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Pamela Harris
State Court Administrator
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January 23, 2017

Honorable Edward J. Kasemeyer
Chair, Senate Budget and Taxation Committee
3 West, Miller Senate Building
Annapolis, Maryland 21401-1991

Honorable Maggie McIntosh
Chair, House Appropriations Committee
121 House Office Building
Annapolis, Maryland 21401-1991

Re: Maryland Judiciary Commentary on the Department of Mental Health and Hygiene (DHMH) Report: Alternatives to Residential Treatment under Section 8-507 of the Health General Article

Dear Chairman and Madam Chair:

Enclosed please find the Judiciary's commentary on the report of the DHMH Behavioral Health Administration pursuant to the 2016 Joint Chairmen's Report, page 72. The Judiciary's report was forwarded to the Department of Legislative Services on December 1, 2016 pending submission of the DHMH report on which it comments, which was submitted on January 20, 2017.

If you have any questions or concerns, please contact Kelley O'Connor, Assistant Administrator, Government Relations, at (410) 260-1560 or kelley.oconnor@mdcourts.gov.

Sincerely yours,

Pamela Harris

Pamela Harris

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cc: Honorable Dennis R. Schrader, Secretary, Department of Health and Mental Hygiene
Honorable Mary Ellen Barbera, Chief Judge, Court of Appeals
Honorable John P. Morrissey, Chief Judge, District Court
Honorable James E. DeGrange, Sr., Chairman, Public Safety, Transportation and Environment Subcommittee
Honorable Keith E. Haynes, Chairman, Public Safety and Administration Subcommittee
Kelley O'Connor, Assistant Administrator, Government Relations
Gray Barton, Director, Office of Problem
Matthew Bennett, Policy Analyst
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Cathy.Kramer@mlis.state.md.us

Court of Appeals of Maryland
Robert C. Murphy Courts of Appeal Building
361 Rowe Boulevard
Annapolis, Maryland 21401-1699

MARY ELLEN BARBERA
Chief Judge

December 1, 2016

The Honorable Edward J. Kasemeyer
3 West Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

The Honorable Maggie McIntosh
121 House Office Building
6 Bladen Street
Annapolis, MD 21401

RE: Maryland Judiciary Commentary on the Department of Mental Health and Hygiene (DHMH) Behavioral Health Administration's Report: Alternatives to Residential Treatment under Section 8-507 of the Health General Article

Dear Chairman and Madam Chair:

Enclosed please find the Judiciary's commentary on the report of the DHMH Behavioral Health Administration pursuant to the 2016 Joint Chairman's Report, page 72, Alternatives to Residential Treatment under Section 8-507 of the Health General Article.

If you have any questions, please contact Kelley O'Connor, Assistant Administrator, Government Relations Division at (410) 260-1560 or kelley.oconnor@mdcourts.gov.

Sincerely,

Mary Ellen Barbera

cc: Honorable Van Mitchell, Secretary Department of Mental Health and Hygiene
Honorable John P. Morrissey, Chief Judge, District Court
Honorable James DeGrange, Sr., Chair, Public Safety, Transportation and Environment Subcommittee

Honorable Keith E. Haynes, Chair, Public Safety and Administration Subcommittee
Pam Harris, State Court Administrator
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Maryland Judiciary Commentary on DHMH Report:

Alternatives to Residential Treatment under Section 8-507 of the Health – General Article 2016 Joint Chairman's Report (page 72)

Residential Treatment and Supportive Housing upon Initial §8-507 Commitment

The Judiciary concurs with the Behavioral Health Administration's conclusion found on page 7:

> While the Department is committed to providing the least restrictive setting for individuals in need of substance use treatment services, it is also committed to identifying medically appropriate placements that follow the levels of care under the American Society of Addiction Medicine's (ASAM) criteria. Therefore, the Department is required to place an individual under an §8-507 court order according to the results of an evaluation under §§8-505 or 8-506 of the Health General Article. As is current practice, the Department will continue to consider and place in a least restrictive alternative setting whenever the evaluation does not require a residential treatment placement, including outpatient treatment combined with recovery housing or other supportive housing.

The Behavioral Health Administration's emphasis on strict adherence to clinical appropriateness in determining placement is on point. The majority of defendants ordered placed in residential treatment pursuant to §8-507 are transferred directly from detention centers or prisons to residential treatment facilities. Of necessity, trial courts consider public safety in making the final decision to order §8-507 placement.

