the crisis in the long-term. Developing adequate in-state therapeutic community-based residential placement options for these children will require the public will and the Maryland General Assembly to make a significant financial investment. The above-referenced foster care support fund and cost-savings from governmental efficiencies will be, at most, a down payment on what will be necessary to build adequate capacity to accommodate the needs of these deserving children.

For these reasons, the CRBC urges a favorable committee report on HB 406 – Children in Out-of-Home Placements – Placement in Medical Facilities.

Citizens Review Board for Children
1100 Eastern Boulevard, Baltimore, Maryland 21221 • Phone: (410) 238-1320 • Fax: (410) 238-1395
email: crbc.mail.maryland.gov website: http://dhr.maryland.gov/crbc

HB 406 testimony by MY Mirviss.pdf

Uploaded by: Mitchell Mirviss

Position: FAV

VENABLE LLP

750 E. PRATT STREET SUITE 900 BALTIMORE, MD 21202
T 410.244.7400 F 410.244.7742 www.Venable.com

Testimony of Mitchell Y. Mirviss, Esq. before the House Appropriations Committee
HB 406: Children in Out–of–Home Placements – Placement in Medical Facilities

Position: SUPPORT
February 11, 2022

I represent the class of Baltimore City foster children in the custody of the Baltimore City Department of Social Services ("BCDSS") in the federal class action, *L.J. v. Massinga*. Since 1988, the Department of Human Services ("DHS") and BCDSS have been subject to a federal consent decree, as substantially modified and expanded in 2009, regarding conditions and services for the foster children and their families. Defendants have never been in substantial compliance, and they are far from compliance now.

The modified consent decree ("MCD") prohibits placement of Baltimore foster children in hospitals, offices, and other unlicensed placements. Despite the MCD's clear prohibition of the practice, for the past four years, BCDSS and other local departments of social services have been warehousing children in psychiatric hospitals, psych wards of other hospitals, and even in hospital E.R.s due to a statewide placement shortage now in its sixth year running. These illegal and grossly inappropriate placements can last weeks, months, or even a year or longer.

In 2021 alone, fifty different Baltimore City foster children had a total of 69 separate hospital overstays. ***The average length of hospitalization is 55 days.*** And Baltimore City accounts for less than half of the total foster care population in the State. As of December 31, ***eleven children*** were in hospital overstays statewide. One Baltimore City child has stayed in a hospital for 483 days. All of these children have been warehoused in psychiatric hospitals or wards without medical justification or have been kept in emergency rooms of hospitals for extended periods of time without medical justification.

During 2019, the OPD represented one child who had been wrongly hospitalized on seven different occasions. One of the children was only *six years old*. Some children have been hospitalized three or four times. As we speak here today, there are foster children who are stuck in a surreal, highly illegal *Cuckoo's Nest* world.

This is a disaster. In my 37 years of representing foster children in Baltimore, I have never seen anything this bad. That includes children sleeping in hard chairs in DSS office buildings without showers or bathing facilities; dozens of children sheltered in a motel run by social services without adequate supervision; and children stuck in residential treatment centers because less restrictive placements are not available.

Children have been discharged by their treating psychiatrists or released by administrative law judges because the child does not meet the criteria for involuntary hospitalization but remain stuck in the hospital because the local DSS refuses to pick up the child, stating that no placement is available. Juvenile judges have resorted to ordering the placement of the child in a private psychiatric hospital for no reason other than the lack of an appropriate placement. Children have

moved from E.R. to E.R., staying days and sometimes weeks at a time, for no reason other than the lack of an appropriate placement.

Hospitals are not licensed child placement agencies. These placements are illegal and unconstitutional, yet they persist because DHS lacks adequate placements. Federal legislation, the Families First Services Prevention Act of 2018 prohibits use of congregate-care placements for foster children, yet here in Maryland we are using the very worst, the absolutely most restrictive types of placements—psychiatric wards and E.R.s—for our most vulnerable, highest need children. A psychiatric hospital is a terrible place for a child: he or she does not go to school, does not have contact with the community, is separated from family and friends. These children already are highly traumatized, highly vulnerable children, and yet we traumatize them further. The literature confirms that over-hospitalized children are likely to suffer regression and trauma.

Children are kept in hospitals because Maryland has a shortage of adequate foster care placements. It has failed to develop an appropriate array of supportive services that can allow children to live in community placements without disruptive hospitalizations. Unfortunately, DHS has failed to plan for the actual needs of its foster care population and to budget for services that would fix the problem. The State has been well aware of the problem for four years running now. A year ago, several advocates and I were preparing to sue but did not because the State announced plans to expand and create dozens of new placements and beds. That information turned out to be misleading (at best). New plans were announced this summer, but they are a long way from fruition. As of today, ***only three new beds have been filled***, and these are (a) reserved for developmentally disabled children; and (b) located in Frostburg, far from Baltimore. DHS and MDH continue to advise that several dozen more beds will open by this summer. Given past setbacks and the four-year failure to address the problem, we are not confident that this will occur.

Because the State has failed to curb these illegal placements, the General Assembly needs to step in and enact strong measures that will prevent DSS agencies from continuing to mistreat foster children in this way. HB 406 provides legal clarity and financial protection to hospitals, imposes clear prohibitions and enforceable, and provides accountability. All of these are vital measures. Similar measures, such as HB 1032 (2020) have put DHS and MDH on clear notice that such provisions might be necessary if they did not create placements for these children.

HB 406 would, if enacted, curb the worst aspects of the crisis. No foster child should be warehoused in a psychiatric hospital or an emergency room merely because the State has failed to take steps to develop appropriate placements for the children. This is a clear dereliction of our *parens patriae* responsibility to care for these maltreated children as if they were our own.

Respectfully submitted,

/s/ Mitchell Y. Mirviss

MPA Testimony 2022 - Support HB406 - Children in

Uploaded by: Pat Savage
Position: FAV

10480 Little Patuxent Parkway, Ste 910, Columbia, MD 21044. Office 410-992-4258. Fax: 410-992-7732. www.marylandpsychology.org

OFFICERS OF THE BOARD

President
Linda McGhee, PsyD, JD

President-elect
Rebecca Resnik, PsyD

Past President
Esther Finglass, PhD

Secretary
Tanya Morrel, PhD

Treasurer
Brian Corrado, PsyD

Representatives-at-large
Shalena Heard, PhD
Jessica Rothstein, PsyD

Representative to APA Council
Peter Smith, PsyD

COMMITTEE CHAIRS

Communications
Robyn Waxman, PhD

Diversity
Whitney Hobson, PsyD

Early Career Psychologist
Meghan Mattos, PsyD

Educational Affairs
Laurie Friedman Donze, PhD

Ethics
Cindy Sandler, PhD

Legislative
Pat Savage, PhD

Membership
Linda Herbert, PhD

Professional Practice
Selena Snow, PhD

PROFESSIONAL AFFAIRS OFFICER
Paul C. Berman, PhD

EXECUTIVE DIRECTOR
Stefanie Reeves, CAE

February 11, 2022

Delegate Maggie McIntosh, Chair
Delegate Mark Chang, Vice Chair
Appropriations Committee
Room 121, House Office Building
Annapolis, MD 21401

Bill: HB406 – Children in Out-of-Home Placements – Placement in Medical Facilities

Position: Support with Concerns

Dear Chairwoman McIntosh, Vice Chair Chang, and Members of the Committee:

The Maryland Psychological Association (MPA), which represents over 1,000 doctoral-level psychologists from throughout the state, is writing in **SUPPORT** of **HB 406 – Children in Out-of-Home Placements-Placement in Medical Facilities**.

We applaud and support purpose of the bill, to better manage the placement of children and adolescents into medical facilities/programs. We also strongly support the inclusion of Psychologists as one of the mental health specialists uniquely qualified to evaluate the mental health status of children and adolescents.

