
MENTAL HEALTH CRISIS IN MARYLAND: A LACK OF
HOSPITAL BEDS FOR THE MENTALLY ILL PRESENTS
MARYLAND LEGISLATURE WITH CONCERNS ABOUT THE
LEGALITY AND PRACTICALITY OF DETAINMENT

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INTRODUCTION

“Nearly 20% of the hospital beds for the nation’s most severely ill and dangerous psychiatric patients were eliminated in the last five years, at the same time [as] demand for them skyrocketed”¹ The result has been “widespread waiting lists for hospital admission from jails and prisons, and pending or threatened civil rights lawsuits against states from coast to coast.”²

A rise in public awareness of mental illness in recent years coincides with a troubling trend of increasingly inadequate treatment available to patients. Perhaps one could understand if greater acknowledgement of mental health issues has led to more diagnoses and more hospital commitments, thereby straining the capacity of mental health treatment facilities.³ However, in Maryland, improved recognition of mental illness is not the sole reason for the lack of hospital beds available to patients who have been court-ordered to receive mental health treatment.⁴ “[M]ore people with profound mental illness are being arrested and booked into jails, while the number of beds at state hospitals” has rapidly decreased.⁵

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¹ *Psychiatric Hospital Bed Shortages “Beyond Disastrous” in 2016*, TREATMENT ADVOC. CTR., <http://www.treatmentadvocacycenter.org/home-page/71-featured-articles/3084-psychiatric-hospital-bed-shortages-qbeyond-disastrousq-in-2016-> (last visited Dec. 1, 2017).

² *Id.*

³ See, Dan Morse, *Mental-Health Crisis Ensnarers Inmates, Judges, Jailers and Hospitals*, WASH. POST, (June 7, 2016), https://www.washingtonpost.com/local/public-safety/mental-health-crisis-ensnarers-inmates-judges-jailers-and-hospitals/2016/06/07/b5379c7c-2aa1-11e6-a3c4-0724e8e24f3f_story.html.

⁴ See, Dan Morse, *Maryland Lawsuit Seeks Hospital Beds for Mentally Ill Inmates*, WASH. POST, (June 10, 2016), https://www.washingtonpost.com/local/public-safety/maryland-lawsuit-seeks-hospital-beds-for-mentally-ill-inmates/2016/06/10/185f288c-2f26-11e6-9de3-6e6e7a14000c_story.html.

⁵ Morse, *supra* note 3.

In Maryland, psychiatric inpatient capacity has “declined from about 3,000 beds in the 1980s to about 960 [beds] now.”⁶ This “shortage comes as 80 percent of those admitted to such facilities are arriving via the criminal justice system.”⁷ As a result, criminals in Maryland who have been court-ordered to receive treatment prior to or concurrent with serving their sentences are literally being turned away at the doors of hospitals.⁸ The Maryland Department of Health and Mental Hygiene (“DHMH”), the state department to which forensic patients are directed, reported in the summer of 2016 that “84 jail inmates are waiting for court-ordered bed space.”⁹ “Defense lawyers, prosecutors and detention center officials” agree that the problem has reached critical levels, and is “getting worse.”¹⁰ Current projections estimate that, even if the system were to be made more efficient, “an extra 216 beds would be needed” in state psychiatric hospitals over the next decade in order to meet the increasing need for statewide mental health treatment.¹¹

Many of the inmates who have been denied hospital treatment have been convicted of serious crimes, including attempted murder and arson.¹² Maryland judges, irritated by the inability of the DHMH to carry out their court orders, have begun to ask state health officials to “explain why inmates who are a risk to themselves or others cannot get a psychiatric hospital bed.”¹³ Baltimore Circuit Judge Gale E. Rasin issued orders requiring six DHMH officials “to show why they should not be held in civil contempt” for their failure to comply with a judge’s orders.¹⁴ Maryland’s current Health Secretary, Van T. Mitchell, was called into court by state judges to “explain why the state’s hospitals weren’t accepting defendants who were ordered into treatment after being found not competent to stand trial.”¹⁵ The inability of the state to provide treatment for these individuals has resulted in their extended detainment, despite not having been tried and sentenced.

The DHMH union representatives claim that the bed shortages are explained by “a deliberate policy of pushing care into the private sector.”¹⁶ The DHMH claims that it has had trouble finding private health care providers that are willing to take these difficult, often dangerous patients into their communities.¹⁷ Additionally, the DHMH argues that they cannot be held responsible for their lack of “capacity when [the state] is shutting facilities or units and [is] not willing to hire anyone” to fill

6 Michael Dresser, *With Psychiatric Beds Full, Mentally Ill in Maryland are Stuck in Jails*, BALTIMORE SUN, (June 8, 2016), <http://www.baltimoresun.com/health/bs-md-mental-health-beds-20160608-story.html>.

7 *Id.*

8 Morse, *supra* note 3.

9 Morse, *supra* note 4.

10 Dresser, *supra* note 6.

11 Morse, *supra* note 3.

12 Morse, *supra* note 4.

13 Morse, *supra* note 3.

14 Dresser, *supra* note 6.

15 Pamela Wood, *Maryland’s Mental Health Treatment Wait List Shortened*, BALTIMORE SUN (Sept. 14, 2016), <http://www.baltimoresun.com/health/bs-md-mental-health-beds-20160913-story.html>.

16 Dresser, *supra* note 6.

17 Morse, *supra* note 3.

positions required to provide the necessary treatments.¹⁸ The DHMH’s principal contention is that it is not being granted the minimum resources requisite for compliance with judicial orders.

A complaint brought pro bono by a prominent law firm in Maryland states that the “DHMH, by its actions and inactions, requires plaintiffs and class members to languish unlawfully in jail or detention facilities.”¹⁹ The complaint further accuses the DHMH of having handled similar cases in a “one-off” fashion in the past, while failing to address the defective system.²⁰ The result is that jails are serving as “de facto mental hospitals.”²¹ Housing patient-inmates in “facilities that were not designed to meet their needs . . . can be triple the cost of tending to other inmates.”²² Officials explain that it would be difficult to “design a system to treat these people as ineffectively and as expensively as” a jail.²³

These sorts of allegations worry state attorneys, who fear that if hospital beds are not available, cases against criminals requiring mental health treatment could be lost.²⁴ Delegate Kathleen Dumais²⁵ explained that “none of the judges she knows wants to release a potentially dangerous person” as a result of the state’s inability to provide court-ordered treatment to inmates.²⁶ However, the premature return of these often dangerous inmates to the communities in which they have committed crimes is the reality facing the public. Delegate Dumais further stated that “because the court orders actually commit the individual to the state Department of Health and Mental Hygiene—and not sentenced to the custody of the county or state correctional system—it creates a legal liability issue for the jails that might amount to illegal imprisonment”²⁷ In June 2016, concern within the community had begun to force the Maryland legislature to finally act to address the growing problem, rather than disregarding recommendations for action.²⁸

18 Dresser, *supra* note 6 (quoting Patrick Moran, president of AFSCME Council 3) (internal quotations omitted).

19 Morse, *supra* note 4 (quoting a complaint brought on behalf of four inmates who had been denied court-ordered treatment) (internal quotations omitted).

20 *Id.*

21 Dresser, *supra* note 6 (quoting Paul DeWolfe, Maryland’s chief public defender) (internal quotations omitted).

22 Morse, *supra* note 3.

23 *Id.* (quoting John Snook, Treatment Advocacy Center’s executive director) (internal quotations omitted).

24 Dresser, *supra* note 6.

25 Delegate Kathleen Dumais is a Democrat who represents Maryland’s 15th District, an area encompassing the western and northern portions of Montgomery County, in the House of Delegates. Delegate Dumais has served as Vice Chair of the Judiciary Committee since 2011.