Confidence in the accuracy of the Department's §8-505 evaluations is critical. While the concept of the "least restrictive alternative" should govern the level of placement for substance use treatment commitment, it should be a least restrictive placement that is fully consistent with clinical appropriateness and public safety considerations. There is room for supportive housing coupled with out-patient treatment within the range of §8-507 commitments. Indeed, in Baltimore City there have been many successful completions of §8-507 commitments consisting exclusively of supportive housing coupled with out-patient treatment. Yet, overreliance on a supportive housing or recovery housing model might damage sentencing confidence and undermine the overarching justice reinvestment goal of encouraging viable treatment alternatives to incarceration that are consistent with public safety.

Commitment for residential treatment under §8-507 should also be viewed in relation to the far more extensive use of out-patient substance abuse treatment as a condition of "regular probation" and in light of the elements in Maryland's many drug courts and other diversionary programs. The use of §8-507 residential treatment varies from jurisdiction to jurisdiction. However, statutory §8-507 placements tend to be for defendants with longstanding substance use disorders and with a history of frequent detentions and incarcerations. In short, many defendants clinically appropriate for less restrictive treatment receive that treatment through drug courts, other diversion programs and regular probation, all avenues that fall short of an §8-507 statutory commitment.

The guiding principle should remain the best possible clinical assessment and placement based upon the most appropriate application of ASAM criteria. The Judiciary encourages the further development of comprehensive §8-505 evaluations with emphasis on mental health needs and verified history taking, with less reliance on defendant self-report.

Institutions for Mental Disease (IMD): Clinically Appropriate Treatment throughout the Course of the §8-507 Commitment

The Judiciary supports the Department's efforts to obtain federal financial participation for services provided to Maryland individuals residing in Institutions for Mental Diseases (IMD):

> Currently, Maryland is in the process of renewing its HealthChoice 1115 demonstration waiver. As part of its renewal application submitted on June 30, 2016, Maryland is seeking an amendment that would allow Medicaid payment for services in IMD's. This would (1) target private IMDS treating individuals with SUD treatment needs, and (2) allow adults aged 21 to 64 to continue to receive services in IMDs, rather than is general acute care hospitals. The Department anticipates receiving a final decision on January 1, 2017 for the waiver amendment request. Until a decision is made, the Department cannot move forward with the proposed changes. Id. at p. 4.

As noted, the current IMD exclusion has detrimental consequences for defendants who are under criminal justice supervision as well as for other persons seeking substance use treatment:

> The effects of the IMD exclusion are significant. The IMD exclusion incentivizes hospitalization in a general acute care hospital rather than in an SUD residential treatment program. These hospitalizations typically only treat the medical effects of individuals' illness while neglecting the illnesses themselves and the long-term consequences of the SUD's. The National Council on Alcoholism and Drug Dependence – Maryland noted that the IMD exclusion results in individuals seeking treatment in lower levels of care than what is clinically recommended. Id. at p. 4.

Federal funding participation for defendants committed pursuant to §8-507 and residing in IMD's certainly would be of great help.

True clinical appropriateness should govern not only the initial selection of the §8-507 treatment placement, but also the length of treatment. Health General §8-507 (j) allows the court to commit initially for not more than one-year and allows the Department to terminate treatment if continued treatment is not in the best interest of the defendant or the defendant is no longer amenable to treatment. That the potential federal reimbursement may cover only two 30-day stays annually for certain levels of care does not limit the continued court ordered **commitment** under this Maryland statute:

> More specifically, Maryland has applied for expenditure authority for otherwise-covered services provided to Medicaid -eligible individuals aged 21 to 64 who are enrolled in Medicaid MCO and reside in a non-public IMD for American Society of Addiction Medicine (ASAM) Residential levels 3.1, 3.3, 3.5, 3.7 and 3.7WM. Effective July 1, 2017,

> Maryland proposes to provide reimbursement for up to two 30-day stays annually for ASAM levels 3.7, 3.5 and 3.3.Maryland intends to phase in coverage of ASAM level 3.1 beginning on January 1. Id. at p. 5.

The clinically appropriate length of stay at the clinically appropriate level of treatment should be the guiding principle as to the duration of treatment as well as to the initial selection of the level of treatment. An arbitrary end to treatment contradicts the §8-507 statute. General funds payments may be required after the exhaustion of federally matched payments to assure the continuation of clinically appropriate treatment throughout the commitment period.