The bill is a good start to building out a system of care that needs attention. For the Committee's consideration the MPA wanted to share these additional points:

1. Requiring the evaluation be set for 48 hours prior to a court hearing may be difficult to meet for several reasons. Some flexibility could be helpful.
2. The use of fines to local departments involved in this process may create the unintended consequence of conflict rather than encourage coordination between facilities and local childcare services.
3. The availability of out-of-home placements for children/adolescents in Maryland is sorely lacking. Additional legislation, in the form of establishing the funding for adequate numbers of out-of-home placements, would provide necessary resources to help fulfill the aims of this bill.

For these reasons, we urge a favorable report on HB 406. If we can provide any additional information or be of any assistance, please do not hesitate to contact the MPA Executive Director, Stefanie Reeves, MA, CAE at 410-992-4258 or exec@marylandpsychology.org.

Respectfully submitted,

Sincerely,

Linda McGhee
Linda McGhee, Psy.D., J.D.
President

R. Patrick Savage, Jr.
R. Patrick Savage, Jr., Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

HB 406 - Children in Out-of-Home Placements - Plac

Uploaded by: Pegeen A. Townsend

Position: FAV

MedStar Health

Pegeen A. Townsend
Vice President, Government Affairs
9 State Circle, Suite 303
Annapolis MD 21401
410-292-8824 CELL

HB 406 – Children in Out-of-Home Placements – Placement in Medical Facilities

Position: *Support*
February 15, 2022
House Appropriations Committee

Bill Summary

HB 406 would require local departments of health and social services to find a placement for a child determined not to require hospitalization or pay a fine into a Foster Care Support Fund.

MedStar Health's Position

One of the most frustrating situations in caring for our communities is when a child with a disability, cognitive impairment, or behavioral health issue is brought to the emergency department, is treated and stabilized, and no longer needs acute care services but we cannot find an appropriate placement to discharge the child to. These children often spend days and weeks in the emergency department, and some spend months in our inpatient unit while we search for an appropriate placement. Some argue that because the child is in a safe environment, that child is not to be prioritized by the state for placement.

This is a disservice to the child who should be in a more appropriate setting. It is a disservice to the community when a bed is occupied by someone who does not need acute care services. And, it is a disservice to health care providers who need to care for acute patients.

It is clear the state does not have sufficient resources to properly care for these children. A survey last fall by the Maryland Hospital Association found that the weekly average for youth in hospitals meeting "overstay criteria" is 50 (25 youth in in-patient units / 25 youth in the emergency department). The average age for the youth meeting "overstay criteria" was 14, with an even split between males and females. Typically, these patients are waiting for Department of Social Services placement or waiting for inpatient psychiatric placement. Common reasons for discharge delays include: 1) aggressive behaviors; 2) developmental disabilities and/or autism with psychiatric features; 3) sexually relative behaviors, and; 4) age (too young/too old for available youth placement). These are some of the most vulnerable patients we care for and they should have access to the care they need in the most appropriate setting.

For the reasons listed above, we respectfully ask that you give HB 406 a ***favorable*** report.

It's how we treat people.

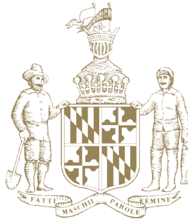
Sponsor Written Testimony

Uploaded by: Sponsor Reznik

Position: FAV

Kirill Reznik
Legislative District 39
Montgomery County

Appropriations Committee
Chair
Health and Social
Services Subcommittee



Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 427
Annapolis, Maryland 21401
301-858-3039 · 410-841-3039
800-492-7122 *Ext.* 3039
Fax 301-858-3126 · 410-841-3126
Kirill.Reznik@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
Annapolis, Maryland 21401

February 15, 2022

Good afternoon Madam Chair and members of the Appropriations Committee. I'm here today to present HB 406 - Children in Out-of-Home Placement- Placement in Medical Facilities. With one exception, this bill is identical to a bill this Committee passed out during the 2020 session sponsored then by Delegate Lierman. Unfortunately, the day after the bill crossed to the Senate, we shut down because of COVID.

The main purpose of this bill is to address hospital overstays for children in DHS custody. It specifies the conditions under which a child can be admitted for psychiatric or behavioral health needs, and requires the department to take timely action when it is no longer medically necessary for the child to be in a hospital setting. The one difference from two years ago is the addition of a reporting requirement for DHS to notify the Office of the Public Defender whenever a child is moved to a different placement. This will allow the Public Defender to track where the children are being placed and prevent the Department from picking up a child overstaying at a hospital and checking them into another hospital, which has repeatedly been done.

There is no reason that the Department cannot open new group homes, residential treatment facilities, or other treatment centers. Back during the 2018 session, DHS asked me to sponsor legislation to allow more flexibility in issuing additional licenses to circumvent certificate of need processes when there were no available placements. Since passing that legislation, at their request, only last year did the Department open four, and only to stave off a pending class action lawsuit on behalf of the children in their care. Let me be clear, not four facilities. Four beds.

These children are being dumped in hospitals and emergency departments, being brought in initially for acute care, and then left there after it's been determined it is no longer medically necessary for them to stay. Because it is not considered medically necessary, Medicaid will not reimburse the costs, and our hospitals are forced to eat the costs. These kids are sitting alone in hospital rooms or crowded EDs, with minimal staff interaction, no socialization with peers, no schooling, not being allowed outside, etc. This situation is unacceptable. And with our current state of emergency, it is a health risk to keep them in hospitals, and it wastes precious beds.

At the present time, there is a child at Johns Hopkins who has been living in the hospital for six months. Another child has lived at Sheppard Pratt for over a year.

I am aware of concerns some advocates have about the bill about potential unintended consequences. If the department feels like they have to get the kids out of hospitals before they've found a placement, there is concern that they could end up being housed in hotels or even sleeping on the floor of DHS offices. Neither of those is a good solution, although it is harder to not pay for a hotel room than a hospital bed. I am happy to work with the advocates on finding a solution that all are more comfortable with, and that is the purpose of the bill's proposed work group to find a solution.

I am also disappointed in the Attorney General's opposition. It appears that the AG's information is wrong and needs to be addressed. These children, for the most part, are not in psychiatric facilities. In fact, there are only 12 juvenile psychiatric beds in the entire state - another issue that this Administration has repeatedly failed to address. These children are mostly in regular hospital rooms or emergency department beds. Their mental health issues are varied and unique and a psychiatric facility is not always the most appropriate course of residence or treatment. Residential treatment facilities, group homes, living back home with family and one-to-one care are all appropriate approaches based on the individual needs of the children.

The problem is that the Administration has simply not wanted to spend the money to do what is right by these children, and dumping them in a hospital is, at the moment, free to the Administration. Only legislation or the threat of lawsuits spur their actions.

The goal of this bill is not to take kids out of a hospital setting if it is medically necessary, but rather to help those who don't need to be in a hospital to find a better placement, and to keep all stakeholders accountable and aware of the status of the children. I am happy to answer any questions, and ask the committee for a favorable report on HB406.

HB 406 Children in Out-of-Home Placements- Placeme

Uploaded by: Erin Dorrien

Position: FWA

House Bill 406- Children in Out-of-Home Placements- Placement in Medical Facilities

Position: ***Support with Amendments***
February 15, 2022
House Appropriations Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of House Bill 406. Maryland hospitals care for everyone who comes through their doors, but too often patients are unable to access the level of care needed to transition back into the community.

Prior to the COVID-19 pandemic, our hospitals began to study the myriad reasons a patient may be difficult to discharge. In 2019 hospitals participated in two studies of discharge delays among behavioral health patients in both inpatient settings and emergency departments. These studies found:

- During the 90-day study of behavioral health inpatients, 3% of patients experienced a discharge delay [1]
- During the 45-day study of emergency departments, 42% of behavioral health patients experienced a delay [2]

In both studies, children and adolescents were identified as at risk for a delay, especially children with involvement in one or more state agencies. Foster youth, especially children and teens with complex medical needs, face many barriers to appropriate care.