26 Dresser, *supra* note 6 (paraphrasing Delegate Kathleen Dumais, a Montgomery County Democrat who serves as vice chairman of the House Judiciary Committee).

27 Wood, *supra* note 15.

28 Dresser, *supra* note 6 (“The state hired the CannonDesign consulting group about five years ago to study the system’s needs. In a 2012 report, the group noted severe deficiencies and recommended that the state add at least 216 mental health hospital beds. O’Malley administration Health Secretary Dr. Joshua M. Sharfstein rejected the recommendation in a 2012 letter to the legislature’s budget chairmen. He said it would be ‘premature to undertake the substantial expense of building a new facility’ Matthew A. Clark, a spokesman for Hogan, said the department is trying to create added capacity within its existing facilities. He would not commit to increased spending to add beds.”).

Part I of this Note will further examine the roots and landscape of the hospital bed shortage crisis in Maryland. In Part II, this Note will briefly examine similar crises experienced by other states, and explore the approaches of their legislatures in developing resolutions. Part III will explain the current approaches and proposals to resolving the hospital bed shortage crisis which are being debated and employed in Maryland. Finally, in Part IV, this Note will provide recommendations for further steps to alleviate the shortage of hospital beds available to mentally ill patients in Maryland, and will make suggestions to help prevent similar crises from occurring in the future.

I. ORIGINS AND LANDSCAPE OF MARYLAND'S MENTALLY ILL INMATE HOSPITAL BED SHORTAGE CRISIS

The Treatment Advocacy Center²⁹ recommends that a minimum of fifty hospital beds per 100,000 people be dedicated to the treatment of mental illness.³⁰ As of 2010, Maryland had 18.3 beds per 100,000 people.³¹ Since 2010, the total number of beds in Maryland decreased from 1,058³², to about 960 beds in 2016.³³ During roughly the same period of time, the population in Maryland has increased by about four percent.³⁴ As the population has continued to increase, the number of hospital beds available to treat those suffering from mental illness has declined. The ratio of hospital beds dedicated to the treatment of mental illness to the general population has declined over the first half of this decade. At the same time, groups such as the Mid-Atlantic Association of Community Health Centers (“MACHC”)³⁵ have successfully “improved recognition of mental health disorders” throughout the state;³⁶ effectively contributing to an increased acknowledgement of a greater population of mentally ill patients. The implication evidenced by these statistics is that, as the population of Maryland increases and more people are recognized as

29 *Who We Are and What We Do*, TREATMENT ADVOC. CTR., <http://www.treatmentadvocacycenter.org/about-us> (last visited Dec. 1, 2017). (“The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illness. The organization promotes laws, policies, and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses.”).

30 *Maryland*, TREATMENT ADVOC. CTR., <http://www.treatmentadvocacycenter.org/browse-by-state/maryland> (last visited Dec. 1, 2017).

31 *Id.*

32 *Id.*

33 Dresser, *supra* note 6.

34 *Quick Facts: Maryland*, US CENSUS BUREAU, <http://www.census.gov/quickfacts/table/PST045215/24> (last visited Dec. 1, 2017).

35 The Mid-Atlantic Association of Community Health Centers (“MACHC”) is a “non-profit membership organization, whose members consist of community, migrant and homeless health centers, local non-profit and community-owned healthcare programs.” MACHC is the foremost advocate for the health care needs of underserved residents in the state. See *Who We Are*, MID-ATLANTIC ASSOC’N OF COMMUNITY HEALTH CTRS., <https://www.machc.com/content/who-we-are> (last visited Dec. 1, 2017).

36 HEALTH MGMT. CONSULTANTS, ENVIRONMENTAL ANALYSIS OF MARYLAND’S PUBLIC OUTPATIENT MENTAL HEALTH SYSTEM (July 2005), <https://www.machc.com/sites/default/files/documents/Maryland%20Mental%20Health.pdf>.

suffering from mental illness, the availability of treatment afforded to these individuals is diminishing.

In the face of such obvious quantitative evidence of an impending crisis, one might expect the state to have taken action to correct this troubling trend—and, to a limited extent, it has. In 2011, the state hired the CannonDesign³⁷ consulting group to look into the implications of the trend and to make recommendations on how to avoid a crisis.³⁸ In 2012, CannonDesign filed a report with the state in which it identified numerous “severe deficiencies” with the current system, and recommended that substantial additional resources, including 216 new mental health hospital beds and the personnel to care for them, be allocated toward a resolution.³⁹ However, as Delegate Dumais explains, both the Democratic Governor, Martin O’Malley, in 2012 and his successor, Republican Governor Larry Hogan, have largely ignored the results of the investigation.⁴⁰ In 2012, O’Malley’s administration believed that it would be “premature to undertake the substantial expense of building a new facility.”⁴¹ Under Hogan’s current administration, the DHMH is “trying to create added capacity within its existing facilities” rather than “commit[ing] to increased spending to add beds.”⁴²

Clearly, financial considerations have been a major deterrent to expanding mental health treatment facilities.⁴³ “One person in a state facility bed costs more than \$200,000 per year,⁴⁴ according to the Community Behavioral Health Association of Maryland^{45,46} Accordingly, Hogan’s administration has sought alternative methods of ameliorating shortcomings in the system in the wake of the critical levels of backlog reached during the summer of 2016.⁴⁷ Since that time, “[t]he number of court-ordered individuals waiting to be treated in Maryland state

37 CannonDesign is an “integrated global design firm” that solves client and societal challenges. Among the portfolio of services offered by CannonDesign are Health Advisory Services. *See Our Firm*, CANNONDESIGN, <https://www.cannondesign.com/about/our-firm/> (last visited Dec. 1, 2017).

38 Dresser, *supra* note 6.

39 *Id.*

40 *Id.*

41 *Id.* (quoting O’Malley administration Health Secretary Dr. Joshua M. Sharfstein) (internal quotations omitted).

42 *Id.* (paraphrasing Hogan spokesman Matthew A. Clark).

43 *See* Vickie Connor, *Maryland Decreases Psychiatric Hospital Bed Backlog*, CAP. GAZETTE, (Sept. 16, 2016), http://www.capitalgazette.com/news/for_the_record/mdcpsychiatric-beds-20160916-story.html.

44 This figure includes the costs of personnel to care for and provide treatment to the patient, as well as the general costs of room and board.

45 The Community Behavioral Health Association of Maryland (“MDCBH”) “has been the leading advocacy organization for over fifty of Maryland’s community-based mental health and addiction treatment providers state-wide.” MDCBH advocates “for high-quality, community-based care for families and individuals with mental illness, addiction, and substance-use disorders by providing leadership and statewide coordination on important public policy, financing, preferred clinical models, and quality assurance issues.” *See About Us*, COMMUNITY BEHAV. HEALTH ASS’N. OF MD., <http://www.mdcbh.org/about-us> (last visited Dec. 1, 2017).

46 Connor, *supra* note 43.

47 *Id.*

psychiatric hospitals decreased by about 85 percent.”⁴⁸ This is largely attributable to the work group created by Maryland Health Secretary Van T. Mitchell.⁴⁹

Secretary Mitchell presented the findings and recommendations of the workgroup to lawmakers at the end of the summer of 2016.⁵⁰ The group concluded that “[b]ed availability is really based upon admissions and clinically appropriate discharges,” and that “[w]e have to manage that process on a day to day basis.”⁵¹ The group further determined that a shortage of beds was not the exclusive reason for backlog, but that lack of communication also played a critical role in the inability of treatment facilities to take in new patients.⁵² In the summer of 2016, the Behavioral Health Administration⁵³ (“BHA”) examined admissions and discharge data of mentally ill patients in Maryland’s designated mental health treatment hospital beds.⁵⁴ The BHA discovered ninety-eight cases of patients labeled “ready to discharge, yet who remained in the hospitals.”⁵⁵ Communication between hospitals and the various authorities to which these ninety-eight patients were to be released broke down such that the patients continued to occupy bed space, despite receiving medical clearance to be released.⁵⁶ The consequence was a contribution to the backlog which resulted in eighty-four inmates who had been court-ordered to receive treatment in one of those beds being denied admission to the hospital.