State General Funds Should Continue to be reinvested in Residential Treatment, Supportive Housing and Recovery Housing Consistent with each Defendant's Continuity of Care Plan

The 2016 General Assembly prioritized §8-507 treatment and reaffirmed the legislative intent for expeditious placement upon the execution of an §8-507 commitment order. "Prompt" placement was replaced by "immediate" placement. A subsequent hearing was authorized at 21 days after the signing of the commitment order. This legislative change was driven, in part, by the Justice Reinvestment Act goal of redirection of state general funds from incarceration to clinically appropriate treatment-if such medically appropriate treatment is also consistent with public safety. The availability of federal funds for §8-507 placement would be ideal. However, even if federal funds are not forthcoming, there is true economy in appropriating adequate state dollars for viable treatment in lieu of incarceration. The per diem rate for most residential substance abuse treatment is comparable to prison and detention per diem rates. The benefit in slowing re-arrest and relapse through quality treatment justifies the clear policy decision made during the 2016 General Assembly Session to expedite §8-507 placements.

Defendants, committed under §8-507, who successfully complete residential treatment often step down to less intense treatment levels and wrap-around community services in line with a continuity of care plan. Probation orders are often amended to include special conditions regarding housing, medication, community mental health treatment, further substance abuse treatment, employment, education, day activity and the like. It has been understood during the last decade that aftercare planning is critical upon successful completion of the residential treatment aspect for the clear majority of §8-507 commitments. Protocols were established to focus residential treatment providers and others on the importance of developing viable continuity of care plans.

Supportive housing and recovery housing often play a key role as defendants progress through an §8-507 commitment. In Baltimore City, frequently, defendants move from a more traditional residential treatment facility to a supportive housing model as their §8-507 commitment successfully proceeds. A continuity of care plan following residential treatment and incorporating supportive housing or recovery housing along with other wrap around services should play an increasing role in more statewide §8-507 cases. However, a rigid requirement for such a change in housing is not justified as the §8-507 commitment moves forward. A step down is suitable only when it is consistent with the defendant's therapeutically driven continuity of care plan.

Proactive mechanisms are needed for matching competent treatment providers with clinically appropriate defendants

The addition of $3 million through the Governor's supplemental funding appropriation during the 2016 General Assembly Session was welcome. However, this funding spread across the existing three state procurement contractual providers has not resulted in immediate placement or even prompt placement. Treatment beds devoted to §8-507 defendants have increased, yet, providers continue to claim unused but available capacity. The rigidity of the procurement process has been criticized. Many trial judges, defendants and defense attorneys show a continuing reluctance to use §8-507 due to delays in placement.

Members of the Judiciary have worked, not only with BHA officials, but also with providers, criminal justice partners and many others primarily through the Behavioral Health Advisory Board, Forensic Committee in an effort to encourage additional mechanisms to match the clear §8-507 demand for placements with the apparent supply of Maryland residential treatment beds. The existing procurement contracts are valuable and form the backbone of the §8-507 placement system. Yet, effort is needed beyond renegotiation of the existing statewide procurement contracts. It is hoped that a plan based on sufficient public health, finance and substance use disorder expertise will emerge. Non-compliance with the clear legislative mandate of "immediate placement" is not an option.

Conclusion

Thorough evaluation is critical in the selection of the clinically appropriate level of §8-507 placement. Clinically appropriate treatment, in conformance with ASAM criteria, needs to be maintained throughout the duration of the commitment. Inadequate placements would undercut the viability of §8-507 as a treatment alternative to incarceration. Recovery housing and supportive housing have a valuable place within the §8-507 commitment regimen: in some instances as an initial placement and with greater frequency as a housing component of a continuity of care plan following residential treatment.

Demand for §8-507 beds continues to exceed the supply. The current statutory mandate of "prompt" placement has not been met. There is a forthcoming mandate of "immediate" placement. The expenditure of state general funds for clinically appropriate treatment, consistent with public safety, is an economical reinvestment. Moreover, federal funding participation would be welcome. The current three provider procurement contracts are essential. What continues to be needed is the development of a further mechanism to match the available capacity of competent substance use treatment providers with appropriate §8-507 defendants.