In the fall, hospitals joined the state Department of Health to better define the reasons behind discharge difficulties in this population. Hospitals reported the number of youths in an "overstay," defined as being in the emergency department for longer than 48 hours or in an inpatient unit beyond medical necessity. Over an eight-week span, an average of 39 hospitals reported weekly, with an average of 16 hospitals reporting at least one child meeting overstay criteria. On average, there were 25 youth meeting overstay criteria in the emergency department and 25 youth meeting overstay criteria in inpatient units each week.

During this study, hospital staff were able to provide additional context to understand the reason behind a discharge delay. While capacity issues were most cited for the delay, hospital staff identified a state agency process as a primary or secondary cause of delays for the majority of the overstays. These include:

---

[1] www.mhaonline.org/docs/default-source/resources/mha-report-jan-2019.pdf
[2] www.mhaonline.org/docs/default-source/resources/behavioral-health/behavioral-health-patient-delays-in-emergency-departments-study-2019.pdf

- Unable to place in a group home
- No foster care placement identified
- No available therapeutic foster care placement
- Parents abandoned patient or passed away
- Guardian wants to relinquish rights
- Waiting on interstate compact approval

We thank the sponsor of the bill for recognizing this very important issue. As noted, there are multiple and complex reasons for these delays. Any sustainable solution will require a holistic approach that includes coordination among all state agencies responsible for the health and care of foster youth.

However, while well intentioned, HB 406 contains several provisions that warrant further review. The bill prevents a hospital from keeping a minor who is in the custody of a local department of social services longer than authorized even if an appropriate alternative placement is unavailable. Federal guidelines direct how hospitals discharge and evaluate patients. [3] Maryland hospitals cannot discharge any patient without a safe discharge plan in place. Although the bill allows a hospital to petition the court to remove a child from the facility, there are concerns about this approach given the time and resources needed to petition the court.

Additionally, the bill creates a Foster Children Support Fund and requires the Department of Social Services to pay a fine for each day a child is kept in the hospital beyond medical necessity into this fund. The fund is operated and administered by the Community Health Resources Commission collects. There are unanswered questions about the type of grant opportunities this would include and whether this funding would only be utilized for the benefit of foster youth.

When we craft policies that impact foster youth, it is imperative to remember our responsibility to ensure they have every opportunity to thrive and lead healthy, happy lives like their peers who are not in the care of the state. We must remember these experiences shape childhood memories and that most foster youth remember each placement—good or bad. On behalf of Maryland's hospitals, we extend our gratitude to Del. Reznik and the Appropriations Committee for bringing this issue into the public arena. **Our foster youth deserve nothing less than commitment from the state, hospitals, and other stakeholders to work together to address this issue and ensure they have access to the care and support they need.**

For more information, please contact:
Erin Dorrien, Vice President, Policy
Edorrien@mhaonline.org

[3] Centers for Medicare & Medicaid Conditions of Participation. 42 CFR § 482.43

Pediatric Hospital Overstay- Study Overview- HB 40

Uploaded by: Erin Dorrien
Position: FWA

PEDIATRIC HOSPITAL OVERSTAY DATA COLLECTION PROJECT

Maryland
Hospital Association

PARTICIPATING HOSPITALS

- Adventist HealthCare Shady Grove Medical Center
- Adventist Healthcare White Oak Medical Center
- CalvertHealth Medical Center
- Carroll Hospital
- Children's National Hospital
- ChristianaCare, Union Hospital
- Frederick Health
- Garrett Regional Medical Center
- Grace Medical Center
- Greater Baltimore Medical Center
- Holy Cross Germantown Hospital
- Holy Cross Hospital
- Luminis Health Anne Arundel Medical Center
- Luminis Health Doctors Community Medical Center
- MedStar Franklin Square Medical Center
- MedStar Good Samaritan Hospital
- MedStar Harbor Hospital
- MedStar Montgomery Medical Center
- MedStar Southern Maryland Hospital Center
- MedStar St Mary's Hospital
- MedStar Union Memorial
- Mercy Medical Center
- Mt. Washington Pediatric Hospital
- Northwest Hospital
- Sheppard Pratt Health System
- Sinai Hospital of Baltimore
- Suburban Hospital
- The Johns Hopkins Hospital
- TidalHealth Peninsula Regional Medical Center
- University of Maryland Capital Region Medical Center
- University of Maryland Laurel Medical Center
- University of Maryland Shore Medical Center at Chestertown
- University of Maryland Shore Medical Center at Easton
- University of Maryland Shore Medical Center at Dorchester
- University of Maryland Shore Medical Center at Queenstown
- University of Maryland Baltimore Washington Medical Center
- University of Maryland St Joseph Medical Center
- University of Maryland Medical Center
- University of Maryland Medical Center Midtown Campus
- UPMC Western Maryland
- University of Maryland Rehabilitation & Orthopedic Institute

WEEKLY AVERAGES

39 hospitals reporting

16 hospitals with at least one youth meeting “overstay criteria”

23 hospitals reporting no youth meeting “overstay criteria”

50 youth in hospitals meeting “overstay criteria”

25 youth in inpatient units

25 youth in the Emergency Department

26 Females, 23 Males

1 Non-Binary/Unknown Gender

HOSPITALS WITH OVERSTAYS

6 hospitals reported youth overstays every week

Baltimore City, Baltimore County and Montgomery County	Range of 1 to 18 youth per hospital	Averaging 40% of ED patients in overstays, 90% of patients in inpatient overstays

YOUTH HOSPITAL OVERSTAYS BY UNIT

Number of Reported Youth Overstays

70
60
50
40
30
20
10
0

0 1 2 3 4 5 6 7 8 9

Week #

Total youth in hospitals meeting "overstay" criteria
Total youth in ED
Total youth in Inpatient Unit

COMMON PATIENT PROFILES

Adolescents	Average age 14 years old
	Even split between males and females
	Waiting for DSS or waiting for inpatient psychiatric placement
Infants	Average age less than 1 year old
	Waiting for DSS or waiting for inpatient pediatric rehabilitation bed

PRIMARY REASONS FOR DISCHARGE DELAYS

Other

- Most frequently identified reason

Aggressive Behaviors

Diagnosed Development Disabilities and/or Autism with Psychiatric Features

Sexually-Reactive Behaviors

Age (Too young/too old for available youth placements)

*Additional reasons included in form: medically fragile, human trafficking victim, actual/suspected fire setting.

DEEPER DIVE INTO "OTHER"

STATE AGENCY PROCESS

- Waiting for Dept. of Social Services
  - Unable to place in a group home
  - No foster care placement identified
  - No available therapeutic foster care placement
  - Parents have abandoned patient or passed away
  - Guardian wants to relinquish rights
  - Waiting on interstate compact approval

AVAILABLE CAPACITY

- Waiting for inpatient psychiatric bed
  - No male beds available
- Waiting for a Residential Treatment Center (RTC) placement
  - Multiple denials from in state
  - Multiple denials from out of state
- Waiting for pediatric rehab bed

HB 406 CINA Place in Med FacilitiesI .pdf
Uploaded by: Evelyn Burton
Position: FWA

Testimony on HB 406
Date: February 15, 2022
From: Schizophrenia & Psychosis Action Alliance,
Evelyn Burton, Maryland Advocacy Chair
Position: Support with amendments

The Maryland chapter of the Schizophrenia & Psychosis Action Alliance (SPAA), a non-profit supporting and advocating for individuals with psychotic illnesses and their families, recognizes the problem of Emergency Department boarding and lack of appropriate residential programs for children in need of assistance (CINA). However, HB406 needs extensive amendments before we could support it. As written, HB406 would create barriers to access for in-patient psychiatric care for these children when needed. It would also prevent a judge from making a decision based on all current and pertinent information. It requires unreasonable discharge standards standards and finally, may conflict with a hospital's obligation to follow federal legislation (EMTALA) regarding the discharge and transfer of emergency department patients.