In addition to the debate surrounding the pervasive lack of communication, much of the discussion at Secretary Mitchell’s work group’s presentation was focused on the allocation of funding.⁵⁷ The DHMH “received an additional \$3 million from the state for [the fiscal year that started in July of 2016].”⁵⁸ However, this money was allocated throughout all of the DHMH’s operations, not exclusively to the resolution of the mental health patient backlog.⁵⁹ The American Federation of State, County and Municipal Employees (“AFSCME”), a union for public service employees, “asked for more properly trained staff and higher levels of compensation in the psychiatric hospitals”—both of which necessarily entail a greater allocation of funds.⁶⁰ Additionally, the BHA asserted that, “a lack of investment in community-

48 *Id.*

49 *Id.*

50 *Id.*

51 *Id.* (quoting Barbara Bazron, executive director of the Behavioral Health Administration) (internal quotations omitted).

52 *Id.*

53 The Department of Health and Mental Hygiene’s Behavioral Health Administration (“BHA”) was created to “develop an integrated process for planning, policy and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions. The BHA will, through publically-funded [sic] services and support, promote recovery, resiliency, health and wellness for individuals who have or are at risk for emotional, substance related, addictive, and/or psychiatric disorders.” See *About Us*, MD. DEP’T. OF HEALTH BEHAV. HEALTH ADMIN., <https://bha.health.maryland.gov/Pages/About-Us.aspx> (last visited Dec. 1, 2017).

54 Connor, *supra* note 43.

55 *Id.* (internal quotations omitted).

56 Wood, *supra* note 15.

57 Connor, *supra* note 43.

58 *Id.*

59 *Id.*

60 *Id.*

based behavioral health services” accounts for some of the backlog of pending patients in state facilities.⁶¹ In response to these requests for financing, Secretary Mitchell explained that the DHMH will “establish a committee to track the progress of state hospitals and continue to make recommendations.”⁶²

This non-committal tone has become all too familiar when state officials address the requests for funding to combat the mental health treatment shortage facing the state. Unwilling or unable to appropriate or redirect funds at the time they are desperately requested, officials have instead deferred any allocation in lieu of continued monitoring of the situation. The consequence has been that the issue has grown to the point that relatively menial capital injections, which once may have kept the system afloat, will no longer be effective in preventing future crises. Instead, a systematic overhaul, likely demanding extensive short-term investments, followed by regular funding will be necessary in order to address the circumstances which have led to the backlog crisis.

Any meaningful, enduring change in policy to alleviate backlog and address future conditions which may result in a similar situation will require coordination between the legislative and executive branches, and communication with the judicial branch. In crafting such resolutions, Maryland will find it useful to explore and examine the methods applied by other states in addressing similar crises.

II. APPROACHES OF OTHER STATES IN ADDRESSING MENTAL HEALTH PATIENT HOSPITAL BED SHORTAGE CRISES

The mental health crisis experienced by Maryland during the summer of 2016 is only the latest in a string of similar hospital bed backlog emergencies observed throughout the United States. “Over the past forty years, the United States has witnessed a systematic dismantling of a massive mental-health system of hospitals and asylums and replaced it with prisons.”⁶³ Similar to the trend in Maryland, “[t]he number of public psychiatric hospital beds available for mentally ill patients in America declined from 560,000 in 1955 to fewer than 60,000 in 2005.”⁶⁴ The reduction in hospital beds is largely attributed to “budget cuts for critical social-service programs.”⁶⁵ Clinical and legal concerns about managing dangerous patients in community treatment programs⁶⁶ has contributed to the skyrocketing rate of incarceration, which currently stands at approximately 716 out of every 100,000 people in the United States.⁶⁷ “Many patients lacked access to care because

61 *Id.*

62 *Id.*

63 Hannah Robertson Miller, “A Meaningless Ritual”: *How the Lack of a Postconviction Competency Standard Deprives the Mentally Ill of Effective Habeas Review in Texas*, 87 TEX. L. REV. 267, 270 (2008).

64 *Id.*

65 *Id.*

66 See Howard Telson, M.D., *Outpatient Commitment in New York: From Pilot Program to State Law*, 11 GEO. MASON U. C.R.L.J. 41, 44 (2000).

67 Michelle Ye Hee Lee, *Yes, U.S. Locks People Up at a Higher Rate than Any Other Country*, WASH. POST (July 7, 2015), https://www.washingtonpost.com/news/fact-checker/wp/2015/07/07/yes-u-s-locks-people-up-at-a-higher-rate-than-any-other-country/?utm_term=.675db33a9866.

community mental health centers were not funded or developed to the extent that originally had been planned.”⁶⁸

Throughout the nation, “[p]risons and jails have become the largest providers of psychiatric services in the United States,” with “more than 300,000 American prisoners . . . currently in need of intensive psychiatric services.”⁶⁹ In the words of Judge William Wayne Justice:

It is deplorable and outrageous that . . . prisons appear to have become a repository for a great number of . . . mentally ill citizens. Persons who, with psychiatric care, could fit well into society, are instead locked away, to become wards of the state’s penal system. Then, in a tragically ironic twist, they may be confined in conditions that nurture, rather than abate, their psychoses.⁷⁰

“In California, the number of . . . psychiatric beds available in hospitals statewide decreased by 2,700 . . . from 1995 to 2013 . . .”⁷¹ After facing a court-ordered hospital bed availability shortage crisis similar to that of Maryland, California made efforts to increase the number of psychiatric inpatient beds through 2016.⁷² “However, that increase becomes less significant when taking into account the increase in the state’s population over that period⁷³ and, more importantly, the dramatic decline in the number of hospital beds for more than a decade before 2010.”⁷⁴ Even after the increase in the number of psychiatric hospital beds in California, “[i]t still takes approximately 90 days from when the court orders placement in a state hospital to when the hospital can receive the inmate,” according to Assistant Sonoma County Sheriff Randall Walker.⁷⁵ California has about fifteen hospital beds per 100,000 people,⁷⁶ while, as noted earlier, the Treatment Advocacy Center recommends at least fifty beds per 100,000 people.⁷⁷ “The increase in beds in California was not enough to compensate for the loss over the past 20 years . . .”⁷⁸

California’s election to increase hospital beds for mental health patients is constrained by the budget “at the state level, where lawmakers must balance other community needs such as schools, roads and clean water with the need for more

68 Telson, *supra* note 67, at 43.

69 Miller, *supra* note 64 at 270–71.

70 *Id.* at 270.

71 Abby Sewell, *Mentally Ill Inmates are Swamping the State’s Prisons and Jails. Here’s One Man’s Story*, L.A. TIMES, (June 19, 2016), <http://www.latimes.com/local/california/la-me-mentally-ill-inmate-snap-story.html>.

72 See Martin Espinoza, *Decline in Psychiatric Hospital Beds Concerns Sonoma County Jail Officials*, THE PRESS DEMOCRAT, (June 5, 2016), <http://www.pressdemocrat.com/news/5689613-181/decline-in-psychiatric-hospital-beds>.

