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NASW MARYLAND CHAPTER
National Association of Social Workers

Senate Budget and Taxation Committee
March 30, 2022

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, the end result of decades of neglect by our state government.

HB 406 as amended appropriately puts the onus of responsibility on the Maryland Department of Health to provide the beds necessary to accommodate children's treatment needs. In fact, if 25 'no eject, no reject' psychiatric crisis beds were opened, every 'stuck' child would have a safe and stable treatment setting for discharge pending the next step. Enabling youth on overstay to discharge would open in-patient beds and reduce unconscionable waits in the emergency rooms.

There are those who suggest that these children are stuck because caseworkers aren't doing their jobs. These people will share stories with you about uncaring local departments who "dump" children in the hospital and never look back, never even visiting. This is unfortunate, as scapegoating the workforce is simply a distraction from very real systemic failings.

A deeper dive to understand the real driver of 'stuck children' readily uncovers a crumbling placement system only worsened by COVID-related staffing shortages. In recent years, roughly 450 beds for children with complex needs have closed without no plans for replacement. As a reminder, DSS's 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.

Along with children and youth on overstay in hospitals, 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.

The authority responsible for licensing behavioral health programs to meet the treatment needs of those 'stuck' in the hospital 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.

What is most significant about HB406 is that it represents an important step forward to addressing the acute crisis in treatment settings for children and youth with high intensity behavioral health needs. Requiring that Maryland Department of Health, the agency with the authority to approve behavioral health treatment settings, authentically share responsibility with the Department of Human Services for a full continuum of treatment and placement options represents the start of a solution.

We ask for the following amendments:

On Page 10 insert on Line 17: "(One) representative of the National Association of Social Workers - Maryland Chapter" with knowledge and experience in extended hospital overstays for foster children.

This will enable the backing of an organization with a collective of knowledge and experience in the delivery of public child welfare services.

We also ask that Lines 9 through 14 be deleted on Page 7, a section referencing multiple notifications to the Mental Health Division of the Public Defenders Office by the local department with responsibility for the children.

Hospital staff are mandated by Md. Health-General Code 10-625 to notify the Mental Health Division in the Office of the Public Defender whenever children are hospitalized by certification. Furthermore, HB406 requires the appointment of a coordinator who will also be required to notify the OPD at prescribed intervals. For DSS to do so would be redundant and has no utility for the children.

In addition to the above amendments, we believe the following steps would go a long way to help address the very serious issues facing Maryland foster children:

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. Require MDH to develop 25 "no reject, no eject" psychiatric respite beds for children and youth as an appropriate alternative to overstay in hospitals or 'boarding' in an emergency room.

3. 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.

4. We understand there was an early February 2022 deadline for an RFP issued by DHS to create 35 new "Diagnostic, Evaluation Treatment" beds and 25 psychiatric respite beds. Did any providers bid on a contract? If not, the reasons need to be urgently explored.

5. 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.

6. 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.

7. Rate reform for providers, already many years in the making, has once again been put off, now until 2026. 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. The roughly $10 million spent currently on 1:1 staffing could be re-routed to the programs to strengthen services instead of hire outsiders.

8. 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," couldbe 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

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Executive Direct

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 duringthe 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.

- 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 foryouth 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 ofthe local department, caregivers are drained and desperate. Rarely do LCT partners haveresources 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.