We do support establishment of a Foster Children Support Fund and a Task Force to Examine the Placement of Foster Children in Emergency Departments to collect data and study the issue more wholistically and make recommendations ways to address the issue with creating barriers to care, including recommendations on the creation of types and numbers of residential facilities and services needed.

We have specific concerns with the following sections and recommend they be changed or deleted as indicated below:

Page 3, Lines 7-8: As in hospital commitment hearings before an administrative law judge, the court should be able to consider all the evidence, not only the evidence by medical professionals. At those hearings, evidence by others such as family members, police, social workers, etc is also considered. It should be noted that Health General §10-632 does not place any limits on those presenting evidence at a hospital commitment hearing. For example medical evidence may be presented by a psychiatric nurse who is the attending medical practitioner. We recommend these line 7 be changed as follows: "evidence, INCLUDING EVIDENCE PROVIDED BY A LICENSED PSYCHIATRIST, PSYCHOLOGIST OR PSYCHIATRIC NURSE WHO HAS EXAMINED THE CHILD WITHIN THE PREVIOUS 48 HOURS that:"

Page 3, Lines 16 through 28: Delete all of these lines.

These provisions would limit the judge's ability to consider all pertinent information presented and, in some instances, prevent him from following the legislative intent of allowing the judge to order inpatient care when criteria 1-4 are met, including when inpatient care is needed for the protection of the child or others. In addition, some of the terms are vague and undefined, including "clinical staff" and "facility". A judge should be able to take into

consideration the finding of administration law judge, however it should not limit the judge's decision. Since there is no definition of the danger standard for commitment, the interpretations among administration law judges vary greatly. For example, some administration law judges only consider dangerous behavior that relates to actions in the hospital and not to behaviors that occurred outside the hospital. The judge needs to take all evidence into consideration.

We do not support placement of children in a hospital, emergency facility, or an inpatient facility merely because the Department of Health cannot find a suitable out-of-home placement for a CINA. However, this statement is not needed because if that were the only reason for placement, the other required criteria would not be met.

Page 4, lines 15-18: A psychiatric examination should also be required where appropriate. Add "AND IF APPROPRIATE A PSYCHIATRIC EXAM," AFTER "MEDICAL".

Page 4, Lines 19-23: This section should be deleted. It is a barrier to obtaining emergency care for a child that needs inpatient psychiatric care. First of all, the term "medical evaluation" is undefined. However, more importantly, if in the opinion of any professional eligible to EP, at any time, the child meets the requirements for an EP (has a mental disorder and presents a danger to self or others), that professional should not be prohibited from executing an EP, regardless of what an examination by someone else concluded 7 days ago. This would preclude treatment for children who were treated within the previous 7 days but released before they were stable or it was erroneously found 7 days ago that further treatment was not medically necessary.

Page 4, lines24-28: Four hours is an unreasonably short time to arrange for discharge. It was noted in testimony for HB 1832 that the Department of Health is not required to be seeking arrangements for placements on an ongoing basis and there is a constant need for suitable placements for children no longer in need of inpatient treatment.

Page7-8 Section 10-624 (C). Delete all. We have concerns that this section would violate federal law requiring emergency facilities to stabilize or transfer a patient to appropriate care.

HB 406 FWA NASW.pdf
Uploaded by: Judith Schagrin
Position: FWA

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.

Judith Schagrin, LCSW-C
Legislative Committee Chairperson

Mary Beth DeMartino, LCSW-C
Executive Director

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.

HB0406_CC_Keegan.pdf
Uploaded by: Kevin Keegan
Position: FWA

House Bill 406
Children in Out–of–Home Placements – Placement in Medical Facilities
House Appropriations Committee
February 15, 2021
Support with Amendments

House Bill 406 was introduced to address the issue of foster youth remaining in hospitals after discharge. Catholic Charities of Baltimore understands this issue and supports efforts to address the root causes and to be part of a solution that will also create accountability for those ultimately responsible.

Inspired by the gospel to love, serve and teach, Catholic Charities provides care and services to improve the lives of Marylanders in need. We are committed to a Maryland where each person has the opportunity to reach his or her God-given potential. We fulfill this commitment as a provider of behavioral health services to children, including many in foster care, through school based behavioral health services, out-patient mental health clinics, a residential diagnostic unit, a residential treatment center and a nonpublic special education school.

Children and youth should be in the least restrictive environment that fits their needs. We agree with the sponsor that children should not be left in hospitals after discharge. However, we believe the solution for this problem involves more parties than just local DSS and workers. This is a system wide issue that expands across the purview of other departments, most notably the Behavioral Health Administration in the Maryland Department of Health.

The issues we are dealing with are not new; children staying in hotels, sleeping at DSS offices, and being stuck in hospitals. The Baltimore Sun has documented all of these issues over recent decades. Most recently the MD Children's Cabinet published the "Interagency Plan: Developing Resources To Address the Complex Needs of Maryland Youth in Care Prepared By: State of Maryland Children's Cabinet April 2020". (The last public update to the plan was in February 2021.) This strategic plan is strikingly similar to the Interagency Strategic Plan created in 2008 under the prior administration.

The goal of any legislation should be to hold the State's Children's Cabinet and entire child-serving system accountable for implementing these strategies in a timely and robust fashion.

There are healthy discussions and efforts underway to address foster children stuck in hospitals, voluntary placements for children, crisis response systems for children, etc. The biggest mistake that we make is to treat these issues as separate and discrete. There is only one child-serving system, and it is housed across a number of agencies that must be accountable for working together to take care of all of Maryland's children.

The issues that exist are both long-term and short-term. There is an immediate need for youth crisis/treatment beds to alleviate the current stress on the system. There is a longer-term need for evidence-based preventative services to treat the behavioral health needs of Marylanders. The number one driver of entries to child welfare is behavioral health. Adult substance use is the number one driver of young children entering care. Youth and parent mental health issues are the primary driver of teens entering the system. The systems MUST come together. This isn't a political issue – the plan has already been written, multiple times, by consecutive republican and democrat administrations.

With this legislation, an oversight committee should be established that is responsible for urgently overseeing implementation of the above referenced Interagency Plan. The committee should have representatives from the legislature, DHS, MDH, local DSS, MARFY providers, attorneys for the youth, and other stakeholders. This Children's Cabinet should be required to provide the committee with regular progress reports. The youth and adults served by these programs deserve the very best our State can offer.

Thank you for your consideration of our views.

Submitted By: Kevin Keegan, Director of Family Services

HB 406.DRMtestimony.ChildreninOOHPlacements.Medica

Uploaded by: Megan Berger
Position: FWA

Empowerment. Integration. Equality.