73 From 1995 to 2013, California’s state population grew by 20%. See Sewell, *supra* note 72.

74 Espinoza, *supra* note 73.

75 *Id.* (internal quotations omitted).

76 *Id.*

77 TREATMENT ADVOC. CTR., *supra* note 30.

78 Espinoza, *supra* note 73.

psychiatric beds.”⁷⁹ California’s decision to increase hospital bed funding despite its draw from an already strained budget has proven to be an exceptional measure rather than a standard approach. The majority of states, Maryland included, have employed a wait-and-see approach to address the critical shortage of beds available to inmates who have been court-ordered to receive mental illness treatment.

In Maryland’s neighboring state of Virginia, “increasingly expensive to operate and difficult to control” mental health treatment facilities began to be closed during the 1960s as lawmakers were optimistic about the reliability of emerging psychotropic medications.⁸⁰ Lawmakers increasingly forced the privatization of mental health treatment by limiting the funds allocated to public treatment and care of mentally ill patients.⁸¹ Paul F. Stavis, founding director of the Law and Psychiatry Center at George Mason School of Law in Arlington, VA, argued in 2000 that “[c]ommunity treatment is undoubtedly the future of care for persons with mental illness.”⁸² Stavis asserted that “the large and long-term psychiatric hospital has gone the way of the dinosaur,”⁸³ and that “programs like the Bellevue Pilot in New York City . . . hold much promise to combine suitable treatment, including supervision, along with the necessities for community survival.”⁸⁴

The Pilot was a study in the effectiveness of an outpatient mental illness treatment program at Bellevue Hospital in New York City.⁸⁵ The program included 142 participants, seventy-eight of whom had been court-ordered to receive mental health treatment.⁸⁶ The determination was that court-ordered patients responded equally well to the outpatient treatment as voluntary patients.⁸⁷ The Pilot ran from 1995 through 1998, when an independent evaluation firm delivered its final report to the New York legislature.⁸⁸ “Nine months later, New York passed ‘Kendra’s Law,’⁸⁹ which made involuntary ‘assisted outpatient treatment’ available throughout the state for five years beginning in November 1999.”⁹⁰

Outpatient commitment has come to be “viewed as a way to mandate treatment without depriving individuals of their liberty.”⁹¹ In the wake of research, such as the Pilot, “[s]ome form of outpatient commitment currently is available in over forty

79 *Id.*

80 Paul F. Stavis, *The George Mason University Civil Rights Law Journal & the George Mason University Law and Psychiatry Center Foreword Symposium Issue: First Annual Forum on Mental Illness and the Law*, 11 GEO. MASON U. C.R.L.J. 1, 3 (2000); *See also* Telson, *supra* note 67.

81 Stavis, *supra* note 81.

82 *Id.*

83 *Id.*

84 *Id.*

85 Henry J. Steadman, Ph.D., et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATR. SERV. 330 (2001), available at <https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.52.3.330>.

86 *Id.* at 331.

87 *Id.* at 332.

88 Telson, *supra* note 67, at 41.

89 “[‘Kendra’s Law’ was] named for Kendra Webdale, who was pushed to her death in front of a subway train by a man with a history of psychosis, repeated hospitalization, and outpatient medication noncompliance. Kendra’s Law broadens the scope of eligibility for and access to preventive outpatient commitment.” *Id.*

90 *Id.*

91 *Id.* at 45.

states and the District of Columbia,” although states have widely varying statutes outlining the requirements of outpatient commitment.⁹² In New York, “Kendra’s Law” has authorized courts to order Assisted Outpatient Treatment (AOT).⁹³ Under AOT, the counties are required to “[c]ontract for one or more AOT teams, which are based on the Pilot’s Coordinating Team.”⁹⁴ These AOT teams “are responsible for investigating cases of patients who may be eligible for court orders.”⁹⁵ AOT teams “are required to assist patients, families, and providers through the legal process, and to monitor patients in the program.”⁹⁶ The AOT teams in New York function as centralized points of information available to each patient, as well as to all parties concerned with the patient’s treatment. The availability of a single coordinating entity for each patient and the enhanced individual monitoring this provides has facilitated forensic patients’ expeditious movement through treatment by encouraging prompt transitions to outpatient care, thereby preventing a backlog of hospital beds.

It must be noted, however, that the outpatient treatment program in New York is not without complications of its own. The nature of outpatient treatment requires a “good working relationship with patients, family members, attorneys, and scores of mental health providers.”⁹⁷ If a patient lacks the fundamental infrastructure to succeed in an outpatient program, then outpatient treatment can be even less efficient and more costly than alternative measures. Additionally, outpatient programs present a new set of considerations for legislators and judges, as they must determine which criminals qualify to receive outpatient treatment and which do not.⁹⁸ “Outpatient commitment is an order to comply with treatment and services, and these must be available, appropriate, and of good quality for patients to do well.”⁹⁹ A “good quality” service requires “a specific treatment plan that includes providers for all of the services required.”¹⁰⁰ Some patients may require a few initial meetings with service providers, while others require on-going treatment in order to prevent relapse and re-hospitalization.¹⁰¹ Furthermore, critics of outpatient treatment argue “that it is unnecessary, interferes with civil rights, and stigmatizes individuals with mental illness.”¹⁰² Of principal concern are legal questions regarding the courts’ authority to dictate and monitor patients’ medications outside of prisons or court-ordered inpatient treatment facilities.¹⁰³

New York has not relied solely upon its outpatient treatment programs to alleviate the stress on its hospitals. The New York State Legislature has continued

92 *Id.* at 45–46.

93 *Id.* at 77–78.

94 *Id.* at 78.

95 *Id.*

96 *Id.*

97 *Id.* at 57–58.

98 *Id.* at 59.

99 *Id.* at 73.

100 *Id.*

101 *Id.*

102 *Id.* at 46.

103 *Id.* at 65–66.

its “longstanding policy of reducing the census of state hospitals” while, through the Community Mental Health Resources Act, “requir[ing] that the money saved be invested in a wide array of community-based services for individuals with serious and persistent mental illness.”¹⁰⁴ The result of this policy is that the monies initially intended to contribute to the treatment of mentally ill patients continue to be appropriated to that end — ideally in a manner which is both more effective and more efficient.

In Tennessee, current state law authorizes outpatient commitment, but not as an initial option.¹⁰⁵ Instead, in an approach referred to as “conditional discharge,” outpatient commitment “is permitted only after an individual is discharged from inpatient commitment.”¹⁰⁶ Current Tennessee law requires that a patient first be hospitalized in order to be eligible for outpatient commitment— “[t]hen, and only then, may a court release him to mandatory outpatient care.”¹⁰⁷ This statutory position results in judges choosing between releasing individuals without treatment, or forcing a hospital to take a patient with explicit instructions to recommend outpatient commitment at the next hearing.¹⁰⁸ The result is that “patients who do not need hospitalization end up in the hospital simply because of the language of the statute, and patients who might have benefited from outpatient commitment may fall through the cracks.”¹⁰⁹ Additionally, because some amount of time in a hospital bed is required for all patients regardless of whether or not they would benefit from immediate outpatient treatment, there is greater potential for backlog than in New York’s system, which allows judges to order outpatient treatment for qualifying patients without delay.

In Tennessee, a “current shortage of public hospital beds dedicated to mental health treatment means that individuals who have inpatient commitment orders frequently spend time in jail rather than in mental hospitals where they can get the help they need.”¹¹⁰ In 2010, Tennessee had just 18.1 beds per 100,000 people¹¹¹— slightly less than Maryland’s 18.3 beds per 100,000 people.¹¹² As in Maryland, the result is that “many of the mentally ill [in Tennessee] end up in prisons.”¹¹³ Proposals to amend Tennessee law in order to permit outpatient commitment as an initial matter argue that “initial outpatient commitment holds the promise of allowing treatment for those who do not require hospitalization, thus freeing up hospital beds for those who truly need them.”¹¹⁴ In Texas, lack of outpatient commitment programs has led to

104 *Id.* at 48.

