Comments to the Draft Recommendations (dated July 27, 2016)

Comment 1: John Robison, Chief Executive Officer, Clifton T. Perkins Hospital Center

Some minor gammar/spelling edits:

- page 1, paragraph 3 "necks at **the** every point within..." should read "necks at every point within..."
- page 1, paragraph 4 "making longer-term recommendation...." should read "making longer-term recommendations"
- page 3, paragraph 2 "Sited studies included...." should read "**C**ited studies included....."
- page 8, 3rd bullet "Return to court request are tracked...." should read "Return to court request**s** are tracked...."
- page 9, paragraph 4 "suffering for those who get**s** caught up...." should read "suffering for those who get caught up...."

Question about page 12, 5th bullet point "Transfer policy to include" is that recommendation to mean ***DEVELOP*** a transfer policy to include....?

Question about all references to ALU verbage...is the intention to specify those beds as ALUs as defined by COMAR regs (which would be separate licensure from current hospital license) or is it a general term applied to a step down unit (ex: Transitional Care Unit) that would operate under existing hospital COMAR regs and hospital licensure? Don't mean to be so technical with this particular question, but believe the answer would certainly impact creation/opening of the 24 beds referenced in the report.

Comment 2: The Judiciary

On behalf of the Judiciary, we would like to submit the following comments (also submitted via the comment form) regarding the Forensic Services Workgroup Draft Recommendations dated 7/27/16:

The Maryland Judiciary appreciates the opportunity for meaningful input into this critical issue. While the report is reflective of the general discussion, the administrative and procedural recommendations directed at DHMH (namely, recommendations 3 and 5) are not a subject upon which the Judiciary could or should comment. In implementing any recommendations, the Department should strictly adhere to the relevant statutes and judicial orders.

With regard to Recommendation 5, judges ethically are not permitted to participate in policy development and/or decision-making functions of the Judiciary's executive or legislative partners. While the Judiciary will always makes itself available for questions, the Judiciary respectfully requests not to be included on the proposed Forensic Steering Committee.

Comment 3: Laura Cain, Disability Rights Maryland (formerly Maryland Disability Law Center)

1. Although the introduction notes that there was not unanimous agreement on every recommendation, the language in recommendation #1 implies that everyone agreed about the need for "some" more beds and opening an Assisted Living Unit. As our organization opposes both recommendations, we

request that the first sentence in paragraph 2 on page 4 use a qualifier, e.g., "some" or "many" before "membership.

2. The overview section should lay out the statutory provisions governing evaluations for competency to stand trial and criminal responsibility, and commitments upon findings of IST or NCR, as well any actual statutory time frames, rather than using undefined statements such as "honor[ing] court commitments within statutory time requirements, or "responding to court orders for commitment for evaluations as to criminal competency . . . ". For example, the statute authorizes a court to order the Department to, in its discretion, (1) confine the defendant, pending competency examination, in the hospital it designates; or (2) immediately conduct a competency examination of the defendant. Thus, the statute does not authorize the court to directly commit a person to a hospital. By contrast, the statute authorizes a court to order commitment to a facility designated by the Department for examination of criminal responsibility (but only if a medical wing or other secure unit in the correctional facility is not available). With respect to evaluations, the only time frames in the statute refer to when the defendant is entitled to have the evaluation report (7 days, plus extensions). With respect to commitment upon a finding of IST, the statute does not provide a time for when the defendant must be admitted to a hospital bed. It is fine to assert that everyone agreed that commitments and returns to court should be prompt, but the phrasing is misleading.

3. We are disappointed that the report does not include a recommendation to amend the statute to limit the maximum time a defendant may be under treatment to restore competency to stand trial to a time frame consistent with the literature and the National Judicial College's Best Practices Model, and adopted by numerous other states. In light of this failure, at the very least, we recommend that rather than limiting weekly review by the proposed Forensic Steering Committee to cases "approaching or already outside of the statutory time limits," the review include cases in which treatment has extended beyond 90 – 180 days.

4. While input was solicited on recommendations for improvements throughout the system, the draft report is limited to recommendations that can be implemented by the Department. This is an unfortunate omission – regardless of whether the judiciary, legislature or other entities would choose to act on any particular recommendation, omitting such recommendations in a public report on short and long-term solutions leaves a perception that only the Department is to blame for the "crisis" and only the Department can solve it.

5. Under the "potential" recommendation for medication over objection: rather than "settings other than a hospital" use "correctional settings." The facilitator brought this up in the context of forcibly medicating people in the community on conditional release. However, a recent Court of Appeals decision makes clear that any law proposing forcibly medicating people in the community is not going to withstand legal challenge. Therefore, if there is going to be any future discussions on the issue of expanding forced medication, it must be limited to correctional settings.

Comment 4: Crista Taylor, Behavioral Health Systems Baltimore

The draft is a good summary of what was discussed in previous meetings. I have a few specific comments but want to start with one overarching theme. Whenever possible, we should use person first, non-stigmatizing language in the document. The document itself references the need to address

stigma but some language in the document perpetuates it. For example, pages 1 and 9 reference "the mentally ill" or "mentally ill individuals." It is less of a label defining who the person is to use language like individuals with mental illness.

My specific comments are the following:

1. page 4 - 1B - I believe there was consensus on a need for ALU or step-down beds for state hospital clients to help with the movement through the system. However, I do not believe there was discussion let alone consensus that the addition of ALU beds should be within the the "existing DHMH infrastructure." There was discussion that ALU beds could possibly be better managed and help facilitate a more timely and appropriate discharge plan if run by a community provider.

2. Page 7 - 3A - 2nd bullet - It is not clear what is meant by adding case management staff to the Office of Forensic Services. This was not discussed in the work group and should receive more attention to develop more clarity around the specific case management OFS is being asked to do.

3. Local authorities (CSA, LAA, LBHA) play a large role in local communities in ensuring that the continuum of services meets the needs of individuals in the community. In fact this is a specific role mandated to local authorities from BHA. The role of local authorities needs to be added to this document. Specifically, at the top of page 7, first paragraph and also 3A, 2nd bullet about case management, local authorities should be added to the coordination process. Also, on page 12 where the need for a DHMH representative is needed to make financial decision, the local authority should be involved in this process as the funding would ultimately run through a CSA and the local jurisdiction would be responsible for ensuring the funding is used as ultimately intended. Local authorities are and should continue to be a regular participant in the coordination process as mandated by existing MOUs with BHA.

4. Page 11, 5th line - "loss of mental health beds in the 2000's" - what mental health beds? I believe you are referencing a loss of state hospital beds.

5. Page 10 - 4B - 4th bullet - concerning the non-discrimination clause - It states for anyone who "receives state funds." Can this also be applied to anyone serving Medicaid recipients?

6. Housing - the need for financial support of housing came up in every meeting. I think it is important to specifically mention this as a barrier to community service. Specifically there is a need for increased funding for things not funded by Medicaid or the FFS system. It is often barriers like this, housing or extra home care supports that are not funded by traditional rates that are barriers to an individual moving through the system and this should be clearer in the document as it was discussed in the work group meetings.