1500 Union Ave., Suite 2000, Baltimore, MD 21211
Phone: 410-727-6352 | Fax: 410-727-6389
www.DisabilityRightsMD.org

HOUSE APPROPRIATIONS COMMITTEE
TESTIMONY OF DISABILITY RIGHTS MARYLAND
HOUSE BILL 406 – Children in Out-of-Home Placements-Placement in Medical Facilities

February 15, 2022

POSITION: SUPPORT WITH AMENDMENT

Disability Rights Maryland (DRM) is Maryland's designated Protection and Advocacy agency, and is federally mandated to advance the civil rights of people with disabilities. DRM advocates for systemic reforms and policies that improve services and supports for youth with disabilities, and ensures that their rights are protected. We regularly advocate for children in DHS care and custody who stay in clinical settings long past when they are recommended for discharge because DHS has not located a safe placement for them. In many cases, these children remain hospitalized for months past their discharge date. **House Bill 406 recognizes the grave impact that excessive time in hospital and institutional settings has on youth with emotional and behavioral disabilities.** HB 406 also implements critical reforms and safeguards that ensure that children and youth are not needlessly warehoused in emergency departments and hospitals and are returned to community placements and settings as quickly as medically recommended. DRM cautions, however, that the true root of the grave hospital overstay problems that this bill addresses will not fully be remedied until new community placements, preferably therapeutic foster care or small community group homes, are developed and funded, as well as preventive and wraparound services to prevent crises and psychiatric hospitalizations whenever possible. As such, **DRM supports HB 406 with an amendment directing that funds from the Foster Children Support Fund created by this bill may be used for a range of placements and supplementary services, including therapeutic foster care, provision of 1:1 aides for children, and other additional services that will enable children and youth to return to or remain in the community.**

We strongly believe that youth with disabilities have the right to live and thrive in their communities. DRM regularly receives calls from foster families, guardians and family members of youth in DHS custody who lack appropriate placements and services. Under the *Americans with Disabilities Act*, public entities, including DHS, are required to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). By definition, children overstaying their clinical treatments have no medical reason to be in a restrictive hospital setting and are appropriate for community-based placements or residential treatment programs. Further, children with disabilities have the right to a "free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living" under the *Individuals with Disabilities Education Act*. 20

U.S.C. 1400(d). Many of these children are denied their legal rights while hospitalized. When youth overstay hospital or inpatient treatments, the result is heartbreaking. Youth in overstay circumstances face significant harm, such as isolation, loss of friendships and significant relationships, severe trauma, and risk of abuse. Youth in these circumstances frequently cannot go outside or breathe fresh air for weeks or months on end, often receive zero education services or a paltry education through home-hospital teaching, and face daily living in highly sterile spaces.

Emergency rooms and hospitals are not designed to, nor do they provide, individual therapy, treatment, habilitation, ongoing behavioral support, and other services that children need to address the underlying behaviors and trauma that resulted in their hospitalization. These settings prioritize stabilization and medication of patients, with an eye to discharging them to ongoing services at the earliest possible date. Extending clinical stays beyond their medical necessity only hinders children and can exacerbate existing disabilities.

One of our previous clients, "Frank," [1] a thirteen year-old young man in DHS custody, was cleared for medical discharge from a hospital but was forced to wait in the hospital for two-and-a-half months while an appropriate community placement was located. Prior to his hospital admission, Frank lived with a foster family who were certified as therapeutic providers. This placement ended due to abuse from his then-foster mother, and the resulting instability resulted in Frank going into crisis and being admitted to the hospital for psychiatric treatment, where he remained for the two-and-a-half months. As a result of DRM's advocacy, he was finally moved to a temporary, 90-day placement at a Residential Treatment Center. Due to Frank's extensive abuse history, his being in a hospital environment was especially traumatizing. He had been removed from his biological home due to pervasive abuse and neglect, and his trauma at what he perceived as **abandonment at being left in an inpatient psychiatric unit for months** triggered numerous aggressive behaviors towards staff. The result was that he was physically restrained and injected with sedatives on multiple occasions. Frank's hospitalization disrupted a successful educational placement with caring teachers, and geographically separated Frank from his education guardian, who regularly spent time with Frank in the community. His education guardian calls Frank daily, and Frank always asked her when he would be able to "go home."

We acknowledge that DHS does submit applications to residential treatment programs and residential child care programs on behalf of hospitalized kids in their care and custody, and that it is difficult to find placements for children with challenging behavior. **Additional community placements, including therapeutic foster care and small community group homes, are urgently needed**. **Preventive and wraparound services are needed to help kids remain in the community and out of crisis.** Discharge planning should begin early in the child's stay, and back-up plans should be

[1] Our client's name has been changed to respect confidentiality.

identified. Additional collaboration between sister agencies like the Developmental Disabilities Administration and the Behavioral Health Administration should be encouraged. All too often, it appears that DDA, BHA and DHR engage in prolonged negotiations over who will accept responsibility for finding and funding a placement for the child. It is our conclusion that urgent changes are necessary to ensure that children and youth in DHS care and custody are discharged from the hospital at the earliest possible time and receive appropriate care and services in the community.

For the foregoing reasons, DRM supports HB 406 with Amendment.

Thank you for the opportunity to present this information to you today. For more information, please contact Megan Berger, Esq. at 410-727-6352 ext. 2504 or Megan.Berger@disabilityrightsmd.org.

2022-02-15 HB 406 (Oppose).pdf
Uploaded by: Hannibal Kemerer
Position: UNF

BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

CAROLYN QUATTROCKI
Deputy Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

FACSIMILE NO.

WRITER'S DIRECT DIAL NO.
443-463-0751

February 15, 2022

To: The Honorable Maggie McIntosh
Chair, Appropriatons Committee

From: Hannibal G. Williams II Kemerer
Chief Counsel, Legislative Affairs, Office of the Attorney General

Re: House Bill 406 – Children in Out-of-Home Placements – Placement in Medical Facilities – Oppose

---

The Office of the Attorney General urges the Appropriations Committee to unfavorably report House Bill 406. Although this bill recognizes a grave problem in serving children's basic needs, this bill does not provide a solution to the lack of resources that underpin that problem. House Bill 406 proposes to restrict foster children from accessing certain emergency inpatient mental health treatments and requires the local departments of social services to take custody of any children who remain in an inpatient facility longer than four hours after discharge.

House Bill 406 would compel the local departments of social services to remove children with complex mental health issues from inpatient mental health treatment facilities, even when the child was not previously in the care of the local department and the child's parents, guardians, or the local department cannot access an alternative that would serve the child's best interests and treatment needs. When a mental health facility recommends discharge of a child from inpatient treatment, Residential Treatment Centers (RTCs) are commonly identified as the most appropriate service for the child. Unfortunately, because most RTCs have lengthy waiting lists, the Department of Human Services has found that it takes, on average, two months to locate and place the child in a recommended placement—whether inside or outside of the State. Alternative settings are not equipped to manage the complex mental health needs of those youth. The use of those settings place the child, the child's caregiver, and the broader community at substantial risk.

The bill contains specific measures that deny foster children the same access to emergency mental health treatment that is available for other children. The bill would strip certain mental health professionals of the authority to certify the necessity of inpatient treatment for foster youth and it would prevent them from admitting a foster youth with a demonstrated medical need absent a showing of recent behavioral changes in the youth's condition. That differential treatment extends even to a foster youth's needs for emergent care for conditions that are not related to mental-health conditions.

Moreover, the bill strips the juvenile court of its role to make an independent determination of what serves to further the foster child's best interests. It prohibits the juvenile court from placing a child in an inpatient facility if (1) an administrative hearing officer has made a determination that the child does not require such treatment even though the local department was not a party to that proceeding or allowed to present evidence to the contrary; (2) undefined "clinical staff" of the child's current facility determine it is not necessary; or (3) the local department cannot locate a suitable, alternative placement. In divesting the juvenile court's ability to act in the child's best interests, the bill threatens to deprive foster youth of critical care that other non-foster youth could receive.

Finally, the bill unnecessarily provides a private right of action by the hospital, emergency facility, or RTC against DHS to remove the child and to levy a fine. That fine is paid to a Commission whose sole function is to increase access to community health resources but does not provide a solution to the problem.

We urge the Committee to issue an unfavorable report on HB 406.

cc: Del. Reznik and Appropriations Committee Members

hb406.pdf
Uploaded by: Sara Elalamy
Position: UNF

MARYLAND JUDICIAL CONFERENCE
GOVERNMENT RELATIONS AND PUBLIC AFFAIRS

Hon. Joseph M. Getty
Chief Judge

187 Harry S. Truman Parkway
Annapolis, MD 21401

MEMORANDUM

TO:	House Appropriations Committee
FROM:	Legislative Committee Suzanne D. Pelz, Esq. 410-260-1523
RE:	House Bill 406 Children in Out-of-Home Placement – Placement in Medical Facilities
DATE:	February 9, 2022 (2/15)
POSITION:	Oppose

The Maryland Judiciary opposes House Bill 406. The bill amends § 3-816.1 of the Courts and Judicial Proceedings Article, which governs out-of-home placement for children in need of assistance. The bill creates new restrictions and procedures for youth who are placed in a psychiatric care facility or emergency facility.