105 Lori R. Holyfield, *One Fell Through the Cracks: Why Tennessee Needs an Initial Outpatient Commitment Statute*, 42 U. MEM. L. REV. 221, 225 (2011).

106 *Id.*

107 *Id.*

108 *Id.*

109 *Id.*

110 *Id.* at 236.

111 *Id.* at 244.

112 Justin Moyer, *Fewer Public Psychiatric Beds in Maryland, Virginia*, WASH. POST., (July 23, 2012), https://www.washingtonpost.com/opinions/fewer-public-psychiatric-beds-in-maryland-virginia/2012/07/23/gJQAnfsI5W_story.html?utm_term=.11d278975fd9.

113 Holyfield, *supra* note 106, at 244.

114 *Id.* at 246.

people with mental illness “return[ing] to jail so often, sometimes on minor charges, that they become familiar to the psychiatric staff.”¹¹⁵ These people have come to be known as “frequent fliers” because of the frequency with which they revolve through the jail system after being released without further care provided.¹¹⁶ One mentally ill patient, a thirty-nine-year-old woman, was booked forty-five times between 2001 and 2008 because she, like many others, is not properly supervised upon release and has nowhere but the criminal justice system to turn in order to receive treatment.¹¹⁷ The President of Mental Health America of Greater Houston¹¹⁸ (“MHAGH”), Betsy Schwartz, considers these policies to be “criminalizing mental illness.”¹¹⁹

In Harris County, Texas, where Houston is located, there are fewer than 1500 rooms “where the mentally ill can receive supervision or services.”¹²⁰ Current need for such rooms is around 10,000.¹²¹ Ms. Schwartz argues that “[m]any need to be placed in permanent supervised housing” in order to alleviate the strain on jails, where it costs around \$80,000 per person per year to house and treat mentally ill patients.¹²² Proponents of this plan believe that “the number of mentally ill cycling through jails and psychiatric wards can be greatly reduced” if inmates were not forced to receive treatment exclusively through their incarceration.¹²³

In Texas’s current system, many mentally ill patients “never fill their prescriptions or return to counseling” after they are released from their prison sentences.¹²⁴ Patients, who receive virtually no oversight and often lack the means, are unable to get the help that they desperately need in order to reintegrate into society.¹²⁵ For mental health staff in jails, it is frustrating to see inmates who have been stabilized during their stays “drift into psychosis” after their release.¹²⁶ In Texas, utilization of outpatient treatment for those suffering from mental illness could not only alleviate the strain on hospitals to receive mentally ill patients, but also help to mitigate the “frequent flyers” problem by assisting patients as they reintegrate into society.¹²⁷ One of the principal advantages of an outpatient treatment program would

115 Bill Murphy, *To Get Help, Mentally Ill Go in and out of Harris County Jail*, CHRON, (July 21, 2008), <http://www.chron.com/news/houston-texas/article/To-get-help-mentally-ill-go-in-and-out-of-Harris-1538856.php# page-1>.

116 *Id.*

117 *Id.*

118 Mental Health America of Greater Houston (“MHAGH”) is a mental health education and advocacy organization “focused on shaping the mental health of people and communities” in the area. The group works to “replace misperceptions and misunderstanding about mental illness with compassion and proper treatment; link people to mental health services; provide education and training for key sectors of the community; remove barriers to mental health care by facilitating change in systems and advocate for legislative solutions that address the vast unmet need for public mental health services.” See *About Mental Health America of Greater Houston*, MENTAL HEALTH AM. OF GREATER HOUS. <http://www.mhahouston.org/how-mha-works/> (last visited Oct. 12, 2017).

119 Murphy, *supra* note 116 (internal quotations omitted).

120 *Id.*

121 *Id.*

122 *Id.*

123 *Id.*

124 *Id.*

125 *Id.*

126 *Id.*

127 *Id.*

be regular monitoring of patients who are reentering society, whether from a hospital or from a prison. Absent support and accountability available to patients once they are no longer institutionalized, they gravitate towards the actions which initially led to their incarceration.

III. MEASURES TAKEN BY MARYLAND'S LEGISLATURE SINCE THE CRITICAL BACKLOG REACHED IN THE SUMMER OF 2016

Following the public outcry over the backlog of hospital beds experienced during the summer of 2016, Maryland has had some success in shortening the mental health treatment waitlist.¹²⁸ By the Fall of 2016, Maryland had reduced the number of patients who remained in jail as they awaited treatment to about a dozen¹²⁹—down from eighty-four patients a few months earlier.¹³⁰ In large part, this reduction is attributed to the release of “dozens of patients who were ready to be discharged to make room for court-ordered patients.”¹³¹ Furthermore, Health Secretary Mitchell, in a briefing before members of four legislative committees, explained that the DHMH is “planning to add a few more spaces for patients by shuffling money and resources.”¹³² Mitchell told legislators that “some minor renovations at Clifton T. Perkins Hospital Center in Jessup, [MD]—which houses patients with the greatest potential for violence—could add room for 16 more patients.”¹³³ According to Mitchell, the costs of the renovations would be about \$300,000, “and the money for salaries would come from reducing overtime costs elsewhere in the state hospital system.”¹³⁴ These proposals for additional financing from within the administration come in stark contrast to the pre-crisis approaches to dealing with hospital bed backlog.

Additionally, the state contracted with a private health care provider “to set up a 16-bed unit at Springfield Hospital Center in Eldersburg, [MD] to help patients ‘step down’ from inpatient psychiatric care to outpatient care.”¹³⁵ This approach coincides with the recommendations of Mitchell’s work group to improve “crisis services in the community and increas[e] outpatient treatment offerings.”¹³⁶ This proposal, unlike the approach of Texas, immediately reduces the population of inmates required to stay in hospitals, and may have the additional benefit of reducing the numbers of mentally ill who enter the justice system. Still, Delegate Erik L. Barron, a Democrat from Prince George’s County, believes that “more work needs to be done to keep mentally ill people out of the courts in the first place.”¹³⁷ Representatives of private mental health groups say that they “need more funding to treat people when

128 Wood, *supra* note 15.

129 *Id.*

130 Morse, *supra* note 4.

131 Wood, *supra* note 15.

132 *Id.*

133 *Id.*

134 *Id.*

135 *Id.*

136 *Id.*

137 *Id.*

they get out of state hospitals and to help people before they end up in the criminal justice system.”¹³⁸

Despite the progress of these initial steps to alleviate the backlog crises, some lawmakers have “said they expect the state to develop longer-term solutions.”¹³⁹ Accordingly, Secretary Mitchell’s work group was tasked with providing “recommendations on how to reduce unnecessary congestion in Maryland’s State Hospital System by providing improved efficiencies, maximizing appropriate throughput and providing for immediate system relief, as well as making longer-term recommendations that may require significant system-wide changes to prevent a similar backlog from occurring in the future.”¹⁴⁰

In their final report, Secretary Mitchell’s work group summarized their duties and objectives as follows:

The longstanding issues the Workgroup were asked to address included, but were not limited to, the lack of availability of State Hospital beds to complete court ordered forensic evaluations and honor court commitments within statutory time requirements; the length of time it takes for individuals assessed as ready for release following their commitment by the courts to return to court for disposition; appropriate placement of incarcerated individuals ordered for evaluation and assessed, but not yet adjudicated as incompetent; and the impact on state facility staff from state hospital census’ consistently being at or above maximum capacity, managing a predominantly forensic (vs. civil) patient population and not being staffed nor compensated based on a “forensic” classification.¹⁴¹

The work group concluded that the lack of treatment for these patients is not only due to the lack of hospital beds, but also to “the consequences of a disjointed system that, over many years, has created bottle necks at every point within the system; from initial evaluation to release to the community, and virtually every step in between.”¹⁴² The work group then provided six main recommendations to meet its given objectives:

1. Increase bed capacity within DHMH[;]
2. Increase availability of Community Crisis Services[;]
3. Expand the capacity of the Office of Forensic Services[;]
4. Increase outpatient provider capacity to meet the needs of forensic patients[;]
5. Centralize DHMH forensic processes[;]
- 6.

138 *Id.*

139 *Id.*

140 STEPHEN B. GOLDBERG, M.D., FORENSIC SERVS WORK GROUP, REPORT OF RECOMMENDATIONS 1, 1 (2016), <http://bha.dhmm.maryland.gov/Documents/Final%20Forensic%20Workgroup%20Report%20Revised.pdf>.

141 *Id.* at 2.

142 *Id.*

Increased education to reduce stigma in both the general public and the mental health treatment community.¹⁴³

Additionally, the work group offered several further recommendations which were considered, but upon which the work group was unable to make a consensus determination.

A. *Work Group Recommendation 1—Increase Bed Capacity Within DHMH*

The work group called for the “[i]mmediate opening of 24 inpatient hospital beds (one unit), initially on a temporary basis, to address current backlog of court committed individuals.”¹⁴⁴ In addition, the work group recommended the creation of twenty-four “step-down” beds to be implemented within the existing DHMH infrastructure.¹⁴⁵ Although this will add additional costs up front, it will provide more beds which can be operated at lower cost than an additional inpatient facility.¹⁴⁶ It will also immediately reduce the number of patients in inpatient beds and help reduce the backlog of court-committed individuals.¹⁴⁷

The work group also proposed “[e]xpedited contracting with community-based hospitals/systems to use private sector psychiatric beds.”¹⁴⁸ The ability to tap into the private sector psychiatric beds will “allow for expansion and contraction of use based on need.”¹⁴⁹ Finally, the work group calls for re-assessment of actual bed needs, both inpatient and step-down, after the previously stated improvements associated with bed numbers have been instituted.¹⁵⁰ Although adjustment of the number of beds available to patients is not the only factor that needs to be corrected in a system pervaded by inefficiencies, it will have an immediate impact on the backlog crisis.

B. *Work Group Recommendation 2—Increase Availability of Community Crisis Services*

The work group calls for an “[i]mmediate statewide assessment of currently available crisis services.”¹⁵¹ Existing mapping of crisis services by the Core Service Agencies needs to be updated to reflect the recent surge in demand for mental health treatment and services.¹⁵² The work group next recommends “determination of

143 Memorandum from Linda McMillan, Senior Legislative Analyst, to the Public Safety Committee and the Health and Human Services Committee (Oct. 7, 2016), http://www.montgomerycountymd.gov/council/Resources/Files/agenda/cm/2016/161010/20161010_PSHHS4.pdf.

144 GOLDBERG, *supra* note 141, at 6.

145 *Id.*

146 *Id.*

147 *Id.*

148 *Id.* at 6–7.

149 *Id.* at 6.

150 *Id.* at 7.

151 *Id.*

152 *Id.*

which active crisis services programs are most effective in responding to crises in a way that minimizes entry/re-entry into the criminal justice system.”¹⁵³ Finally, the work group proposes increased funding through reallocation/additional budget allocation to support the community crisis services, which have been determined to be effective.¹⁵⁴ Critical to preventing backlog is the prevention of entry into the forensic patient treatment system, wherever possible, as an initial matter.

C. Work Group Recommendation 3—Expand Capacity of the Office of Forensic Services

The Office of Forensic Services¹⁵⁵ (“OFS”) is the office within the DHMH charged with coordinating “all court ordered evaluations, monitoring those committed as incompetent to stand trial, not criminally responsible and individuals on conditional release and reporting back to the judiciary.”¹⁵⁶ The OFS is uniquely positioned to track data related to forensic services across all jurisdictions in the state.¹⁵⁷ Reorganization and expansion of OFS functions provides the opportunity to “improve[] efficiency across the system.”¹⁵⁸ The work group recommends an “[i]mmediate increase in the number and efficiency of forensic services staff.”¹⁵⁹ In order to do this, the state is advised to hire more outpatient evaluators in order to ensure timely evaluations and establish minimum training standards.¹⁶⁰ Next, the work group advises restructuring of the DHMH command chain in order to improve OFS reporting to the courts.¹⁶¹ The work group lays out a detailed plan to streamline communication between courts, evaluators, hospitals, out-patient caregivers, and the OFS that will consolidate “coordination of all statewide forensic services” and “ensure adequate resources are available to jurisdictions as they are needed.”¹⁶² Finally, the work group recommends “[e]xpedited review [by the OFS] of newly generated data to determine where to place existing resources and evaluate the need for additional resources, including inpatient and [s]tep-down [u]nit bed space needs.”¹⁶³ Implicit in the recommendation that the OFS be able to make determinations for future resource allocation based upon newly generated data is the need for the legislative and executive branches to acknowledge the preeminent

153 *Id.*

154 *Id.* at 8.

155 The Office of Forensic Services (“OFS”) “oversees services provided for individuals with mental disorders and developmental/intellectual disabilities who are court-involved.” See OFF. OF FORENSIC SERVS., <https://bha.health.maryland.gov/Pages/Forensics.aspx> (last visited Dec. 1, 2017).

156 GOLDBERG, *supra* note 141, at 8 (“They must coordinate with the outpatient evaluators, detention center personnel (both officers and contracted medical providers), State Hospitals, community-based hospitals, and courts from every jurisdiction to ensure statutory compliance with all court orders and reporting requirements.”).

157 *Id.*

158 *Id.*

159 *Id.*

160 *Id.*

161 *Id.* at 9.

162 *Id.*

163 *Id.*

position of the OFS on these matters, and to afford OFS suggestions appropriate weight.

D. Work Group Recommendation 4—Increase Outpatient Provider Capacity to Meet the Needs of Forensic Patients

Finding outpatient providers to take in forensic patients involves a new set of concerns. These patients are often stigmatized by society, but there are “also reasonably founded concerns about the additional workloads associated with this population, increased personal risk and/or increased liability treating those with a known history of violence, as well as the potential for negative impact on a clinic’s/provider’s reputation in the event there was a publicized negative outcome.”¹⁶⁴ Beyond the obvious benefit of decreased utilization of forensic beds, outpatient treatment helps to decriminalize mental illness by supplying much needed treatment without the intervention of the criminal justice system.¹⁶⁵

The work group recommends “[i]mmediate increase in support to existing providers who already accept forensically involved patients.”¹⁶⁶ In addition, the work group proposes providing treatment specialized “towards [the] management and treatment of forensic patients in an outpatient or residential setting” at no cost to outpatient providers willing to take on forensic patients.¹⁶⁷ The work group’s recommended support also includes “free”¹⁶⁸ legal advice and guidance to outpatient forensic providers.¹⁶⁹ These measures are directed towards making the prospect of treating forensic patients more appealing to private outpatient providers. Next, the work group advocates an “assessment of [the] outpatient provider reimbursement structure.”¹⁷⁰ The proposed reimbursement structure seeks to make treatment of forensic patients more attractive for outpatient providers, while remaining less costly than the inpatient alternative.¹⁷¹

E. Work Group Recommendation 5—Centralize DHMH Forensic Processes

One of the principle factors contributing to the critical backlog experienced in the summer of 2016 is the “dramatic change in the percentage¹⁷² of public mental health inpatient beds occupied by forensically involved persons.”¹⁷³ A successful

¹⁶⁴ *Id.* at 10.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ The concept of providing legal advice at no cost to outpatient forensic providers is somewhat misleading. In order to do so, the state would necessarily have to divert resources from the Office of the Attorney General to provide guidance to the outside providers.