Although the Judiciary understands the intent of this legislation, implementation is problematic. First, the bill contains several mandatory provisions. The bill limits the court's discretion and authority to commit a child for inpatient care and treatment in a psychiatric facility. Specifically, the court may not commit a child for such treatment if: (1) an administrative law judge (ALJ) has made a determination that the child does not require such treatment; (2) clinical staff of the facility caring for the child has determined that the child does not meet the medical standard for hospitalization; or (3) commitment is sought due to the inability of a local department to find another suitable placement for the child. The bill also states that the court may not commit a child for inpatient care unless the court finds, on the record, that a licensed psychiatrist or psychologist has examined the child within the preceding 48 hours and made the requisite findings about the child's mental health.

This bill would strip the court of its authority to order a youth to be kept in a facility while the arrangements for his or her placement are being made. This includes, for example, a youth for whom a placement has been found, but at which there is a wait list, or a youth for whom the only available placement is out of state, and arrangements for transportation and other logistics simply cannot be made within the timeframe required by this bill. Removing the court's authority to order a youth to be held at a facility pending placement increases the risk of harm to both the youth and the community. It is often exceedingly difficult to find a placement for these youth, and the placements that exist are often out of state. Even when a placement can be found, it is not likely to be

feasible to transfer a child to that placement within the timeframe mandated by this bill, and the bill would strip the court of its authority to order a youth to be kept in a facility while the arrangements for his or her placement are being made.

The proposed language regarding administrative law judges would also have a significant impact on these hearings. The bill mandates that the findings of an administrative law judge are admissible as evidence in a hearing under this subtitle. The Department is not permitted to have a representative attend the hearings before the ALJ. This bill would effectively prohibit the juvenile court from conducting a full evidentiary hearing and would prevent the court from effectively making a decision that is in the best interest of the child. It would hamstring the court's ability to hear evidence and make findings of fact and would instead require the court to base much of its decision on the administrative law judge's findings, in essence substituting the ALJ's judgment for its own. This runs counter to the court's mandate to hear all the evidence and make a determination based on the best interests of the child.

cc. Hon. Kirill Reznik
Judicial Council
Legislative Committee
Kelley O'Connor

MCF_LOI_HB 406.pdf
Uploaded by: Ann Geddes
Position: INFO

HB 406 – Children in Out-of-Home Placements – Placement in Medical Facilities

Committee: Appropriations
Date: February 15, 2022
POSITION: Letter of Information

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling issue.

HB 406's goal is to address a pressing problem that has continued to get worse over recent years: the problem of children who are in out-of-home placements being stuck in inappropriate settings - namely hospitals and psychiatric facilities. This is part of a larger problem of a lack of resources for children and youth with intensive mental health needs and/or significant developmental disabilities and/or severe behavior problems.

There has been a strong impetus over the last decade to close residential psychiatric facilities for children and instead serve youth with community-based services, but robust community-based services have failed to materialize. In 2008, 848 children and youth were served in Maryland Residential Treatment Centers; by 2018 that number had dropped to 454. That decade saw the closure of hundreds of psychiatric residential treatment beds in Maryland, and since 2018 one more residential treatment center has closed. **Currently there are just 258 operational Residential Treatment Center beds in Maryland.** At the same time, the number of therapeutic group homes has been slashed. While the desire to serve children in their communities whenever possible is commendable:

- There are still children who need more intensive psychiatric services. These children have not gone away.
- Many services that would help to keep children and adolescents in their community placements, such as 24/7 Mobile Response and Stabilization Services, crisis beds, respite, and high-fidelity wraparound, don't exist in Maryland.

The dramatic decline in the number of psychiatric residential beds has had the consequence of children lingering in inpatient units, because there is nowhere appropriate for them to go on

discharge. Families sometimes refuse to take a child home from an inpatient unit because they feel they cannot care for them in their home, further creating a bottleneck.

This has had a domino effect – children now can sit in emergency departments for days, weeks and sometimes months, waiting for an inpatient bed. Youth with developmental disabilities in addition to mental health needs can be particularly difficult to place in an inpatient unit.

The problem of kids being stuck in medical facilities is larger than just children involved with the Department of Human Services, although these children are especially vulnerable. The entire system is clogged with children and families needing help. This issue has already been addressed by the Children's Cabinet, which developed an Interagency "Hospital Overstays Plan" in April 2020, which was updated in February 2021. While some of the components of the plan have been implemented, progress has been slow. DHS and MDH must move more urgently to enact the plan.

Contact: Ann Geddes
Director of Public Policy
The Maryland Coalition of Families
10632 Little Patuxent Parkway, Suite 234
Columbia, Maryland 21044
Phone: 443-926-3396
ageddes@mdcoalition.org

HB406 - Letter of Information.pdf
Uploaded by: Cameron Edsall
Position: INFO

CHANGING
Maryland
FOR THE BETTER

GOVERNOR'S COORDINATING OFFICES

Community Initiatives · Service & Volunteerism · Performance Improvement
Crime Prevention, Youth, & Victim Services · Small, Minority, & Women Business Affairs
Banneker-Douglass Museum · Volunteer Maryland · Deaf & Hard of Hearing

February 15, 2022

Chair Maggie McIntosh
House Appropriations Committee
Room 121
House Office Building
Annapolis, Maryland 21401

RE: HB 406: Children in Out–of–Home Placements – Placement in Medical Facilities

Dear Chair McIntosh and Members of the House Appropriations Committee:

The Governor's Office of Crime Prevention, Youth, and Victim Services is submitting this letter of information on behalf of the Children's Cabinet regarding HB 406: Children in Out–of–Home Placements – Placement in Medical Facilities. The Children's Cabinet includes the secretaries from the departments of Budget and Management; Disabilities; Health (MDH); Human Services; and Juvenile Services; as well as the State Superintendent of Schools for the Maryland State Department of Education and the Executive Director of the Governor's Office of Crime Prevention, Youth, and Victim Services.

This legislation seeks to change the circumstances under which a court may commit a youth for inpatient psychiatric care; establishes requirements and procedures for the placement by local departments of social services (LDSS) of certain children in medical facilities; authorizing certain psychiatric providers to petition a court to compel a local department to remove a child from said provider under certain circumstances; requiring the Department of Human Services (DHS) to submit a specific payment for violation of this legislation; establishing the Foster Child Support Fund to be administered by the Community Health Resources Commission; prohibiting an emergency facility from admitting or keeping a youth beyond a certain period of time under certain circumstances; and establishing the Task Force to Examine the Placement of Foster Children in certain psychiatric treatment providers.

For all inquiries, please contact
Cameron Edsall, Legislative Affairs Manager
410-855-2538
Cameron.Edsall2@maryland.gov

The issue of overstaying psychiatric necessity within an Emergency Department (ED) or hospital is extremely complex and involves multiple systems of care, each with its own policies and procedures. In an effort to decrease the number of youth experiencing a stay in an ED or hospital past medical necessity, the Children's Cabinet worked collaboratively to develop an Interagency Plan to Address Youth with Complex Needs[1].