¹⁶⁹ GOLDBERG, *supra* note 141, at 11.

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.* at n.6 (“In Maryland, the ratio of beds occupied by forensic vs. civil patients has changed from 38% forensic to over 90% forensic in less than 15 years.”).

¹⁷³ *Id.* at 10.

treatment system demands efficient use of available resources in the face of volatile demands.¹⁷⁴ The workgroup has recommended that the DHMH can address these issues by:

centralizing its management of both the forensic and hospital system, to include centralized admission, discharge and transfer policies; regular and coordinated communications with the Judiciary, Public Defenders and the Office of the State’s Attorney for justice involved patients; and consistent channels of communication and support for community providers that accept forensically involved persons.¹⁷⁵

The centralization of processes related to the delivery of forensic services would demand the establishment of a “Forensic Steering Committee” (FSC), according to the work group.¹⁷⁶ This proposed committee would be chaired by the OFS, and its members would include “a state hospital representative as well as representatives and/or liaisons from the Judiciary, Office of the Public Defenders and State’s Attorney.”¹⁷⁷ On a weekly basis, the FSC would be charged with reviewing cases approaching or beyond statutory time limits, as well as establishing consistent admission, discharge, and transfer policies.¹⁷⁸ Perhaps most significantly of all, the FSC would be the central point of contact for all jurisdictions.¹⁷⁹ This will prevent much of the confusion and “finger pointing” that currently takes place when judges’ orders are not followed due to DHMH incapacity to fulfill their demands. In many regards, the proposed FSC is analogous to New York’s private AOT team structure, although the FSC would be a creature of the state and would wield more centralized authority.

The work group also claims that the “reassessment and reclassification of staff at all State Hospitals to a ‘forensic’ classification” is necessary in order to centralize the DHMH forensic process.¹⁸⁰ This recommendation is largely “due to the overwhelming percentage of forensic patients in all of the regional hospitals.”¹⁸¹ The work group’s instruction is that, because state hospitals have become de facto forensic hospitals anyway, they should require all relevant staff to receive forensic training, adjust staffing levels to manage a forensic population, and provide compensation consistent with providing forensic treatment.¹⁸²

174 *Id.* at 12.

175 *Id.*

176 *Id.*

177 *Id.*

178 *Id.*

179 *Id.* at 13.

180 *Id.*

181 *Id.*

182 *Id.*

*F. Work Group Recommendation 6—Increased Education to Reduce
Stigma in Both the General Public and the Mental Health Treatment
Community*

“The impact of stigma cannot be overstated and its insidious consequences can only be overcome through education.”¹⁸³ The work group has included a three part educational campaign directed at reducing stigma in the public, as well as among mental health professionals. First, the work group advises “[i]mmediate inclusion of anti-stigma education for providers who receive training as per” the previous recommendations.¹⁸⁴ Next, the work group proposes the “[r]apid development/expansion of public anti-stigma educational programs, including use of Crisis Intervention Training (CIT) for police and first responders.”¹⁸⁵ Finally, the work group suggests “[e]xpeditious inclusion of anti-stigma educational funding in [the] next budget cycle and state support to pursue grant funding.”¹⁸⁶

*G. Additional Work Group Proposals Discussed But Not Formally
Recommended*

In addition to these six recommendations, the work group discussed, but was unable to reach a consensus, on (1) required medication in settings other than a hospital, (2) increased use of Psychiatric Advanced Directives, and (3) outright privatization of the forensic patient care, including court-ordered evaluations and hospitalizations.¹⁸⁷ Perhaps the work group was unable to reach a consensus due to the litany of legal and practical questions that arose from these approaches. As a result, it is doubtful that the state legislature will seriously consider adopting any of these three proposals.

Many of these recommendations will appear before the Maryland General Assembly in various bills and budgets during the first session of 2017. It is worth noting that all of the work group’s recommendations would require additional funding in order to achieve the stated goals. This will be problematic as Maryland begins to prepare its 2017 budget¹⁸⁸ because of the financial strain that Maryland faces with its current budget. As Maryland legislators prepare for the January 2017 legislative session, they face “[r]evenue projections that have proven unreliable,” and “mandated spending that grows every year whether it’s affordable or not”¹⁸⁹ Projected spending “exceeds projected revenues for the coming fiscal year by about \$400 million,” and there is little room for expansion of programs, which are instead

183 *Id.*

184 *Id.* at 14.

185 *Id.*

186 *Id.*

187 *Id.*

188 According to the DEP’T OF BUDGET AND MGMT., <http://dbm.maryland.gov/budget/Pages/FAQs.aspx> (last visited Dec. 1, 2017), Maryland operates using a fiscal year running from July 1 through June 30.

189 Editorial, *Maryland’s Budget Problems*, BALT. SUN (Dec. 12, 2016), <http://www.baltimore-sun.com/news/opinion/editorial/bs-ed-maryland-budget-20161212-story.html>.

more likely to see budget cuts.¹⁹⁰ Consequently, many of the long-term approaches suggested by the work group will likely be postponed or forced to obtain funding through reallocation or outside grants. The most effective work group proposals will be those which propose a transformation within the current mental health treatment infrastructure, rather than those which seek further investment in order to change the current process.

IV. RECOMMENDATIONS FOR FURTHER ALLEVIATION OF HOSPITAL BED SHORTAGE AND FOR PREVENTION OF FUTURE BACKLOG CRISES

In a reality of finite resources and unforeseeable complications, there is no single prescription which might resolve the problem of backlogged forensic patients awaiting placement in hospital beds so that they can receive court-ordered treatment. Instead, a multi-faceted approach is required, both to account for unanticipated obstacles and to avoid the need for substantial investment in a single approach. In light of this Note's examination of other states' responses to similar mental health hospital bed shortages, as well as Maryland's implemented and proposed responses, Maryland should adopt the following three approaches: (1) commit to a scheduled increase in hospital beds available for the treatment of mentally ill patients which corresponds to the recent rate with which mentally ill patients have been increasingly committed to hospitals; (2) centralize and streamline communication between the courts, the patients, the patients' families or caregivers, the OFS, the DHMH at large, and private outpatient institutions; (3) enhance the prominence of the role of outpatient care in the treatment of both forensic and civil patients.

A. *Proportionate Increase in Hospital Beds*

In its 2016 report, the Treatment Advocacy Center found that the number of hospital beds per 100,000 people in Maryland has fallen to 11.7 beds¹⁹¹, down from 18.3 beds per 100,000 people in 2010.¹⁹² This decrease in beds occurred as the number committed to hospital beds in Maryland increased. Simply in order to keep pace with the increasing numbers of mentally ill patients being committed, the legislature should require that hospital beds be added annually over the next five years at the same rate that mentally ill patient hospital commitments, including court ordered commitments which were denied due to lack of space, have increased over the previous five years. This five year timeline should be evaluated annually to ensure that the recent spike in commitments of mentally ill patients was not merely an isolated phenomenon—although this is unlikely given that similar trends have been witnessed throughout the nation.