Since the development of this plan, the following has been accomplished by Cabinet agencies:

1. Development of Psychiatric Residential Treatment Facility (PRTF)-Level Beds
   - In FY 21, the Governor provided $5 million in funding via a Notice of Funding Availability through the Maryland Department of Health (MDH) for providers that will develop programming targeted at the population experiencing overstays.
   - One provider is up and running in Western Maryland. Three youth that were in an active overstay were able to be placed into this program in December 2021. A second provider is building its operation and is anticipated to start receiving youth in summer 2022.
2. Community-Based/Respite Placements
   - 49 specialized high-intensity group home beds were created in 2020 through DHS.
   - A Statement of Need was issued in December 2021 by DHS to obtain 60 community-based beds for psychiatric respite care.
3. Mobile Crisis and Stabilization
   - MDH secured $4.8 million from an emergency COVID grant dedicated to mobile crisis and stabilization training, technical assistance, implementation, and direct services.
   - MDH is dedicating $1.57 million out of BHA's COVID-related Mental Health Federal Block grant dedicated to fiscal and quality monitoring of mobile crisis and stabilization, care coordination and related expenses.
   - MDH is dedicating $9 million out of BHA's COVID-related Substance Use Disorder Federal Block grant. Again earmarked to support and expand crisis services, care coordination efforts, training, monitoring, and oversight.
   - Through Project Bounce Back, to address social-emotional learning, MSDE is implementing a statewide Maryland School Mental Health Response Program to assist local school systems and provide technical assistance for accessing behavioral health services for students.
   - MDH (BHA and Medicaid) applied for and received a CMS technical assistance grant for almost $800,000 which is being used to engage Health Management Associates to assist the state in the process of including mobile crisis services into

[1] The Children's Cabinet Interagency Plan to Address Youth with Complex Needs can be found here: http://goccp.maryland.gov/wp-content/uploads/Childrens-Cabinet-Interagency-Hospital-Overstays-Plan.pdf

For all inquiries, please contact
Cameron Edsall, Legislative Affairs Manager
410-855-2538
Cameron.Edsall2@maryland.gov

a revised state plan amendment in order to fully access the 85% Federal match opportunity under the American Recovery Plan Act (ARPA)

4. Build-out of Evidence-Based Practices (EBPs)/1915i

   .
   - Maryland already has the capacity to access enhanced rates for certain EBPs under existing State Plan Amendment and Medicaid waivers (1915b and 1915i)

   - These areas are also under exploration for future expansion options through a technical assistance contract under grant funds primarily targeting crisis services, as these EBPs are an essential component of high intensity stabilization services for youth and families

   - Based upon a prior independent audit affiliated with the last Medicaid 1915b waiver renewal, the state recognizes the need to increase both the provider pool (Care coordination providers and 1915i service providers) as well as the utilization of both of these services. Goals include building out the availability of these EBPs and exploring barriers to families accessing these services.

5. Public Awareness Efforts/Relationship Building - State and Local, Public and Private
   - BHA is working on training for police engagement with mobile crisis teams in a collaborative partnership that supports developmentally appropriate engagement only when absolutely necessary.
   - Strong relationship building continues with the Maryland Hospital Association to partner in identifying possible overstays and coordinating a team to assist in putting a service plan in place.
6. Local Care Team (LCTs) Revitalization
   - The Children's Cabinet approved protocols directly linking hospitals with LCTs to open up communication flow for youth in or at risk of an overstay. The Maryland Hospital Association helped develop those discharge protocols and implementation is underway.
   - The Children's Cabinet dedicates $1.8 million in funding yearly for every Local Care Team to employ a Local Care Team Coordinator to facilitate the work being done.
   - Additional staff time support at the local Core Service Agency / Local Behavioral Health Agency are being supported on a county by county basis to the limit of funding availability.

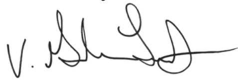
For all inquiries, please contact
Cameron Edsall, Legislative Affairs Manager
410-855-2538
Cameron.Edsall2@maryland.gov

Finally, the Children's Cabinet collaborated in the preparation of the FY 2021 Out-of-Home-Placement Report[2] which showed improvement in the population experiencing inpatient hospital care.

- 629 placements were identified as either a medical or psychiatric hospital stay which is a 23.4% decrease from FY 2020.
- 9% decrease in all out-of-home placements from FY 2020.

Please feel free to reach out to the Office if any additional information is needed.

Sincerely,



V. Glenn Fueston, Jr.
Executive Director
Governor's Office of Crime Prevention, Youth, and Victim Services

[2] The Children's Cabinet FY 21 Out-of-Home Placement Report can be found online here: http://goccp.maryland.gov/wp-content/uploads/2021-OOHP-Report.pdf

HB406_FosterKids_KennedyKrieger_LOI.pdf
Uploaded by: Emily Arneson
Position: INFO

Bradley L. Schlaggar, MD, PhD
President and CEO
Zanvyl Krieger Faculty Endowed Chair

A comprehensive resource for children with disabilities

February 15, 2022

The Honorable Maggie McIntosh
Chair, House Appropriations Committee
Room 121 House Office Building
Annapolis, MD 21401

Re: Letter of Information on House Bill 406 - Children in Out–of–Home Placements – Placement in Medical Facilities

Dear Chair McIntosh:

Kennedy Krieger Institute applauds Delegate Reznik for his sponsorship of House Bill 406 and for serving as a tireless advocate for some of Maryland's most vulnerable children and adolescents.

Maryland's youth must 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.

A child who is made to endure unnecessary or extended hospitalizations will have little to no access to educational and enrichment programs during that hospitalization. This scenario is not only detrimental to the child, it is also a significant resource drain limiting the hospital's ability to admit and treat more patients. Placement agencies are overwhelmed in their attempt to find the appropriate community placement and treatment options for the child owing to the scarcity of necessary resources in the community. Importantly, needed resources include not only pediatric inpatient acute and subacute psychiatric beds, but also skilled staffing necessary to serve patients utilizing those beds. As a consequence, the child often languishes in the acute care hospital or is placed in an inappropriate placement which typically leads to a return to the hospital.

As mentioned above, when a child experiences unnecessary or extended hospitalizations, they are subject to trauma. These traumas, also known as Adverse Childhood Experiences (ACEs), are associated with increased risk for a broad range of negative social outcomes, psychiatric and substance use disorders, health risk behaviors, and medical health problems.

Trauma, especially when untreated, can have devastating long-term adverse effects to an individual, including major health concerns (such as obesity, diabetes, depression, cancer, nicotine addiction, alcoholism, and others), and decreased life potential (such as decreased graduation rates, lower academic achievement, and others).

707 North Broadway • Baltimore, Maryland 21205 • KennedyKrieger.org
main 443.923.9300 • **facsimile** 443.923.9317 • **tty** 443.923.2645 • **email** Schlaggar@KennedyKrieger.org

Maryland, like arguably every State in the US, has a shortage of available mental health beds, staff, and resources to support children and adolescents who are in need. Staffing shortages predate the pandemic and, of course, have been exacerbated by it. It is critically important for the State to take stock of the current number of available pediatric psychiatric beds along with the current staffing of those beds, and then quantify the current and anticipated total bed and staffing needs, in order to calculate the magnitude, statewide, of the delta between current and needed resources. Additionally, the State should explore multi-layered solutions to include, but not be limited to, building staffing capacity to create communities of safety and well-being for Maryland's most vulnerable children.

We deeply appreciate the efforts of the Committee to engage in identifying and implementing needed solutions.

Respectfully,

Bradley L. Schlaggar, MD, PhD
President and CEO

HB0406 Children Out of Home Placement _ MHAMD LOI.

Uploaded by: Margo Quinlan

Position: INFO

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

Heaver Plaza
1301 York Road, #505
Lutherville, MD 21093
phone 443.901.1550
fax 443.901.0038
www.mhamd.org

House Bill 406 Children in Out-of-Home Placement –
Placement in Medical Facilities
House Appropriations
February 15, 2022

Letter of Information

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health, mental illness and substance use. We appreciate this opportunity to offer this letter of information regarding House Bill 406.