This measure is not focused at long-term repair of the system, so much as long-term prevention of a worsening situation. Presumably, medical and social recognition of mental illness will continue to grow in the coming years. In order to

¹⁹⁰ *Id.*

¹⁹¹ DORIS A. FULLER ET AL., GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS, 2016 AT 1 (2016), <http://www.treatmentadvocacycenter.org/going-going-gone>.

¹⁹² *Id.* at 15.

avoid encountering regular crises similar to that experienced in the summer of 2016, Maryland must commit to at least this minimal infrastructural expenditure. Admittedly, this approach is unlikely to be popular among fiscally conservative legislators. However, if financial justification for this measure is needed, it can be found in the relative costs of treating forensic patients in jails rather than in hospitals, or in the avoidance of impending civil rights lawsuits brought against the state for the wrongful detainment of mentally ill individuals who have not been able to stand trial. Additionally, the state cannot overlook non-financial justifications, including providing for the safety and interests of these patients, fellow inmates, and the communities into which these patients are eventually released.

B. *Centralization of Information and Communication*

Similar to the recommendation of Secretary Mitchell's work group, this note advocates the need for centralization of information among the relevant parties in order to simplify communication and avoid blame games. A commission, like the FSC proposed by the work group, would enable courts, the patients, the patients' families or caregivers, the OFS, the DHMH at large, and private outpatient institutions to have a central point of communication. This commission would allow for coordinated movement of mental health patients, forensic and otherwise, through their prescribed treatments, similar to the services provided by the AOTs in New York. Essential to the commission's functions would be holding treatment providers accountable to regular assessments of patients. Consistently administered assessments will allow the commission to promptly determine when a patient has moved beyond the medical need for an inpatient hospital bed and is ready to move to outpatient treatment, stand trial, or return to jail. A commission similar to the proposed FSC could track individual patients through the system and make determinations about bed placements based on individual circumstances.

The importance of the commission being in contact with *all* parties involved in the treatment process cannot be overemphasized. In the recommendations of the work group, and in the vast majority of outstanding research and proposed recommendations, there is one party conspicuously absent from most suggested resolutions: family. A commission that fails to realize the importance of a patient's familial support system has foregone perhaps the most valuable asset in the patient's treatment. The family element of treatment takes on a leading role, particularly in the context of outpatient care and prevention of "frequent flyers." After patients are released from inpatient facilities—assuming they are not incarcerated following a trial—they return to their homes. However, many of these patients feel estranged from their families due to the stigma associated not only with mental illness, but also from their involvement in the criminal system. It is not uncommon for patients to avoid reaching out to family for help obtaining their prescribed medication, or for transportation to appointments. The result is that these patients do not receive the treatment they need, they stop taking their medications, sometimes revert to self-medication, and, in a matter of time, often return to the penal system. At this point, the patients begin the process of evaluation and treatment anew, and the patients fall into the category of "frequent fliers."

The commission needs to be able to communicate with patients' families regarding treatment and release conditions. In order to do this, Maryland legislators must enact legislation that challenges or circumvents the federal Health Insurance Portability and Accountability Act¹⁹³ of 1996 ("HIPAA") in the context of mentally ill patients. Open communication between treatment providers and the families of adult patients suffering from mental illness cannot be obstructed. Excluding the family component from participating in the treatment deprives the state and the patient of a critical element of the resolution.

A centralized data collecting commission would help prevent Maryland from "blindly adopt[ing] and perpetuat[ing] costly practices that may contribute to bed shortages, possibly without any offsetting public or individual benefits."¹⁹⁴ A single body with jurisdiction over the entire process of treating mentally ill patients would have unlimited access to data and statistics. This body would be invaluable in analyzing potential future obstacles, and proposing meaningful resolutions to the legislature. As mentioned in discussion of the work group's proposed FSC, a centralized commission would require the ear of the legislature and the executive in order to have significance as a data-collecting, recommendation-providing entity. In the past, the recommendations of CannonDesign, the private consulting firm which the state hired to propose resolutions to the impending hospital bed shortage crisis, were overlooked. The state cannot afford to ignore the recommendations of the relevant experts in the field if it wishes to avoid similar crises in the future.

C. Increased Role of Outpatient Care

"Tools and strategies exist to intercept and treat people with serious mental illness before they need the last resort of a state hospital bed."¹⁹⁵ Diverting the flow of patients suffering from mental illness to outpatient facilities before they have reached a critical point at which they must be committed to a psychiatric hospital by court order allows for treatment within the patient's community. A patient receiving outpatient treatment is able to do so without significant interference to his or her daily life. Outpatient treatment allows patients to retain a semblance of normalcy in their lives, which eases the integration or reintegration into society.

Diversion of patients to outpatient treatment will decrease the need for those patients to remain in hospital beds, thereby limiting hospital bed backlog. Assisted outpatient treatment ("AOT") is "[a] treatment option that utilizes a court order to

193 See *Summary of the HIPAA Rule*, U.S. DEP'T OF HEALTH AND HUMAN SERVS., <https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html> (last visited Dec. 1, 2017) ("The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The "Privacy Rule," or *Standards for Privacy of Individually Identifiable Health Information*, establishes national standards for the protection of certain health information. The *Security Standards for the Protection of Electronic Protected Health Information* (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form.") (emphasis in original).

194 FULLER ET AL., *supra* note 192, at 3.

195 *Id.* at 4.

require adherence to treatment for mentally ill individuals with a history of treatment non-adherence and rehospitalization or reincarceration, among other criteria.”¹⁹⁶ Maryland is one of only five states that do not authorize AOT.¹⁹⁷ If the legislature were to authorize AOT, Maryland courts would be able to immediately divert patients who require treatment, but not necessarily of the intensity offered by a hospital. This measure would instantly impact the number of hospital beds available if a critical backlog appeared imminent. Furthermore, in conjunction with this section’s second recommendation, the court could work with the centralized information and communication body to evaluate patients and identify those who are appropriate for outpatient care. Maryland should adopt an outpatient program similar to that implemented in New York, which would allow patients to be ordered into outpatient care as an initial matter, prior to receiving treatment in a psychiatric hospital, and overseen by the centralized commission.

CONCLUSION

The critical shortage of hospital beds for mentally ill patients in Maryland in the summer of 2016 was foreseeable in light of the trends observed in mental health treatment and population in recent years. These trends have been similarly observed nationally, and many states have already enacted measures to address their own treatment deficiencies. Measures like those employed in California and New York to increase hospital bed numbers, improve systematic communication, and enhance the availability of outpatient treatment have met with success in reducing the shortage of hospital beds. Meanwhile, restrictive measures, like continuing to cut funding for hospital beds and limiting access to outpatient care, have increased backlog and amplified tensions among courts, patients, civil rights proponents, prisons, and state health departments.

In Maryland, some recent measures have been successful in reducing the immediate levels of critical backlog experienced in the summer of 2016. However, the state is still in search of long term resolutions to limited hospital bed availability. After reviewing the current recommendations by the Health Secretary’s work group and considering the unique social and economic concerns facing the state, this Note advocates three recommendations. First, Maryland must commit to preventing the growth of the disparity between mentally ill patients requiring psychiatric hospitalization and the number of beds available. This will necessarily demand the appropriation or reallocation of funds in future budgets to support an increase in treatment infrastructure. Second, the state needs to establish a centralized information and communication body that can coordinate with all relevant parties and improve systematic efficiencies. Finally, the legislature must adapt to provide for increased prominence of the role of outpatient care in the treatment of mentally ill individuals. A coordinated, comprehensive restructuring of mental health treatment in Maryland offers the state the best prospect of providing for the general welfare of its citizens.

¹⁹⁶ *Id.*

¹⁹⁷ TREATMENT ADVOC. CTR., *supra* note 30.