HB 406 establishes a timeline for out-of-home placements after a child is treated in a psychiatric facility. But it does not address the community treatment capacity issues that make it difficult to quickly discharge youth to an appropriate level of care.

In Maryland, community behavioral health services are often inaccessible to families and their children living with a mental illness. Recent closures of several residential treatment centers (RTCs) have only exacerbated this lack of access. More restrictive emergency departments are increasingly being utilized for behavioral health care due to the limited options in community behavioral health programs for children. The Maryland Hospital Association released data demonstrating that some children have been hospitalized "more than 100 days past medically necessary while they waited for a transfer."[1]

This is alarming. It is an example of a system that is woefully under-resourced to discharge minor patients from a hospital to a community program. Mental Health Association of Maryland has seen an uptick of helps calls from families seeking services for a child with a behavioral health concern that is stuck in the emergency department. These children are being forced to remain in a setting that could worsen their condition and further delay their recovery. HB 406 is a good start at responding to the issue, but additional measures should be taken to improve the children's system of care. The root cause of the issue of youth stuck in hospital overstays is a lack of placement options.

MHAMD supports the language creating a Task Force to Examine the Placement of Foster Children in Emergency Departments, particularly the mandate of the Task Force to make recommendations on, "a structure to maximize cooperation between the Maryland

[1] The Washington Post. "MD youths needing psychiatric care find long waits, drives." December 11, 2019. (https://www.washingtonpost.com/local/md-youths-needing-psychiatric-care-find-long-waits-drives/2019/12/11/516058a2-1c6e-11ea-977a-15a6710ed6da_story.html)

Department of Health and the Department of Human Services in securing appropriate placement for children in foster care." We believe that an approach which fosters collaboration across agencies will best serve youth as we all look toward the gaps in our child-serving system of care.

We applaud the leadership of the bill sponsor and the advocates who have been working to address this issue. MHAMD and our Children's Behavioral Health Coalition support the urgent need to address gaps in behavioral health resources for youth and would like to see further discussion and attention paid to this critical issue.

For more information contact:
Margo Quinlan, Director of Youth & Older Adult Policy: 410-236-5488 / mquinlan@mhamd.org

HB406_MARFY_INFO.pdf
Uploaded by: Therese Hessler
Position: INFO

February 15, 2022

House Bill 406
Children in Out-of-Home Placement - Placement in Medical Facilities
Appropriations Committee

Position: Letter of Information

The Maryland Association of Resources for Families and Youth (MARFY) is an association of private child caring organizations providing foster care, group homes, and other services through more than 200 programs across Maryland. The members of MARFY represent providers who serve Maryland's most vulnerable children who are in out of home placements due to abuse, neglect or severe mental health, and medical needs. We operate group homes, treatment foster care programs and independent living programs, primarily serving the foster care population as well as a juvenile services population.

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.

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.

1500 Union Avenue, Suite 2500, Baltimore, MD 21211
410-727-6367 | www.marylandnonprofits.org

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 youths 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.

1500 Union Avenue, Suite 2500, Baltimore, MD 21211
410-727-6367 | www.marylandnonprofits.org

- 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.
- While 14 counties in Maryland do have Mobile Crisis teams, not all of them serve children with Mobile Crisis. 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 regard 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

1500 Union Avenue, Suite 2500, Baltimore, MD 21211
410-727-6367 | www.marylandnonprofits.org

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, ensuring that all Maryland counties have Mobile Crisis that serve children and adolescents.
- 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.

1500 Union Avenue, Suite 2500, Baltimore, MD 21211
410-727-6367 | www.marylandnonprofits.org

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.
- Align rates that support social workers/therapists' pay in line with schools and hospitals.
- 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 breakdown in information sharing.

Resources to Implement Family First Prevention Services Act: While the concept is critical in regard 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.

MARFY recognizes the abundant challenges surrounding these issues and appreciates the effort of the Sponsor and the Committee to engage in meaningful conversation on solutions. Thank you.

1500 Union Avenue, Suite 2500, Baltimore, MD 21211
410-727-6367 | www.marylandnonprofits.org

HB 406 - Information - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: INFO

February 10, 2022

The Honorable Maggie McIntosh
House Appropriations Committee
House Office Building - Room 121
Annapolis, MD 21401

RE: Letter of Information – HB 406: Children in Out–of–Home Placements – Placement in Medical Facilities

Dear Chairman McIntosh and Honorable Members of the Committee:

Thank you for the opportunity to share our unique experiences and insights that relate to the core of what House Bill 406: Children in Out–of–Home Placements Medical Facilities (HB 406) seeks to address. MPW/WPS appreciate the sponsors' attempt to put into motion procedures to protect vulnerable children harmed by unnecessary hospitalizations due to insufficient community-based treatment options.

The Maryland Psychiatric Society (MPS) and Washington Psychiatric Society (WPS) are professional organizations of over 1,000 psychiatrists that work to foster high-quality, accessible, culturally humble comprehensive, effective, and patient-centered care for Maryland residents living with mental health and substance use conditions. MPS/WPS's mission is to advocate for the highest quality of care for all Maryland residents living with mental health and substance use disorders. In addition, the societies work to ensure that historically disadvantaged and marginalized individuals have access to culturally respectful, comprehensive treatment, serve and represent the professional needs of Maryland psychiatrists, including underrepresented and diverse voices within the psychiatric community, and collaborate with other professional, community, and government organizations to advocate for our patient's rights and interests.

Specific to HB 406, MPS/WPS represent psychiatrists across the state, including psychiatrists with subspecialties such as child and adolescent and forensic psychiatry, many of whom work in inpatient units with some of the most complex clinical and social cases. Unfortunately, inpatient pediatric services are already lacking in beds for critically ill patients, and the length of stay of children and adolescent patients waiting for an inpatient bed in emergency rooms has increased over the past few years. This reality has only worsened with the high demand for acute services that hospitals have experienced during the pandemic. Sadly, child and adolescent psychiatry inpatient units often have patients admitted to acute services but cannot be discharged because, while clinically stable, they do not have a place to reside.

Over the past several years, due to insufficient community-based treatment, child and adolescent psychiatry inpatient units have experienced an alarming increase in the length of

Washington Psychiatric Society

stay for our young patients. Some children have been hospitalized for over 100 days beyond what is medically necessary. During these extended and unnecessary hospitalizations, children have little to no access to ongoing education, outdoor recreational activities, or community and family engagement, all of which contribute to the worsening of their mental health. This extended hospitalization is not only detrimental to the child, but it is also a significant resource drain limiting the ability of child and adolescent psychiatry inpatient units to admit and treat more patients.

The cost to the hospital and the state is significant, with inpatient services costing $2,109 per day on average. For children who have been hospitalized for over 100 days, the costs incurred by the hospital easily exceed $200,000. This critical funding could otherwise be dedicated to more efficient and appropriate treatment for multiple children. These long lengths of stay are attributed to a lack of appropriate community and inpatient placements, as well as lack of social supports, especially for youth who are under the care of the Department of Social Services when transitioning to out-of-home placement takes place and there is not an expedited process to place the child who is already stable clinically. The problem is even more pressing for children with neurobehavioral disorders such as autism spectrum disorder or other developmental disabilities.

This lack of capacity often results in children languishing in hospital emergency departments or inpatient units, and occasionally being placed out of state where they are segregated from their family and surroundings. The various channels of state government that are responsible for addressing the needs of these children are challenging to navigate for social workers responsible for finding appropriate placement prior to discharge. The responsible agency often varies based on diagnoses or age of the patient, and coordination is needed, but lacking when more than one agency or department is involved.

Children kept in medical facilities because of a lack of appropriate alternatives is a systemic problem and requires a comprehensive review by all the stakeholders. MPS/WPS thanks the sponsor of HB 406 for starting the discussion of these important issues by introducing this bill.

If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee